2002 Annual Report

The John A. Hartford Foundation

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.

"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."

John A. and George L. Hartford, founding fathers of The John A. Hartford Foundation

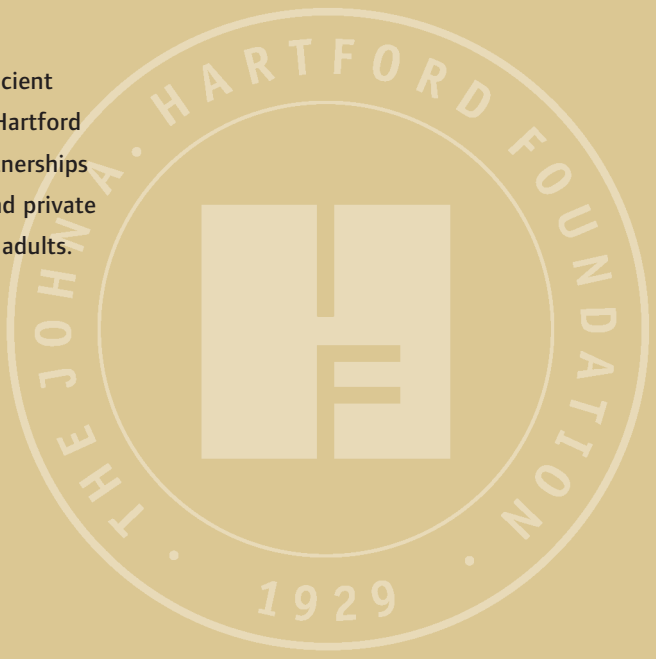
Statement of Purpose

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

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

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

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



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I AM HONORED TO INTRODUCE the John A. Hartford Foundation's 2002 Annual Report. Before describing the Foundation's accomplishments during the past year, I would like to recognize the extraordinary leadership and dedication of James D. Farley. At our last Annual Meeting, Jim, after more than 13 years at the helm, stepped down as Chairman of the Foundation's Board of Trustees. His stewardship has been exemplary, overseeing dramatic growth in the Foundation's endowment, grantmaking and programs. As the new Chairman, my goal is to continue to build on this impressive legacy.

This year's Annual Report features Project IMPACT (Improving Mood—Promoting Access to Collaborative Treatment for late-life depression), the Foundation's innovative work in the treatment of depression among older adults at seven sites nationwide. The research conducted through the initiative, coordinated by the University of California, Los Angeles, School of Medicine, offers significant hope to the large number of older adults suffering from depression.

Norman H. Volk,
Chairman

Project IMPACT, begun in 1999 with $8.4 million in funds from the Foundation, as well as additional support from several philanthropic partners, has tested a ground-breaking team model for depression treatment in primary care. This approach uses nurses or psychologists to serve as depression care managers, who collaborate with primary care physicians and a psychiatrist to aid patients in their recovery. Initial results, published in the December 11, 2002, issue of the *Journal of the American Medical Association,* showed that after 12 months, over half of patients in the IMPACT care model had a significant reduction in their level of depression, compared to fewer than 20 percent of patients receiving usual care. Exciting results of the effects of this team strategy on different racial and ethnic groups of elders, as well as its cost-effectiveness, will likely be ready by the end of this year.

In 2002, the Foundation also continued to invest in the training of health care professionals so they are better prepared to care for the growing number of older adults. Notably, the Trustees approved a three-year, $2 million grant to the Society of General Internal Medicine to embed aging issues more fully into academic divisions of general internal medicine. The project will also enhance the education of internal medicine residents, many of whom go on to become the front-line primary care doctors who diagnose and treat older patients.

The Trustees also made six grants, totaling $1.8 million, to Centers of Excellence in Geriatric Medicine—Duke University, Harvard University, Johns Hopkins University, Mount Sinai Medical Center, the University of Michigan and the University of California, Los Angeles. Begun in 1988, this program has been a cornerstone of the Foundation's efforts in academic geriatrics, providing nearly $26 million to 28 medical schools to increase the number of faculty knowledgeable in geriatrics.

Closer to home, New York City continued to recover from the September 11, 2001 attacks on the World Trade Center. The Foundation's $153,000 grant to the Council of Senior Centers and Services launched the Project for Responsible Emergency Planning, including an *Emergency Planning Guide for New York City's Senior Service Providers,* seminars on disaster preparedness planning for agency staffs, and an *Emergency Information Kit* for seniors. Through presentations and the World Wide Web, these resources are being shared with communities across the country.

As was the case throughout the country, Hartford's financial well-being was adversely affected by the bursting of the Internet bubble, followed by a series of corporate scandals and international events. Investor confidence plummeted and stock prices tumbled further in 2002 than at any time since the 1970s. We navigated the first two years of the bear market with limited impact on the endowment, but there were very few places to invest productively in 2002. Although the Foundation's efforts to diversify into alternative asset classes resulted in the portfolio outperforming the major market indices, the Foundation's assets fell to $490 million at year end.

The Foundation was able to increase grant payments in 2002 to $26.0 from $24.9 million in 2001. However, because of the decline in the value of its assets in 2002, the Foundation is reluctantly reducing its near-term grantmaking in order to maximize its future contribution to the aging field. Despite lower spending anticipated in 2003, growth in grant payments will have averaged more than five percent a year during the last decade.

As I write this, global uncertainties continue to dampen investor enthusiasm. However, we are confident that over the long term, the Foundation's portfolio is positioned to grow at a pace, though likely slower than in the 1990s, that will enable us to maintain our strong grants program.

At our Annual Meeting, the Board of Trustees moved through an orderly succession. James D. Farley became Chairman Emeritus. The Board was also pleased to elect Kathryn D. Wriston as President, and William B. Matteson as Secretary of the Foundation.

I am optimistic about the current and future prospects of the Foundation. It is a privilege to work with Hartford's dedicated and talented Board members and staff, each of whom ensures that we collectively provide important leadership to the field of aging and health for which the Foundation has become known.

Norman H. Volk

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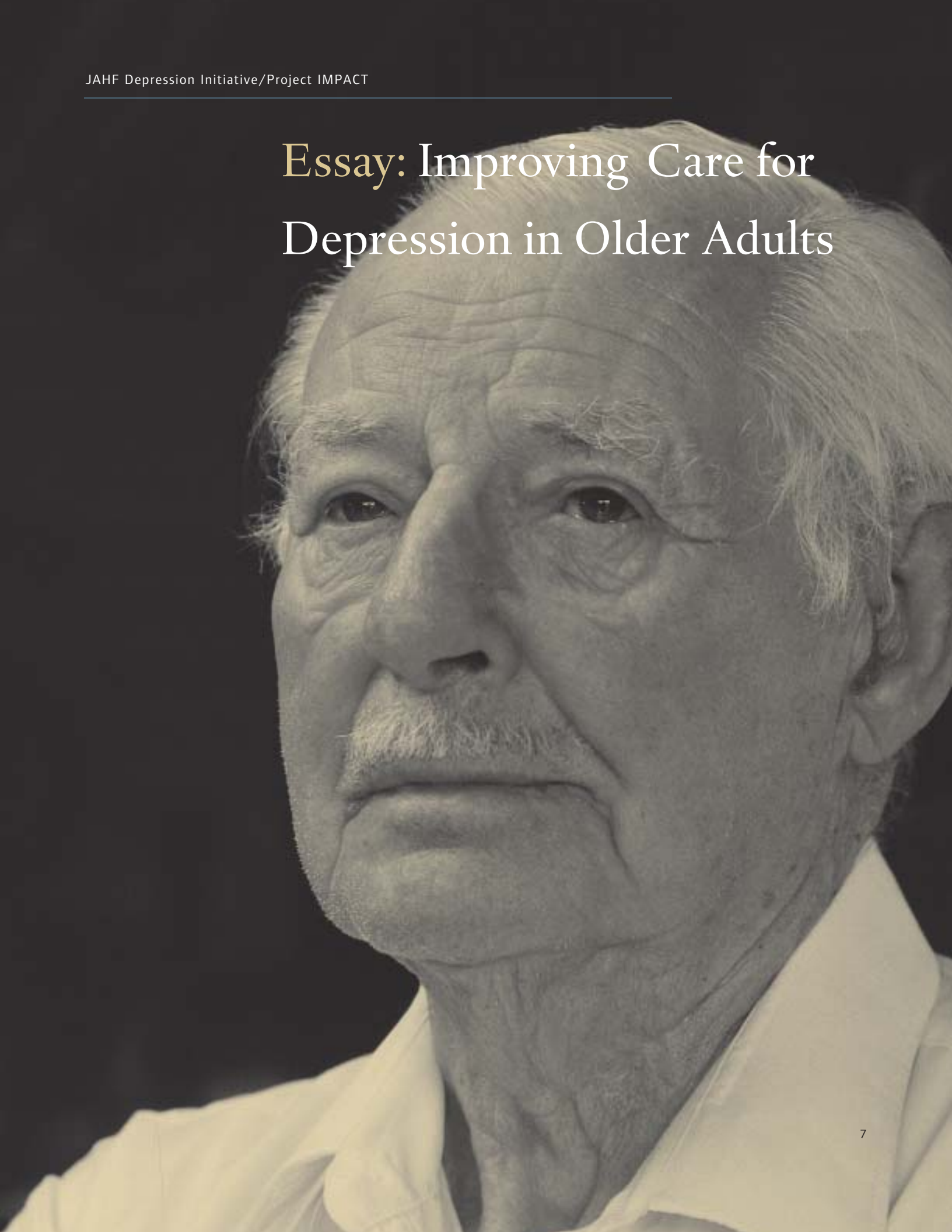
Essay: Improving Care for Depression in Older Adults



Phyllis, 78, never knew she suffered from depression.

Neither did her primary care physician at Group Health Cooperative, a non-profit organization that provides health care in the Seattle area. Fortunately for Phyllis, Group Health — a national leader in chronic illness research — was taking part in a test of a new approach to depression treatment in primary care settings. During a routine visit to her doctor, Phyllis filled out a one-page form designed to recruit individuals to Project IMPACT, a multi-site randomized clinical trial using a model of collaborative care developed with Hartford Foundation support.

Phyllis was surprised to receive a call telling her she might qualify for the depression project. "It really didn't dawn on me that I had been depressed for a long time. I just thought, this is how life is." Phyllis took a while to be convinced. When she finally understood that so many of her problems — among them, not feeling worthy — were symptoms of depression, everything changed. "It was like a revelation."

She met regularly for a number of weeks with Kathleen Nierenberg, a Group Health nurse trained by the project as a depression clinical specialist. "It was wonderful to talk to somebody who was interested and compassionate. It was very therapeutic." But Phyllis didn't really improve until she started taking Prozac, an antidepressant, at Nierenberg's suggestion. It changed her life. "My marriage has improved. So has my relationship with my children. I'm more tolerant, and that's helpful in any relationship." She worries less about her two children, five grandchildren and six great-grandchildren. "Nothing is so dramatically negative anymore. I've always been pretty intense, but I roll with the punches more than I used to. It sure makes life easier. It's been a wonderful thing."

Phyllis continues to cope with family health problems. Her younger son was recently diagnosed with cancer. "That's been kind of tough, but even so, I think I'm dealing with that better." Sitting in her garden (left), in full bloom in late August, it is clear that she has a green thumb. But arthritis is making it more difficult for her to pursue gardening, her "great love and passion." On the other hand, she has overcome a great many fears, including driving long distances alone, which has enabled her to regularly drive to Phoenix and back to visit her grandchildren. "My mother used to say, `It's hell to get old.' But I try not to sweat it. I appreciate each day a little more. Despite everything, life is so much better."

Fact:

Of the 33 million Americans aged 65 and older, nearly 5 million suffer from symptoms of depression.

DEPRESSION IS A SERIOUS MEDICAL PROBLEM and a major chronic illness among older Americans. About 15 percent — or nearly 5 million of today's 33 million Americans 65 and older — suffer from symptoms of depression.[1] By 2010, it is estimated that of the 40 million Americans who will then be over 65, over 20 percent will suffer from problems related to mental health.[2]

Depression takes a terrible emotional toll on those individuals who are suffering, as well as their families. It reduces quality of life, interferes with an individual's ability to function normally, and increases risk for further physical and mental deterioration.

Studies show that older adults with depression are more frequent users of medical services and incur significantly higher inpatient and outpatient health care costs. In fact, their costs are 50 percent higher, "attributed to higher utilization in every category of care (emergency department, primary care, medical specialty, medical inpatient, pharmacy, laboratory)."[3] For example, depressed adults in one inner-city primary care clinic had 38 percent more outpatient visits and 61 percent greater outpatient costs over a nine-month period than those without depression.[4] And, hospital stays are "significantly longer for all conditions when depression is a co-morbid factor."[5]

Untreated depression can also lead to higher rates of mortality and morbidity. Older adults have the highest rate of suicide in the United States. Elderly men are particularly vulnerable. Their suicide rate is five times higher than average. In addition, depression exacerbates other medical problems and reduces benefits from rehabilitation efforts. "The mortality rate for depressed patients with cardiovascular disease," for example, "is twice that of those without depression."[6]

Yet, despite this country's growing awareness of depression as a serious medical disorder, and despite a string of prominent Americans — from Mike Wallace to Barbara Bush — who have openly discussed crippling bouts of depression in their lives, few older adults seek or receive appropriate treatment.

1. Lebowitz, "Diagnosis and Treatment of Depression in Late Life. An Overview of the NIH Consensus Statement." *American Journal of Geriatric Psychiatry, Volume 4, Supplement, 1996.*
2. "Health Care News," *Annals of Long-Term Care, Volume 10, Number 11, Nov. 2002.*
3. Unützer, Patrick, Simon, et al, "Depressive symptoms and the cost of health services in HMO patients aged 65 years and older." *JAMA, 1997; 277:1618-1623.*
4. Unützer, Katon, Sullivan, Miranda, "Treating Depressed Older Adults in Primary Care: Narrowing The Gap Between Efficacy and Effectiveness," *The Milbank Quarterly, Volume 77, Number 2, 1999.*
5. Lantz, *Clinical Geritrics: A Clinical Journal of the American Geriatrics Society, Volume 10, Number 10, Oct. 2002*
6. Lantz, *op. cit.*

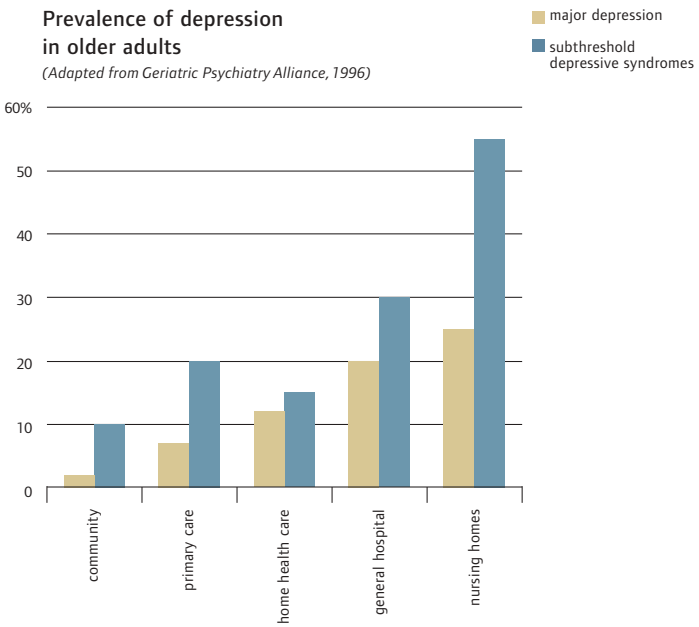
Most People Seek Help from their Primary Care Physician

Most older adults with depression are cared for in primary care settings. The reasons are many. To begin with, notes Robert M. Rose, M.D., a psychiatrist who is Executive Director of the Mind, Brain, Body & Health Initiative at the University of Texas Medical Branch at Galveston, "It became clear a decade ago that there were not enough psychiatrists to see patients who suffered from depression. Psychiatrists only saw between two and four percent of the total outpatient visits in the county. It also became clear that a substantial number of people didn't want to see a psychiatrist or mental health professional. They didn't want to be referred. They wanted to see their own doctors."

