Dedicated to Improving Health Care for Older Americans

The John A. Hartford Foundation

2005 Annual Report

The John A. Hartford Foundation

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

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

Mission Statement

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 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 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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CoE
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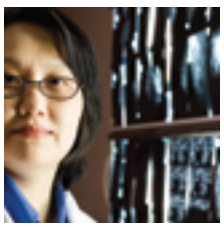

Report of the Chairman

I am privileged once again to introduce the John A. Hartford Foundation's Annual Report. Our focus this year is on the Hartford Centers of Excellence program, an initiative to help medical schools develop the faculty they need to ensure that future doctors are well prepared to meet the needs of their older patients. Since 1988, the Trustees have committed over $36 million to support faculty development and recruitment to geriatric medicine. Currently, 24 Hartford Centers of Excellence in Geriatric Medicine are operating across the country, including two in geriatric psychiatry, as well as a Network Resource Center at the American Federation for Aging Research. This extraordinarily efficient network of training programs, to which $2.6 million was devoted in 2005 alone, supports over 100 medical faculty members each year.

Norman H. Volk
CHAIRMAN

These grants are part of the Foundation's long-term and strategic investment in geriatric medicine. Currently, federal dollars support research fellowships in geriatrics for only one year, after which many promising physician-scientists leave for clinical practice. Funds from this program provide critical support to these individuals, allowing them to pursue a career in academia. We believe it is important to continue to make this aid available, particularly as our population ages and schools of medicine need more faculty to prepare sufficient numbers of geriatricians and geriatrically-prepared physicians. I hope this report communicates both the excitement and ongoing need for private investment in this important area.

During 2005, the Trustees of the Foundation renewed their endorsement of the Building Academic Geriatric Nursing Capacity initiative, awarding more than $15.9 million in grants to two components of the program: a coordinating center at the American Academy of Nursing and five Centers of Geriatric Nursing Excellence. Since their inception in 2000, the five centers have made a significant national impact on the field of geriatric nursing by developing a critical mass of doctorally prepared nurse leaders in geriatric education and research. The centers are located at Oregon Health and Science University, the University of Arkansas for Medical Sciences, the University of Iowa, the University of Pennsylvania, and the University of California, San Francisco.

The Trustees also extended their support of the Practicum Partnership Program which, as part of the Foundation's Geriatric Social Work Initiative, is addressing the shortage of professional social workers with aging expertise. The program's objective is to make rotational field training the norm of graduate geriatric social work education. Between 2000 and 2003, Hartford funding enabled six sites to develop innovative Practicum Partnership Programs, all working with a coordinating center at the New York Academy of Medicine. This year, the Foundation approved nearly $5.2 million over four years in the first part of a broader adoption effort. Eventually, we hope to recruit 1,000 students into geriatric social work and to assist up to 60 schools of social work around the country to create self-sustaining, local Practicum Partnership Programs.

In addition to these training initiatives in the individual disciplines of medicine, nursing, and social work, the Foundation renewed funding to the RAND Corporation to further develop interdisciplinary geriatric research centers via a national, competitive seed-grant program. Each site is required to create at least two interdisciplinary research projects to position itself to compete successfully for federal and other funding. Building on the success of our initial grant in 2001 — which supported five centers at Duke University, Boston University, Yale University, the University of Pennsylvania, and the University of California, Los Angeles — the Trustees approved $2 million over the next 39 months to support an additional five sites.

The Foundation's total assets ended 2005 at $614.2 million, an increase of $16.5 million for the year, after cash payments of $33.3 million for grants, expenses and taxes. We are pleased with the strong 9.4 percent return on the Foundation's portfolio, which bettered the performance of the major financial market averages in the U.S. for both stocks and bonds. Furthermore, in an environment in which the broad equity indices, both domestic and international, have essentially moved sideways over the past five years, we are gratified that the Foundation was able to very nearly maintain the value of its endowment while spending over $150 million for grants and expenses during that period of time. We will continue to prudently seek opportunities to add value in the future so that over the long term the Foundation will attain its goal of growing its assets after spending and inflation.

In December, I had the honor of participating in the 2005 White House Conference on Aging in Washington, DC. The theme of the conference was "The Booming Dynamics of Aging: From Awareness to Action." It was invigorating to be part of this gathering and to see so many of the Foundation's funding partners and grantees there, all committed to improving the quality of life for older adults.

Closer to home, I would like to say what a great privilege it has been to work with Jim Farley, who retired from the Board this year. Jim was elected a Trustee in 1977, held the position of Board Chairman from 1989 through 2002, and was a powerful and positive force in setting and maintaining the Foundation's direction. I am confident that, based on the solid bedrock of Jim's efforts, we will continue to make great strides towards fulfilling the Foundation's mission.

Finally, I wish to express my thanks and appreciation to the Trustees, staff, and all of our many grantees. It is a pleasure to work with each of you, and I continue to be proud to be associated with a group that each year contributes their talent and dedication to improving the health of our nation's older adults.

Norman H. Volk

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The John A. Hartford Foundation Program Initiative

Centers of Excellence in Geriatric Medicine and Training

Developing the Faculty to Teach Doctors about Older Persons' Health Needs

Centers of Excellence in Geriatric Medicine and Training

Together, three statistics illustrate an overwhelming shortfall beginning to face American medicine. First, the number of older Americans is expected to rise sharply from 12 to 20 percent in the next two decades. Second, patients aged 65 and older consume the largest share—by far—of health care services. And finally, only one percent of all physicians in the U.S. are geriatricians. The question is whether the massive health care needs of the growing population of adults over age 65 will be met in the coming years, or if many older people with multiple chronic conditions will be left to manage their own care, shuttling between different doctors treating different problems independently.

Unfortunately, as the need to place greater emphasis on the acquisition of skills and knowledge to treat older adults grows, medical schools are not graduating the numbers of needed doctors who specialize in the care of older patients. By the year 2030, demographers predict a shortfall of 26,000 geriatricians. To avoid this scenario, and the inefficiencies and expense of fragmented care that would result, our country must produce geriatric-trained faculty skilled in research and education to teach future doctors how to treat older patients. But faculty skilled in geriatrics—the crucial lever needed to train tomorrow's doctors—are not available in adequate numbers any more than geriatricians are for treating older patients. In 2001, there were only 900 full time academic geriatricians working in about 120 U.S. medical schools—or less than eight professors per school to teach future doctors about the group of patients who use the most health care services. Observers suggest that at least 2,400 geriatric academicians are needed to train new geriatric fellows, integrate geriatrics into other specialties, and conduct research.

Geriatric Medicine and Training

But there is a weak infrastructure to support the careers of junior faculty and fellows in geriatrics. A quick look at the process of becoming an academic physician specializing in geriatrics illustrates a number of barriers. After four years of medical school, followed by three years of residency, a one-year fellowship to learn the clinical practice of geriatrics is completed, finishing with the attainment of a certificate in geriatric medicine that allows a doctor to practice as a specialist in the care of older patients. To continue in academia, however, one or more additional years of training are required.

For most medical specialties, several years of specialized training are required, and salary support is available through graduate medical education funds. However in geriatrics, federal dollars only support fellowships for one year, resulting in financial pressures that often force potential faculty into careers in clinical practice which provide them a reliable source of income. The critical multi-year period of junior faculty and fellows' career development—when they learn the skills to become successful researchers or teachers—has few regular sources of support. As a result, the demand for faculty with training in geriatrics—the physicians who teach students, residents, and fellows; who conduct research to advance knowledge about aging, health services and systems; and who pioneer new models of care for the elderly—consistently outstrips supply.

Our society needs to maintain and expand the pipeline for the development of faculty skilled in geriatric research in order to produce sufficient capacity to care for the burgeoning numbers of older adults.

The gap in funding in the critical early years following the first (government-funded) year of fellowship and before obtaining career development funding derails many promising academic careers before they can even get started. This is where the John A. Hartford Foundation has stepped in. Recognizing the necessity to actively recruit and train the next generation of academic geriatricians to ensure that tomorrow's care of older patients will be better than today, since 1988, the Foundation has supported advanced fellowship training in geriatrics to prepare future medical school faculty.

The strategy of the Centers of Excellence initiative is to identify medical schools with the necessary components for training academic geriatricians—such as research infrastructure, advanced training opportunities, and academic mentoring—then add resources to these institutions to train larger numbers of future faculty more rapidly

Common Attributes of Hartford Centers of Excellence

UPenn Center of Excellence

The 24 Hartford Centers of Excellence in Geriatric Medicine and Training, including two Centers in Geriatric Psychiatry, share:

- Leadership and depth of faculty (basic science, clinical, and multidisciplinary)
- Successful recruitment of geriatric fellows who pursue research and academic careers
- Existence of a geriatrics department, division, or section
- Access to excellent geriatric clinical facilities across the continuum of care
- Demonstrated success in obtaining competitive research funding
- History of success in producing academic faculty and successful researchers in geriatric medicine
- Highly visible institutional commitment to geriatrics

than would otherwise be possible. Centers of Excellence funds are used as salary support to allow for protected time to conduct research, train to become clinician educators, and pioneer new models of care. Having received the highest quality mentorship and support, these young scholars acquire the skills to build a solid foundation on which to launch successful careers and to become tomorrow's leaders and innovators in the field of geriatric medicine.

Since the inception of this program, the Hartford-designated Centers of Excellence have produced hundreds of geriatric-expert leaders in medical research, education and practice. Centers of Excellence have also helped to create a higher level of recognition and appreciation of the discipline throughout their respective medical centers, universities and affiliated clinical service settings.

Career Development Process for Academic Geriatricians

After graduating from medical school and completing an internal or family medicine residency program:

STEP TOWARD ACADEMIC ADVANCEMENT	FUNDING SOURCES
First year fellowship: One year of specialized training to receive a Certificate of Added Qualifications (CAQ) in geriatric care	Medicare and VA
Second, third, or fourth year of fellowship: Years to complete a substantive research project, further develop a research agenda, expand curriculum vitae, and/or prepare manuscripts for publication	Limited federal funding available Research hospitals, private donors may provide support for trainees
Junior Faculty	National Institutes of Health and privately funded young investigator awards
Senior Faculty	National Institutes of Health Research Project grants, private donors, industry

The Hartford Foundation Centers of Excellence Program provides support for the critical transition period between first-year fellowship and the first career development award. Without this support, many promising young scholars would fail to realize their academic ambitions.

A Brief History of Geriatrics

The Development of a Medical Discipline to Meet Patients' Emerging Needs

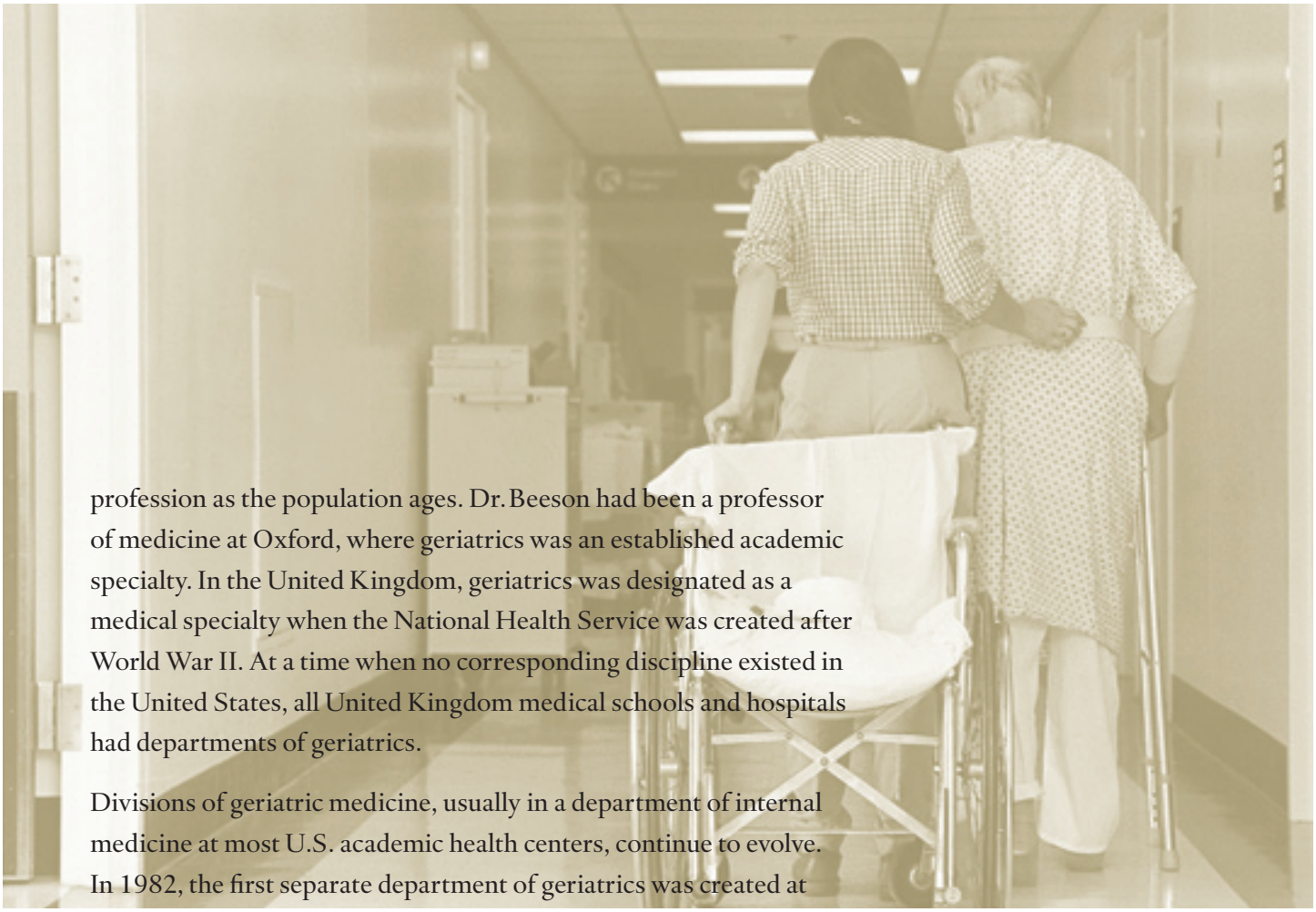
The challenge of preparing sufficient numbers of future leaders in geriatrics is made even more difficult by the fact that geriatric medicine is a young discipline, which has not yet gained equal stature with more established specialties in many academic medical centers.

While the term "geriatrics" was first coined in 1909, geriatrics has established itself as a medical discipline in the U.S. only in the last three decades. Writing in 2004 in the journal *Geriatrics and Gerontology International*, William R. Hazzard, MD, states that prior to 1978, "there were no trained geriatricians; no geriatrics faculty to develop model geriatrics care programs, train geriatricians, educate medical students, residents, or practicing physicians, or conduct aging-related research. There was no recognition as a specialty by the American Board of Internal Medicine and no designated training programs for faculty development or clinical geriatrics training."

In 1974, the National Institutes of Health established the National Institute on Aging. In 1975, the Veterans Health Administration (VA) established Geriatric Research, Education and Clinical Care Centers (GRECCs) to improve the quality of care for older veterans. In addition, a few medical centers were setting up programs (but not separate departments) in geriatrics.