There is still a stigma attached to all forms of mental illness, which is one reason most older adults seek help from their primary care physician — be it a practitioner in family medicine, internal medicine or women's health. In fact, notes Hugh Hendrie, M.B., Ch.B., (left), Professor of Psychiatry, Indiana University School of Medicine, who has been practicing geriatric psychiatry for 20 years, "Seventy to eighty percent of elderly patients get almost all their psychiatric care in a primary care setting. It's been very apparent to everybody in geriatric psychiatry that the bulk of the action is in primary care."

Hugh C. Hendrie, M.B., Ch.B., Indiana University, IN.

Studies show that between five and ten percent of older adults seen in primary care are afflicted with major depression or dysthymia (a less intense but long standing form of depression). Yet, the evidence suggests that it is difficult for primary care physicians to recognize and treat mental illness effectively.



Right, Marc Hoffing, M.D., M.P.H., Medical Director and CEO of Desert Medical Group in Palm Springs, CA, discusses treatment progress with a patient.

Depression: Underrecognized and Undertreated

While depression is often unrecognized in every age group, late-life depression is even more difficult to diagnose. There are many reasons why it is commonly overlooked.

First, because many older Americans, like Phyllis, do not know that they suffer from depression, do not ask for help and may not appear, as younger people often do, obviously in need of treatment.

Fact:

Five to ten percent of older adults who visit a primary care physician suffer from major depression.

Second, because depressive symptoms in older adults — confusion, memory loss, diminished appetite, sleeplessness, reduced interest in life, inability to concentrate — are common to many medical conditions associated with aging. They may be mistaken for grieving. They may be misinterpreted as side effects of medications. They may be attributed to Alzheimer's, dementia or other neurological impairments. They may be shrugged off as problems of "normal aging."

Third, because given the limited time and acute-illness focus of primary care physicians, when confronted with older patients who suffer from multiple medical diseases, they first concentrate on the acute illness, and/or the chronic disease — such as diabetes — which can be easily diagnosed by a hard biological marker, such as a blood test. And, whose treatment is more certainly reimbursed under Medicare.

Fourth, because many physicians — reflecting the youth-centered values of American society — may share the belief that old age and the process of aging are, by definition, depressing. Consequently, unlike other chronic diseases to which older people are prone, including congestive heart failure, asthma, emphysema and arthritis, "At best, only about one-fourth of all cases of major depression are diagnosed," says David C. Steffens, M.D., head of Duke's Division of Geriatric Psychiatry.

Even when diagnosed, depression is undertreated. Many primary care physicians in the U.S., says Scottish-born Hendrie, "don't think there is an effective intervention for depressed, older people with multiple medical problems. Their point of view is: these people are old and sick. Wouldn't you be depressed if you were old and sick?"

That an older person can experience the losses and disabilities of aging, yet still be cheerful, active and not depressed, may not be considered a reasonable assumption.

"But the truth is," says University of Washington Professor and Vice Chair of Psychiatry, Wayne J. Katon, M.D. (right), "the elderly are less depressed than young people. Older people are less critical of their family. They are less critical of themselves, and they do reach a period in life where they actually feel better about themselves than younger people who are often still struggling with self-esteem and other issues. I think part of our medical education has to be that this is a treatable illness, even in the elderly — especially in the elderly."

Elizabeth H.B. Lin, M.D., M.P.H., Group Health Cooperative of Puget Sound, Seattle, WA.

Jürgen Unützer, M.D., M.P.H., University of California at Los Angeles.

Wayne J. Katon, M.D., University of Washington, Seattle, WA.

Unfortunately, even when late-life depression is recognized and treated, the outcome of "usual care" is often quite poor. Prescribing a medication or making a referral to a mental health specialist, though a good beginning, is not enough. Is a patient continuing to take the medication? Is it the right medication? Are there serious side effects? Can a patient afford the medication? Has a patient actually set up an appointment with a specialist? Studies show that most busy primary care physicians, despite their best intentions and deep desire to help their patients, do not have the time and are not organized to provide adequate follow-up supervision. As with most chronic diseases, if depression treatment is not closely managed and monitored, over time it frequently fails.

As Katon observes, "The primary care doctors I train are smart, bright, energetic and really want to do the best thing, but the system makes it very hard to do it. A primary care doctor is taking care of 2,000 people with 100 different illnesses and they don't necessarily know if someone doesn't show up. Primary care works really well if you have an earache or chest pain or need to get stitched up. Chronic illness, whether it's depression or anxiety or diabetes or hypertension or asthma, requires educating patients to help manage their illness. It requires proactive visits. You need to do a lot of support for behavioral change. And it's a lot of trial and error with medications to find the right regimen. It's not going to happen very effectively with brief, infrequent visits to a primary care doctor."

That is the bad news.

The good news is that, when properly diagnosed, managed and monitored, most late-life depression — about 80 percent — can be successfully treated. Furthermore, treating patients with late-life depression in a primary care setting — which they prefer — is the lowest-cost alternative. It is also the most affordable to patients, since Medicare requires a 50 percent co-payment for outpatient mental health services. Therefore, if the effectiveness of care can be improved, not only will more people be helped, but this could occur at considerable cost savings to the overall health care system.

History and Background

Since the 1980s, a significant revolution in knowledge and research about depression and its treatment has taken place. Treatment options have proliferated, due to new antidepressant medications, particularly the introduction of SSRIs (selective serotonin reuptake inhibitors). Prozac, for example, first became available in 1987. In addition, a broad array of supportive therapies and collaborative care interventions have been developed and tested by psychiatrists and family care physicians in primary care settings. Pioneers in the field included Seattle-based Katon and Elizabeth H.B. Lin, M.D., M.P.H., a primary care physician at Group Health Cooperative of Puget Sound (GHC) — an independent, staff model HMO with a research arm, the Center for Health Studies — as well as Jürgen Unützer, M.D., M.P.H., a psychiatrist at UCLA, who worked with Katon and Lin on ways of improving recognition and outcomes of depression in primary care.

Fact:

Older adults have the highest rate of suicide in the United States.

Still, there is no single magic bullet. Some individuals do well with drugs. But, "as many as 50 percent of patients will not respond to the initial choice and will have to change medications at least once."[7] Some cannot or will not tolerate medication and prefer counseling. Some need a combination of both. And some severely depressed older adults do not improve with any of these treatments. Even in the best of circumstances, treating depression can take a lot of time.

Quality improvement interventions over the past two decades have largely focused on strategies to improve guidelines, educational materials and the clinical performance of primary care physicians. In particular, they have sought to better train clinicians to look for symptoms of depression, and improve screening instruments for depression. Unfortunately, however, improved education and depression screening, even if coupled with specific treatment interventions, have not significantly improved patient outcomes.

Clearly, while we now have strong evidence that a variety of tools exist to help patients, what we do not have is a system of care that uses these tools effectively. As geriatrician Christopher M. Callahan, M.D. (right), Cornelius & Yvonne Pettinga Scholar in Aging Research at Indiana University and former Beeson Scholar, observes, "There is an important gap between what we do know and the care that is actually provided in routine practice."

7. Unützer, Katon, Sullivan, Miranda, *op. cit., p. 241*

Christopher M. Callahan, M.D., Indiana University, IN.

John W. Williams, M.D., M.H.Sc., Duke University, NC.

JAHF Depression Initiatives

Throughout the 1990s, The John A. Hartford Foundation, concerned by the high percentage of untreated depression in older adults, supported research studies and clinical trials aimed at improving the care of depressed patients in primary care settings. Growing out of its broader work on education in geriatrics and gerontology, and its efforts to improve quality of geriatric care, in 1997, the Foundation invited Howard H. Goldman, M.D., Ph.D., a psychiatrist at the University of Maryland, and consulting investigator with ROW Sciences, to assemble a panel of national experts to research and prioritize mental health issues and suggest ways in which the Foundation could significantly improve mental health care for older adults. The planning group quickly focused on the treatment of depression in primary care. Its resulting 'white paper' underscored the recognition by mental health experts that depression care needs to be based on a chronic disease management model, one which involves the patient and the physician in a proactive medical system that offers a range of comprehensive support and supervisory services on a sustained basis. In short, as with asthma or congestive heart failure, depression care cannot wait for a crisis to develop but must create a system that manages a patient's chronic illness.

The Foundation then turned to a smaller team of research physicians and consultants from the planning group — experts in depression care delivery in primary care — to create the broad outlines of a new intervention. The team included, among others: Christopher M. Callahan, M.D., Mark T. Hegel, Ph.D., Wayne J. Katon, M.D., Cheryl Schraeder, R.N., Ph.D., John W. Williams, M.D., M.H.Sc. (left), and Jürgen Unützer, M.D., M.P.H. They ultimately proposed a collaborative care treatment model built upon some of the newer evidence-based treatments and care strategies tested by Katon, Lin, Unützer and others in prior research studies.

In 1998, the JAHF Board approved Project IMPACT. It represents a major Foundation investment, and is the focus of this year's Report.

Project IMPACT: Improving Mood — Promoting Access to Collaborative Treatment for Late-Life Depression

PROJECT IMPACT IS AN $11 MILLION, FIVE-YEAR, multi-site randomized controlled trial designed to test the effectiveness of a new team care approach to treating late-life depression and dysthymia in primary care, compared with "usual care." Launched in 1999, it is the largest clinical trial on depression treatment in older adults in the U.S., and a complex initiative.

The new treatment model creates the role of the depression clinical specialist (DCS), who works closely with the patient's primary care physician to manage depressed patients' care. The DCS is supported by a designated team psychiatrist and team primary care physician. Patients are offered a choice of treatment, either anti-depressant medication, a brief form of cognitive therapy called Problem Solving Therapy for Primary Care (PST-PC) or a combination of both.

"At the core of the model is respect for the patient," observes Enid M. Hunkeler, M.A., Kaiser Permanente, Northern California Division of Research, who directs Kaiser's National Depression Initiative. "What I love about the IMPACT model is that it pushes the psychiatry piece to come up with new things when people aren't getting better, and it helps people solve problems and deal with very real and difficult situations in their lives. The beauty of the model is that it actually has found a way to take on a very difficult, very underserved population — often chronically depressed patients who nobody thought would get better — and helped them get better."

Overseeing the initiative as the Principal Investigator (PI) of project IMPACT's Coordinating Center at the UCLA Neuropsychiatric Institute is Jürgen Unützer, M.D., M.P.H., geriatric psychiatrist and health services researcher (see profile on page 23). He also co-directs the Southern California Kaiser clinical site in the initiative.

"The basic intervention is built on a number of earlier studies," says Unützer. "What is unique about our model is that we've added a care manager in the primary care clinic who helps the patient take the medication correctly. It sounds simple, but it's not so simple. Often what you see in 'usual care' is that many people start a medication, but then a month later stop taking it or continue on a medication that doesn't do them a bit of good, but the doctor didn't recognize the problem. We've been very aggressive about changing things if they don't work."

Left, depression clinical specialist, Rita Haverkamp, R.N., M.S.N., C.N.S., Kaiser Permanente, Southern California, meeting with a patient to evaluate treatment progress.

- Treatment provided at the patient's regular primary care clinic for up to 12 months.
- Collaborative care approach includes:

  Patient

  Regular primary care physician

  Care manager: depression clinical specialist (DCS)
  - Patient education using a brochure and videotape
  - Close follow-up and monitoring of symptoms and side effects using a computerized tracking system
  - Brief, structured psychotherapy: problem solving therapy in primary care (PST-PC)
- Consultation/weekly supervision meetings with:
  - Primary care physician with expertise in Geriatric Medicine
  - Team psychiatrist
- Treatment follows a stepped care treatment protocol using antidepressant medications and/or 6-8 sessions of psychotherapy (PST-PC) in primary care.

  Patients and their primary care physicians choose treatments.

  Psychiatry consultations for patients who do not improve.

Hartford decided to test the model in a variety of different health care systems. "If everyone can make it work," says Unützer, "it makes the case for the model even more powerful." It was also decided that, to better evaluate the treatment's impact on patients, providers and cost of care, the project needed to make a major investment in monitoring outcomes, as well as treating patients.

Hartford's Focus is on Improving Practice

Once technical specifications for implementing the model were clearly outlined, the Foundation ran a site selection competition, inviting health care groups and organizations to submit proposals for participating in the trial. From the outset, the Foundation stressed that, in addition to improving outcomes for older adults in a primary care setting, a key goal of IMPACT is to change practice. That is, to improve "usual care" by creating a practical model for treating and managing late life depression that addresses existing barriers to change — in patients' attitudes, physicians' offices, and the structure of health care organizations. Therefore, in addition to producing first-class research results, participating health care organizations would be expected to integrate the new system of depression treatment, if successful, into their primary care practice after the four-year trial was complete. In short, the Foundation sought partners in its long-term mission to improve care and change practice.

Seven Sites Selected in Five States

Initially, the Foundation granted four-year awards to five sites. It also sought additional partners to expand the geographical reach and diversity of the trial. The California HealthCare Foundation, Oakland, CA, which has its own program for elders in managed care, agreed to underwrite awards to two additional California sites as well as supplement Coordinating Center costs for a total contribution of more than $3 million.

Seven IMPACT sites in five states — North Carolina, Indiana, Texas, California and Washington — with a total of 18 participating primary care clinics, enrolled 1,801 patients, age 60 and older in the intervention trial. The Robert Wood Johnson Foundation (Princeton, NJ) provided close to $200,000 to support a special examination of the effect of depression treatment on comorbid disease, and The Hogg Foundation for Mental Health (Austin, TX) offered supplemental support for the sprawling Texas site.

Left, depression clinical specialist, Cora Hartwell, R.N., M.S.N., A.N.P., Indiana University, IN, conferring with Michael Weiner, M.D., primary care physician, about an IMPACT patient.

Patient Recruitment and Enrollment

Patients were identified and recruited either by referral from their primary care provider (PCP), or by systematic site-specific screening for depression. Only a small percentage of eligible subjects were eliminated after it was determined, through screening, that they were actively suicidal, had severe alcohol problems or were suffering from severe cognitive impairment. Individuals were not rejected if they suffered from other common chronic illnesses in older adults, such as congestive heart failure. Patients who met the diagnostic criteria for major depression, dysthymia, or both, were then randomly assigned to the intervention program or to care as usual.

Fact:

Every year more than 30,000 deaths in the U.S. are attributed to suicide, and half of those are older adults.

One of the major strengths of the trial is its ethnic, socio-economic and geographic diversity. However, it made the logistics of the trial extremely challenging. "How do we train each site so that the interventions are as similar as possible?" asked Katon. "And at the Seattle site, how do you cost effectively screen 12,000 elderly and get most of them to agree to screening because it's voluntary? You can't do 12,000 at once. We learned to do it in waves." Another up-front hurdle involved training recruiters and training nurses, some of whom had never worked in primary care or with older patients. "It was a huge enterprise."

The average patient age in the trial was 72; the oldest patient screened was over 100. Patients, on average, had four other chronic diseases, including diabetes, hypertension, arthritis and heart disease. Sixty-five percent of the enrolled patients were women; 23 percent were from ethnic minority groups (12 percent African American, 8 percent Hispanic, 3 percent belonged to other minorities). The median household income was $23,000.

Right, team psychiatrist, Jeanne Dickens, M.D. Indiana University, IN, meeting with a patient to discuss medication and treatment progress.

The Coordinating Center

The Coordinating Center at the UCLA Neuropsychiatric Institute, directed by Unützer, orchestrated — and continues to oversee — every phase of the project. During its critical, six-month start-up phase, the Center built or presided over the creation of key project components.

During the one-year treatment phase of the trial, the Center continued to guide, support, and provide technical assistance to every site and its participants. After the treatment phase was over, it analyzed and reported results, oversaw the writing of scholarly papers and other activities, for subsequent dissemination to professional journals, and continues to evaluate the outcome data, which includes post-treatment follow-up patient surveys at 18 and 24 months.