Dr. Paul Beeson

Although the first fellowship in geriatric medicine was created in 1966 (at City Hospital Center, a Mount Sinai School of Medicine affiliate), a major turning point for the field of geriatrics came in 1978 when Paul B. Beeson, MD, spearheaded the first of a series of Institute of Medicine (IOM) reports highlighting the challenges facing the medical



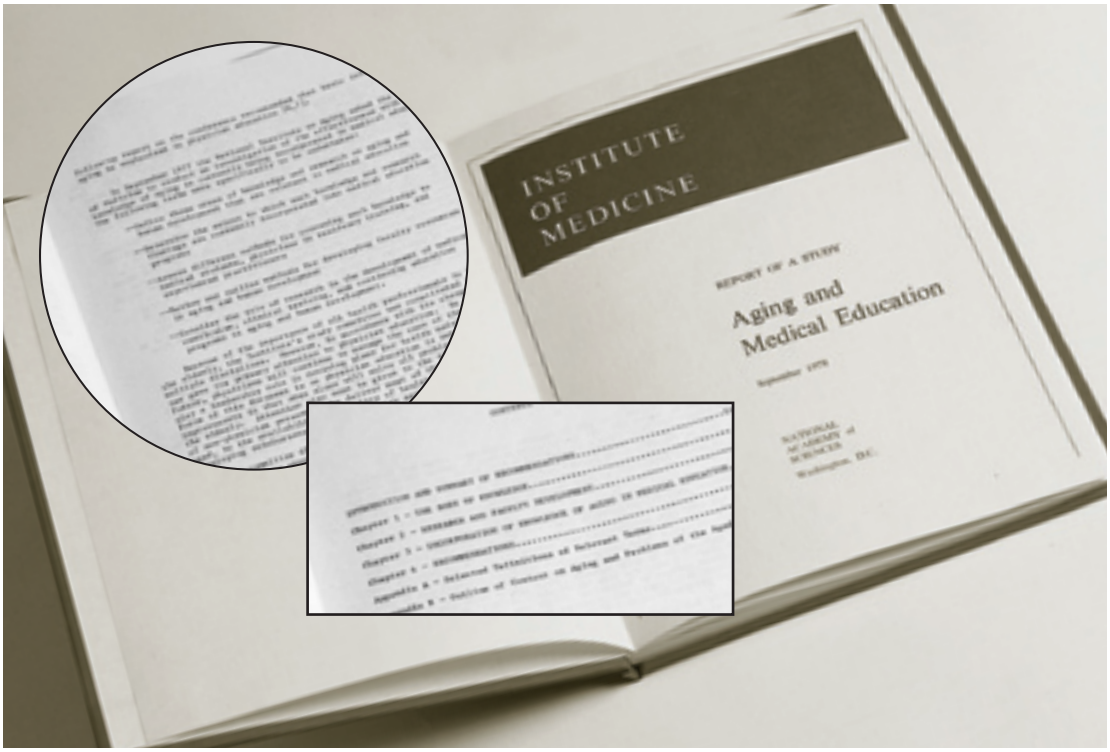
profession as the population ages. Dr. Beeson had been a professor of medicine at Oxford, where geriatrics was an established academic specialty. In the United Kingdom, geriatrics was designated as a medical specialty when the National Health Service was created after World War II. At a time when no corresponding discipline existed in the United States, all United Kingdom medical schools and hospitals had departments of geriatrics.

Divisions of geriatric medicine, usually in a department of internal medicine at most U.S. academic health centers, continue to evolve. In 1982, the first separate department of geriatrics was created at Mount Sinai School of Medicine. Today, there are six departments of geriatrics in medical schools across the country, and 105 U.S. medical schools have some kind of academic geriatric structure.

Thus, training in geriatric medicine has grown considerably in the last two decades. In addition to advanced fellowship training, geriatrics content is now present in many medical schools; in one recent survey 92 percent of family practice programs and 93 percent of internal medicine programs have some geriatric content in their curriculum. And the Hartford Foundation has encouraged early exposure to geriatrics through grants such as the Medical Student Summer Research Training in Aging program at the American Federation for Aging Research and curriculum projects at the Association of American Medical Colleges.

Dr. Beeson's 1978 IOM report, *Aging and Medical Education*, called for increased training in geriatrics, and it recommended that all medical schools and teaching hospitals include curricula on aging for medical students and residents. Also in 1978, the VA established two-year geriatric fellowship programs at 12 VA medical centers. The numbers of geriatric medicine fellowship programs subsequently increased, expanding from 31 programs in 1981 to 93 programs in 1986. Fellowships generally lasted two years.

In the late 1980s, geriatric fellowships grew even more as a result of several factors. Sparking the recognition of the need for more rapid growth was a second IOM study published in 1987. This report emphasized that it was necessary to develop the capacity to train academic leaders in geriatrics, and recommended establishing "Centers of Excellence" in geriatric medicine. To explicitly support advanced fellowship training, in 1988, the John A. Hartford Foundation responded to the findings of this report by funding the first Centers of Excellence.



In 1978, Dr. Paul B. Beeson led the Institute of Medicine (IOM) in publishing the landmark report driving physician preparation in geriatrics, "Aging and Medical Education." By 2004, 131 geriatric medicine fellowship programs in family practice and internal medicine had been established.

In 1988, the American Boards of Family Practice and Internal Medicine established a Certificate of Added Qualifications (CAQ) in geriatric medicine, which required two years of fellowship training. At the same time, the Accreditation Council for Graduate Medical Education (ACGME) accredited 62 internal medicine and 16 family practice geriatric medicine fellowship programs. In 1998, to encourage physicians to enter geriatric fellowship training programs, the two-year requirement was reduced to one year. Between 1988 and 2002, 10,207 doctors received certification in geriatric medicine.

In concert with these changes in the structure of academic geriatrics and the evolution of geriatrics fellowship programs, aging research has mushroomed over the last 30 years. The approved budget of the NIA now exceeds $1 billion. Aging research is on the agenda at other institutes within the NIH including the National Heart, Lung and Blood Institute (looking at cardiovascular disease in the elderly), the National Cancer Institute (as 63 percent of oncology patients in the U.S. are over age 65), the National Institute of Musculoskeletal Disease, the National Eye Institute, and the National Institute of Mental Health.

Yet, despite the impressive progress in elevating the field of geriatrics over the past few decades, there continues to be a critical shortage of geriatricians and geriatrically-trained primary care physicians to care for the growing number of older adults in the U.S.

"Geriatrics is still a very new field, and is still trying to compete for attention with more established disciplines like cardiology, nephrology, and others," says Mary E. Tinetti, MD, the Gladys Phillips Crofoot Professor of Medicine and Epidemiology and Public Health, and Director of the Yale Hartford Foundation Center of Excellence in Aging, Yale University School of Medicine. "We continue to need concerted efforts to enhance the visibility, credibility, and credentials of geriatrics to become embedded in academic medical centers in order to adequately research, teach and care for older people."

Why are Centers of Excellence Needed?

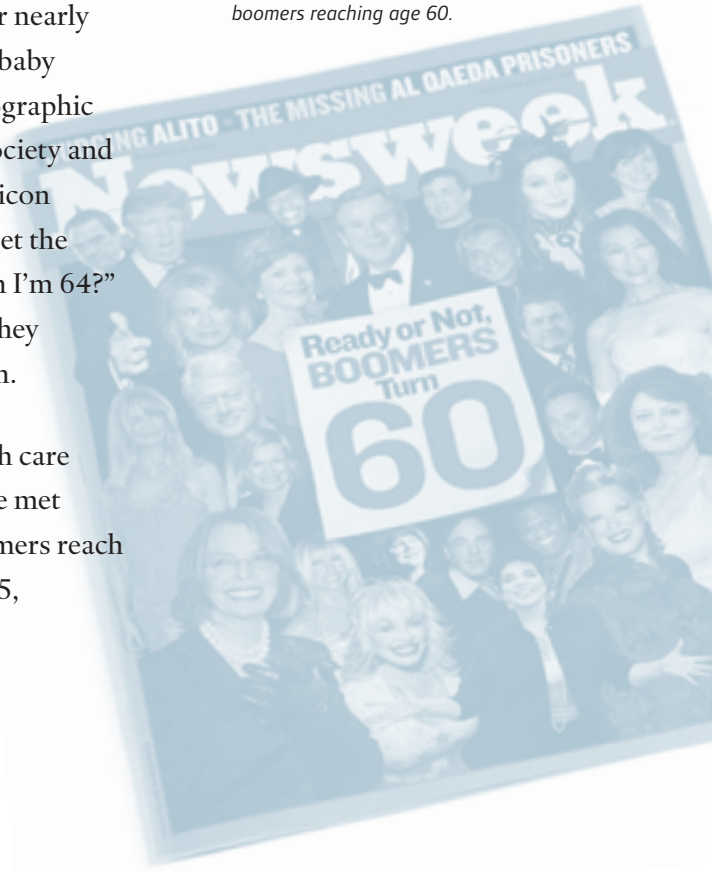
In 1987, Dr. Paul B. Beeson called for the creation of centers of excellence in geriatric medicine, and the John A. Hartford Foundation responded the following year. The necessity for such centers has only grown with time, particularly as the baby boomer generation moves ever closer to retirement age.

"Ready or Not, Boomers Turn 60"

This *Newsweek* cover story (November 14, 2005) reported that 3.47 million babies were born in 1946, a huge jump from 2.36 million in 1940. And that was just the beginning. Over the next 19 years 78 million more babies were born in the U.S.—the famous "baby boom" generation. In 2000, these adult baby boomers accounted for nearly 30 percent of the U.S. population. In 2006, the first wave of baby boomers will turn 60. Because of the sheer size of this demographic group, the baby boomers have influenced many aspects of society and culture throughout their lives. In 2006, Paul McCartney, an icon for the baby boom generation, who was born in 1942, may get the answer to the musical question, "Will you still need me when I'm 64?" As older age appears on the horizon for the baby boomers, they may be poised to have their greatest impact yet on this nation.

The large and weighty question is whether the massive health care needs of the growing population of adults over age 65 will be met in the coming years. By 2030, when the last of the baby boomers reach age 65, there will be more than 70 million Americans over 65, almost twice as many as in 2000.

Popular culture has begun to explore the impact of an aging America, with geriatric medicine developing innovations to meet new demands. A November 14, 2005 Newsweek *cover story heralds the first of 78 million baby boomers reaching age 60.*



Along with the boom in births in the middle of the 20th century, there also has been an increase in life expectancy over the past century. Americans who are 60 years old today have a life expectancy of 82.3 years. However, despite the overall increase in longevity, for many people an unavoidable aspect of the later phase of life is a growing need for and use of health care services, including medications, physician office visits, hospitalizations, and long-term care. More than 40 cents out of every health care dollar spent in the U.S. goes for the care of people over age 65. Research showed that in 2000, people age 65 and older spent four times as many days in the hospital as people younger than 65.

Many older adults have at least one chronic condition and take several medications. Some have impairments, either physical or cognitive, that diminish their ability to function. Diseases such as heart disease, cancer, osteoporosis, Alzheimer's, and others, become more prevalent with age. The health issues that face older adults can be complicated. "There's more to geriatrics than just the diseases that affect older people," says David B. Reuben, MD, Archstone Foundation Chair and Professor of Medicine/Geriatric Medicine and Chief, Division of Geriatrics at the University of California, Los Angeles, a Hartford-designated Center of Excellence in Geriatrics. "You might think that if you are able to manage these diseases one at a time—heart disease, diabetes, etc.—you'd have it pretty well licked, but that's not true."

Despite the advancements made in geriatric medicine in the past few decades, there are still gaps in knowledge about how best to take care of older people. Physicians often know how to treat individual diseases, but much of that knowledge comes from the study of younger

people who have a single disease. Less is known about how to care for older people who may have multiple, often chronic, diseases, who may have a range of physical, social and environmental issues that impact their health, and who may have different treatment goals than their younger counterparts.

These knowledge gaps may lead to substandard care delivered to older adults. A recent study by RAND Health examined the quality of care older adults were receiving. They reported the following findings:

"Vulnerable elders receive about half of the recommended care, and the quality of care varies widely from one condition and type of care to another."

"Preventive care suffers the most, while indicated diagnostic and treatment procedures are provided most frequently."

"Care for geriatric conditions, such as incontinence and falls, is poorer than care for general medical conditions such as hypertension that affect adults of all ages."

"Physicians often fail to prescribe recommended medications for older adults."

Carolyn Welty, MD, University of California, San Francisco, CA, with patient, Anna M. Turner. As medicine extends life expectancy, physicians provide care for increasingly complex patients, often with multiple chronic conditions.

In addition, "providers administered proper care to patients with conditions that demanded immediate treatment (acute conditions) far more frequently than to those with chronic health problems." The experts at RAND Health attributed the short shrift given to geriatric conditions to several factors, including a lack of sufficient training in geriatric conditions in medical schools and primary care residency programs.

There is also a need to prepare all physicians to care for older patients, whether or not geriatrics is their specialty. While more geriatricians clearly need to be trained, there's no escaping the fact that most health care for older adults is, and will continue to be, delivered by non-geriatricians—primarily family physicians and internists.

"Even if we ramped up a hundred-fold, we would not have enough geriatricians to provide care for all the older folks in the U.S.," says Rebecca A. Silliman, MD, PhD, Professor of Medicine and Public Health, Boston University Schools of Medicine and Public Health, and Chief of the Geriatrics Section at Boston Medical Center, a Hartford-designated Center of Excellence in Geriatric Medicine and Training.

According to Harvey Cohen, MD, Director, Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina, "the role of geriatricians is best leveraged by having them in positions to do one of two things: one is to train other physicians to have an appropriate level of expertise to take care of older people, and the other is to generate new knowledge about the care of older people."

Given all of these realities, the future direction of geriatric medicine and aging research must take several paths. Specifically, greater focus must be placed on:

- Training larger numbers of medical researchers who are focused on specific geriatric health conditions and on issues of caring for people with multiple simultaneous conditions.
- Providing adequate training in geriatrics to primary care specialists.
- Encouraging physicians in almost all medical specialties to become more knowledgeable about age-related health issues.
- Increasing the numbers of clinician educators qualified to train geriatricians and to teach primary care physicians and specialists about specific care issues regarding their older patients.
- Fostering greater amounts of age-related research (basic science, clinical, health services) by encouraging more young physicians to pursue academic careers.

Our country's federally-funded system, as it is set up today, contains little incentive to pursue these goals. In 1998, the American Board of Internal Medicine began to allow certification in geriatrics after one year of clinical training. The change from two years to one was intended to increase the number of geriatric fellows. In 1995, only 57 percent of first-year fellowship positions were filled. After the change went into effect, this number jumped to 91percent. But the reduced length of fellowships in geriatrics had an unintended negative consequence. VA and Medicare Graduate Medical Education funding is restricted to the first year of fellowship, supporting specialized clinical training. Funding for second and third year fellowships, the time needed to produce the academic physicians who will conduct the research and train future generations of geriatricians and primary care doctors, is no longer automatically available.

As a result, academic medicine has lost critical resources needed to effectively teach geriatrics. In 2001, there were approximately 900 full-time academic geriatricians working in U.S. medical schools. However, the Alliance for Aging Research estimates that 2,400 geriatric academicians are needed to train new geriatric fellows, integrate geriatrics into other specialties, and conduct research.

While the first year of fellowship is usually funded by the VA and Medicare, support for the advanced years of fellowship training that are geared towards pursuing a career in academic medicine is harder to find. "There are funding gaps between the point in time when someone recognizes they want to do something in geriatrics and the point in time when NIH support is likely to be generated," says Dr. Cohen.

Therefore, support for the crucial years of advanced fellowship from private sources, such as the Hartford Foundation, is essential to ensure the future growth and success of the field of geriatrics.

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CoE
Centers of Excellence











Preparing Tomorrow's Leaders in Geriatic Medicine

JAHF Funds Centers of Excellence

The Foundation initially supported advanced fellowship training with the establishment of the Academic Geriatrics Recruitment Initiative, funding 10 centers of geriatrics beginning in 1988. In 1993, an Institute of Medicine Report, "Strengthening Training in Geriatrics for Physicians," emphasized that there were still inadequate numbers of faculty to meet the nation's training and research needs in geriatrics. The Hartford Foundation responded by transforming the initiative into the Hartford Centers of Excellence program.