"This has really been a blessed project," says Unützer, who has participated in many large, multi-site clinical trials in mental health. "I attribute it mostly to the fact that we have a wonderful group of collaborators across the sites, a great group of people with complementary skills. Most of us have significant experience with similar kinds of research so we could get through the mechanics very quickly."

Jan Eldred, M.S., California HealthCare Foundation.

Jan Eldred, Vice President of the California HealthCare Foundation (left) agrees. "Everyone in this study was a pleasure to work with. This has been the most problem-free initiative I've ever seen. From our perspective it's been a home run. I think the thoughtfulness with which the Foundation created this initiative, and picked the right people, had a lot to do with its success. I think Jürgen is just amazing."

Everyone has highlighted the remarkable leadership skills of Jürgen Unützer.

"One of the reasons the project went so well," says Lin, "is because Jürgen was the coordinator. His greatest strength, aside from being so smart, was his ability to bring the sites — with such different personalities — together, so we could all move forward together."

"Jürgen, without a doubt," says Hunkeler, "was the best leader of a collaborative study that I have ever seen."

"He's been very helpful in terms of problem-solving and logistics, and did a particularly good job in managing all our personalities," notes Katon. "Jürgen has the compulsive skills to be the best researcher, but also has the people skills to be an ambassador."

"He was instrumental in developing the whole idea to begin with," says Mark Hegel, Ph.D., Associate Professor in the Department of Psychiatry and the Department of Community and Family Medicine at Dartmouth Medical School. "Without a doubt, he is the glue that held this whole thing together."

Jürgen Unützer, M.D., M.P.H.
Associate Professor of Psychiatry,
David Geffen School of Medicine at UCLA

"I started out as someone very interested in developing effective treatments," says Unützer, a soft-spoken psychiatrist and physician scientist, born and raised in a small town near Munich, Germany. "Now, with folders full of articles about effective treatments, I'm more interested in how we get these treatments for depression actually used. How do I bridge the gap?"

Unützer, 40, arrived in the U.S in 1982 — a one-year exchange student, with a scholarship to Iowa State University — and never looked back. He snared a scholarship to Vanderbilt Medical School, and a fellowship to the University of Chicago, where he pursued a Masters in Public Policy. That was when he first became interested in systems of care. And while doing his clinical training in general adult psychiatry at UCLA, he discovered how much he enjoyed working with older adults, particularly depressed older adults. "It was almost like bringing some of these patients back to life. I said this really means something to me, and this is what I want to do."

Most depressed older adults never come to an inpatient psychiatry unit at an academic medical center, but seek help from their primary care doctor. Unützer realized he needed more training to help him reach that broader population. That led him to a fairly unique fellowship program in primary care psychiatry, developed and run by Wayne Katon, M.D., a psychiatrist at the University of Washington. Katon sent him to where the action was — two big primary care clinics — where Unützer observed, first hand, the difficulty of delivering mental health services in a primary care setting. While in Seattle, Unützer also earned his Master's in Public Health in health services.

Below, Jürgen Unützer, M.D., M.P.H., director and principal investigator, accessing web-based clinical information software system developed for the IMPACT project.

Over the years, the focus of Unützer's work has largely shifted from treating individual patients (although he does still maintain a small private practice) to changing and improving systems of care.

New Challenges

IMPACT's success has brought Unützer tenure, a Paul Beeson Physician Faculty Scholarship in Aging Research from the American Federation for Aging Research, and a new set of challenges. "Now that we have something that works, how do I get this news out on a really large scale? We did it in eight places, but what about all the other places? What would it take for a physician or nurse to want to learn these skills?"

Unützer is working on many fronts. First, he is engaged in completing the IMPACT project: measuring 24-month outcomes; refining training materials, which he believes will make it even easier to train other depression clinical specialists in the program's core skills; and looking at cost issues, which still present major barriers to change. That includes working with an economist to provide a rationale for changing Medicare coverage. Currently, for example, Medicare does not reimburse for much of the care management performed by the DCSs.

Second, he is working with Kaiser Permanente to make available, to older adults who have suffered a heart attack, a program similar to IMPACT. They are high risk, high cost patients who die more often, in part because depression can prevent them from taking good care of themselves. They can end up being sicker and back in the hospital more often, they can as well. The program could reach 4,000 people a year at 12 primary care clinics in Southern California.

Third, he is using his Beeson award to extend the IMPACT model to the management of chronic pain.

Below, Jürgen Unützer, M.D., M.P.H., presiding over an October 2002, two-day Project IMPACT conference in Seattle, WA, attended by key representatives of all seven sites. Attendees discussed IMPACT's dramatically successful clinical results, as well as how to maximize the visibility and viability of the model throughout the country.

Chronic Pain and Depression

People with chronic pain are at high risk for developing major depression. The two probably drive each other. "Sixty to sixty-five percent of the subjects in our IMPACT study had some type of chronic pain." It ranged from arthritic-related pain to back and joint pain, much of it quite disabling. At first, many patients did better, in terms of their depression, but were still functionally impaired because of their pain. Unützer and Elizabeth Lin decided to take the opportunity of project IMPACT to look at 1000 people in the study with chronic pain from arthritis. They discovered that the intervention not only helped their depression but strongly reduced their pain.

Chronic pain, says Unützer, is underrecognized and undertreated in primary care, very much like depression. Even if treated, people are often medicated with pills whose debilitating side effects make them unacceptable to some patients. In fact, Unützer discovered so many parallels that he has decided to apply the collaborative step care model to chronic pain by, among other things, teaching individuals the basics of chronic pain management and providing them access to a pain specialist. He is designing a project which will train a care manager to handle both depression and chronic pain, using the same combination of medication and problem solving.

Unützer, married, and the father of three children, brings a deeply humanistic approach to his work. He worries, for example, that so much of the medical literature on depression focuses on numbers and statistics. "Nobody really says anything about what it's like to be depressed, and why it's something you don't want to spend too much time in, if you have a bad case of it."

Unützer, whose gift for bringing people together is legendary, particularly enjoyed the interdisciplinary nature of the IMPACT project. "I think what we show is that different types of professionals bring different strengths, and if you put them together in a smart way, it's better than developing each of the separate tracks. It takes some work and skill to figure out how a nurse, a primary care doctor and a psychiatrist work best together, but the collaborative approach really works."

How The Collaborative Stepped-Care Model Works

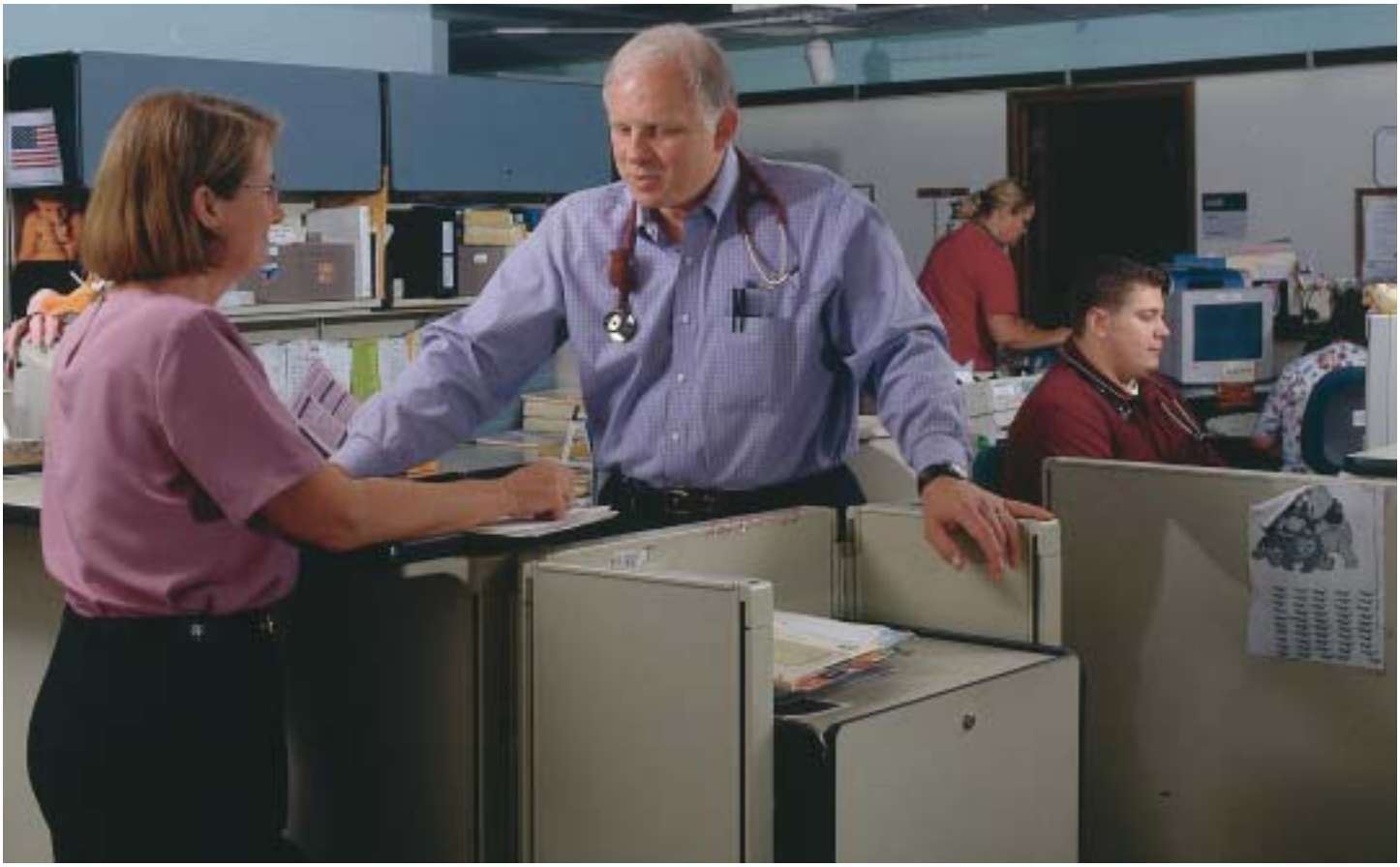
IMPACT is a flexible model, designed to offer the treatment team and patients a number of choices throughout the intervention. The DCS, for example, in consultation with the team psychiatrist, can initiate treatment at Step 1, 2 or 3, depending on the patient's previous mental health and medication history. At the same time, the model encourages patients to be active collaborators in their treatment, and places much emphasis, during the initial visit, on patient education and activation.

"Offering patients a choice of treatment was so unusual in terms of depression research," says Polly Hitchcock Noël, Ph.D., clinical psychologist, Assistant Professor at the University of Texas Health Science Center in San Antonio, Department of Medicine, and co-PI of the Texas IMPACT site, "that it hooked me into wanting to be part of the study."

It is the depression clinical specialist – a nurse, social worker or psychologist — based in a primary care clinic or office, who works most closely with the patient, supported and advised by a professional intervention team.

After the DCS conducts a clinical assessment of the patient's symptoms, a treatment plan is jointly arrived at between the patient and treatment team:

Below, depression clinical specialist, Kathleen Nierenberg, R.N., Group Health Cooperative, Seattle, WA, discusses a patient with primary care physician, Dean F. Carr, M.D.



Flow Chart of Treatment Steps for Typical Intervention Patient

Patient enrolled in the study, and randomized to intervention condition

Initial visit with depression clinical specialist (DCS). DCS consults with treatment team and patient's own primary care provider (PCP).

Step 1

Treatment (8-12 weeks): Antidepressant medication or problem solving therapy in primary care (PST-PC) (if patient prefers psychotherapy)

Reassessment by DCS and discussion with PCP and treatment team. Psychiatric consultation at primary care clinic if clinically indicated.

Persistent depressive symptoms

Remission

Step 2

Treatment (6-10 weeks)

No response in step 1 → Switch of treatment to another antidepressant or PST-PC

Partial response in step 1 → Augmentation with another antidepressant or PST-PC

Relapse prevention
Monthly contact with DCS

Reassessment by DCS and discussion with PCP and treatment team. Psychiatric consultation if clinically indicated.

Persistent depressive symptoms

Remission

Step 3

Treatment (6-12 weeks): Combination of antidepressant(s) and psychotherapy. Consider referral for specialty mental health services, (e.g., ECT).

Persistent depressive symptoms

Remission

Maintenance plan: Monthly contacts with DCS to maintain therapeutic gains.

a DCS, a psychiatrist, the patient's own primary care provider (PCP), and a liaison PCP. The team psychiatrist, for example, makes antidepressant medication recommendations, provides clinical consultation/supervision and is available for direct patient evaluation. The PCP liaison, who meets weekly with the DCS and team psychiatrist, brings a medical perspective to the patient, who may well be suffering from other chronic diseases, from asthma to diabetes.

During the first four weeks of treatment there is weekly phone contact with each patient and/or, depending on the form of treatment, a scheduled clinic visit to do PST-PC.

Fact:

Older white men make up 10 percent of the nation's population but account for 33 percent of all suicides.

The DCS:

- monitors and assesses the patient's progress or lack of progress, using the Patient Health Questionnaire (PHQ-9), a nine-item depression rating scale, and enters the information into a computerized database;
- meets with the team psychiatrist and liaison PCP to review and modify, if necessary, treatment plans; and
- manages the patient's treatment, following the stepped-care protocol.

"If the patient doesn't improve," says Noël, "you ratchet up to the next level. That is where 'usual care' usually falls down on the job. In 'usual care' there is no structured system for assessing how patients are doing, so they are left hanging if treatments don't work. The beauty of this model is not only having a standardized approach to the treatment and the interventions, but also delivering it in a very individualized way according to the patient's needs and preferences."

The team meets once a week to focus on treatment planning for new patients, and to discuss and evaluate ongoing interventions. The DCS discusses treatment options —such as increasing drug dosage or switching to a different antidepressant medication — with the team psychiatrist, and medical problems — such as chronic pain, loss of appetite or medication side effects — with the PCP. Occasionally, a patient might require a one-on-one visit with the psychiatrist.

Noël wonders, having seen how well the collaborative, stepped-care model works, why more people haven't used it all along. "It isn't just a pill or a particular therapy that makes the difference. There are tons of drug studies and tons of psychotherapy studies. There needs to be a model of care to apply these interventions. It's the support, education, assessment, and systematic application of these effective interventions, in a way that doesn't let patients fall between the cracks, that I think accounts for the IMPACT model's success. That is what surprised me the most and I think more people need to hear about it."

Here are the reflections of one DCS, Carol Saur, R.N., M.S.N., C.S.

Carol Saur, R.N., M.S.N., C.S.
Duke University Medical Center

A Patient With Major Medical Problems

"A lot of our 254 patients had complex medical comorbidities. I particularly remember one patient. He was in his sixties, had been on tube feedings for a year with pancreatitis, had severe heart problems, was overweight, had diabetes, was taking insulin and profoundly depressed. He could hardly get out of the house. He'd married a younger woman, very committed to him, but he was feeling very old and she was overcompensating for him, giving him insulin, taking care of him. It was not a good balance in their marriage. We started him on Effexor, but he needed some behavioral activation. We started talking about exercise. To me, part of the goal is self-care, not just a resolution of your depression, but improving your level of function and managing your medical problems. I mean exercise and mental health and cardiac function — it all ties together. Through his cardiologist he was able to get into a cardiac rehab program. By the time he was ready to graduate, he had joined his regular health club, was back to enjoying his family and his symptoms were well controlled."

Below, depression clinical specialist, Carol Saur, R.N., M.S.N., C.S., Duke University, NC, discusses treatment with patient, and with IMPACT treatment team members, psychiatrist David Steffens, M.D., and primary care physician, Linda Harpole, M.D., M.P.H.

Integrating Mental Health and Health Care

"I very much like to practice in a collaborative model with the primary care provider, the psychiatrist, the patient and myself. We were able to show physicians, through IMPACT, what collaborative care can be and how it benefits them. I think that's the provider satisfaction. I had very cordial relationships with all the physicians, and also very much enjoyed empowering patients. I'm continuing to provide mental health care, within a general internal medicine practice, and I have used PST with some patients."

"I think the severity of mental health problems in primary care surprised me. I think mental health care needs to be where the patients are. Clinically, overall, IMPACT was a very rewarding experience, because I could bring together mental health and health care, and because most people did so very well."

Throughout the treatment, the DCS is prompted by a Web-based computer software system which, with input from the DCS, maintains a registry of all patient information. It is also programmed to automatically prompt the DCS of critical dates in each patient's treatment time line, including reminding them to contact patients, monitor treatments, assess side effects, etc.

The software, created for the study, "is truly unique," says Unützer. Not only did it prove essential to the ability of the DCS to handle a large caseload of between 100 to 200 patients, it enabled key team members to monitor and coordinate patient information. "We knew pretty much at all times who was doing what, where, and how every patient was getting treated," says Unützer.

Fact:

Depressed patients' costs are 50 percent higher than average Medicare patients' costs.

Ten weeks into the project, for example, Unützer, who had access to the progress of DCS Rita Haverkamp's patients through the Web-based software system, gave her surprising news. "Your statistics tell me that 77 percent of the people you've treated improved after 10 weeks." At first, Haverkamp didn't believe him. In fact, added Unützer, "They are essentially well or at least 50 percent better."

"I don't understand," Haverkamp replied. "Some of these patients are my chronics, those who used to come and see me and never got much better." Haverkamp, in the field of psychiatric nursing for 30 years, has been providing outpatient care for 15 years at Kaiser Permanente.

But the database doesn't lie. She was elated. "If it's true, then we are doing something really different. I've always felt confident about my skills but with this process I really felt confident that my patients would get better. I could follow them. I could give them the time they needed. I could see them weekly or call them. I could work with them in group therapy."

The computerized tracking concept proved so successful that, after some modification to make it more generally applicable, it may ultimately be marketed as a stand-alone product to support other forms of chronic illness patient care.

DCS Margaret Cyr-Provost, M.A., L.P.C., delivered treatment to 75 patients at two locations, one a VA clinic, and the other a primary care practice. She was particularly effusive about the Web-based information system. "I can't say enough good things about the software because I firmly believe that it prevented what happens to every clinician — patients falling through the cracks. If there were little bugs in it, we'd let them know and they upgraded it. The longer we used it, the better it became. Being able to punch a button and print a screen with the patient's history — in terms of how many times they had been in, what their depression scores were week by week, what level of medication they were on, how many problem-solving sessions they'd had — was a wonderful grid to have, really nice for communicating with the physician and at team meetings."

Once a patient is no longer depressed and in remission, a specific relapse prevention plan is developed for each patient. The DCS continues to conduct monthly telephone follow-ups to monitor depressive symptoms and ongoing treatment for up to one year.

How Problem Solving Therapy for Primary Care (PST-PC) Works

Problem Solving Therapy — originally devised to teach college students problem solving skills and help manage stress — was adapted to treat depressed adults in the mid-1980s, then further adapted for use in a primary care setting by an English investigator at Oxford University, Laurence Mynors-Wallis. He trained other mental health specialists, including Mark T. Hegel, Ph.D. Hegel and his colleagues at Dartmouth, in turn, enhanced the English model. For the IMPACT project, they added more patient education training, and created a more comprehensive training manual for DCSs.

Mark T. Hegel, Ph.D., Dartmouth College, NH.

Hegel and psychologist Patricia Aréan, Ph.D., created both the in-depth training plan for the DCSs, and supervised their five training cases. Thirty percent of the IMPACT patients eventually received a course of PST-PC.

"We felt this was a short, pragmatic, evidence-based treatment," says Katon, "with which we had some experience, some local talent and, from Patricia Aréan's work in San Francisco, further evidence that the elderly took to it."

When people are depressed, they often view their problems as overwhelming. "What PST does," says Katon, "is help break down this overwhelming problem into small parts and possible solutions. They learn that they can break a big problem into small steps and test some of those steps. This gets them activated and, as the steps bring positive results, they become more hopeful."

Group Therapy: A Booster Shot

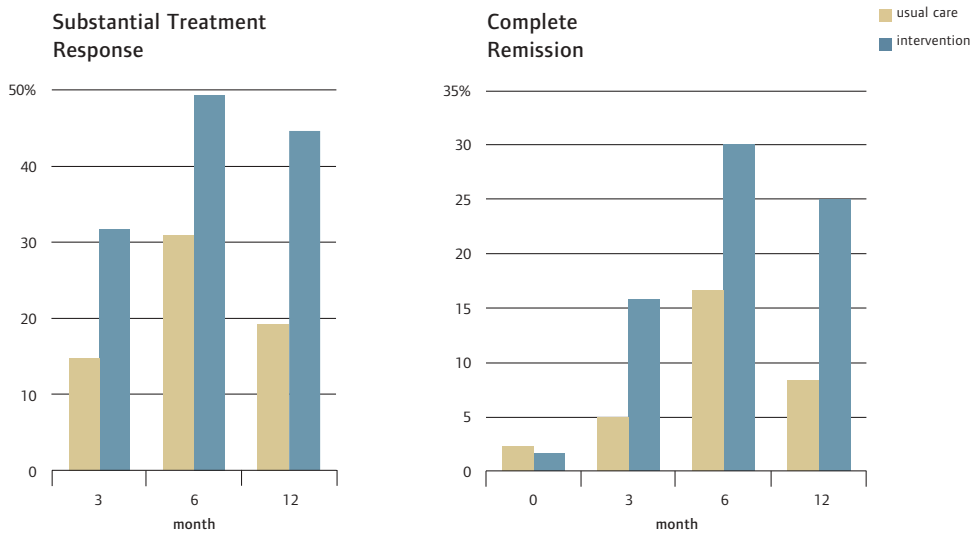
One innovation developed for the project was the creation of PST group sessions for those patients who completed the standard six to eight sessions of PST. Rita Haverkamp was more successful at forming on-going PST groups than any other DCS. "What I really like about 'group' is that you've taught them a technique, and this is a way to keep it going. I always told them they were coming in for a 'booster shot'." She encouraged patients to share positive things they'd done, reviewed the PST process, and helped patients work on problems. Sometimes there were similar problems, such as dealing with the holidays. Gradually, the patients, many of whom had lost family and friends, connected with each other and used it as a support group.

OUTCOMES WERE MUCH BETTER THAN EXPECTED. As reported in the December 11, 2002 issue of the *Journal of the American Medical Association (JAMA)*, the study shows that the IMPACT team care approach more than doubles the effectiveness of depression treatment for older adults in primary care settings. At 12 months, about half of the participants assigned to the intervention treatment group reported a 50 percent or more reduction in depression symptoms, compared with 19 percent of those in "usual care."

"We found that, with the added support and close follow-up provided by the IMPACT team," says Unützer, "patients felt better, functioned better, and enjoyed life more fully than patients treated in 'usual care.' They had a reduced sense of limitation due to their health problems in important parts of their lives, including work, family and social activities. This ability to carry on is vital to maintaining older adults' independence and dignity. It is particularly critical in patients who also face high rates of other health conditions, such as arthritis, hypertension and diabetes."

Patients improved at every site.

"To have an intervention effect at every site is a bit of a surprise," notes Katon, "because that hasn't happened in a lot of trials. The fact that it worked well even in sites that had a more difficult population because of so many other chronic stressors, was both heartening and surprising. It speaks, I think, to the quality of training people got at every site, the meticulous planning and follow up."



December 11, 2002 issue of the Journal of the American Medical Association (JAMA), which published the first article on the outcomes of the IMPACT trial entitled: "Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial." The paper describes the main twelve month outcomes of the trial.

John Williams was equally amazed. "There wasn't this site to site variability, which is extremely unusual, particularly when the intervention is not as simple as giving a pill, but a complex intervention. Sites differed in terms of their organization, their size, their complexity, their patient populations. Yet, despite these variations, it worked about the same. That really was surprising."

Williams believes that a key reason — in addition to well trained care managers and the Web-based information system — is that the intervention is flexible enough to respond to individual patients' needs and "ramp up treatment," if necessary. It is customization vs. fitting patients into pre-ordained solutions. "In San Antonio," Williams notes, "we even had a patient admitted for Electroconvulsive Therapy who benefited a lot."

The IMPACT model turned out to be significantly more effective than "usual care," even as early as three months. "This is the first study to show this amount of improvement relatively quickly," says Eugene Z. Oddone, M.D., M.H.Sc., Duke co-PI, and chief of the Division of General Internal Medicine at Duke University.

"I was surprised to see that the treatment effect was as great as it was," says Richard Della Penna, M.D., a geriatrician who directs the Kaiser Permanente Aging Network, and is co-principal investigator at the San Diego study site, "which makes it very compelling as a model." Della Penna has worked at the local, regional and now national level of Kaiser, the largest nonprofit health care organization in the U.S., serving 8.4 million Americans. As someone with national influence within Kaiser, this has given him more evidenced-based ammunition in his work.

"We see a bigger difference between the intervention and 'usual care' at 12 months than at three and six months," says Unützer. "So it actually gets better. That is something new. I haven't seen that in similar studies before."

"We will continue to follow patients' outcomes at 18 and 24 months, to see how they do after their year of IMPACT treatment," adds Unützer. "We don't know what to expect — will the benefits be maintained, gradually wear off, or even increase? The answer will be important to planning appropriate patient care. If the effect wears off for some patients, then they will need a continuation of IMPACT-like support. If the gains are maintained, we will have evidence that we have truly changed the lives of our patients."

"These findings are so dramatic," says Walter Borschel, Primary Care Administrator for Kaiser Permanente of Southern California, "that if they were about any other disease — 50 percent improvement in people with hypertension or coronary heart disease, for example — it would be on the front page of every newspaper in the country."

Mark Hegel adds, "It is not the very clean, tightly controlled efficacy trials that drug companies do, that change the way people practice. It's the larger real life research like IMPACT that has the biggest potential to influence what happens in real life care."

Measuring Health and Cost Outcomes

In addition to monitoring and measuring health outcomes over 24 months, the project is comparing costs of patient care under IMPACT with "usual care" costs, to see if better depression care lowers costs of overall medical care.

Fact:

Older adults account for 16 percent of the 500,000 hospitalizations for depression annually.

"We know that the average cost of providing IMPACT services totaled $550 per person for 12 months," says Unützer, "a modest amount given Medicare spending of over $6,000 per year for depressed older adults. We also know, through previous studies, that people who get treatment for depression, have significant gains in their household income. So it could turn out that IMPACT is a tremendous investment. I think we will need to work with the people who pay for health care, to show them the value of the investment, and that they can organize their resources and care for people in a more effective way."

A future report will look at the effect of IMPACT on patients' overall health care costs over two years.

IMPACT subcontracted with an independent telephone survey research group to conduct independent assessments of how well patients are doing at 3, 6, 12, 18 and 24 months. Analyses of survey data compare depression symptoms between those randomized to the collaborative treatment model and those randomized to "usual care." Patient productivity, independent living and social functioning are also included in the survey assessments.

"I thought that the outcomes to be measured were the right ones, not only from a clinical sense, but from a business perspective," observes Della Penna (above right). "In health care today, where Medicare managed care costs are going up 10 percent a year, but reimbursement is fixed at about two percent a year, every dollar is looked at very carefully." He adds, "I thought IMPACT would not only answer the basic clinical question — can we use a collaborative model in a primary setting to impact the care of depression in older adults? — it would also show other outcomes that can be used to help build the business case that this is a viable, sustainable model to use in a practical setting. If, for example, you can avoid some health care services by treating depression, there may be some cost offsets that justify the investment. It will take at least another year, before all the facts are in."

The Difficulty of Measuring All Economic Outcomes

"If you could capture all the economic outcomes, it would probably show that this is a more cost-effective way to care for patients," observes site PI, Marc Hoffing, M.D., M.P.H., Medical Director and CEO of Desert Medical Group in Palm Springs, CA. "But the difficulty is capturing all the outcomes — not just whether a patient goes to a doctor more or ends up in the hospital, but related issues, such as how much more functional people are, how much they get out and do things for themselves instead of relying on other people, their children or whomever, who have to miss work. I mean, there are all these kinds of things that are impossible to measure or very difficult to measure, but in general you have to believe that better quality care in the long run is more cost-effective care."

There are many, like Enid Hunkeler (below left), who believe that talking about cost offset is a mistake and a trap. "I totally resent that we are being asked to save money for mental illness, unlike people who treat hypertension or diabetes. The consciousness has to be raised that mental illness is every bit as debilitating as other diseases, and that we need to treat it effectively to alleviate the suffering."

Richard Della Penna, M.D., Director, Kaiser Permanente Aging Network, and Southern California co-PI.

Unützer agrees. "The health care community continues to treat mental health issues differently than traditional medical ones. If a new, effective pill for heart disease comes out and costs $500 a year, nobody asks, does it save money? Mental health interventions get asked that question all the time. It's part of the mental health stigma. The truth is that you can measure depression just as rigorously as you can measure high blood pressure, but somehow, people still think it is less scientific and more fuzzy."

Provider Satisfaction

Patient statistics only capture part of the story. Provider satisfaction, derived from mastering new tools and new techniques to successfully deliver depression care, is another key outcome.

To fully appreciate the transformational effect of IMPACT — on providers, patients and health care organizations — let us listen to the voices of selected nurses, primary care physicians, psychiatrists, administrators and principal investigators from each of the seven sites as they recount the variety and complexity of their personal challenges and successes.

Enid M. Hunkeler, M.A., Kaiser Permanente, Northern California, Division of Research.

The DCS Role

The unique role of the DCS is challenging. It requires clinical knowledge and skill, a high degree of empathy and diplomacy, and the ability to develop a relationship of trust with patients, as well as their primary care physicians and mental health specialists.

DCSs rose to the challenge, welcomed the opportunity and exceeded expectations. How well they did can be measured, in part, by the fact that, supported by their weekly team meetings, they successfully handled 70 to 80 percent of their cases without having to consult outside specialists. Mark Hegel, for one, who trained the DCSs in PST-PC techniques, was enormously impressed. Best of all, a number of the DCSs have continued to provide IMPACT care after the trial and help promote awareness of the model to colleagues and peers through research publications and association presentations.

Below, Don Stockdale, 69, takes a break during his 5:30 a.m. swim in a Seattle public pool. Stockdale finds that swimming daily helps him fight depression.

Depression clinical specialist, Margaret Cyr-Provost, M.A., L.P.C.

Margaret Cyr-Provost, M.A., L.P.C.,
The University of Texas Health Science Center at San Antonio, TX

On PST-PC

"It's a tough model to get, because you look at it and say, this is just common sense. I'm not really adding value here. But it turns out to be elegant and really powerful. Most people have a difficult time grasping it. And it can be daunting when a person comes in and says, I want to work on my panic attacks. I think much depends on the first two steps of PST–defining the problem and choosing a goal. You've got to probe and get them to further define something about the panic attacks. You might ask, what problems do panic attacks cause in your life? Then you use the answer as the problem you begin to work on. It seems very small but you are giving them something tangible they can marshal the PST skills around, and from which they can see change. Often, there is a connection between seeing a problem change and an improvement in mood. Patients start to internalize the process. At the end, some of the folks with sixth-grade educations were solving problems just as well as the people with Master's in engineering."

A Memorable Case

Cyr-Provost's most memorable case involved a woman in her early 70s, "with full marks for depression, daily crying and all. She lived alone, was obese—probably 150 pounds overweight—and had lots of physical problems, including edema in her legs, sleep apnea and chronic pain. She had a fairly traumatic past. Her husband had kidnapped her children, but she'd never told friends about her past and it really haunted her. She'd been forced to retire because of her physical problems, lived a restricted life style and didn't feel at all needed. We did six sessions of PST-PC, and though she did well behaviorally, she was still really depressed. So we convinced her to take medication. She had some improvement, but not a lot. Then we went to Ritalin, a psycho-stimulant. It really helped. It was amazing. To make a long story short, she lost close to 60 pounds, even though we didn't work on dietary things at all. Her sleep improved; she got more exercise despite her pain. She was really a different person by the time we got to the end of the treatment. It was really fantastic to see. She's the one I'll remember the longest. She really covered the most ground."