Rainier Soriano, MD, Mount Sinai Medical Center, New York, NY, with second-year medical students. Dr. Soriano, considered the local geriatric-education "czar" focuses on ensuring that all medical school graduates have sufficient expertise to meet the needs of the largely geriatric population found in hospitals and other healthcare settings.

Geriatric Medicine and Training

Since 1997, the Foundation has invested more than $25.5 million in Centers of Excellence. Currently, there are 24 active Centers of Excellence, 22 in geriatric medicine, and in 2004 the Foundation expanded the program to include two Centers of Excellence in geriatric psychiatry.

The Centers of Excellence initiative provides young scholars with the boost they need to establish their careers, develop programs of research, and prepare for leadership roles in the field of geriatrics. Centers provide support which protects their time from excessive demands of clinical practice, allowing them to nurture their budding academic careers and to prepare to apply for the grant that will sustain a career in academic medicine. Funding is used variously for direct salary support, pilot research, development of service venues for research, and hiring much needed research support personnel. Perhaps the most valuable component of Center of Excellence funding is a built-in flexibility that allows each program's leaders to tailor the support provided for fellows and junior faculty, providing salary support where needed, or using grant monies to customize professional development plans for fellows through tuition support for research and other courses.

"The Hartford Centers of Excellence program does not provide a large amount of money," says UCLA's Dr. Reuben, "but the funds are very strategically targeted." Each Center of Excellence has its own constellation of institutional resources to support fellowships, research, and faculty development. "The strength of the Hartford Center of Excellence program is that it strategically fills the gaps, directing resources where the needs are."

"You're always vulnerable in the academic setting, but never more so than when you're getting started. The Centers of Excellence funds enable us to shepherd people through that vulnerable period of time."

Harvey Cohen, MD, Director, Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina

In general, the Centers of Excellence use their grants to: 1) fund advanced geriatric fellowship training; 2) support junior faculty working to establish themselves in independent academic careers; and 3) draw other areas of medicine into aging-relevant research and training.

"Being able to take somebody who's very promising as a fellow and provide the initial support until they're competitive for their own career development award is key to the success of the program. To have the resources to support these people has been a wonderful tool for our Center," says Dr. Reuben.

This formula has produced tangible results for the field of geriatrics. So far, 163 advanced geriatrics fellows have been trained in Hartford Centers of Excellence and 222 faculty members have been supported for geriatrics development. Evaluation studies have shown that the vast majority (82 percent) of faculty supported by a Center of Excellence pursue careers in academic geriatrics.

Directors of the Hartford Centers of Excellence also report less measurable but equally important benefits, reporting the Centers enhance the field of academic geriatrics and increase the prestige of geriatrics at an institutional and a national level. "Being a member of the Hartford-funded Center of Excellence 'club' is important," says Boston University's Dr. Silliman. "It has given us national visibility and allowed us to compete successfully for other sources of funding."

"Having 24 Hartford Centers of Excellence, and the number of people who've been supported through these centers, is really raising the visibility of geriatrics around the country. It's both the direct knowledge that has been created from the people supported and the critical mass," says Mary Tinetti, MD, Yale University, New Haven, Connecticut. "It's been proven over and over that it takes numerous

"The Hartford Center of Excellence gave us seed money to pilot new ways to apply the science of education and adult learning to reach future doctors about the needs of their older patients. In general there is not much money for education innovation in our system."

Roseanne Leipzig, MD, PhD, Vice Chair for Education, Department of Geriatrics and Adult Development, Mount Sinai School of Medicine, New York City

researchers and educators to make a difference," says Roseanne Leipzig, MD, PhD, Vice Chair for Education, Department of Geriatrics and Adult Development, Mount Sinai School of Medicine, New York City. "Our Center of Excellence provides this critical mass."

"The Centers of Excellence initiative has formed a community of distinguished academic programs that are geared toward training the next generation of leaders in geriatrics," says Dr. Reuben. "The vast majority of academic leaders in geriatrics are being trained at the Centers of Excellence, whether they be clinician educators or clinician scientists; the centers are the training ground for the people who will lead the discipline in the future."

"The resources from the Center of Excellence have helped us to encourage people to choose aging instead of another discipline at a critical time in their career."

Mary Tinetti, MD, Director of the Claude D. Pepper Older Americans Independence Center, Yale University School of Medicine, New Haven, Connecticut

Measuring the Success of the Centers of Excellence Initiative

Success of the Hartford Centers of Excellence program is demonstrated by the program's significant impact on the field of geriatrics. For example, since 1997:

UCSF Center of Excellence

- 68 percent of all geriatrics fellows in the United States were trained at Hartford Centers of Excellence
- 71 percent of all advanced fellows in the United States were trained at Hartford Centers of Excellence
- 163 advanced geriatrics fellows have been trained
- 222 faculty have received direct support for geriatric development
- 82 percent of faculty, supported by a Center of Excellence, remain in academic geriatrics
- Centers of Excellence directors report being able to obtain additional institutional resources to support the Centers of Excellence mission
- Centers of Excellence have increased the prominence of geriatrics institutionally and nationally
- New academic and clinical programs have been developed for teaching good geriatric practices to medical students, residents, and students learning interprofessional team skills.
- Training material and geriatric curricular models have been developed for use at other institutions

Source: Hartford Foundation internal reports and Building Academic Geriatric Capacity: An Evaluation of the John A. Hartford Centers of Excellence Initiative. August 2004 Journal of the American Geriatrics Society.

Centers of Excellence Focus on Research and Training

The Hartford Foundation Centers of Excellence grants primarily fund advanced fellows and junior faculty. Support for fellows allows those interested in pursuing an academic career to continue their fellowship training beyond the first year, thus giving them the resources and assistance they need to make the transition from fellow to faculty member. Support for junior faculty, early in their faculty appointments, can be instrumental as they establish their programs of research and obtain career development awards. Centers of Excellence funding is also used for the development of clinician educators and to foster academic clinician leaders.

Most government-sponsored research development awards provide support for junior faculty who have had the time to document evidence of their scholarly productivity and potential, but in under-funded medical disciplines this policy can create a gap. Hartford Centers of Excellence provide fellows and junior faculty with support for protected time to accomplish the work necessary to develop a track record that illustrates their potential to become independent investigators able to advance science. At a time when financial pressures are often put on faculty to generate their salary by providing patient care, Center of Excellence funding helps bridge that gap. The long-term goal of developing new faculty to teach geriatrics does not have to be sacrificed to new professors' immediate needs to draw a salary.

In general, scholars supported by the Hartford Centers of Excellence pursue one of the following career objectives: basic science researcher, clinical researcher, health services or outcomes researcher, or clinician educator. Centers of Excellence funds also go toward support for fellows and junior faculty from specialties outside geriatrics who are engaged in aging-related research. On the following pages, faculty who have benefitted from their local Center of Excellence discuss the varied roles funding played in their successes to date.

Rebecca Conant, MD with Carmen Navarro, age 106 and Jose Navarro, age 101. Dr. Conant is an Assistant Clinical Professor in the Division of Geriatrics at UCSF, where she leads the UCSF Housecalls Program. The program provides care to seniors and—through home visits—helps medical students to better understand the lives of their older patients.

Centers of Excellence: Support for Basic Science Research

The most traditional route to academic success in medicine has often been a career in basic science research, investigating the biological mechanisms of disease and aging in the hope that this will translate into innovative therapies, drugs, or diagnostic tests. Basic science researchers invent, discover, and develop the new knowledge that is needed to advance the field of geriatrics. They work primarily in laboratories and develop new knowledge from discoveries in the test tube, animal subjects, and eventually through clinical trials in humans.

The typical career path begins with the appropriate training and work in the lab of a mentor. The young researcher then applies for a career development award for his or her own independent research, followed by further grants to fund lab costs and ongoing research. Once a researcher becomes established, continued funding advances the research program and provides research apprenticeships for the next generation of medical students to perpetuate the recruitment and training of new basic science researchers.

For geriatric fellows interested in pursuing this career track, a major obstacle arises at the end of the first year of geriatric clinical fellowship. Just at the time when they need to prove their mettle to the NIH and other funding bodies that grant career development awards, funds become scarce. The Hartford Centers of Excellence assist these young scholars with salary support, lab space, equipment, computers, and mentoring by senior faculty.

Understanding Wound Healing and Tumor Growth in Aging Tissue

"The University of Washington Center of Excellence was a very tangible force for me because they purchased my first microscope, a high-resolution photomicroscope, which I still have in my office today," says May J. Reed, MD, Associate Professor, Division of Gerontology and Geriatric Medicine, University of Washington School of Medicine. "Some fellowships provide salary but they don't pay for the tools to conduct research. Without my laboratory tools it would have been impossible for me to get started," she says.

Dr. Reed chose the University of Washington for her geriatric fellowship because of the choices it offered for both clinical and research training. There she developed an interest in basic science, but not necessarily at the molecular level. "I wanted to do something that was directly applicable to some type of disease that I thought was important, so I chose to investigate wound healing in aging tissue," she says.

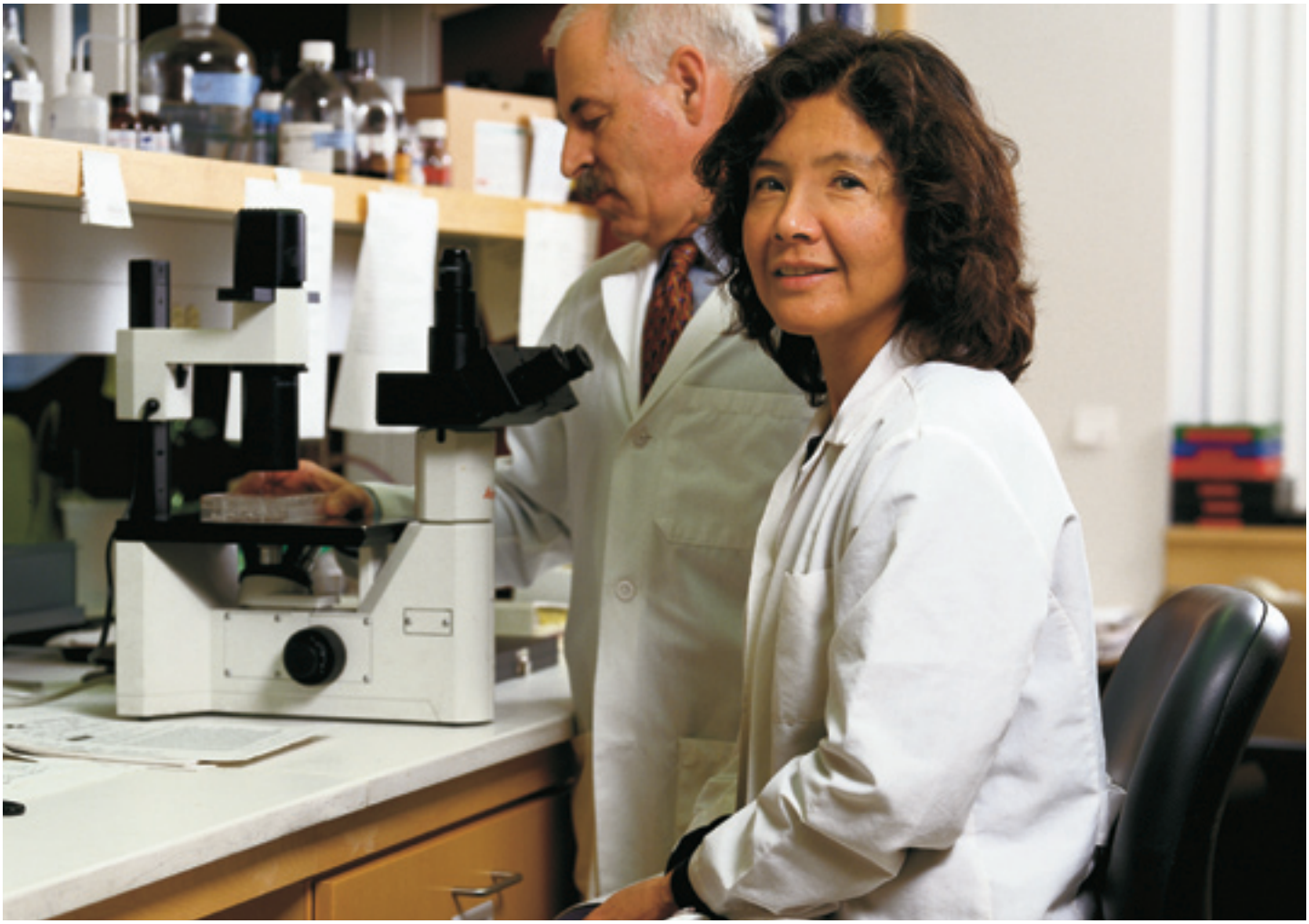
The research Dr. Reed conducts relates to the ability of older patients' endothelial cells—which line the circulatory system and regulate blood pressure, among other functions—to form and repair blood vessels. Blood vessel formation is essential for wound healing and for repair of damaged heart muscle following a heart attack. With age, this function can become impaired for unknown reasons. At the same time, certain types of blood vessel formations are undesirable

as they can be detrimental. For example, blood vessels can arise during tumor growth or cancer progression. These provide tumors with a source of blood, and therefore nourishment, which facilitates further tumor growth. Dr. Reed is investigating the mechanisms underlying both the beneficial and detrimental aspects of blood vessel formation in the elderly.

After her fellowship training, Dr. Reed received a Paul B. Beeson Career Development Award in Aging Research and subsequently received a Research Project (R01) award from NIH. She established an independent laboratory, has published findings in numerous journals and is now well established in her academic career.

"Where the Center of Excellence is so helpful is with the missing pieces—like equipment or gaps in funding—that are so problematic for young investigators," she says. "If you show promise and a commitment to academics, the center is really there for you. It was there for me."

May J. Reed, MD, with mentor Itamar Abrass, MD, University of Washington, Seattle, WA. Center of Excellence director Dr. Abrass provided the critical guidance and laboratory tools that helped Dr. Reed secure both a Beeson Career Development Award and NIH funding.



Centers of Excellence: Support for Clinical Research

For geriatric researchers wishing to work with people to advance therapies and processes of care, clinical research is the career path. Clinical researchers work with human subjects—both well and ill older persons—to advance knowledge in aging research and geriatric medicine. They are committed to understanding the physiology of the body as it ages and the diseases that can impair functioning. They develop or test promising therapies and diagnostics to see how they work in actual patients and investigate clinically relevant research questions. Some clinical researchers take drugs or other therapies developed in a basic science lab and figure out how to apply this new knowledge to the treatment of patients.

In some respects, clinical research can be more complex than basic research. For example, clinical research in geriatrics often must be multidisciplinary, combining expertise in both geriatrics and another medical specialty. For example, research on new treatments for breast cancer in older women would require collaboration among oncologists and geriatricians.

Clinical researchers are generally expected to have teaching responsibilities, to treat patients, to go on rounds, and to lead new service innovations. They are also required to engage in ongoing research activities and to publish their findings in peer-reviewed publications. Many advanced fellows are required to earn their salary by seeing patients in the clinic, thus spending valuable time that could be devoted to research projects.

Funds from the Hartford Centers of Excellence provides salary support for fellows and junior faculty in geriatrics, thus freeing them from clinical and other responsibilities and allowing them to concentrate on their research and scholarly development in academic geriatrics.

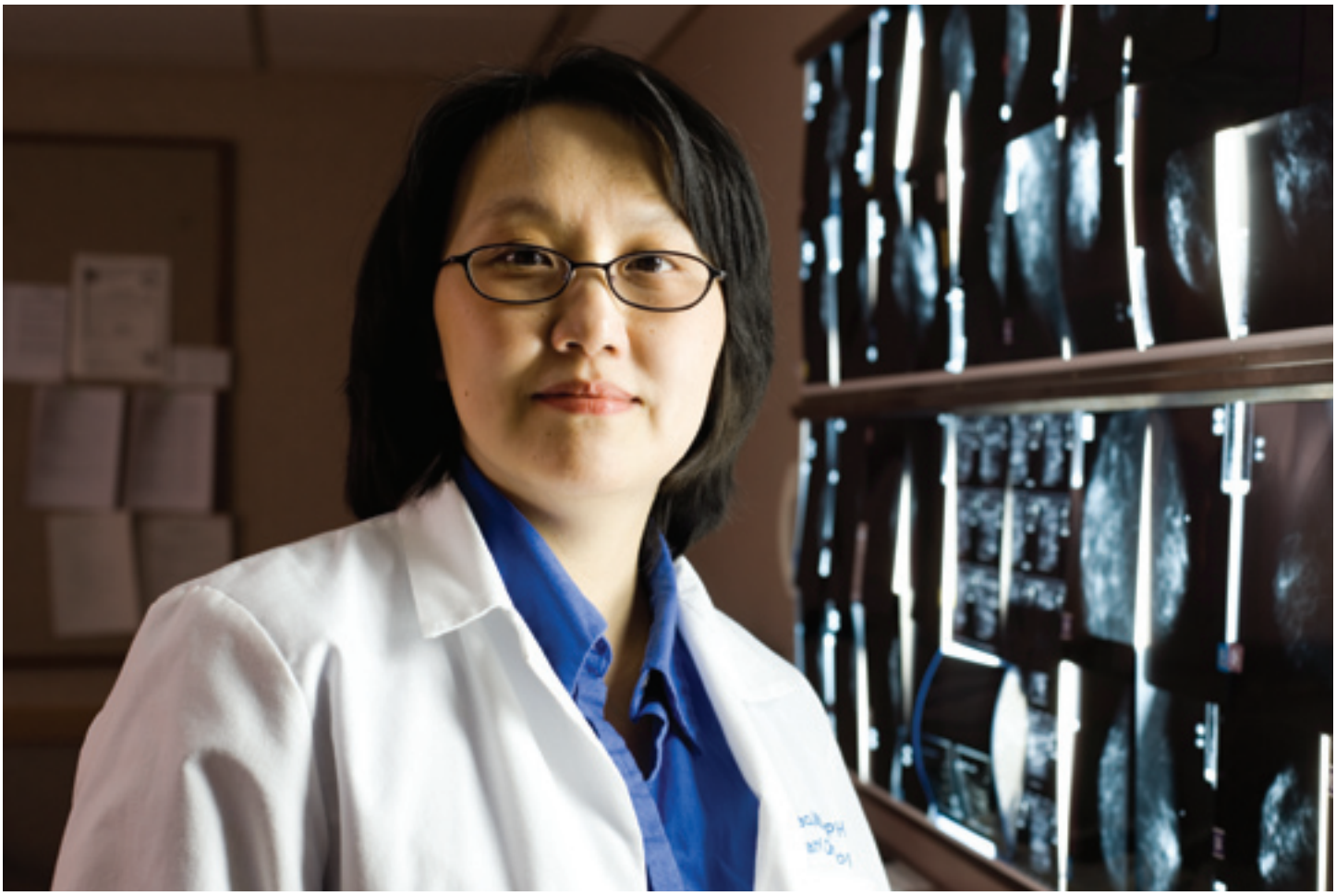
Searching for Biomarkers of Breast Cancer

"Cancer patients on TV may all look 40, but the fact is that cancer is really a disease of older people," says Pearl H. Seo, MD, MPH, Associate, Divisions of Geriatrics and Medical Oncology, Duke University Medical Center, Raleigh, North Carolina. Dr. Seo's original interest was in oncology because she was fascinated by the science. "To understand it fully you have to understand what's happening at the cellular level," she says. But exposure to geriatrics during her residency convinced her that even if she did oncology research, she would benefit from learning the clinical aspects of geriatric medicine, as well.

So Dr. Seo did a geriatrics fellowship at Harvard Medical School, where she studied quality of life in older men with prostate cancer. At Harvard she also met her husband, a North Carolina native. When he accepted a cardiology residency at Duke University, Dr. Seo joined the faculty at Duke with a primary appointment in geriatrics and a secondary appointment in medical oncology. She received Hartford junior faculty support beginning in July 2002 to research outcomes among older cancer patients.

Dr. Seo and her colleagues at the Veterans Administration conducted a geriatric assessment questionnaire on 200 consecutive older men who came to the oncology and radiation clinics. "They were cancer survivors, but they had a lot of functional problems and co-morbidities," says Dr. Seo. A three-year follow-up found that many of these patients complained of depression, pain, and anxiety. Dr. Seo and her associates found that oncologists and primary care doctors were able to effectively treat their cancer but failed to ask them about their emotional life.

During this time, Dr. Seo worked with a lot of female patients with breast cancer. "In the three years I did breast cancer clinical work I only saw patients older than 65,"



Pearl H. Seo, MD, MPH, Duke University Medical Center, Raleigh, NC. Because 63 percent of oncology patients are over the age of 65, cancer research needs to start addressing the health needs of older Americans. Beeson Scholar Dr. Seo was awarded NIA funding to include post-menopausal women in breast cancer research.

she says. So, when she met Dr. Victoria Seewatldt, a researcher in the Duke Comprehensive Cancer Center investigating biomarkers of breast cancer in premenopausal women, Dr. Seo discussed the possibility of broadening the research population to include post-menopausal women, and in August 2005 received a five-year Paul B. Beeson/NIA K08 Career Development Award for the project *PPARgamma: Biomarker for Breast Cancer in Older Women.*

Currrently working with Jeffrey Marks, PhD, the two researchers are analyzing tissue samples to look for biologic predictive markers of breast cancer development in older women. This requires performing aspiration of the breast in high risk women. Because of the invasiveness of this procedure, Dr. Seo is determining if the same biologic information can be obtained from blood samples. "This is my foray into translational medicine, where I have to bridge the clinical side with the bench side," says Dr. Seo.

If a blood marker of breast cancer can be found, it may provide useful information for better tailoring of treatment, predicting whether a specific form of chemotherapy will result in the best outcome, thus sparing the patient trials of ineffective therapies.

Having the Hartford junior faculty support was a great opportunity for Dr. Seo, who will continue her work in the field of translational breast cancer research in older women. "I've been able to do less clinical work and to invest more time in research and to meet people outside of my division," she says. "As junior faculty it's often difficult to make connections, especially outside of your division. Here, there's a commitment to growth and to mentorship. It's a treasure to have this."

Marie-Florence Shadlen, MD, University of Washington, Seattle,WA, with patient. Dr. Shadlen was able to make a career change from clinician teacher to NIH-funded physician scientist with support from the Center of Excellence.

Why Does Alzheimer's Disease Disproportionately Affect African-Americans?

"I was born in Haiti, and I am very interested in cross cultural health, particularly the question of why African-Americans have two times the incidence of Alzheimer's disease as Americans of European descent," says Marie-Florence Shadlen, MD, Assistant Professor, University of Washington School of Medicine, Department of Medicine, Division of Gerontology and Geriatric Medicine.

Dr. Shadlen took a circuitous route to the field of geriatric research. She completed her fellowship in geriatrics at Stanford University in 1990,

after which she began her career as a clinician teacher in geriatrics and a medical director of an Alzheimer's unit. According to Dr. Shadlen, this career choice was a good fit with her roles as both mother and physician. As her children got older, she turned her focus to professional interests and career advancement. But without a track record in research it was difficult for her to get started.

A move to the University of Washington in Seattle brought Dr. Shadlen to the attention of Itamar Abrass, MD, Professor and Division Head, University of Washington School of Medicine, Department of Medicine, Division on Gerontology and Geriatric Medicine. Dr. Abrass is the director of the Hartford Foundation Center of Excellence at the University of Washington, and is responsible for recruiting senior fellows and junior faculty into the program.

"We admit only two to four fellows each year," he says. "We pick individuals who we think have the potential to ultimately develop a leadership role in geriatrics. We recruit the best people and then allow them to decide what excites them. Dr. Shadlen was interested in converting from a clinician teacher to a physician scientist. She came to our division to gain her scholarly experience."

What excited Dr. Shadlen was epidemiologic research in Alzheimer's disease and the epidemiology of dementia. She wanted to discover what, if any, biological or socioeconomic factors underlie the increased incidence of Alzheimer's disease in African-Americans. It's known that conditions such as diabetes, hypertension, and stroke are general risk factors for Alzheimer's disease, and also there is a higher prevalence of these conditions in African-Americans. Dr. Shadlen wanted to find out if this might explain the greater risk for Alzheimer's disease.

"We found that there doesn't seem to be as clear a story as people assume on the effect on Alzheimer's based on whether someone has diabetes, hypertension, or history of stroke," she says. "This would have been an easy explanation and a good one for public health because it would mean there are clear prevention strategies." Instead, Dr. Shadlen identified socioeconomic factors as being more important, particularly as it relates to education.

With a 2003 career development award from NIH entitled Social Factors and Epidemiology of Cognitive Decline, Dr. Shadlen is currently pursuing this line of research. She says that her successful switch to clinical research would not have been possible without the Hartford Foundation. "You need a track record to get funding, so they will feel you're a worthy investment," she says.

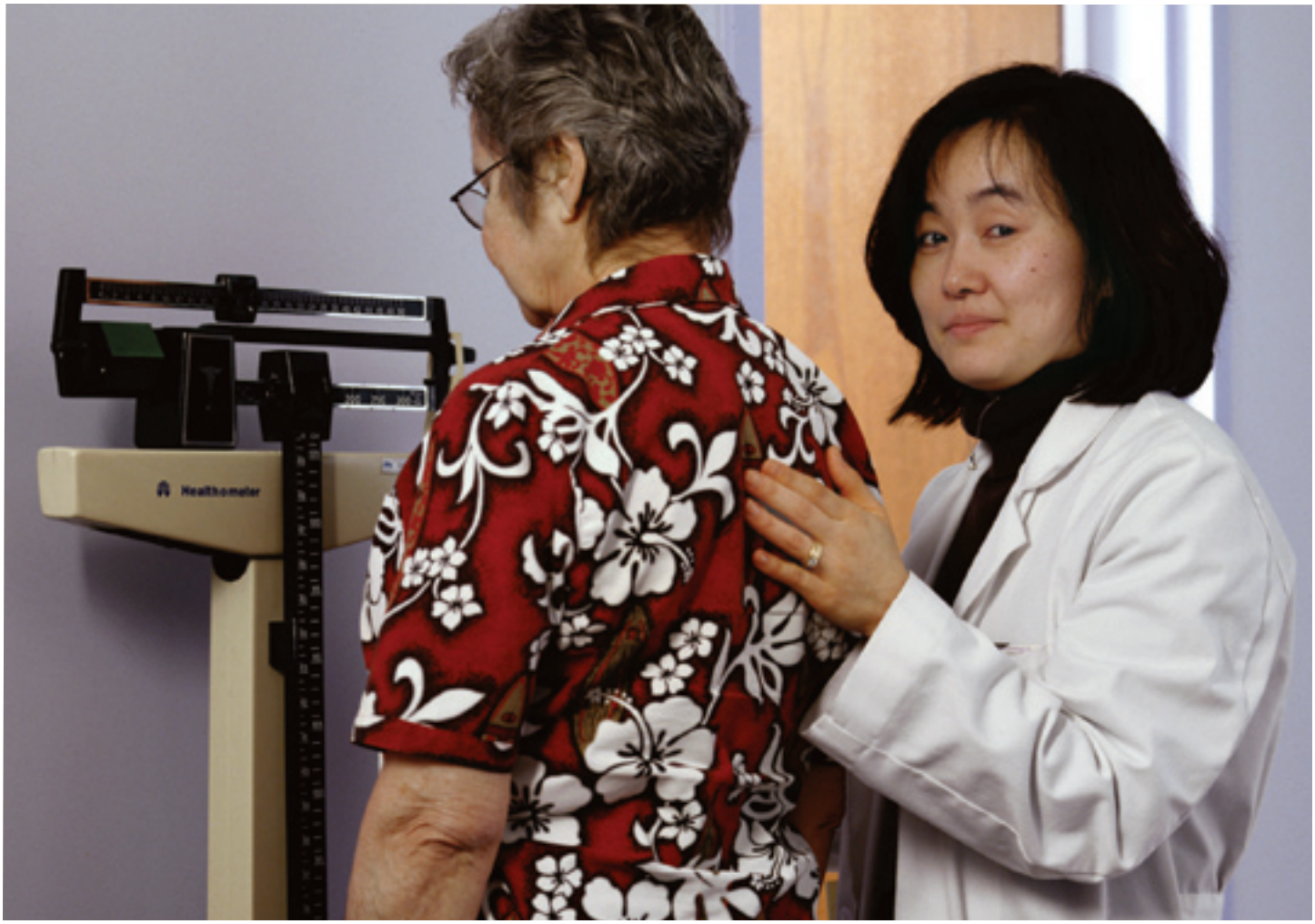
Why Do Older Patients Lose Weight?

"Without the Center of Excellence funding I would be back in practice because I wouldn't have had the time to write my grant proposals and do the work that was necessary to get my research career started," says Michi Yukawa, MD, MPH, Assistant Professor, Department of Medicine, Division of Gerontology and Geriatric Medicine, University of Washington, Seattle. Instead of returning to private practice, Dr. Yukawa, who did her fellowship training (1998-2000) at the University of Washington School of Medicine, spends her time engaged in clinical research, trying to understand why older people lose weight.

Dr. Yukawa's residency training was in traditional internal medicine, after which she joined a group practice. She found that most of her patients were elderly. Yet during her training she had received little exposure to geriatrics. "I wanted to be more competent in taking care of these complicated geriatric patients," she says. This led to her decision to do a fellowship in geriatrics, which sparked her career change from clinical practice to clinical research.

While seeing patients, Dr. Yukawa noticed that many of the older patients would suddenly lose their appetite and consequently lose weight, beginning a downward health spiral. "I couldn't understand why somebody would all of a sudden not want to eat anymore," she says. "There isn't a good understanding of why this happens, and how best to treat it."

Dr. Yukawa decided to investigate the reasons for unexplained weight loss in older adults. In order to do this research, she initiated a collaboration with the Division of Endocrinology. "Endocrinology was one of my least favorite subjects in medical school," she says. "Ironically, now that's all I do." She now has mentors in both the Division of Endocrinology and the Division of Gerontology and Geriatric Medicine.



Michi Yukawa, MD, MPH, University of Washington, Seattle, WA, with patient. Sudden loss of appetite can lead to a dramatic decline in the health of older adults. Dr. Yukawa explores the causes and treatment strategies to prevent unexplained weight loss.

She began by looking at healthy older adults. She had them lose a small amount of weight and then observed how long it took them to gain the weight back, as compared to a group of younger adults. She recorded hormone levels in her patients, trying to determine if hormones impact older adults differently than their younger counterparts. For example, leptin is a protein hormone that helps the body regulate food intake and energy use and may help the body feel "full" after eating. And ghrelin is a hormone produced in the stomach that stimulates appetite. Both may help to explain why older patients have a harder time maintaining or gaining weight. For the most part, healthy older adults do not regain weight after losing a small amount. Dr. Yukawa is now conducting similar studies with patients who are not as healthy.