Paul Grills, A.R.N.P.,
Group Health Cooperative,
Seattle, WA

A Difficult Case

"One male patient, in his early seventies, had multiple psychosocial stressors. He and his wife were talking about divorce, his daughter was having a lot of problems, and he was having severe panic attacks. He scored quite high on the depression scale. The panic attacks were difficult to treat. I talked to Elizabeth Lin, the primary care liaison, and Wayne Katon, the psychiatric liaison, once a week. The primary care doctor started him on Ativan, but it didn't seem to work. He wasn't sleeping, continued having panic attacks, remained depressed and was having thoughts of death, but no suicidal plans. After a number of months, he went on Zoloft. We moved him up to the maximum of Zoloft, and after he also went through PST and lots of counseling, his panic attacks subsided. Three months into the program, he was back down to less than five on the depression scale. Once his attacks subsided, he felt like he could talk to his wife, worked out some of the problems they had—she wanted to move into a retirement home and he didn't want to leave their beautiful house—and soon they arrived at a compromise solution. He was a very analytical guy, perfect for PST. He was so happy with the program that he wrote us a letter telling us how appreciative he was. He'd really thought his life was over."

Depression Clinical Specialist, Paul Grills, A.R.N.P.

Common Patient Problems

"A common problem is helping patients, with multiple medical needs and illnesses, navigate the health care system. Another common problem is helping patients deal with the loss of family and friends, which often leads to extreme isolation. I was really impressed by how well our patients did. It was very rare for a patient not to respond to one—or a combination of treatments—that we offered." Grills is now convinced that medicine alone isn't as effective as medicine with PST or some form of cognitive therapy. "When a problem is weighing heavily on a person, they use a lot of their psychic energy worrying about it. When we work towards solving it, that burden starts to lift and you can see the difference." Grills now works at a mental health clinic in Seattle and uses PST with a lot of his patients.

Cora Hartwell, R.N., M.S.N., A.N.P., Indiana University Regenstrief Institute for Health Care, Indianapolis, IN

On Treating A Low-Income Inner-City Population

Hartwell's patient population faced a set of obstacles most others in the study did not. The Indianapolis site served a uniformly low-income, inner-city, minority population. "The mean patient income," says Hartwell, "is $5,000 a year. As older Americans, they are often primary caregivers to great-grandchildren, and the only ones with an income in the household, even though there may be two or three generations in the household. A lot of families are first generation up from the South. They can barely read, but on the whole they are survivors. It's not so much that they don't understand, it's that you've got to find a way to get them to understand. Once you do, they usually go along with what you are trying to do."

Hartwell, a gifted nurse who has taught and practiced for 30 years, developed a great rapport with her patients. "I have always liked patient care and I particularly liked this population. They are so needy and so grateful. They brought me things like tomatoes and potatoes from their gardens. I'm trying to figure out how to get their rent paid and they are bringing me food." With no previous training in psychology or social work, she used her ingenuity and knowledge of the community as well as her nursing skills, to overcome a mountain of obstacles to help patients, using the IMPACT model. It was not always easy.

"A lot of the things I did was case management. I taught the patients how to take their meds. I made referrals to dieticians, to social workers. I scheduled appointments around the time they had primary care physician appointments. I provided cabs to get them to the appointments, since Indianapolis does not have a good bus system and a lot of our patients don't drive. I sent medication to patients, and after the initial visit, did a lot of my contacts over the telephone, more so than any other DSC. The results were worth it."

Getting Fanny to Take Her Medication

"The biggest problem in any patient population is to get people to take their medication. For example, I spent a lot of time with Fanny, over 70, who had very bad pulmonary disease, was taking anywhere from 10 to 18 pills a day, couldn't read, had poor eyesight and didn't know how to pull things together. One of her biggest problems was getting her meds straightened out and making sure she was taking them in the right order. If she took them, a lot of her symptoms disappeared. After collaborating with a pharmacist who worked with her using visual clues, we were able to get her to take

her medications as ordered and at doses that were beneficial for her. Her emergency room visits decreased, as did her hospital visits, and her quality of life definitely improved. We used the PST-PC process to figure out how to find someone in her family to help her organize her meds, and get her to the clinic so she could keep her appointments. Seeing Fanny emerge from her depression was very rewarding."

On An Angry Patient

"He was a World War II veteran, very much an independent, strong man who had never been ill. He developed diabetes, put on weight, had a lot of family problems he needed to deal with, and was having a hard time adjusting to the limitations his health problems were making on him. During our first interview, he went through so many emotions I couldn't even count them. They just bubbled out of him. He was crying and angry. I directed him to a dietician, taught him how to check his diabetes, and took him through the seven-step process. But probably the fact that he was diagnosed with depression helped him the most. He did not understand what he had. Providing a name for what he was feeling, making it clear that he wasn't doing something wrong but that he had a medical problem called depression, and that we were offering him a way to control the problem, made a huge difference. When people are depressed, they can't make any decisions. Treat their depression and it's like getting them back on their feet again. At the end of the process, it was like he was an entirely different man. I did a tape of his first and last sessions, and the difference was so dramatic, I think Mark Hegel uses it to educate his students."

Below, depression clinical specialist, Cora Hartwell, R.N., M.S.N., A.N.P. with patient.

Patient Larry Rice, 66

Larry Rice, 66, Group Health Cooperative, Seattle, WA

"When I was depressed, it felt like I was walking very slowly through a deep swamp. When they bumped me up from 30 to 45 milligrams of Remeron, the next day it was like somebody drained the swamp. Anytime you can get a good night's sleep, that makes a remarkable difference. That's probably a good part of the problem right there. I knew I was on the right track. There wasn't that sense of hopelessness and despair."

Rice's mental resilience was put to the test when, midway through his treatment, his daughter was killed in an automobile accident. "When I see the Twin Towers collapsing, that's a good representation of what I felt like when I heard that my daughter was killed." He has grieved but not succumbed to despair. A retired social worker, Rice has more energy than before and is working on an exercise program for himself. He is also volunteering at a senior center. "I've tried to raise their level of awareness about depression. I thank God for this study because it has enabled me to get a chance to improve my life. I'm a poster boy for its success."

Patient Tosca, 75

Daneen, 75, A Patient Who Chose Medication

On Grieving

"Dr. Grypma suggested I try this. I was just grieving over my son who passed away. He had congestive heart failure and died last year on Good Friday in Buffalo, New York. I'm from Buffalo, and that's where all my family is, and I just miss that family life. My daughter works and is divorced and I moved out to California, basically, to help my daughter take care of her daughter, picking her up at school and watching her until her mother comes home from work. In January, I was really down, would shake and tremble and all that. I have to watch my diet and take my medication and now have more good days than bad. Now I understand that grief can lead to depression, and so I'm taking Prozac, which has helped level things out. Recently, I went back to Buffalo and went to my son's grave, which I could never have done before, and am just able to handle things a lot better."

Tosca, 75, A Patient Who Chose PST And Added Medication

On Dealing With Family Issues

"I am divorced, have six children—one passed away at 16 and his best friend remained in our family—and when I first started I was very upset with something he did, very depressed over a lot of things that were happening in the family, and the problem-solving helped me work it through, let it go. It wasn't worth the money or the friendship or anything else. Then, I don't know what happened, but I became extremely suicidal. Rita put me on Prozac, which has helped quite a bit, and so between Prozac and PST, I am back to who I was and happy with it. My symptoms have all gone. There are no longer those terrible swings, up and down. Rita has done wonders for me. The program is wonderful. Everybody that I've spoken to that's in it has been very pleased and has benefited from it. Not only am I very surprised at the results, but at how fast they came around."

Donald E. Potter, M.D.
primary care physician

Donald E. Potter, M.D.,
Primary Care Physician,
Group Health Cooperative,
Seattle, WA

"I think there are certain things we don't talk about in this society, and depression has been one of them. In the past, a lot of patients would mostly talk about their physical problems and then, near the end of the interview, would say, oh by the way, I'm not sleeping or I'm depressed or my husband or wife think I'm depressed. Now, when patients come in, the nurses are more attuned to depression, and we give them this survey questionnaire to fill out so it's on the agenda rather than part of the hidden agenda. Hopefully, I was practicing good medicine and addressing depression in the past. But through this intervention, Kathleen Nierenberg used a few medications I would not necessarily feel comfortable with, like the one used with Larry Rice. He is on a medicine that I probably would not have pushed to that degree. It was interesting and exciting to see that drug being used and how well it worked. The IMPACT patients who have been treated for depression complain of physical symptoms less, I need to see them less, and I can address their physical issues more directly when I do."

Jeanne Dickens, M.D.,
Team Psychiatrist,
Regenstrief Institute for Health Care
Indiana University,
Indianapolis, IN

"Surprises and Unknowns in the Trial"

"The depth of social difficulty we saw and the level of complexity required to help patients at our site, came as a major surprise." Despite Dickens' clinical experience treating late-life depression, and her academic interest in depressive disorders in older patients, nothing quite prepared Dickens for the "socio-economic barriers and obstacles our patients faced trying to live out their true potential as human beings. We had patients who were nearly homeless. We saw patients who were not getting their basic nutritional needs met. We saw patients who didn't have adequate clothing. Some of our patients, mostly women, were overwhelmed because of childcare responsibilities."

Dickens is particularly pleased to have been a part of a treatment program that demonstrated its effectiveness in real live primary care outpatient settings. "I think the data speaks to and supports that claim. I saw it happening on a case by case basis, but what is most pleasing is that we in Indianapolis were not unique, that we can generalize the results to other types of treatment care settings nationwide."

On Getting The Word Out

"You want to actually be able to let primary care physicians, hospital policy planners and others know that this program works, and it will work where you are with some minor variations to take into account the unique characteristics of your setting and population. So I can't overstate the joy that I have experienced in being offered the opportunity to get involved in IMPACT and helping it be successfully implemented right here in Indianapolis. While we didn't understand that our patients had such obstacles, we also didn't know that the system would work as well as it did, that the PCPs would be so cooperative, so receptive and so willing to listen to what we had to say. We didn't know that our team would work together so well as a unified force to try to help our patients. There were lots of unknowns at the outset, but I think I can now look back and say, yes, it turned out well, it's been a positive experience for me and, more importantly, we've been able to actually bring about some positive gains in the lives of real people here in the city."

Walter Borschel, L.C.S.W., C.H.E., Primary Care Administrator, Kaiser Permanente, Southern California

On PCPs Giving Up Control of their Patients

"A lot of our doctors did not want to give up control of their patients. That was one of our early challenges. We didn't get a lot of referrals. We had a physician champion, Dr. Lydia Grypma, who was extremely helpful in terms of not only sharing patients, but sharing with other doctors how IMPACT could be helpful. I think a lot of physicians gradually began to realize that they could maintain control because there was someone in their primary care module who would be consulting them about medication or medication changes, so they could be in charge of the patient's treatment. So, over time, more and more doctors began seeing that the integration of a depression specialist really worked and began to refer patients.

Now we're more concerned about overwhelming Rita with her case load.

On What Surprised Him

"Some of our successes were with patients who had been seen in our psychiatry department for long periods of time and hadn't gotten better. They had chronic disabling depression. They not only got better but maintained their gains. That was extremely impressive and surprised me. I was also surprised by the number of people who stayed engaged in the study, which was more than I expected, and the utilization of the psychiatrist's time, which was actually less than I had expected. And I was surprised by the number of people who self-identified their need for services. So there were quite a lot of surprises.

On How IMPACT Changed Him

"It's made me more committed to Kaiser's doing a better job of treating depression within primary care. For three reasons. First, it increased my knowledge and understanding of how many depressed patients we see within primary care. Second, we can do something to make it better. Third, it looks like some of these things we could do by using our existing resources differently. Those are all things I feel very good about."

Below, left to right, Walter Borschel, L.C.S.W., C.H.E., and Andrew Golden, M.D., discussing IMPACT results at the Kaiser Permanente site in San Diego, CA.

Now that IMPACT has powerfully and persuasively demonstrated that depression can be successfully treated and managed in a primary care setting, most sites are laying the groundwork to preserve the intervention locally and are planning to continue offering the IMPACT model as their routine care. Many health care organizations already have nurses, social workers or psychologists who can be trained to provide IMPACT care, not just for depression but for other chronic diseases.

Site PI Enid Hunkeler, for example, a key member of Kaiser Permanente's national disease management team for depression, is highly committed to promoting IMPACT, and integrating it into the "fabric of how we deliver healthcare." She has developed an implementation strategy to do so. "We rolled it out at Kaiser's national Depression Initiative Conference. We've gotten Ohio interested. We funded a project in Southern California. And we're starting to present it to doctors and behavioral medicine specialists, to see how we can help them adapt it."

IMPACT is now a nationally recommended Kaiser model. In some locations it is being implemented as it was formulated for the clinical trial; in some locations, it is being adapted in a modified form. Hunkeler calls it "IMPACT Lite."

"We are an organization of 10,000 physicians," she points out, "a large number of whom are in primary care. My region alone has 100 primary care teams and 22 clinics. Kaiser does not impose its will, but we can drum up interest in recommended models. We go to regional meetings, help regions figure out what is best for them, given their resources, their population, etc., and if a region expresses interest in IMPACT, we will offer free training to their people."

Others within Kaiser are equally enthused about the model.

Kaiser's San Diego region is moving forward in the first quarter of 2003 to implement their adaptation of the initiative.

"Eleven percent of Kaiser Permanente's 500,000 patients in the San Diego service area are older adults," says Andrew Golden, M.D., Chief, Department of Family Practice, Kaiser Permanente, Southern California, "However, they make three times as many visits as the non-elderly." Golden is extremely impressed with IMPACT's success. While IMPACT is still in the midst of a detailed cost analysis, Kaiser's general feeling, says Golden, "is that treating people's depression effectively decreases other visits and other costs related to patients' feeling better and doing well."

"What we've learned," Golden adds, "is that PST is a workable model that doesn't need to be implemented by psychiatrists. We've learned that tracking can be done and makes a difference. The exciting part is the cooperation, integration and acceptance between psychiatry, primary care and patients. We felt it could happen, we just hadn't found a way to do it. This is one model that's really done it well." Equally exciting, says Golden, "The model shows us that we can use the same approach to other chronic diseases. What we are hoping to do in a primary care setting is use the same person to integrate the management of all our older patients' chronic illnesses."

Fact:

Patients older than the age of 65 spent more than $700 million in 1998 on the three top-selling anti-depressant medications alone.

"The challenge for us," says Walter Borschel, "is how can we take the key components that made this effective and integrate them into our system in a way that doesn't add a lot of cost to the care of members?"

Rita Haverkamp continues to deliver elements of the IMPACT model to patients in Kaiser Permanente's San Diego region. Unfamiliar with PST and "pretty skeptical" at the start of the study, she has gone from skeptic to passionate PST proselytizer, and hopes to teach other nurses as well as patients. "PST seems to be the thing I really like. I want to use it in whatever way I can."

At present, neither insurance companies nor Medicare or Medicaid pay for care management services. "We still live in a world," says John Williams, "where primary care physicians sometimes cannot bill and get paid for treating depression. The economic silos to pay for care are separate for physical and mental healthcare, which perpetuates the mind-body divide. And there is no parity. There are different limits on coverage for mental health and higher co-pays." Given these economic realities, even within capitated health care systems, collaborative care may be implemented in modified forms. For example, Kaiser in Southern California, in addition to making depression care part of a more comprehensive disease management program, plans to offer depression education groups and/or antide-pressant prescriptions by primary care providers earlier on, use clinical assistants working with a primary care R.N. to do the initial tracking and follow up,

Above, Enid Hunkeler, presenting research data from Project IMPACT to physicians and staff at the Fremont, CA, Kaiser Permanente clinic.

add a psychiatry staff person to primary care, and save the DCS — the most expensive part of the intervention —for their most difficult cases. Kaiser hopes to secure funding to study the impact of their model, and expects to look at the healthcare utilization costs of these patients over a three to five year period.

"We will tinker with the intervention," says Della Penna, "but it's terribly important that we measure as we tinker."

In Texas, thanks to the support of Jeff Griffin, M.D., director of the Internal Medicine Clinic at San Antonio's VA Medical Center, the Center is working to sustain the IMPACT model. Griffin has committed resources and allocated a nurse practitioner and psychiatrist at the clinic to deliver team care. "We're hoping that after we successfully get this off the ground," says Polly Hitchcock Noël, "we can show this to other directors and administrators within our VA region, and ultimately, try to assimilate it elsewhere through the VA, which serves several million veterans."

"The biggest challenge in primary care is that all those things take more dollars up front to better manage people's care of chronic diseases," says Mark Hegel. "Our belief is that down the road it saves hospitalization and also improves quality of life. But you have to be willing to spend the dollars up front."

The Desert Medical Group in Palm Springs is also planning to gradually integrate a DCS into its primary care practice. "We have 100,000 patients, 20,000 of whom are over 65," says Marc Hoffing. "Economically, our patients are mid-to-lower-income seniors enrolled in Medicare Plus Choice HMO programs. Because we are capitated for all professional care, we are allowed to allocate our resources as we see fit. We've essentially said we are going to reallocate our resources to use a DCS.

Right now, we are doing a kind of spin-off study for IMPACT applying the intervention to homebound elderly patients. Once that's up and running, then we'll go back and start offering it again as a direct referral from primary care physicians."

At Duke, Carol Saur has been hired to continue providing DCS services within the division of General Internal Medicine. Eugene Z. Oddone, M.D., M.H.Sc., was instrumental in bringing Saur on board. Since starting to offer IMPACT care to other patients in the clinic, she has been overwhelmed with referrals.

In Seattle, Elizabeth Lin and Wayne Katon are enhancing the role of a regular clinic nurse within Group Health, to cover some of the DCS functions. Mental health personnel within the clinic, to whom the sicker patients are referred, are being taught PST. "We are brainstorming what we can do to help sustain this model and improve care," says Lin. Katon and Lin are also conducting an NIH study using the IMPACT model for patients with diabetes.

Fact:

20 percent of older adults who commit suicide visit their primary care physician earlier that same day; 40 percent visit the same week; and 70 percent, a month prior to their suicide.

"Just as all politics are local," says Katon, "all health care is local. You have to figure out what are the strengths of your system, and who can do the job, without costing the system too much money."

Hartford's Pivotal Role

"It's very hard to get the appropriate amount of attention focused on older Americans," says Hunkeler. "I particularly commend the Foundation for not just taking this on, but for targeting the most difficult members of this population. That is exactly the role foundations should play, leading the way in the most ethical and moral directions, to find innovative solutions for these problems."

"There are a tremendous number of people over 60 who are depressed, and that number is growing all the time," notes Borschel. "Unfortunately, it is still more acceptable to focus on so-called 'hard' health problems, like congestive heart failure, than 'soft' ones. I don't think a lot of foundations have been willing to support looking at depression, in particular among the elderly. It took a certain amount of courage. I'm grateful to them for designing new models which those of us who work with these patients can try."

"Without these clinical trials to provide scientific evidence," emphasizes Lin, "we can't change policy, and we can't move the whole field forward. Hartford's role is visionary."

Barriers To Change

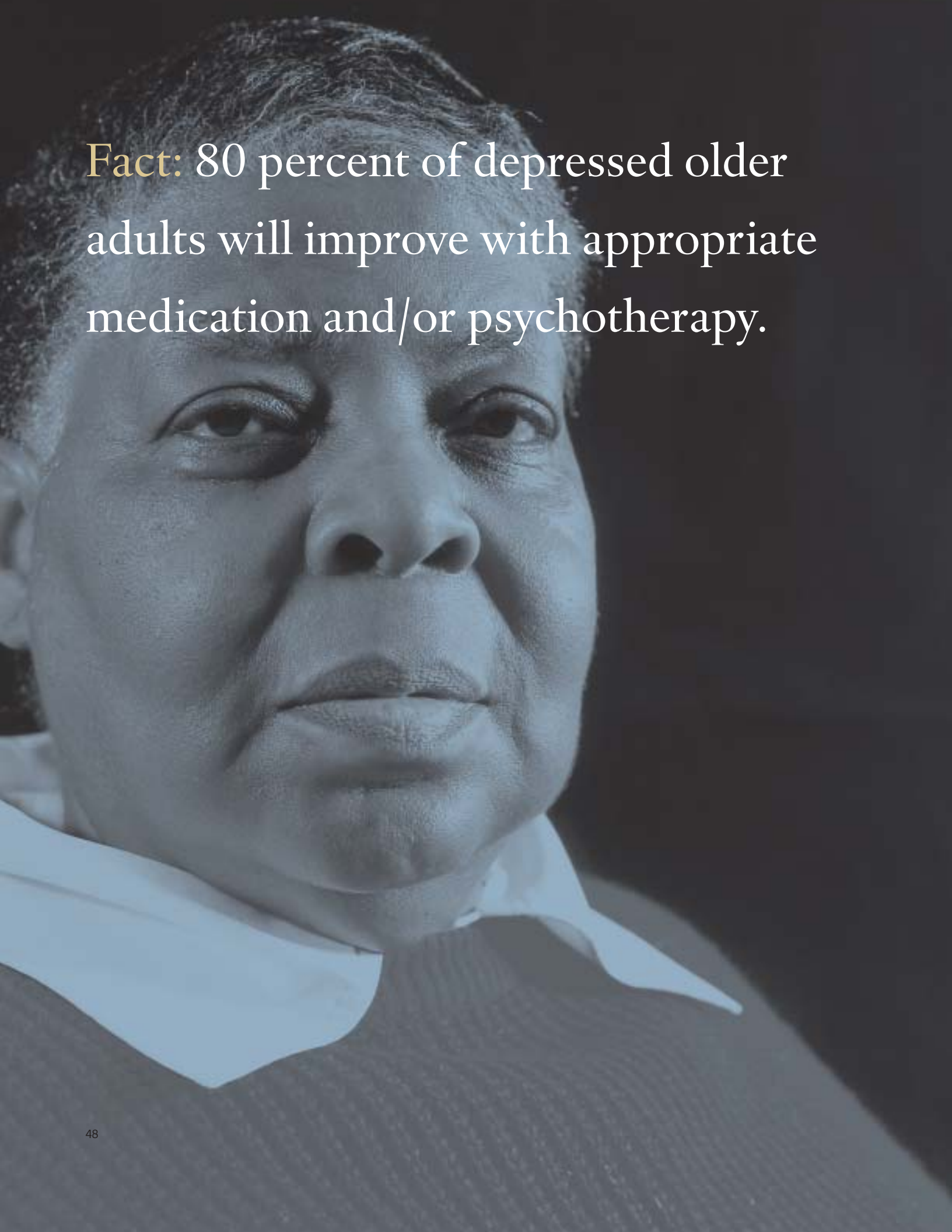
In an integrated HMO health care environment, such as Kaiser, Group Health, Desert Medical Group or the VA system, it is both feasible and sensible — clinically and financially — to allocate existing resources more effectively, so that investing more up front helps reduce usage of medical services, and costs, down the road.

In a fee-for-service primary care environment, which is where most of the Medicare world is located, the big question is how to afford a nurse or social worker doing the intervention, when reducing, say, hospital costs will not financially benefit the PCP. In fact, with Medicare and health insurance weighted towards remunerating "procedures," not towards reimbursing chronic health care maintenance, one could argue that reducing the primary care visits of a depressed patient might even diminish a physician's income. In short, the wrong financial incentives are in place to provide the type of collaborative, integrated treatment that we now know works best for patients.

As Hoffing observes, "It is an excellent intervention. For everybody to be able to use it would require a change in the way a lot of health is funded and delivered. There has to be reimbursement for it. Care that is not reimbursed turns into no care."

"Care is currently not organized for chronic illnesses and for seniors' needs," says Elizabeth Lin.

"There needs to be a paradigm change about what constitutes quality care for older Americans with chronic illnesses," says Wayne Katon. "The fact is that most elderly patients are not getting the kinds of caseworker services they need. Whether it's diabetes or depression, if you want to improve outcomes you have to have these care extenders and models in place. Regulators and insurers need to ask the right questions, such as how many people are actually getting better? And what are the direct and indirect costs to the patient, the family, the employer and medical system — not just the medical system?"



Fact: 80 percent of depressed older adults will improve with appropriate medication and/or psychotherapy.

MUCH HAS CHANGED FOR THE BETTER SINCE THE MID-1990S.

First, it is increasingly accepted that taking care of depression is the responsibility of the primary care physician. Not only is it appropriate and effective, it is considered part of high quality care in primary care to be concerned about depression. That is a major positive shift.

Second, other Foundations are making increased investments in the area of depression in primary care — working to increase public awareness, provider recognition and the availability of treatment guidelines as well as calling attention to economic issues, including developing innovative ways to pay for good care.

Third, there has been a groundswell of interest — from providers, health care plans, research agencies and government agencies — in improving the recognition and treatment of depression, something unheard of a decade ago.

Fourth, through the publication of IMPACT outcomes in a variety of medical, nursing and mental health journals, plus a full-court-press by participating members of the IMPACT team at their respective professional association meetings, a collaborative care treatment model for chronic illness is increasingly being viewed as the route to quality care and improved outcomes. "We're putting together a tool kit for presentations to academic audiences, to get the word out," says Hegel. He will be addressing psychology professionals involved in primary care mental health research, while others will be presenting to internal medicine, psychiatry, nursing, and family medicine.

The Hartford Foundation and the IMPACT team hope to capitalize on these changes and on the evidence their work has produced — and will produce — to help transform the way late-life depression is treated nationwide. In partnership with other organizations and foundations working on these issues, they hope to change the health care system: to enable both government and private health insurers to be rational and cost effective purchasers of care; to help providers deliver the highest quality care of which they are capable; and to ensure that older people enjoy improved health, function and quality of life. Current plans include: offering training and technical assistance to organizations adopting the IMPACT model; continuing economic and policy analysis to identify changes needed to stimulate adoption; and creating educational opportunities for future health care professionals to learn how to do this kind of work in the future.

Depression in older adults no longer is falling between the cracks.

In 2002, The John A. Hartford Foundation awarded 14 grants under its Aging and Health program totaling $6,039,846.

New York Academy of Medicine
New York, NY
Practicum Partnership Program Coordinating Center
Patricia J. Volland, M.B.A., M.S.W.
$950,000, Three Years

The New York Academy of Medicine will use its support to continue to lead a six-site demonstration of an aging-rich rotational model of field instruction for master's social work trainees. Each site consists of partnerships between one or more schools plus community health and social service organizations. This is a renewal of a previous grant. The Academy will support the sites' work in the final year of the program, facilitate dissemination and adoption, and lead a national effort to engage public policy-makers in the quest for improved training for future social workers who will care for older adults.

Society of General Internal Medicine
Washington, DC
Increasing Education and Research Capacity to Improve Care of Older Americans
C. Seth Landefeld, M.D.
$1,641,931, Three Years

With this grant, the Society of General Internal Medicine will create ten formal academic health center collaborations between divisions of general internal medicine and geriatrics and, in tandem with the Association of Program Directors in Internal Medicine, will work to enhance geriatrics content in medical residency programs. Both organizations will attempt to foster increased research and teaching relevant to generalist physician care of older adults.

New York University
New York, NY
Geriatric Interdisciplinary Team Training Dissemination
Terry T. Fulmer, Ph.D., R.N.
$273,967, 28 Months

This grant renews support for the Geriatric Interdisciplinary Team Training (GITT) Resource Center, which has been housed at New York University's Division of Nursing since 1995. It will facilitate the adoption of interdisciplinary training models in at least six institutions through a small grants program. Also, it will support other programs with consulting and educational materials. Increased training in interdisciplinary teamwork will better prepare future health professionals to care for older adults.

American Society of Clinical Oncology
Alexandria, VA
Enhancing Geriatric Oncology Training: Cohort Expansion
Charles M. Balch, M.D.
John M. Bennett, M.D.
$335,000, Four Years

Augmenting an earlier award, this grant will enable the American Society of Clinical Oncology (ASCO) to support two additional centers, for a total of ten centers, that will develop future leaders trained in both geriatrics and oncology and foster research that enhances the care of older cancer patients.

American Academy of Homecare Physicians
Edgewood, MD
Transitioning of Home Care Certifying Exam
Constance F. Row
$20,000, One Year

This grant will enable the American Academy of Homecare Physicians to improve homecare, a vital service for older adults, by supporting the administration of a certifying exam to interested health care professionals.

American Geriatrics Society, Inc.
New York, NY
Geriatric Tools Distribution Project Augmentation
Nancy E. Lundebjerg, M.P.A.
$341,187, 30 Months

The American Geriatrics Society (AGS) will use this award to distribute 19,000 booklets and pocket cards containing geriatric information to future physicians and nurses as they train to care for older adults. An electronic version of the booklets will also be created for use on handheld personal digital assistants, including the Palm Pilot.

Medical students, residents and nurse practitioners will receive the AGS's *Geriatrics at Your Fingertips* pocket guide (http://www.geriatricsatyourfingertips.org) and Stanford University's *Tools for Geriatrics Care* pocket card (http://sfdc.stanford.edu/sugerc/resource3.html). The latter was developed by a Foundation-supported consortium of geriatricians, working with internal and family medicine residency programs. The AGS will distribute each tool to some 8,000 resident physicians and 11,000 nurse practitioner trainees. When complete, the electronic version of *Geriatrics at Your Fingertips* will be available at no cost in return for user registration and completion of a brief geriatrics questionnaire.

Centers of Excellence in Geriatric Medicine: Renewals
$1,800,000, Three Years

The John A. Hartford Foundation renewed six grants in order to continue to increase the number of physician faculty dedicated to geriatrics. These grants allow academic health centers to provide support for fellows and junior faculty beginning their careers in academic geriatrics as well as efforts to attract academic physicians from other areas of medicine to geriatric issues.

The Foundation's Centers of Excellence in Geriatric Medicine program began in 1988 to meet the need for physician faculty trained to advance research and prepare physicians in the health care needs of older adults. There are currently 20 centers located around the nation. They have succeeded in increasing the number of academically-oriented physicians trained in geriatrics. In addition, these faculty have strengthened geriatrics in their institutions by obtaining additional research funds and developing new approaches to education and training.

Duke University
Durham, NC
Harvey Cohen, M.D.
$300,000, Three Years

University of California, Los Angeles
Los Angeles, CA
David Reuben, M.D.
$300,000, Three Years

Harvard Medical School
Boston, MA
Lewis Lipsitz, M.D.
$300,000, Three Years

University of Michigan
Ann Arbor, MI
Jeffrey Halter, M.D.
$300,000, Three Years

Johns Hopkins University
Baltimore, MD
John Burton, M.D.
$300,000, Three Years

Mount Sinai Medical Center
New York, NY
Rosanne Leipzig, M.D.,Ph.D.
$300,000, Three Years

Foundation Administered Grant
Extending Gains and Celebrating our 75th Anniversary
$368,551, Three Years

Using the opportunity provided by the Foundation's upcoming milestone anniversary in 2004, grantees, consultants and staff will create and disseminate materials for advancing geriatric care and training based on Hartford's Aging and Health programs. An expanded Annual Report, colloquia at key stakeholder meetings and an academic journal supplement are to be produced as part of the project. The publications developed for the project will also be available on the Foundation's Web site.

Highlighting the expertise of the Foundation's grant recipients, these materials will focus on the role of academia in creating the knowledge to provide high quality care for older adults and to meet the information and training needs of doctors, nurses and social workers. Emphasis will also be placed on the role of practitioners in creating new delivery mechanisms and interdisciplinary models for improved gerontological care. The project will offer academic leaders, practitioners, policy makers, health care leaders and foundation executives practical ideas to improve geriatric training, research and practice.

American Federation for Aging Research (AFAR) Inc.
New York, NY
Communications and Dissemination Initiative
Stephanie Lederman
$309,210, Three Years

With this renewal grant, American Federation for Aging Research (AFAR) staff and consultants will continue to provide aging and health communications training and support to the Foundation's grantees.