How does she like clinical research with geriatric patients? "It's fun, frustrating at times. But most of the time, it's very rewarding to work with older people," she says. In 2003, Dr. Yukawa received a five-year career development award to study "Body Weight Regulations of Older Adults" from the NIH.

Centers of Excellence: Support for Health Services and Outcomes Research

A third research career path in geriatrics relates to the task of translating newly acquired medical knowledge into the practice of caring for patients. For example, if a new treatment strategy for delirium is identified by clinical researchers, it will only have an impact on patient care if a system is in place to support this practice at the bedside or in the clinic.

Academic geriatricians devoted to health services research devise strategies to effectively translate new medical knowledge into care practices. They also focus on quality of life issues, such as types of care that improve functional status or prevent functional decline, thereby helping patients to live independently or without pain.

Strategies for providing more effective geriatric care have numerous benefits for both patients and health care institutions, including improved patient safety, better clinical outcomes, enhanced patient satisfaction, and strengthened financial position for health care institutions along with reduced liability.

Geriatric academicians engaged in this type of research face similar obstacles as those in basic science and clinical research. And again, the Hartford Centers of Excellence provide the essential resources to fill the gaps in support for talented physician scientists interested in researching new models to improve health care delivery to the elderly.

Why are African-Americans Less Likely to Use Hospice Services?

Even though African-Americans have higher rates of mortality from cancer and heart disease than Caucasians (the two leading diagnoses among hospice patients), African-Americans are less likely to use hospice services. This statistic intrigued Kimberly S. Johnson, MD, Associate, Division of Geriatrics, Duke University, Durham, North Carolina. When she arrived at Duke University as a resident, she was already interested in end-of-life care, but she hadn't yet considered a career in academic medicine.

"I grew up in a small town in Mississippi, attended medical school at Johns Hopkins University, and knew that one day I was going to practice geriatric medicine," says Dr. Johnson. "But my idea was to go back and practice in my home town. Physicians in practice were my role models, not people in academics." During her residency at Duke, Dr. Johnson encountered Dr. Harvey Cohen, director of the Duke Center for Aging and Center of Excellence, and other geriatricians on the wards, who inspired her to change career goals. "I decided there was absolutely no other place for me than an academic medical center," she says.

Her interest in research also grew out of interactions with patients and families, where she noted cultural differences in preferences for treatment at the end of life. The reasons for lower rates of hospice use among African-Americans are not well defined. Speculative explanations include mistrust of the health care system,

issues related to spiritual beliefs and acceptance of death, less access to health care in general, and not being informed about hospice care.

Dr. Johnson's research involves analyzing local and national databases of hospice users to look for racial differences. She's also undertaking a study to interview community-dwelling elders about their attitudes and beliefs that might affect future hospice use.

"Currently, hospice is considered the gold standard for end-of-life care," says Dr. Johnson. She hopes to identify strategies for intervention to increase its use by African-Americans. Specifically, she is looking at hospice organizations that have successfully attracted higher numbers of African-Americans to determine best practices that might be applied in other hospice organizations. Strategies may include more ethnically diverse staff and volunteers and better education and outreach programs.

"Without the Centers of Excellence experience, I probably wouldn't have thought of these research questions," says Dr. Johnson. "Having appropriate mentorship, and being surrounded by people who are accomplished clinical investigators, has been a major help to me."

Kimberly S. Johnson, MD, Duke University, Durham, NC. Dr. Johnson's research seeks to identify strategies that will increase use of hospice—considered the "gold standard" for end-of-life care—by African-Americans.

Centers of Excellence: Support for Clinician Education

Paradoxically, clinician educators—academicians focused on training the next generation of doctors—have not always had good career paths at most American teaching hospitals. Promotion pathways have historically been based on a basic science paradigm, which requires academicians to acquire grant funding for their research and to publish. Almost by definition, this paradigm precludes clinician educators from professional advancement as their work was not of central interest to promotion and tenure committees. Another part of the uphill battle for clinician educators is the requirement that they support 100 percent of their salary by seeing patients—a recipe for burnout when added to the demands of teaching.

Starting in the early 1990s, many medical centers began to develop career tracks for clinicians interested in education, with geriatrics often leading the way. These clinician educators not only teach but also devise new educational paradigms to improve geriatrics education. The challenge has been to make this career pathway parallel to the scientific research pathway and to avoid second-class citizen status for clinician educators.

For the Hartford Centers of Excellence, the introduction of formal clinical-educator career tracks has allowed them to expand the teaching of medicine for older patients. At Boston University, Dr. Rebecca Silliman and her colleagues use the Hartford Center of Excellence funding to train clinician educators who are not geriatricians. "There's a great need to train clinicians in other specialties about geriatrics, so they will not only be better providers but also better teachers," says Dr. Silliman.

Center of Excellence funds support fellows and junior faculty as they train to become clinician educators. Funds can also be used for curriculum development. The Mount Sinai School of Medicine Center of Excellence is committed to making the clinician educator career path more attractive and viable. "We have used the Center of Excellence to develop a cadre of physician educators who are well respected and who deliver geriatric content throughout the institution," says Dr. Rosanne Leipzig.

Bringing Geriatrics Education to a Department of Family Medicine

When Laura Goldman, MD, joined the Department of Family Medicine at Boston University in 1998, "no one was focused on geriatrics and there was no one to head up the geriatrics program," she says. In addition, the department wanted to set up a nursing home practice. "This was an experience we felt was essential for training our residents."

Before coming to Boston University, Dr. Goldman had been in clinical practice for 16 years. But she lacked expertise in geriatrics. To gain the geriatric-focused training she needed, Dr. Goldman became a Center of Excellence in Geriatrics Faculty Scholar. "This was not only an opportunity to fill a niche for my department, it took my career off in a different direction," she says.

Today Dr. Goldman is the Director of Geriatrics in the Department of Family Medicine, where she designs and teaches the geriatrics curriculum for the pre-doctoral and residency programs, and she directs the department's nursing home practice. After attending the Stanford Faculty Development Program, where she trained in teaching geriatrics in primary care, Dr. Goldman now teaches these seminars to second-year residents. "I've been focusing all of my efforts towards becoming proficient in geriatrics," she says.

When a new textbook was adopted for the third-year family medicine clerkship, Dr. Goldman was astounded to discover that the textbook contained nothing about geriatrics. She and her colleagues immediately went to work to add reading material about geriatrics to the curriculum. "We take care of a lot of older people, so this is absolutely necessary," she says, adding that "the Center of Excellence experience gave me the legitimacy and the contacts to influence the curriculum in this way."

Since Dr. Goldman first arrived at Boston, the Department of Family Medicine has come a long way in it's commitment to geriatrics. From having essentially no focus on it at all, the department now sees geriatrics as an area of growth and seeks to recruit more geriatricians. "Our nursing home practice took off instantly," says Dr. Goldman, so this has been an area of growth as well.

"It's been very fulfilling for me as a midcareer faculty member to have the opportunity to change course and do something new and different," she says. "It's almost a luxury for a doctor to be able to focus on learning and teaching."

Laura Goldman, MD, with Viviana Ionescu-Tiba, MD, Boston University, Boston, MA. As Director of Geriatrics in the Department of Family Medicine, Dr. Goldman transitioned from clinician to expert faculty with Center of Excellence support. Today, she champions geriatric content within the medical curriculum.

Rainier P. Soriano, MD, Mount Sinai School of Medicine, New York, NY, with 2nd year medical students. Dr. Soriano, a Center of Excellence Faculty Scholar, successfully lobbied to change grading guidelines to increase the weight of geriatrics in students' medical clerkship marks to better reflect patient demographics.

Mount Sinai's Geriatric Education 'Czar'

During his medical residency training in 1994 at Englewood Hospital and Medical Center in Englewood, New Jersey, Rainier P. Soriano, MD, saw nursing home patients admitted to the hospital with severe pressure ulcers and an array of ailments that discouraged him from desiring a career in geriatric medicine. Today, as Assistant Professor of Geriatrics and Director of Medical Student Education in the Brookdale Department of Geriatrics and Adult Development at the Mount Sinai School of Medicine, he's not only committed to geriatrics but also intent on integrating geriatric content throughout the pre-existing medical school curriculum at Mount Sinai.

Dr. Soriano attributes this transition and his change of perspective to a move to Mount Sinai School of Medicine and to his year as a Hartford Foundation Center of Excellence scholar.

When he first arrived at Mount Sinai School of Medicine, Dr. Soriano planned to use his geriatrics fellowship training to pursue his goal of becoming a director of a fellowship program. During his second fellowship year, he received a Hartford Center of Excellence grant and used the financial support to attend the Stanford Faculty Development Program in Palo Alto, California, which teaches clinical teaching skills. "Once you've attended the program, you then return to your academic institution and use the skills you've learned to teach others how to teach," says Dr. Soriano.

This proved to be the catalyst for a change in career plans for Dr. Soriano. On returning to Mount Sinai, he turned his focus to teaching medical students and, in particular, to making sure they receive a healthy dose of education and training in geriatrics. In 2000, he took advantage of a change in the medical school curriculum to help design a new Integrated Medicine-Geriatrics Clerkship for third year students. He successfully lobbied for a change in the grading system as well, carving a larger role for geriatrics in determining students' marks. Prior to the change, medicine was an 8-week program taught in the third year and geriatrics was a 4-week program in the fourth year. "Teaching geriatrics in the fourth year sometimes feels like a lost cause," says Dr. Soriano. "The students have already matched to their desired residencies and learning geriatrics is not their top priority," he says.

The new 12-week integrated clerkship he helped to create is a win-win situation for geriatric education at Mount Sinai. "Medicine is one of the most important core clerkships," says Dr. Soriano. "Every student wants to get an honors grade in medicine so they will have a better chance of obtaining the residency that they want." Geriatrics now contributes one-third to the grade, so every medical student who wants an honors grade in medicine must also do well in geriatrics.

Dr. Soriano also teaches in the preclinical years, and he directs the Introduction to Clinical Medicine/Physical Diagnosis course for second years, called The Art and Science of Medicine II. In this capacity, he is able to incorporate geriatric principles early in the medical school training. Dr. Soriano also teaches a course in practical teaching techniques for fourth-year medical students. "We use geriatrics content in this course, which is my way of reinforcing geriatric principles to fourth year students while also imparting teaching skills that they can use in their residency," says Dr. Soriano.

"With the support from the Hartford Foundation, I was able to gain additional training in medical education and the accompanying skills for effectively disseminating geriatrics into the medical school curriculum," says Dr. Soriano. Rosanne M. Leipzig, MD, PhD, Vice Chair for Education, and Director of the Hartford Center of Excellence at Mount Sinai School of Medicine jokingly refers to him as the 'czar' of geriatric medical student education at Mount Sinai.

"The Hartford Centers of Excellence program is unique in that it recognizes that in the field of geriatrics, education is just as important as clinical care and research," says Dr. Soriano. "It's refreshing to get support for what you do as a clinician educator in geriatrics."

Centers of Excellence: Infusing Aging into Clinical Specialties

At Yale University School of Medicine, Mary Tinetti, MD, and her colleagues decided to focus their Hartford Center of Excellence on identifying fellows and junior faculty from the subspecialities of internal medicine who have an interest relevant to aging. "We give them support and integrate them into some of our clinical and teaching activities," says Dr. Tinetti. "We don't expect them to become geriatricians. Instead, the idea is that they will bring a geriatric focus to their specialty," says Dr. Tinetti.

By giving fellows and junior faculty research support, and mentoring them in their research, this strategy has been "spectacularly successful." Hartford Foundation funding is used for work on age-related research within their specialty. For example, an infectious disease fellow is examining diagnostic criteria for urinary tract infections in nursing home residents. A cardiologist who specializes in transplantation is likewise investigating immunologic changes with aging.

"For people who want to do patient-focused research, we provide an outstanding state-of-the-art research infrastructure with help with data collection, data analysis, and research design, which they don't have access to otherwise," says Dr. Tinetti. She reports that the physicians who they've trained have remained focused in geriatrics and many continue to work with the Section of Geriatrics on educational efforts.

Focus on Functional Status of Older ICU Patients

"My pulmonary medicine colleagues and I no longer groan when an older person comes into the intensive care unit because I've demonstrated that these patients don't necessarily do worse, as long as we take care of them properly," says Margaret Pisani, MD, who is an assistant professor in the Department of Internal Medicine, Section of Pulmonary and Critical Care Medicine, Yale University School of Medicine. Dr. Pisani, who is not herself in the Section of Geriatrics, has been influential in spreading the word about providing optimal care for geriatric patients among her pulmonary medicine colleagues.

What qualifies Dr. Pisani to deliver this message is expertise gained from her research on outcomes in older ICU patients. When she first developed this interest, she wasn't sure how she would be able to pursue her patient-focused research within the pulmonary section at Yale, a basic science oriented section. At a meeting on fellowship training at Yale, Dr. Pisani spoke up about her interests and serendipitously met Dr. Mary Tinetti.

Because of her Hartford Center grant, Dr. Tinetti was on the lookout for promising fellows and junior faculty from the subspecialities of internal medicine who had interests relevant to aging. "By supporting them through the Hartford Center of Excellence and integrating them into some of our clinical and teaching activities, we hope that they will bring a geriatric focus to their subspecialty," says Dr. Tinetti. She asked Dr. Pisani to submit a project proposal, and offered to support her through the Hartford Center of Excellence.

The questions Dr. Pisani wanted to answer were this: why can two older people in the ICU with the same critical condition have vastly different outcomes,

Margaret Pisani, MD, Yale University, New Haven, CT at Yale-New Haven Hospital ICU. Dr. Pisani's research is helping physicians to better understand how to provide care for older patients in the ICU.

and how can these patients be managed to maintain an older person's cognitive and physical functioning through a critical care episode? Her research project during the time she was funded by the Hartford Center of Excellence looked at the impact of dementia on patient outcomes. While this factor proved to have no significant impact, it prompted Dr. Pisani to look further at baseline risk factors as well as modifiable ones, such as medication use.

"The Hartford fellowship was the launching pad for me," says Dr. Pisani. It provided some money to pay for research support, such as a nurse to help collect data and a statistician to help analyze the data. Subsequently, she received additional funding, including a five-year career development award from the NIH entitled, *Impact of Psychoactive Drugs on Delirium in ICU Patients.* "I was very fortunate to get the support from the Hartford Foundation, because it would have been easy to completely fail in this endeavor without support."

Dr. Pisani has not only succeeded in funding her own research, she's helped to raise awareness among her colleagues about delirium, medication use, and other factors that impact an older ICU patient's ability to maintain functional status. Her influence has also broadened beyond Yale University. She's been asked to chair a session at the 2006 Annual Meeting of the American Thoracic Society on care of the geriatric patient in the ICU, and expects to share her research at other professional association meetings, as well.

The Hartford Foundation's Continued Commitment to Geriatric Medicine

The Hartford Foundation has made a long-term commitment to develop the medical school faculty needed to improve health care for older Americans. Through the Centers of Excellence in Geriatric Medicine and Training initiative, hundreds of junior faculty and fellows in geriatrics have been trained, promising new research is underway, geriatrics education in medical schools has expanded, and the prestige and prominence of the field of geriatrics has been raised. But more work remains to be done, and the Center of Excellence program continues to evolve to meet the challenges ahead.

Jennifer Kapo, MD, Assistant Professor examining patient, George E. Moody with Jerry Johnson, MD, University of Pennsylvania Center of Excellence. Dr. Kapo was awarded a Hartford Academic Fellowship in 2001.

Building on the success of the Centers of Excellence Initiative, the Foundation has identified additional areas where funding will further enhance the program's impact. For example, each of the 24 Hartford Centers of Excellence has independently developed a model to use funds to best serve the goals of faculty recruitment and development within the context of the individual medical center. Through this process, each Center has learned valuable lessons and developed techniques for recruiting and training future geriatric leaders. But this information has not been systematically shared with other Centers of Excellence or with the wider community of academic medical centers.

The Hartford Center of Excellence Network Resource Center was funded in 2005 to facilitate information exchange among the centers and to disseminate the Centers' best practices to the academic community. The Network Resource Center has begun the development of a best practices inventory, collecting descriptions of model programs from Centers of Excellence directors. By identifying these best practices and preparing comprehensive descriptions, the Network Resource Center will serve as a hub of information for all Centers of Excellence directors. In the following years, the Network Resource Center will produce topical papers on current issues in academic geriatrics development and recruitment using the experiences of the Centers of Excellence in their role as the country's exemplar programs in geriatric faculty development. The papers will be disseminated to Centers of Excellence program directors and members of the Association of Directors of Geriatric Academic Programs.

By identifying these best practices and preparing comprehensive descriptions, the Network Resource Center will serve as a hub of information for all Centers of Excellence directors.

The Hartford Foundation recognizes the need to improve health care systems so older adult patients benefit from the innovations in aging research and geriatric medicine that are generated in academic centers. To encourage medical centers to develop model systems of geriatric care, the Foundation launched the Centers of Excellence Clinical Service Initiative. Five Centers of Excellence were awarded challenge grants for projects aimed at improving systems for delivering care to

Center of Excellence Clinical Services Challenge Grants

Advances in aging research and geriatric medicine will ultimately improve health care for the elderly only if systems are in place to translate new medical knowledge into everyday clinical practice. The Hartford-designated Centers of Excellence are ideally positioned to serve as productive laboratories for testing new ways to structure and deliver health care to older patients.

In 2005, five Centers of Excellence received two-year challenge grants to jump-start the development of new models to improve clinical care for older adults, as well as to improve the training of future physicians, nurses and other team members.

Boston Medical Center, Boston, Massachusetts

Redesigning Long-Term Care Services for Urban Vulnerable Elders

Boston University (BU) Geriatric Services cares for 2,500 patients in its integrated system of care, which includes an ambulatory practice, home care program, nursing home program and inpatient service. Funds from the Hartford Foundation will support costs to redesign care provided to local residents to reduce the use of the emergency department, which will reduce the frequency of ambulance diversion from its emergency room.

Johns Hopkins University, Baltimore, Maryland

Geriatric Floating Interdisciplinary Team

Johns Hopkins University is using its Hartford Foundation grant to implement the Geriatric Floating Interdisciplinary Team, a new model of geriatric hospital care for older adults. This model of care is intended to improve the safety and efficiency of care and care transitions within the hospital and after discharge to a post-acute care setting. Mechanisms are being developed to identify and track frail elders upon admission and after discharge, which include educating patients and families about managing transitions and ensuring that patients' goals and essential information are transmitted to appropriate new providers with each care transition.

Mount Sinai Medical Center, ACE Unit, New York

geriatric patients. By fostering innovation in health care delivery, these centers also position themselves to increase recruitment of students and residents to careers in geriatric medicine. The projects address diverse clinical needs, targeting a variety of health care settings across the continuum of care. Starting in 2006, each of the five centers will receive $155,000 for two years to develop these new venues of care.

Mount Sinai Medical Center, New York, New York

The Four "C's" of Excellent Geriatric Hospital Care: Coordination, Collaboration, Communication, Continuity

Mount Sinai Medical Center plans to implement its Four "C's" intervention in their 34-bed Acute Care of Elders (ACE) unit. The grant will support training and staff time to assist internal medicine residents with responsibilities such as completing discharge summaries, making post-discharge telephone calls, and determining whether admission might have been prevented, to help future doctors understand the effects of hospitalization on the overall health of older patients.

University of California, Los Angeles

Redesigning a Geriatrics Practice to Manage Chronic Conditions

This grant addresses the need to improve the effectiveness and efficiency of outpatient care for frail older adults with multiple health problems. Focusing on five conditions (falls, urinary incontinence, dementia/cognitive impairment, depression and heart failure), medical trainees will learn chronic disease management and nurse practitioner trainees will observe new models of professional practice. All students will be exposed to interdisciplinary teamwork and will become familiar with use of an electronic health record to manage chronic disease.

University of California, San Francisco

Going Home

The "Going Home" project was created to improve hospital care and the care patients receive as they move among different sites of care, and especially as they are discharged from a health care facility to go home. It focuses on the goals of patients and families for safe and independent living and uses home visits as a teaching venue. It involves an interdisciplinary team of practitioners from geriatrics, hospital medicine, nursing, pharmacy and social work.

FINALLY, the Hartford Foundation has expanded the Centers of Excellence in Geriatric Medicine and Training Initiative to include geriatric psychiatry. An important component of the capacity to provide quality health care to older adults is the ability to meet their mental health needs. Yet a critical shortage of geriatric psychiatrists threatens to deny many older people the mental health care services they need. As with geriatric medicine, rectifying this requires increasing the number and quality of physician faculty specializing in geriatric psychiatry. Because physicians pursuing an academic career in geriatric psychiatry face similar obstacles as those in academic geriatric medicine, the Hartford Foundation is using the Centers of Excellence approach to bolster geriatric psychiatry faculty development. Two Centers of Excellence in Geriatric Psychiatry have been designated: University of California, San Diego and University of Pittsburgh.

San Diego is creating a Center of Excellence in Geriatric Psychiatry to train a new generation of geriatric psychiatrists and physician-researchers to meet the needs of older persons with illnesses ranging from depression to psychotic disorders such as schizophrenia. "With the Hartford Foundation grant and establishment of the Center of Excellence in Geriatric Psychiatry, we will be able to provide positive role models for promising psychiatric researchers, develop award programs and affinity groups, share resources, make programs sensitive to trainees' practical needs, and assist individuals with the transition to an academic career," says the Center's director Dilip Jeste, MD, Estelle and Edgar Levi Chair in Aging and professor of psychiatry and neurosciences.

The University of Pittsburgh's Department of Psychiatry already trains nearly 20 percent of the academic geriatric psychiatrists

now working in the United States. Through the Hartford Center of Excellence, the university continues to train future geriatric psychiatrists to specialize in research and physician education. "The importance of training physician educators can not be overstated," says Center director Charles F. Reynolds III, MD, professor of psychiatry, neurology and neuroscience, University of Pittsburgh School of Medicine. "Now and in the future, a primary care doctor will be the first point of entry for elderly who seek treatment for mental illness. It is critical that these doctors receive specialized training in identifying and treating mental illness in this population."

In December 2005, the Trustees of the Hartford Foundation reviewed and approved a strategic plan to continue and refine the Centers of Excellence initiative. Recognizing that American medical education is, at current rates, still several decades away from being able to adequately prepare all doctors for the patient demographics in the society in which they will practice medicine, the Foundation has recommitted to the Centers of Excellence initiative. New and renewal grants, beginning in 2006, will provide incentives to focus on recruitment into geriatric medicine, provide for longer grant awards in order to help further stabilize academic medicine, require leadership and management training for program participants, and provide support to senior faculty at Centers of Excellence when they are recruited to lead their own geriatric development programs. Recognizing society's immense need for this work, the Foundation will continue to seek out funding partners to support this work, as well. Cumulatively, the Centers of Excellence in Geriatric Medicine and Training and the Foundation and its funding partners are preparing for the time when older patients routinely receive the health care that meets their needs efficiently and respectfully.

Centers of Excellence

Baylor College of Medicine
Boston University
Cornell University
Duke University
Emory University (Southeast CoE)
Indiana University
Harvard University
Johns Hopkins University
Mount Sinai School of Medicine
University of Alabama (Southeast CoE)
University of California, Los Angeles
University of California, San Diego, (Geriatric Psychiatry)
University of California, San Francisco
University of Chicago
University of Colorado
University of Hawaii
University of Michigan
University of North Carolina Chapel Hill
University of Pennsylvania
University of Pittsburgh
University of Pittsburgh (Geriatric Psychiatry)
University of Rochester
University of Texas Health Science Center at San Antonio
University of Washington
Yale University

2005 Aging and Health Grants

In 2005, The John A. Hartford Foundation awarded 26 new grants under its Aging and Health program totaling $32,211,101. Authorizations for new programs or large renewal grants are described here.

Academic Geriatrics and Training

American Academy of Nursing
Washington, DC
Nursing Initiative Coordinating Center and Scholar Stipends Renewal
Patricia G. Archbold, PhD, RN, FAAN
$10,740,685, Five Years

This grant supports the continuation of the coordinating center for the Building Academic Geriatric Nursing Capacity initiative, including 60 predoctoral/MBA and postdoctoral awards, leadership development, interdisciplinary research, collaborations among Hartford geriatric nursing projects, and dissemination.

Centers of Geriatric Nursing Excellence
The Foundation renewed its five centers of geriatric nursing excellence to build upon and expand multi-faceted programs in the areas of aging education, research, practice, recruitment, policy and dissemination.

Oregon Health and Science University, Portland, OR
Heather Young, PhD, GNP, FAAN
$1,050,000, Five Years

University of Arkansas for Medical Sciences, Little Rock, AR
Claudia J. Beverly, PhD, RN, FAAN
$1,050,000, Five Years

University of California, San Francisco, San Francisco, CA
Margaret I. Wallhagen, PhD, APRN
$1,050,000, Five Years

University of Iowa, Iowa City, IA
Kathleen L. Buckwalter, PhD, RN, FAAN
$1,050,000, Five Years

University of Pennsylvania, Philadelphia, PA
Neville E. Strumpf, PhD, RN, FAAN
$1,050,000, Five Years

New York Academy of Medicine
New York, NY
Practicum Partnership Program Adoption Initiative
Patricia J. Volland, MSW, MBA
$5,119,908, Four Years

The Practicum Partnership Program (PPP) provides social work students with field education that spans the fragmented systems of care in which they will work after graduation. Funding will provide seed grants to support masters of social work degree programs to adopt the rotational model in 35 graduate education programs.

American Association of Colleges of Nursing
Washington, DC
Enhancing Gerontology Content in Baccalaureate Nursing Education Programs
Geraldine Polly Bednash, PhD, RN, FAAN
$2,595,890, Four Years

AACN will develop a national initiative to prepare up to 700 tenure-track baccalaureate faculty to teach and mentor colleagues and students in geriatric nursing.

RAND-University of Pittsburgh Health Institute
Developing Interdisciplinary Research Centers for Improving Geriatric Health Care Services - Phase II
Pittsburgh, PA
Harold A. Pincus, MD
$2,000,000, 39 Months

Through a national competition, up to five interdisciplinary research centers in geriatrics will be created to bring together faculty members from medicine, nursing, social work and related disciplines to pursue new directions in health services and clinical research for older people.

American Federation for Aging Research (AFAR), Inc.
New York, NY
Hartford Center of Excellence Network Resource Center
Odette van der Willik
$473,742, Four Years

The Foundation's 24 Centers of Excellence in Geriatric Medicine and Training possess considerable capacity in recruiting and developing physician leaders in geriatrics. The Network Resource Center will identify and disseminate best practices in geriatrics recruitment and career development.

Association of American Medical Colleges
Washington, DC
Dissemination of Hartford/AAMC Geriatric Education Models
M. Brownell Anderson
$325,100, Two Years

With this grant, the Association will host a consensus conference on geriatrics education in medical schools and transfer Hartford-funded educational tools to a high-traffic geriatrics education Web site *www.POGOe.org*.

American Society of Clinical Oncology Foundation
A Commitment to Geriatric Oncology
Alexandria, VA
Hyman B. Muss, MD
$290,033, 40 Months

With this grant, ASCO will fund two Young Investigator Awards, facilitate geriatric retreats at annual meetings and sponsor an annual B.J. Kennedy Award and Lecture for Scientific Excellence in Geriatric Oncology.

Association of Directors of Geriatric Academic Programs
New York, NY
The Status of Geriatrics Workforce Study: Phase III
Gregg A. Warshaw, MD
$258,559, Three Years

Support will be used to expand a longitudinal study of the geriatric medicine workforce and enhance national dissemination of resources.

Integrating and Improving Services

University of Colorado Health Sciences Center
Denver, CO
Dissemination of Geriatric Interdisciplinary Teams in Practice
Eric A. Coleman, MD, MPH
$1,128,206, Three Years

This grant will support the adoption of team-based models of care developed under the Geriatric Interdisciplinary Teams in Practice initiative.

University of Pennsylvania
Philadelphia, PA
Translating Research Into Practice: Transitional Care for Elders
Mary D. Naylor, PhD, RN
$472,839, 30 Months

This grant will help implement a nursing-based post-hospitalization transitional care model within the Kaiser health care system. Variations of the model will be tested at three sites to investigate the best use of advanced practice and registered nurse staff.

The Foundation also awarded Clinical Services Challenge Grants to five academic health centers affiliated with the Centers of Excellence in Geriatric Medicine and Training initiative. These grants are discussed on pages 48-49.

Other Aging and Health Grants

National Health Policy Forum
Washington, DC
Judith Miller Jones
$1,514,049, Three Years

The Forum will help bridge the gap between academic and industry experts and Washington policy makers utilizing whitepapers, briefs, broad background reviews, "mini" site visits and seminars for new or senior legislative staff.

Strategic Communications and Planning
Wayne, PA
John Beilensen
Communications and Dissemination Initiative Expansion
$676,140, Three Years

This initiative will provide direct consultation to grantees, hold annual cross-disciplinary conferences for faculty scholars and principal investigators, offer consultations to Foundation staff, and oversee the publication of the e-newsletter *Hartford Foundation Report*.

People-to-People Health Foundation, Inc.
Bethesda, MD
Health Affairs Journal Thematic Issues on Aging and Health
John K. Iglehart
$150,000, Two Years

Foundation funding will support the development of thematic issues on health care of older adults.

The John A. Hartford Foundation

Financial Reports

Financial Summary

On December 31, 2005, the Foundation's assets were $614.2 million, an increase of $16.5 million for the year after cash payments of $33.3 million for grants, expenses and taxes. Total return on the investments, income plus realized and unrealized capital gains, was 9.4 percent.

Equity market returns in the U.S. and overseas were positive in 2005 for the third consecutive year after the severe correction that followed the bursting of the technology bubble in 2000. Although the markets were virtually flat over this entire five-year period, the Foundation was very nearly able to maintain the value of its assets after disbursements of over $150 million.

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 returns for the broad market indices are likely to remain at single-digit levels, at least into the near future, the Foundation is confident it can achieve this goal through value-added active management and prudent diversification.

At the end of the year, the Foundation's asset mix was 69 percent public equities, 5 percent fixed income, and a combined 26 percent in event-driven, real estate, private equity and venture capital funds, versus 67, 7 and 26 percent, respectively, at the end of 2004.

As of December 31, 2005, AllianceBernstein Investment Research and Management, Private Capital Management, Sound Shore Management, T. Rowe Price Associates and Wasatch Advisors manage the Foundation's public equity investments. In addition, the Foundation is an investor in venture capital funds managed by Oak Investment Partners, Brentwood Associates, Middlewest Ventures and William Blair Capital Partners. Private equity partnerships are managed by GE Investments, Greenhill Capital Partners and Brentwood Associates. Real estate investments consist of funds managed by TA Associates Realty, Angelo, Gordon & Co., Heitman/JMB Advisory Corporation and High Rise Capital Management. Event-driven investment managers are Angelo, Gordon & Co., Canyon Capital Partners and Quellos Capital Management.