Activities will include dissemination consulting for grantees; meetings to instruct young faculty leaders in gerontological medicine, nursing and social work on strategic communications planning and media skills; and workshops to bring leaders of major Foundation grant programs together for skills training. In addition, AFAR will provide communications support to Foundation staff so that its work may be more effectively conveyed to the media, the funding community, and policy makers.

Financial Reports

On December 31, 2002, the Foundation's assets were $489.2 million, a decrease of $98.7 million for the year after cash payments of $30.9 million for grants, expenses and Federal excise tax. Total return on the investments, income plus realized and unrealized capital gains, was negative 12.2 percent.

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.

Although the Foundation's assets fell in 2002 for the second consecutive year, we were gratified that the negative performance was less than many of the broad stock market averages both here and abroad. It again proved that prudent diversification of the portfolio by investment style and into alternative asset classes that can produce good absolute returns and take advantage of the volatility in the market can enable a foundation with a long time horizon to withstand a difficult investment environment. At the end of the year the Foundation's asset mix was 69 percent equities, both traditional and alternative, 10 percent fixed income, and a combined 21 percent in venture capital, private equity, real estate, event-driven and hedge fund partnerships, virtually the same allocation as at the end of 2001.

As of December 31, 2002, Capital Guardian Trust Company, Sound Shore Management, William Blair & Co., T. Rowe Price Associates, Wasatch Advisors, Pequot Capital Management and Andor 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, 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., Heitman/JMB Advisory Corporation and High Rise Institutional Partners. Event-driven investment managers are Angelo, Gordon & Co., Canyon Capital Partners, Halcyon/Alan B. Slifka Management Co. and Whippoorwill Associates.

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. JPMorgan Chase Bank, N.A. is custodian for all the Foundation's securities. A complete listing of investments is available for review at the Foundation offices.

Independent Auditors' Report

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

Ladies and Gentlemen:

We have audited the balance sheets of The John A. Hartford Foundation, Inc. (a New York not-for-profit corporation) as of December 31, 2002 and 2001 and the related statements of revenues, grants and expenses and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The John A. Hartford Foundation, Inc. as of December 31, 2002 and 2001 and its changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audit was made for the purpose of forming an opinion on the basic financial statements taken as a whole. The data contained in pages 65 to 73, 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 4, 2003

The John A. Hartford Foundation, Inc. **Exhibit A**
Balance Sheets
December 31, 2002 and 2001

	2002	*2001*
Assets		
Cash in operating accounts	$ 5,739	$ 7,511
Interest and dividends receivable	380,725	777,871
Prepayments and deposits	137,270	132,537
Prepaid taxes	166,346	210,407
	690,080	1,128,326
Investments, at fair value or adjusted cost (Notes 2 and 3)		
Short-term cash investments	24,790,877	26,640,558
Stocks	334,472,975	400,873,649
Bonds	24,084,564	39,710,012
Investment partnerships	74,733,413	99,179,475
Real estate pooled funds	26,756,828	16,379,307
Total Investments	484,838,657	582,783,001
Office condominium, furniture and equipment (net of accumulated depreciation of $1,531,211 in 2002 and $1,190,953 in 2001) (Note 5)	3,643,849	3,984,107
Total Assets	$489,172,586	$587,895,434
Liabilities and Net Assests		
Liabilities:		
Grants payable (Note 2)		
Current	$ 24,429,159	$ 22,312,600
Non-current (Note 7)	33,632,050	59,438,570
Accounts payable	633,104	617,983
Deferred Federal excise tax (Note 2)	31,869	691,656
Total Liabilities	58,726,182	83,060,809
Net Assets - Unrestricted		
Board designated (Note 2)	2,549,886	6,570,668
Undesignated	427,896,518	498,263,957
Total Net Assets (Exhibit B)	430,446,404	504,834,625
Total Liabilities and Net Assets	$489,172,586	$587,895,434

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

The John A. Hartford Foundation, Inc. **Exhibit B**
Statements of Revenues, Grants and Expenses and Changes in Net Assets
Years Ended December 31, 2002 and 2001

	2002	*2001*
Revenues		
Dividends and partnership earnings	$ 4,396,766	$ 4,956,994
Bond interest	1,361,970	3,512,748
Short-term investment earnings	603,425	2,232,768
Total Revenues	6,362,161	10,702,510
Grants and Expenses		
Grant expense (less cancellations and refunds of $8,543,775 in 2002 and $559,374 in 2001)	1,801,933	42,887,719
Foundation-administered projects	404,835	601,460
Grant-related direct expenses	108,426	108,358
Excise and unrelated business income taxes (Note 2)	262,302	139,282
Investment fees	1,628,048	1,850,339
Personnel salaries and benefits (Note 6)	2,104,186	1,974,176
Office and other expenses	871,255	938,958
Depreciation	340,258	340,924
Professional services	70,824	110,876
Total Grants and Expenses	7,592,067	48,952,092
Excess (deficiency) of revenues over grants and expenses	(1,229,906)	(38,249,582)
Net Realized and Change in Unrealized Gains (Losses) (Note 3)	(73,158,315)	(15,641,886)
Increase (Decrease) in Net Assets	(74,388,221)	(53,891,468)
Net Assets, beginning of year	504,834,625	558,726,093
Net Assets, End of Year (Exhibit A)	$430,446,404	$504,834,625

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, 2002 and 2001

	2002	*2001*
Cash Flows Provided (Used)		
From Operating Activities:		
Interest and dividends received	$ 5,249,088	$ 11,273,570
Cash distributions from partnerships and real estate pooled funds	4,852,034	4,673,358
Grants and Foundation-administered projects paid (net of refunds)	(25,879,931)	(24,751,969)
Expenses and taxes paid	(5,007,390)	(5,649,977)
Net Cash Flows Provided (Used) by Operating Activities	(20,786,199)	(14,455,018)
From Investing Activities:		
Proceeds from sale of investments	221,506,132	329,512,219
Purchases of investments	(202,427,830)	(307,789,983)
Sale of fixed assets	–	425
Net Cash Flows Provided (Used) by Investing Activities	19,078,302	21,722,661
Net Increase (Decrease) in Cash and Equivalents	(1,707,897)	7,267,643
Cash and equivalents, beginning of year	26,439,401	19,171,758
Cash and equivalents, end of year	$ 24,731,504	$ 26,439,401
Reconciliation of Decrease in Net Assets to Net Cash Used by Operating Activities		
Increase (Decrease) in Net Assets	$ (74,388,221)	$ (53,891,468)
Adjustment to reconcile increase in net assets to net cash used by operating activities:		
Depreciation	340,258	340,924
Decrease in interest and dividends receivable	397,146	2,414,048
Increase in prepayments and deposits	(4,733)	(25,227)
Increase (decrease) in grants payable	(23,689,961)	18,730,411
Decrease in accounts payable	(28,256)	(42,798)
Net realized and change in unrealized (gains) losses	73,158,315	15,641,886
Other	3,429,253	2,377,206
	$ (20,786,199)	$ (14,455,018)

The John A. Hartford Foundation, Inc. **Exhibit C**
Statements of Cash Flows
Years Ended December 31, 2002 and 2001

	2002	*2001*
Supplemental Information:		
Detail of other:		
Investment partnerships and real estate pooled funds:		
Cash distributions	$ 4,852,034	$ 4,673,358
Less: reported income	1,510,220	1,842,988
	3,341,814	2,830,370
Tax expense	262,302	139,282
Less: Taxes paid	174,863	592,446
Excess (tax on realized gains and change in prepaid/payable)	87,439	(453,164)
Total - Other	$ 3,429,253	$ 2,377,206
Composition of Cash and Equivalents:		
Cash in operating accounts	$ 5,739	$ 7,511
Short-term cash investments	24,790,877	26,640,558
Unrealized (gain) loss on forward currency contracts	(65,112)	(208,668)
	$24,731,504	$26,439,401

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, 2002 and 2001

1. Purpose of Foundation

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

2. Summary of Significant Accounting Policies

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

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

All net assets of the Foundation are unrestricted.

Investments
Investments in marketable securities are valued at their fair value (quoted market price). Investment partnerships where the Foundation has the right to withdraw its investment at least annually are valued at their fair value as reported by the partnership. Investment partnerships, real estate partnerships and REIT's which are illiquid in nature are recorded at cost adjusted annually for the Foundation's share of distributions and undistributed realized income or loss. Valuation allowances are also recorded on a group basis for declines in fair value below recorded cost. Realized gains and losses from the sale of marketable securities are recorded by comparison of proceeds to cost determined under the average cost method.

Grants
The liability for grants payable is recognized when specific grants are authorized by the Board of Trustees and the recipients have been notified. Annually the Foundation reviews its estimated payment schedule of long-term grants and discounts the grants payable to present value using the prime rate as quoted in the Wall Street Journal at December 31 to reflect the time value of money. The amount of the discount is then recorded as designated net assets. Also recorded as designated net assets are conditional grants for which the conditions have not been satisfied.

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

Tax Status
The Foundation is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code and has been classified as a "private foundation." The Foundation is subject to an excise tax on net investment income at either a 1% or 2% rate depending on the amount of qualifying distributions. For 2002 and 2001 the Foundation's rate was 1%.

The John A. Hartford Foundation, Inc. Exhibit D
Notes to Financial Statements
December 31, 2002 and 2001

2. Summary of Significant Accounting Policies (Continued)

Investment expenses for 2002 include direct investment fees of $1,628,048 and $131,000 of allocated salaries, legal fees and other office expenses. The 2001 comparative numbers were $1,850,339 and $134,000.

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

The Foundation intends to distribute at least $25,800,000 of undistributed income in grants or qualifying expenditures by December 31, 2003 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 (losses) in 2002 are summarized as follows:

	Cost	*Fair Value*	*Appreciation*
Balance, December 31, 2002	$481,651,723	$484,838,657	$ 3,186,934
Balance, December 31, 2001	$513,617,368	$582,783,001	$ 69,165,633
Decrease in unrealized appreciation during the year, net of decreased deferred Federal excise tax of $659,787			$(65,318,912)
Realized loss			(7,839,403)
Net realized and change in unrealized gains (losses)			$(73,158,315)

For 2001, the unrealized loss was $48,738,759, net of decreased deferred Federal excise tax of $492,311. The realized gain was $33,096,873 net of a provision for Federal excise tax of $334,312.

Receivables and payables on security sales and purchases pending settlement at December 31, 2002 and 2001 were as follows:

	2002	*2001*
Proceeds from sales	$ 701,922	$ 179,708
Payables from purchases	(768,204)	(159,937)
Net cash pending settlement	$ (66,282)	$ 19,771

3. Investments (Continued)

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:

	2002	*2001*
U.S. Government	$23,729,647	$39,258,262
Corporate	354,917	451,750
	$24,084,564	$39,710,012

The Foundation is a participant in thirteen investment limited partnerships. As of December 31, 2002, $87,069,769 had been invested in these partnerships and future commitments for additional investment aggregated $2,930,231.

In addition, the Foundation was a participant in three other investment partnerships which are either in liquidation or have reached the completion of their original term and are winding down. The recorded value of the these investments is $318,925.

Three of the Foundation's investment partnerships permit withdrawals at least once a year. These are valued at their fair value, $56,184,372 (adjusted cost $58,887,447).

Real estate investments included three limited partnerships and five real estate investment trusts. The Foundation had invested $27,850,000 at December 31, 2002 and future commitments for additional investment aggregated $17,150,000. In addition, one other real estate investment with a recorded value of $35,231 has completed its term and is winding down.

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, 2002 the Foundation's open foreign currency forward sale and purchase contracts totaled $2,060,925. Total foreign denominated investments at the same date were $20,749,641.

5. Office Condominium, Furniture and Equipment

At December 31, 2002 and 2001 the fixed assets of the Foundation were as follows:

	2002	*2001*
Office condominium	$4,622,812	$4,622,812
Furniture and equipment	552,248	552,248
	5,175,060	5,175,060
Less: Accumulated depreciation	1,531,211	1,190,953
Office condominium, furniture and equipment, net	$3,643,849	$3,984,107

The John A. Hartford Foundation, Inc. Exhibit D
Notes to Financial Statements
December 31, 2002 and 2001

6. Pension Plan

The Foundation has a defined contribution retirement plan covering all eligible employees under which the Foundation contributes 14% of salary for employees with at least one year of service. Pension expense under the plan for 2002 and 2001 amounted to $188,580 and $149,547, respectively. The Foundation also incurred additional pension costs of approximately $24,000 in 2002 and 2001 for payments to certain retirees who began employment with the Foundation prior to the initiation of the formal retirement plan.

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

7. Grants Payable

The Foundation estimates that the non-current grants payable as of December 31, 2002 will be disbursed as follows:

2004	$17,781,321
2005	11,115,630
2006	5,101,728
2007	2,083,198
2008	100,059
	36,181,936
Discount to present value	(2,549,886)
	$33,632,050

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 2002 and 2001 was 4.25% and 4.75%, respectively.

At December 31, 2001, a portion of a grant in the amount of $522,550 was contingent on the grantee raising additional funds. This amount was shown as part of board designated net assets. During 2002, this condition was satisfied and the amount has been included in grant expense.

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:

	2002	*2001*
Partnership earnings	$ 774,573	$ 702,421
Realized gains (loss)- net of taxes of $9,165 in 2001	(114,479)	(907,271)
Unrealized gain (loss) - net of deferred excise tax provision (recovery) of $(18,095) and $2,804	(1,791,394)	277,543
	$(1,131,300)	$ 72,693

Summary of Active Grants

		Balance Due January 1, 2002	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2002
AGING AND HEALTH					
Academic Geriatrics and Training					
American Academy of Home Care Physicians *Transitioning of Home Care Certifying Exam* Constance F. Row, F.A.C.H.E.	Edgewood, MD		$ 20,000	$ 20,000	
American Academy of Nursing *Nursing Initiative Coordinating Center and Scholar Stipends* Claire M. Fagin, Ph.D., R.N., F.A.A.N.	Washington, DC	$ 6,443,145		1,215,685	$ 5,227,460
American Academy of Nursing *Nursing School Geriatric Investment Program* Claire M. Fagin, Ph.D., R.N., F.A.A.N.	Washington, DC	1,831,035		340,088	1,490,947
American Association of Colleges of Nursing *Enhancing Geriatric Nursing Education at Baccalaureate and Advanced Practice Levels* Geraldine Polly Bednash, Ph.D., R.N., F.A.A.N.	Washington, DC	2,603,548		262,948	2,340,600
American Association of Colleges of Nursing *Creating Careers in Geriatric Advanced Practice Nursing* Geraldine Polly Bednash, Ph.D., R.N., F.A.A.N.	Washington, DC	2,000,518		423,190	1,577,328
American Federation for Aging Research, Inc. *Paul Beeson Physician Faculty Scholars in Aging Research Program* *Stephanie Lederman*	New York, NY	8,539,626		2,505,936	6,033,690
American Federation for Aging Research, Inc *Medical Student Geriatric Scholars Program (Renewal)* Odette van der Willik	New York, NY	1,206,059		805,078	400,981
American Federation for Aging Research, Inc. *Centers of Excellence Coordinating Center* Odette van der Willik	New York, NY	901,589		435,443	466,146
American Geriatrics Society, Inc. *Increasing Geriatrics Expertise in Surgical and Medical Specialties - Phase III* John R. Burton, M.D David H. Solomon, M.D.	New York, NY	5,291,866		932,754	4,359,112
American Geriatrics Society, Inc. *Integrating Geriatrics into the Subspecialties of Internal Medicine* William R. Hazzard, M.D.	New York, NY	1,276,644		366,776	909,868
American Geriatrics Society, Inc. *Distribution of Geriatrics Educational Materials* Nancy E. Lundebjerg	New York, NY	220,900	341,187	390,337	171,750
American Geriatrics Society, Inc *Enhancing Geriatric Care Through Practicing Physician Education, Phase II* Sharon A. Levine, M.D. Bruce E. Robinson, M.D.	New York, NY	132,805		132,805	

Summary of Active Grants

		Balance Due January 1, 2002	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2002
American Society of Clinical Oncology *Enhancing Geriatric Oncology Training* Charles M. Balch, M.D. John M. Bennett, M.D.	Alexandria, VA	$ 1,725,907	$ 335,000	$ 264,705	$ 1,796,202
Association of American Medical Colleges *Enhancing Geriatrics in Undergraduate Medical Education* M. Brownell Anderson	Washington, DC	1,786,020		1,222,336	563,684
Association of Directors of Geriatric Academic Programs *Geriatric Leadership Development Program* David B. Reuben, M.D.	New York, NY	1,286,556		155,326	1,131,230
Association of Directors of Geriatric Academic Programs *Developing a New Generation of Academic Programs in Geriatrics* William J. Hall, M.D.	New York, NY	763,875			763,875
Baylor College of Medicine *Center of Excellence* George E. Taffet, M.D.	Houston, TX	300,000		132,976	167,024
Boston Medical Center *Center of Excellence* Rebecca A. Silliman, M.D., Ph.D.	Boston, MA	300,000		122,009	177,991
Council on Social Work Education *Preparing Gerontology-Competent Social Workers: Phase II* Frank R. Baskind, Ph.D.	Alexandria, VA	1,163,767		737,252	426,515
Council on Social Work Education *Transforming Geriatric Social Work Education* Nancy Hooyman, Ph.D.	Alexandria, VA	2,817,329		2,172,575	644,754
Duke University *Center of Excellence* Harvey J. Cohen, M.D.	Durham, NC	225,000	300,000	149,180	375,820
Emory University *Southeast Center of Excellence* Joseph Ouslander, M.D.	Atlanta, GA	375,000		116,805	258,195
Gerontological Society of America *Hartford Geriatric Social Work Faculty Scholars Program and National Network* Barbara J. Berkman, D.S.W.	Washington, DC	4,862,606		1,586,266	3,276,340
Gerontological Society of America *Hartford Geriatric Social Work Doctoral Fellows Program* James E. Lubben, D.S.W.	Washington, DC	1,782,267		140,000	1,642,267
Harvard Medical School *Center of Excellence* Lewis A. Lipsitz, M.D.	Boston, MA	225,000	300,000	145,005	379,995

		Balance Due January 1, 2002	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2002
Hunter College, City University of New York *Geriatric Social Work Practicum Implementation* Joann Ivry, D.S.W.	New York, NY	$ 75,000		$ 25,885	$ 49,115
Johns Hopkins University *Center of Excellence* John R. Burton, M.D.	Baltimore, MD	222,060	$ 300,000	132,292	389,768
Mount Sinai Medical Center *Center of Excellence* Rosanne M. Leipzig, M.D., Ph.D	New York, NY	151,973	300,000	75,000	376,973
New York Academy of Medicine *Geriatric Social Work Practicum Implementation: Coordinating Center* Patricia J. Volland, M.S.W., M.B.A.	New York, NY	182,608	950,000	432,771	699,837
New York University *The John A. Hartford Foundation Institute for Geriatric Nursing* Mathy D. Mezey, Ed.D., R.N., F.A.A.N.	New York, NY	4,300,000		984,936	3,315,064
New York University *Geriatric Interdisciplinary Team Training Program: Resource Center Renewal* Terry T. Fulmer, Ph.D., R.N., F.A.A.N.	New York, NY	107,690	273,967	221,644	160,013
Oregon Health & Science University *Center of Geriatric Nursing Excellence* Patricia G. Archbold, D.N.Sc., R.N., F.A.A.N.	Portland, OR	1,062,896		208,447	854,449
Partners in Care Foundation, Inc. *Geriatric Social Work Practicum Implementation* W. June Simmons, L.C.S.W.	Burbank, CA	125,000		125,000	
RAND Corporation *Developing Interdisciplinary Research Centers for Improving Geriatric Health Care Services* Harold Alan Pincus, M.D.	Arlington, VA	1,105,776			1,105,776
Society of General Internal Medicine *Increasing Education and Research Capacity to Improve Care of Older Americans* C. Seth Landefeld, M.D.	Washington, DC		1,641,931	151,302	1,490,629
Stanford University *Enhancing Dissemination of Innovations in Geriatric Education* Georgette A. Stratos, Ph.D.	Stanford, CA	382,075		149,837	232,238
State University of New York, Albany *Geriatric Social Work Practicum Implementation* Anne E. Fortune, Ph.D.	Albany, NY	74,507		33,874	40,633
University of Alabama at Birmingham *Southeast Center of Excellence* Richard M. Allman, M.D.	Birmingham, AL	375,000		134,746	240,254

Summary of Active Grants

		Balance Due January 1, 2002	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2002
University of Arkansas for Medical Sciences *Center of Geriatric Nursing Excellence* Claudia J. Beverly, Ph.D., R.N., F.A.A.N.	Little Rock, AR	$ 1,065,000		$ 219,243	$ 845,757
University of California, Berkeley *Geriatric Social Work Practicum Implementation* Barrie Robinson, M.S.S.W.	Berkeley, CA	145,015		53,944	91,071
University of California, Los Angeles *Center of Excellence* David B. Reuben, M.D.	Los Angeles, CA	150,136	$ 300,000	48,234	401,902
University of California, San Francisco *Center of Geriatric Nursing Excellence* Jeanie Kayser-Jones, Ph.D., R.N., F.A.A.N.	San Francisco, CA	1,064,509		202,945	861,564
University of California, San Francisco *Center of Excellence* C. Seth Landefeld, M.D.	San Francisco, CA	350,000		156,442	193,558
University of Chicago *Center of Excellence* Greg A. Sachs, M.D.	Chicago, IL	319,817		168,025	151,792
University of Colorado *Center of Excellence* Andrew M. Kramer, M.D	Denver, CO	300,000		160,074	139,926
University of Hawaii *Center of Excellence* Patricia L. Blanchette, M.D., M.P.H.	Honolulu, HI	375,000		42,955	332,045
University of Houston *Geriatric Social Work Practicum Implementation* Virginia Cooke Robbins, L.M.S.W.-A.C.P.	Houston, TX	104,220		56,784	47,436
University of Iowa *Center of Geriatric Nursing Excellence* Meridean L. Maas, Ph.D., R.N., F.A.A.N.	Iowa City, IA	1,064,450		194,459	869,991
University of Michigan *Center of Excellence* Jeffrey B. Halter, M.D.	Ann Arbor, MI	152,143	300,000	63,651	388,492
University of Michigan *Geriatric Social Work Practicum Implementation* Ruth E. Dunkle, Ph.D.	Ann Arbor, MI	75,000		37,017	37,983
University of Pennsylvania *Center of Geriatric Nursing Excellence* Neville E. Strumpf, Ph.D., R.N., C, F.A.A.N.	Philadelphia, PA	1,065,000		134,040	930,960
University of Pennsylvania *Center of Excellence* Jerry C. Johnson, M.D	Philadelphia, PA	244,531		132,947	111,584
University of Pittsburgh *Center of Excellence* Neil M. Resnick, M.D.	Pittsburgh, PA	414,895			414,895

		Balance Due January 1, 2002	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2002
University of Rochester *Center of Excellence* William J. Hall, M.D.	Rochester, NY	$ 303,223			$ 303,223
University of Texas Health Science Center at San Antonio *Center of Excellence* David V. Espino, M.D.	San Antonio, TX	303,604		$ 124,603	179,001
University of Washington *Center of Excellence* Itamar B. Abrass, M.D.	Seattle, WA	450,000			450,000
Yale University *Center of Excellence* Mary E. Tinetti, M.D.	New Haven, CT	375,000		44,966	330,034
Subtotal		$64,547,190	$ 5,362,085	$19,291,538	$50,617,737
AGING AND HEALTH **Integrating and Improving Services**					
Buffalo General Foundation *Home Hospital National Demonstration* Bruce J. Naughton, M.D.	Buffalo, NY	128,899		77,160	51,739
Carle Foundation Hospital *Evaluation of Geriatric Team Care in Medicare Risk* Cheryl Schraeder, Ph.D., R.N	Urbana, IL	265,547		86,828	178,719
Duke University *Improving Depression Care for Elders* Linda H. Harpole, M.D.	Durham, NC	239,068		205,413	33,655
Fallon Community Health Plan *Home Hospital National Demonstration* Jeffrey B. Burl, M.D	Worcester, MA	296,940		73,595	223,345
Group Health Cooperative of Puget Sound *Delivering Effective Primary Care to Older Adults: The Senior Resource Team at Group Health Cooperative* Edward H. Wagner, M.D., M.P.H.	Seattle, WA	1,272,837		281,847	990,990
Indiana University *Improving Depression Care for Elders* Christopher M. Callahan, M.D.	Indianapolis, IN	296,458		224,504	71,954
Intermountain Health Care *Evaluating the Impact of Geriatric Care Teams* Paul D. Clayton, Ph.D.	Salt Lake City, UT	1,248,373		295,474	952,899
Johns Hopkins University *Home Hospital National Demonstration and Evaluation: Coordinating Center* John R. Burton, M.D	Baltimore, MD	1,000,567		432,669	567,898

Summary of Active Grants

		Balance Due January 1, 2002	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2002
The National Council on the Aging, Inc. *Promoting Vital Aging Through Teamwork Between Community Organizations and Health Care Providers* Nancy A. Whitelaw, Ph.D.	Washington, DC	$ 999,514		$ 259,419	$ 740,095
National PACE Association *Expanding the Availability of the PACE Model of Care* Shawn M. Bloom	Alexandria, VA	375,000		262,658	112,342
National PACE Association *Accelerating State Access to PACE* Peter Fitzgerald	Alexandria, VA	609,916		95,067	514,849
Omega of Palm Beach County, Inc. *Senior Services Program Implementation* Kerry A. Rodriguez Diaz, J.D.	West Palm Beach, FL	979,816		330,671	649,145
Partners in Care Foundation, Inc. *Preventing Medication Errors: the Home Health Medication Management Model* W. June Simmons, L.C.S.W.	Burbank, CA	228,821		155,628	73,193
PeaceHealth Oregon Region *A Senior Health Center Interdisciplinary Team Approach: Health and Organizational Outcomes* Ronald D. Stock, M.D	Eugene, OR	958,607		349,455	609,152
Portland VA Medical Center *Home Hospital National Demonstration* *Scott L. Mader, M.D.*	Portland, OR	192,741		159,153	33,588
Rush-Presbyterian-St. Luke's Medical Center *Virtual Integrated Practice: A New Approach to Health Care Teams* Steven K. Rothschild, M.D.	Chicago, IL	1,477,230		403,608	1,073,622
Spartanburg Regional Medical Center Foundation *Improving Geriatric Care in Rural Healthcare Delivery Systems* R. Bradford Whitney, M.D.	Spartanburg, SC	88,854		88,854	
State University of New York, Albany *The Capital District: Creating an Aging-Prepared Community* Philip McCallion, Ph.D	Albany, NY	50,350			50,350
University of California, Los Angeles *Improving Depression Care for Elders: Coordinating Center* Jürgen Unützer, M.D., M.P.H.	Los Angeles, CA	1,306,108		425,878	880,230
University of California, Los Angeles *Improving Depression Care for Elders* Jürgen Unützer, M.D., M.P.H.	Los Angeles, CA	401,466		196,563	204,903
University of Colorado *An Interdisciplinary Team Approach to Improving Transitions Across Sites of Geriatric Care* Eric A. Coleman, M.D., M.P.H.	Denver, CO	935,242		256,810	678,432

		Balance Due January 1, 2002	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2002
University of Texas Health Science Center at San Antonio *Improving Depression Care for Elders* Polly Hitchcock Noël, Ph.D. John W. Williams, Jr., M.D.	San Antonio, TX	$ 314,980		$ 201,247	$ 113,733
University of Washington *Improving Depression Care for Elders* Wayne Katon, M.D.	Seattle, WA	301,105		185,862	115,243
University of Wisconsin, Madison *Improving the Quality of Care and the Retention of Direct Care Workers in Community Based Long-Term Care* Mark A. Sager, M.D	Madison, WI	108,160		81,851	26,309
Subtotal		$14,076,599		$ 5,130,214	$ 8,946,385
AGING & HEALTH **Other**					
American Federation for Aging Research, Inc. *Communications and Dissemination Initiative Renewal* Stephanie Lederman	New York, NY		$ 309,210		309,210
George Washington University *Advancing Aging and Health Policy Understanding* Judith Miller Jones	Washington, DC	1,087,634		395,271	692,363
Project HOPE - People-to-People Health Foundation, Inc. *Health Affairs Thematic Issue on the Health Care Work Force* John K. Iglehart	Bethesda, MD	60,000		60,000	
Subtotal		$ 1,147,634	$ 309,210	$ 455,271	$ 1,001,573
NEW YORK FUND					
American Federation for Aging Research, Inc. *Gala support* *Hadley C. Ford*	New York, NY		10,000	10,000	
The American Geriatrics Society Foundation for Health in Aging, Inc. *2002 Lifetime of Caring Gala* Linda M. Hiddemen	New York, NY		10,000	10,000	
Council of Senior Centers and Services of *"September 11: Responding to the Needs of Older New Yorkers"* Igal Jellinek	New York, NY	50,000		50,000	
Hunter College, City University of New York *Aging and Health work-study curriculum for MSW students* Roberta Graziano, D.S.W.	New York, NY	20,000		10,000	10,000
Medicare Rights Center *Web-based services for people with Medicare in New York City* Robert M. Hayes	New York, NY	10,000		10,000	

Summary of Active Grants

		Balance Due January 1, 2002	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2002
Medicare Rights Center *Host Committee for New President Reception* Robert M. Hayes	New York, NY		$ 2,000	$ 2,000	
New York Academy of Medicine *Support for the New York City participants in the David E. Rogers Fellowship Program* Lorraine LaHuta	New York, NY	$ 27,500		9,000	$ 18,500
New York Academy of Medicine *Gala support* Jeremiah A. Barondess, M.D.	New York, NY		10,000	10,000	
Village Care of New York, Inc. *Village Adult Day Health Center* John Hughes	New York, NY	20,000		3,100	16,900
Subtotal		$ 127,500	$ 32,000	$ 114,100	$ 45,400
OTHER GRANTS					
AcademyHealth *Operating support* Kristine Metter	Washington, DC		2,000	2,000	
The Foundation Center *General operating support* Sara L. Engelhardt	New York, NY		10,000	10,000	
Grantmakers in Aging *General Support* Carol A. Farquhar	Dayton, OH		5,000	5,000	
Grantmakers in Health *General Support* Lauren LeRoy, Ph.D.	Washington, DC		10,000	10,000	
New York Regional Association of Grantmakers *General support* Barbara Bryan	New York, NY		12,500	12,500	
RAND Corporation *General Support/RAND Associates Membership* James A. Thomson	Arlington, VA		5,000	5,000	
Matching Grants*			577,131	577,131	
			$ 621,631	$ 621,631	
Grants Refunded or Cancelled		$ 8,422,915	$(8,543,775)	$ (120,860)	
Discount to Present Value		(6,570,668)	4,020,782		(2,549,886)
Total (All Grants)		$81,751,170	$ 1,801,933	$25,491,894	$58,061,209

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

	Expenses Authorized, Not Incurred January 1, 2002	Projects Authorized During Year	Expenses Incurred During Year	Expenses Authorized, Not Incurred December 31, 2002
FOUNDATION-ADMINISTERED PROJECTS				
Evaluation of the Foundation's Geriatric Nursing Program	$803,513		$242,833	$560,680
Geriatric Social Work Initiative Evaluation	70,263		70,263	
Extending Gains and Celebrating our 75th Anniversary		$368,551		368,551
To Pursue Selected Activities in the Strategic Plan		91,739	91,739	
Total	$873,776	$460,290	$404,835	$929,231
ADDITIONAL ACTIVE GRANTS				
AGING AND HEALTH Academic Geriatrics and Training				
University of Medicine and Dentistry of New Jersey *Expansion of Home Care into Academic Medicine* *R. Knight Steel, M.D.* *1996; $933,492; 51 months*				
AGING AND HEALTH Integrating and Improving Services				
Seattle Institute for Biomedical and Clinical Research *Client Outcomes in Community Residential Settings in the State of Washington* *Susan C. Hedrick, Ph.D.* *1997; $511,577; 6 years*				

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 the 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