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, 2005 and 2004 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, 2005 and 2004 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 74, inclusive, are presented for purposes of additional analysis and are not a required part of the basic financial statements. This information has been subjected to the auditing procedures applied in our audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Respectfully submitted,

Owen J. Flanagan & Company
New York, New York
March 3, 2006

The John A. Hartford Foundation, Inc. **Exhibit A**
Balance Sheets
December 31, 2005 and 2004

	2005	2004
Assets		
Cash in operating accounts	$ 4,033	$ 2,292
Interest and dividends receivable	786,136	654,936
Prepayments and deposits	60,428	215,608
Prepaid taxes	104,682	75,318
	955,279	948,154
Investments, at fair value or adjusted cost (Notes 2 and 3)		
Short-term cash investments	47,315,488	54,694,970
Stocks	473,620,643	466,740,354
Bonds	-	489,436
Investment partnerships	34,290,491	29,645,216
Real estate pooled funds	55,000,529	41,933,281
Total Investments	610,227,151	593,503,257
Office condominium, furniture and equipment (net of accumulated depreciation of $2,169,781 in 2005 and $1,903,292 in 2004) (Note 5)	3,014,770	3,270,772
Total Assets	$614,197,200	$597,722,183
Liabilities And Net Assets		
Liabilities:		
Grants payable (Note 2)		
Current	$ 17,452,899	$ 17,732,850
Non-current (Note 7)	41,793,845	37,092,022
Accounts payable	1,044,342	875,426
Deferred Federal excise tax (Note 2)	720,673	939,295
Total Liabilities	61,011,759	56,639,593
Net Assets - Unrestricted		
Board designated (Note 2)	7,233,832	6,048,251
Undesignated	545,951,609	535,034,339
Total Net Assets (Exhibit B)	553,185,441	541,082,590
Total Liabilities and Net Assets	$614,197,200	$597,722,183

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, 2005 and 2004

	2005	2004
Revenues		
Short-term investment earnings	$ 1,706,587	$ 563,042
Dividends, interest and partnership earnings	7,155,057	6,202,971
Net realized capital gains	64,794,065	64,650,552
Net change in unrealized gains, net of deferred Federal excise tax (Note 3)	(21,643,624)	(3,024,302)
	52,012,085	68,392,263
Direct investment expenses	(4,173,588)	(2,995,793)
Excise and unrelated business income taxes	(660,318)	(1,002,455)
Net Investment Revenue	47,178,179	64,394,015
Grants and Expenses		
Grant expense (less cancellations and refunds of $503,541 in 2005 and $471,518 in 2004)	30,676,330	28,759,828
Foundation-administered projects	618,122	463,208
Grant-related direct expenses	84,872	70,317
Personnel salaries and benefits (Note 6)	2,410,413	2,129,089
Office and other expenses	867,062	936,286
Depreciation	266,489	250,648
Professional services	152,040	105,369
Total Grants and Expenses	35,075,328	32,714,745
Increase in Net Assets	12,102,851	31,679,270
Net Assets, beginning of year	541,082,590	509,403,320
Net Assets, End of Year (Exhibit A)	$553,185,441	$541,082,590

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, 2005 and 2004

	2005	2004
Cash Flows Provided (Used)		
From Operating Activities:		
Interest and dividends received	$ 7,191,567	$ 4,872,505
Cash distributions from partnerships and real estate pooled funds	20,237,234	13,015,401
Grants and Foundation-administered projects paid (net of refunds)	(26,871,045)	(24,304,442)
Expenses and taxes paid	(6,447,085)	(6,115,719)
Net Cash Flows Provided (Used) by Operating Activities	(5,889,329)	(12,532,255)
From Investing Activities:		
Purchase of equipment	(10,487)	(164,973)
Proceeds from sale of investments	309,848,005	278,971,935
Purchases of investments	(311,312,087)	(248,137,732)
Net Cash Flows Provided (Used) by Investing Activities	(1,474,569)	30,669,230
Net Increase (Decrease) in Cash and Equivalents	(7,363,898)	18,136,975
Cash and equivalents, beginning of year	54,708,063	36,571,088
Cash and equivalents, end of year	$ 47,344,165	$ 54,708,063
Reconciliation Of Increase In Net Assets to Net Cash Used By Operating Activities:		
Increase in Net Assets	$ 12,102,851	$ 31,679,270
Adjustment to reconcile increase in net assets to net cash used by operating activities:		
Depreciation	266,489	250,648
Increase in interest and dividends receivable	(131,198)	(207,515)
Decrease (increase) in prepayments and deposits	155,180	(33,909)
Increase in grants payable	4,421,872	4,926,153
Increase in accounts payable	189,613	181,772
Net realized and change in unrealized gains	(43,150,441)	(61,626,250)
Other	20,256,305	12,297,576
	$ (5,889,329)	$(12,532,255)

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, 2005 and 2004

	2005	2004
Supplemental Information:		
Detail of other:		
Investment partnerships and real estate pooled funds:		
Cash distributions	$20,237,234	$13,015,400
Add: investment fees reported	1,608,013	1,015,553
Less: reported income	(1,538,878)	(1,685,990)
	20,306,369	12,344,963
Tax expense	660,318	1,002,455
Less: Net taxes paid	(710,382)	(1,049,842)
Difference (change in prepaid/payable)	(50,064)	(47,387)
Total - Other	$20,256,305	$12,297,576
Composition of Cash and Equivalents:		
Cash in operating accounts	$ 4,033	$ 2,292
Short-term cash investments	47,315,488	54,694,970
Unrealized loss on forward currency contracts and foreign cash	24,644	10,801
	$47,344,165	$54,708,063

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, 2005 And 2004

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 and real estate 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, money market mutual funds and commercial paper. Short-term cash investments also include the unrealized gain or loss on open foreign currency forward contracts and foreign cash.

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 2005 and 2004 the Foundation's rate was 1%

The John A. Hartford Foundation, Inc. Exhibit D
Notes To Financial Statements
December 31, 2005 And 2004

2. Summary of Significant Accounting Policies (Continued)

Tax Status (continued)
Investment expenses for 2005 include direct investment fees of $4,173,588 and $380,000 of allocated salaries, legal fees and other office expenses. The 2004 comparative numbers were $2,995,793 and $330,680.

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 $22,700,000 of undistributed income in grants or qualifying expenditures by December 31, 2006 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 change in unrealized gains in 2005 are summarized as follows:

	Cost	Fair Value	Appreciation
Balance, December 31, 2005	$538,159,865	$610,227,151	$ 72,067,286
Balance, December 31, 2004	$499,573,725	$593,503,257	$ 93,929,532
Decrease in unrealized appreciation during the year, net of decreased deferred Federal excise tax of $218,622			$(21,643,624)

For 2004, the decrease in unrealized appreciation was $3,024,302 net of decreased deferred Federal excise tax of $30,549.

Receivables and payables on security sales and purchases pending settlement at December 31, 2005 and 2004 were as follows:

	2005	2004
Proceeds from sales	$ 337,074	$1,295,749
Payables from purchases	(1,054,799)	(1,921,082)
Net cash pending settlement	$ (717,725)	$ (625,333)

The net amount has been included with short-term cash investments in the accompanying balance sheet. The Foundation is a participant in six investment limited partnerships. As of December 31, 2005, $22,881,359 had been invested in these partnerships and future commitments for additional investment aggregated $33,118,641.

The John A. Hartford Foundation, Inc. Exhibit D
Notes To Financial Statements
December 31, 2005 And 2004

3. Investments (Continued)

In addition, the Foundation was a participant in five other investment partnerships which were in liquidation. The recorded value of these investments is $3,998,335.

One of the Foundation's investment partnerships permit withdrawals at least once a year. It is valued at its fair value, $19,512,485 (adjusted cost $18,444,913).

Real estate investments included three limited partnerships and five real estate investment trusts. The Foundation had invested $51,800,000 at December 31, 2005 and future commitments for additional investment aggregated $33,200,000. One of the real estate investments is considered liquid and is recorded at fair value, $15,304,418 (adjusted cost $13,633,266).

In addition, three other real estate investments are in liquidation. The recorded values of these investments is $4,950,790.

4. Foreign Investments

At December 31, 2005 the Foundation's foreign denominated investments were $38,923,202.

5. Office Condominium, Furniture and Equipment

At December 31, 2005 and 2004 the fixed assets of the Foundation were as follows:

	2005	2004
Office condominium	$4,622,812	$4,622,812
Furniture and equipment	561,739	551,252
	5,184,551	5,174,064
Less: Accumulated depreciation	2,169,781	1,903,292
Office condominium, furniture and equipment, net	$3,014,770	$3,270,772

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 2005 and 2004 amounted to $191,671 and $190,388, respectively. The Foundation also incurred additional pension costs of approximately $24,000 in 2005 and 2004 for payments to certain retirees who began employment with the Foundation prior to the initiation of the formal retirement plan.

7. Grants Payable

The Foundation estimates that the non-current grants payable as of December 31, 2005 will be disbursed as follows:

2007	$17,229,540
2008	12,837,459
2009	12,908,023
2010	3,646,349
2011	1,654,841
2012	278,626
	48,554,838
Discount to present value	(6,760,993)
	$41,793,845

The John A. Hartford Foundation, Inc. Exhibit D
Notes To Financial Statements
December 31, 2005 And 2004

7. Grants Payable (Continued)

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 2005 and 2004 was 7.25% and 5.25%, respectively.

At December 31, 2005, one grant in the amount of $472,839 was contingent on the grantee meeting certain conditions. This amount is shown as part of board designated net assets.

8. Non-Marketable Investments Reported at Adjusted Cost

As previously mentioned, the Foundation values the majority of its investment partnerships and real estate investments at cost adjusted for the Foundation's share of distributions and undistributed realized income or loss. If a group of investments has total unrealized losses, the losses are recognized.

Income from these investments is summarized as follows:

	2005	2004
Partnership earnings	$ 907,608	$1,102,053
Realized gains	5,891,613	2,440,676
Unrealized gain, net of deferred taxes $14,072 in 2005 and 19,087 in 2004	1,393,157	1,889,613
Investment management fees	(1,225,528)	(711,015)
	$6,966,850	$4,721,327

9. Alternative Investment Incentive Fees

Most alternative investment vehicles provide for an incentive allocation of gains to the general partner or organizer of the Fund. These fees are deducted from the share of gains reported to Foundation. It is estimated these fees were approximately $3,700,000 in 2005 and $2,700,000 in 2004.

10. Other Investment Fees

Certain alternative investments organized offshore are in the legal form of corporate stock investments. Income is only recognized when dividends are declared or a sale of shares takes place. Unrealized gain (loss) is recorded for the change in value. Accordingly, investment fees paid by the corporation are not recorded in these financial statements. The approximate amount of fees paid by these investments was $960,000 in 2005 and $1,467,000 in 2004.

11. Reclassification

During 2005, the Foundation analyzed its investment fees paid through alternative asset vehicles. These fees, previously netted against income, have been included in direct investment expenses this year. Previous year numbers have been reclassified to conform to the current year presentation.

Summary of Active Grants

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
Aging and Health					
Academic Geriatrics & Training					
American Academy of Nursing *Nursing Initiative Coordinating Center and Scholar Stipends Renewal* Patricia G. Archbold, D.N.Sc., R.N., F.A.A.N.	Washington, DC	$ 4,527,554	$ 10,740,685	$ 2,409,187	$12,859,052
American Academy of Nursing *Nursing School Geriatric Investment Program* Patricia G. Archbold, D.N.Sc., R.N., F.A.A.N.	Washington, DC	541,868		541,868	
American Association of Colleges of Nursing *Enhancing Gerontology Content in Baccalaureate Nursing Education Programs* Geraldine Polly Bednash, Ph.D., R.N., F.A.A.N.	Washington, DC		2,595,890	204,250	2,391,640
American Association of Colleges of Nursing *Creating Careers in Geriatric Advanced Practice Nursing Renewal* Geraldine Polly Bednash, Ph.D., R.N., F.A.A.N.	Washington, DC	2,272,931		493,813	1,779,118
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	300,051		204,405	95,646
American Federation for Aging Research, Inc. *Paul Beeson Physician Faculty Scholars in Aging Research Program* Stephanie Lederman and Odette van der Willik	New York, NY	7,156,082		2,470,928	4,685,154
American Federation for Aging Research, Inc. *Medical Student Summer Research Training in Aging Program* Odette van der Willik	New York, NY	1,848,170		262,625	1,585,545
American Federation for Aging Research, Inc. *Hartford Center of Excellence Network Resource Center* Odette van der Willik	New York, NY		473,742	52,085	421,657
American Geriatrics Society, Inc. *Increasing Geriatrics Expertise for Surgical and Related Medical Specialties - Phase III & IV* David H. Solomon, M.D. and John R. Burton, M.D.	New York, NY	5,515,667		1,381,022	4,134,645
American Geriatrics Society, Inc. *Integrating Geriatrics into the Subspecialties of Internal Medicine - Restoration, Augmentation and Renewal* Kevin P. High, M.D. and William R. Hazzard, M.D.	New York, NY	793,851		700,179	93,672

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
American Geriatrics Society, Inc. *Geriatric Tools Distribution Project Augmentation* Nancy E. Lundebjerg, M.P.A.	New York, NY	$ 75,204		$ 75,204	
American Society of Clinical Oncology *Enhancing Geriatric Oncology Training* Charles M. Balch, M.D.	Alexandria, VA	408,850		357,948	$ 50,902
ASCO Foundation *A Commitment to Geriatric Oncology* Hyman B. Muss, M.D.	Alexandria, VA		$ 290,033		290,033
Association of American Medical Colleges *Dissemination of Hartford/AAMC Geriatric Education Models: Leveraging Further Change and Preparing for the Future* M. Brownell Anderson	Washington, DC		325,100	110,413	214,687
Association of American Medical Colleges *Enhancing Geriatrics in Undergraduate Medical Education* M. Brownell Anderson	Washington, DC	32,198		32,198	
Association of Directors of Geriatric Academic Programs *Geriatric Leadership Development Program* Edmund H. Duthie, Jr., M.D.	New York, NY	894,074		410,653	483,421
Association of Directors of Geriatric Academic Programs *The Status of Geriatrics Workforce Study - Phase III* Gregg A. Warshaw, M.D.	New York, NY		258,559		258,559
Association of Directors of Geriatric Academic Programs *Developing a New Generation of Academic Programs in Geriatrics* William J. Hall, M.D.	New York, NY	162,380		162,380	
Baylor College of Medicine *Center of Excellence Renewal* George E. Taffet, M.D.	Houston, TX	255,823		104,976	150,847
Beth Israel Deaconess Medical Center *Harvard Center of Excellence* Lewis A. Lipsitz, M.D.	Boston, MA		100,000	50,000	50,000
Boston Medical Center *Center of Excellence Renewal* Rebecca A. Silliman, M.D., Ph.D.	Boston, MA	216,610		114,203	102,407
Cornell University *Center of Excellence* M. Carrington Reid, M.D., Ph.D.	New York, NY	450,000		72,474	377,526

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
Council on Social Work Education *National Center for Gerontological Social Work Education* Julia M. Watkins, Ph.D.	Alexandria, VA	$ 1,875,674		$ 488,007	$ 1,387,667
Council on Social Work Education *Transforming Geriatric Social Work Education (Gero-Rich)* Nancy Hooyman, Ph.D.	Alexandria, VA	258,269		62,542	195,727
Duke University *Center of Excellence Renewal* Harvey J. Cohen, M.D.	Durham, NC	162,277		162,277	
Emory University *Southeast Center of Excellence Renewal* Joseph Ouslander, M.D.	Atlanta, GA	389,340		114,076	275,264
Foundation for Health in Aging Inc. *Hartford Geriatrics Health Outcomes Research Scholars* Eric A. Coleman, M.D., M.P.H., A.G.S.F.	New York, NY	1,762,871		608,230	1,154,641
Gerontological Society of America *Hartford Geriatric Social Work Faculty Scholars Program and National Network and Augmentations (Cohorts II - VII)* Barbara J. Berkman, D.S.W. and Linda Krogh Harootyan, M.S.W.	Washington, DC	5,249,893	$ 263,184	2,633,314	2,879,763
Gerontological Society of America *Hartford Doctoral Fellows in Geriatric Social Work Program Restoration, Augmentation and Expansion and Renewal* James E. Lubben, D.S.W., M.P.H.	Washington, DC	5,494,818		1,149,022	4,345,796
Harvard Medical School *Center of Excellence Renewal* Lewis A. Lipsitz, M.D.	Boston, MA	49,893		49,893	
Indiana University *Center of Excellence* Steven R. Counsell, M.D.	Indianapolis, IN	450,000		75,000	375,000
Johns Hopkins University *Center of Excellence Renewal* Linda P. Fried, M.D., M.P.H.	Baltimore, MD	259,046		89,630	169,416
Mount Sinai Medical Center *Center of Excellence Renewal* Rosanne M. Leipzig, M.D., Ph.D.	New York, NY	150,000		96,284	53,716
New York Academy of Medicine *Partnership Practicum Program and Adoption Initiative* Patricia J. Volland, M.S.W., M.B.A.	New York, NY	156,753	5,119,908	931,871	4,344,790

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
New York University *The John A. Hartford Foundation Institute for Geriatric Nursing: Phase II and Restoration* Mathy D. Mezey, Ed.D., R.N., F.A.A.N.	New York, NY	$ 2,265,700		$ 1,113,529	$ 1,152,171
Oregon Health & Science University *Center of Geriatric Nursing Excellence Renewal* Heather M. Young, Ph.D., G.N.P., F.A.A.N.	Portland, OR	345,596	$ 1,050,000	242,468	1,153,128
RAND Corporation *Developing Interdisciplinary Research Centers for Improving Geriatric Health Care Services: Phase I & II* Harold Alan Pincus, M.D.	Santa Monica, CA	357,438	2,000,000	546,111	1,811,327
Society of General Internal Medicine *Increasing Education and Research Capacity to Improve Care of Older Americans and Augmentation* David Karlson, Ph.D.	Washington, DC	129,732	77,766	207,498	
Society of Hospital Medicine *Improving Hospital Care for the Elderly through Hospitalist Interventions* Laurence Wellikson, M.D., F.A.C.P.	Philadelphia, PA	409,025		193,332	215,693
Stanford University *Stanford Faculty Development Program for Geriatrics in Primary Care (GiPC)* Georgette A. Stratos, Ph.D.	Palo Alto, CA	21,452		21,452	
University of Alabama at Birmingham *Southeast Center of Excellence Renewal* Richard M. Allman, M.D.	Birmingham, AL	371,923		121,923	250,000
University of Arkansas for Medical Sciences *Center of Geriatric Nursing Excellence Renewal* Claudia J. Beverly, Ph.D., R.N., F.A.A.N.	Little Rock, AR	366,198	1,050,000	228,798	1,187,400
University of California, Los Angeles *Center of Excellence Renewal* David B. Reuben, M.D.	Los Angeles, CA	205,190		109,967	95,223
University of California, San Diego *Center of Excellence in Geriatric Psychiatry* Dilip V. Jeste, M.D.	La Jolla, CA	450,000		75,000	375,000
University of California, San Francisco *Center of Geriatric Nursing Excellence Renewal* Margaret I. Wallhagen, R.N., C.S., G.N.P., Ph.D.	San Francisco, CA	368,827	1,050,000	242,441	1,176,386
University of California, San Francisco *Center of Excellence Renewal* C. Seth Landefeld, M.D.	San Francisco, CA	200,000		100,000	100,000
University of Chicago *Center of Excellence Renewal* Greg A. Sachs, M.D.	Chicago, IL	220,428		100,000	120,428

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
University of Colorado *Center of Excellence Renewal* Andrew M. Kramer, M.D. Robert S. Schwartz. M.D.	Denver, CO	$ 250,000		$ 123,539	$ 126,461
University of Hawaii *Center of Excellence Renewal* Patricia L. Blanchette, M.D., M.P.H.	Honolulu, HI	375,417		175,417	200,000
University of Iowa *Center of Geriatric Nursing Excellence Renewal* Kathleen C. Buckwalter, Ph.D., R.N., F.A.A.N.	Iowa City, IA	390,967	$ 1,050,000	265,945	1,175,022
University of Michigan *Center of Excellence Renewal* Jeffrey B. Halter, M.D.	Ann Arbor, MI	183,728		46,635	137,093
University of North Carolina at Chapel Hill *Center of Excellence* Jan Busby-Whitehead, M.D.	Chapel Hill, NC	450,000		75,000	375,000
University of Pennsylvania *Center of Geriatric Nursing Excellence Renewal* Neville E. Strumpf, Ph.D., R.N.C., F.A.A.N.	Philadelphia, PA	394,562	1,050,000	266,250	1,178,312
University of Pennsylvania *Center of Excellence Renewal* Jerry C. Johnson, Ph.D., M.D.	Philadelphia, PA	250,000		50,000	200,000
University of Pittsburgh *Center of Excellence in Geriatric Psychiatry* Charles F. Reynolds III, M.D.	Pittsburgh, PA	450,000		75,000	375,000
University of Pittsburgh *Center of Excellence Renewal* Neil M. Resnick, M.D.	Pittsburgh, PA	344,877		121,332	223,545
University of Rochester *Center of Excellence Renewal* William J. Hall, M.D.	Rochester, NY	298,723		92,378	206,345
University of Texas Health Science Center at San Antonio *Center of Excellence Renewal* David V. Espino, M.D.	San Antonio, TX	300,000		171,029	128,971
University of Washington *Center of Excellence Renewal* Itamar B. Abrass, M.D.	Seattle, WA	367,860		117,860	250,000
Yale University *Center of Excellence Renewal* Mary E. Tinetti, M.D.	New Haven, CT	300,000		100,000	200,000
Total Academic Geriatrics & Training		$51,777,790	$27,494,867	$21,653,861	$57,618,796

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
Integrating & Improving Services					
Boston Medical Center *Clinical Service Challenge Grant: Redesigning Long-Term Care Services for Urban Vulnerable Elders to Improve Efficiency, Quality, and Satisfaction* Rebecca A. Silliman, M.D., Ph.D.	Boston, MA		$ 155,000		$ 155,000
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	$ 317,593		$ 215,117	102,476
Intermountain Health Care *Evaluating the Impact of Geriatric Care Teams in Ambulatory Practice* Adam Wilcox, Ph.D.	Salt Lake City, UT	540,362		284,214	256,148
Johns Hopkins University *Guided Care: Demonstration Project and Diffusion Planning* Charles E. Boult, M.D., M.P.H., M.B.A.	Baltimore, MD	1,880,467		282,936	1,597,531
Johns Hopkins University *Translating Research into Practice: The Johns Hopkins Home Hospital* Bruce Leff, M.D.	Baltimore, MD	1,638,836		449,904	1,188,932
Johns Hopkins University *Home Hospital National Demonstration and Evaluation: Coordinating Center* Bruce Leff, M.D.	Baltimore, MD	179,568		179,568	
Johns Hopkins University *Clinical Service Challenge Grant: Johns Hopkins Hospital Geriatrics Floating Interdisciplinary Team* Samuel C. Durso, M.D.	Baltimore, MD		155,000		155,000
Mount Sinai Medical Center *Clinical Service Challenge Grant: The Four Cs of Excellent Geriatric Hospital Care: Coordination, Collaboration, Communication, Continuity* Rosanne M. Leipzig, M.D., Ph.D.	New York, NY		155,000		155,000
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	96,392		86,392	10,000
National PACE Association *Accelerating State Access to PACE* Peter Fitzgerald	Alexandria, VA	26,443		26,443	

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
PeaceHealth Oregon Region *A Senior Health Center Interdisciplinary Team Approach: Health and Organizational Outcomes* Ronald D. Stock, M.D.	Eugene, OR	$ 169,633		$ 169,633	
Rush University Medical Center *Virtual Integrated Practice: A New Approach to Health Care Teams* Steven K. Rothschild, M.D.	Park Ridge, IL	342,158		324,639	$ 17,519
State University of New York, Albany *Elder Network of the Capital Region Implementation Plan* Sheri Sanduski	Albany, NY	328,189		138,568	189,621
University of California, Los Angeles *Clinical Service Challenge Grant: Redesigning a Geriatrics Practice to Manage Chronic Conditions* David B. Reuben, M.D.	Los Angeles, CA		$ 155,000		155,000
University of California, Los Angeles *Improving Depression Care for Elders: Coordinating Center Supplemental Follow-up* Jürgen Unützer, M.D., M.P.H.	Los Angeles, CA	44,275		44,275	
University of California, San Francisco *Clinical Service Challenge Grant: Going Home Clinical Services Project* C. Bree Johnston, M.D., M.P.H.	San Francisco, CA		155,000		155,000
University of Colorado Dissemination of Geriatric Interdisciplinary Teams in Practice (GIT-P) Eric A. Coleman, M.D., M.P.H., A.G.S.F.	Denver, CO	227,219	1,128,206	450,376	905,049
University of Pennsylvania *Translating Research into Practice: Transitional Care for Elders* Mary D. Naylor, Ph.D., F.A.A.N., R.N.	Philadelphia, PA		472,839		472,839
University of Texas Health Science Center at San Antonio *Improving Depression Care for Elders* Polly Hitchcock Noël, Ph.D.	San Antonio, TX	9,947		9,947	
University of Washington *Improving Depression Care for Elders: IMPACT Model Dissemination* Jürgen Unützer, M.D., M.P.H.	Seattle, WA	2,528,057		528,489	1,999,568
Total Integrating & Improving Services		$8,329,139	$2,376,045	$3,190,501	$7,514,683

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
Aging and Health - Other					
American Federation for Aging Research, Inc. *Communications and Dissemination Initiative Renewal* Stephanie Lederman	New York, NY	$ 60,831		$ 60,831	
George Washington University *Advancing Aging and Health Policy Understanding Renewal* Judith Miller Jones	Washington, DC	158,278	$1,514,049	395,778	$1,276,549
New York University *Creation of an Endowed Chair in Gerontological Nursing at New York University* Mathy D. Mezey, Ed.D., R.N., F.A.A.N.	New York, NY	100,000		100,000	
Project HOPE - People-to-People Health Foundation, Inc. *Health Affairs Journal: Thematic Issues on Aging & Health* John K. Iglehart	Bethesda, MD		150,000	79,452	70,548
Total Aging and Health - Other		$319,109	$1,664,049	$636,061	$1,347,097
New York Fund					
American Federation for Aging Research, Inc. *Scientific Symposium* Stephanie Lederman	New York, NY		$ 1,000	$ 1,000	
American Geriatrics Society, Inc. *Sponsorship of Tote Bags for the American Geriatrics Society 2005 Annual Meeting* Linda M. Hiddemen-Barondess	New York, NY		10,000	10,000	
Council of Senior Centers and Services of New York City *CSCS 2005 Benefit* Igal Jellinek	New York, NY		500	500	
Foundation for Health in Aging Inc. *Sixth Annual Lifetime of Caring Gala* Linda M. Hiddemen-Barondess	New York, NY		8,200	8,200	
Gerontological Society of America *Sponsorship of Registration Bags for the GSA 57th Annual Scientific Meeting* Carol A. Schutz	Washington, DC	$10,000		10,000	
The Hospital for Special Surgery Fund Inc. *Annual Support* John R. Ahearn	New York, NY		3,000	3,000	
Marc Lustgarten Pancreatic Cancer Foundation *In Memory of Mr. Walter B. Wriston* Enes J. Carnesecca	Bethpage, NY		5,000	5,000	

		Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
The NASW Foundation *NASW 50th Anniversary Gala*	Washington, D.C.		$ 5,000	$ 5,000	
New York Academy of Medicine *Support for the New York City Participants in the David E. Rogers Fellowship Program* Lorraine LaHuta	New York, NY	$12,500		12,500	
New York Presbyterian Hospital *Spring Gala 2005* Lucy Sardana	New York, NY		1,000	1,000	
Primary Care Development Corporation *2005 Spring Gala Dinner* Beth Bieluczyk	New York, NY		500	500	
State University of New York, Albany *The Internships in Aging Project* *Fifth Anniversary Awards Cocktail Reception* Linda Mertz	Albany, NY		500	500	
United Hospital Fund *Annual Support* James R. Tallon, Jr.	New York, NY		2,500	2,500	
United Hospital Fund *2005 Annual Gala* James R. Tallon, Jr.	New York, NY		1,200	1,200	
Visiting Nurse Service of New York *2005 Benefit* Carol Raphael	New York, NY		2,300	2,300	
Total New York Fund		$22,500	$40,700	$63,200	
Other Grants					
The Foundation Center *Annual Support* Sara L. Engelhardt	New York, NY		$ 10,000	$ 10,000	
Grantmakers in Aging *Annual Support* Carol A. Farquhar	Dayton, OH		5,000	5,000	
Grantmakers in Health *Annual Support* Lauren LeRoy, Ph.D.	Washington, DC		10,000	10,000	
New York Regional Association of Grantmakers *Annual Support* Michael Seltzer	New York, NY		12,450	12,450	

	Balance Due January 1, 2005	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2005
Total Other Grants		$ 37,450	$ 37,450	
Matching Grants*		$ 720,341	$ 720,341	
Staff Discretionary Grants**		$ 32,000	$ 32,000	
Grants Refunded or Cancelled	424,585	(503,541)	(78,956)	
Discounts to Present Value	(6,048,251)	(1,185,581)		(7,233,832)
Total (All Grants)	$54,824,872	$30,676,330	$26,254,458	$59,246,744

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

	Expenses Authorized, Not Incurred January 1, 2005	Projects Authorized During Year	Expenses Incurred During Year	Expenses Authorized, Not Incurred December 31, 2005
Foundation-Administered Projects				
Evaluation of the Foundation's Geriatric Nursing Programs	$ 928,713		$299,998	$ 628,715
Communications & Dissemination Initiative Renewal		$676,140		676,140
Extending Gains and Celebrating our 75th Anniversary	300,350		170,541	129,809
To Pursue Selected Activities in the Strategic Plan		140,686	140,686	
Total	$1,229,063	$816,826	$611,225	$1,434,664

The John A. Hartford Foundation

Application Procedures

Application Procedures

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 institutions 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:

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

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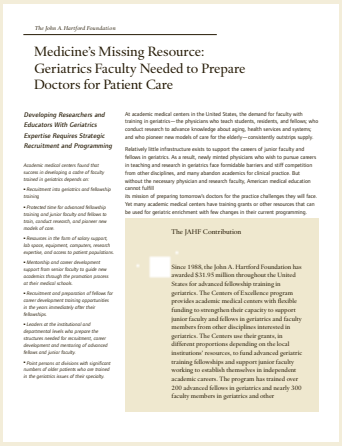
For More Information On Advancing Academic Geriatrics

In 2005, as part of its award-winning 75th Anniversary Annual Report, the John A. Hartford Foundation produced two brief guides to help speed the adoption of new training programs in geriatric medicine and to help financial officers consider how to best fit geriatrics into their business plans. Both are available at the Foundation's Web site.

Medicine's Missing Resource: Geriatrics Faculty Needed to Prepare Doctors for Patient Care

www.jhartfound.org/IDEAS/medfaculty



The John A. Hartford Foundation

Medicine's Missing Resource: Geriatrics Faculty Needed to Prepare Doctors for Patient Care

Developing Researchers and Educators With Geriatrics Expertise Requires Strategic Recruitment and Programming

Academic medical centers found that success in developing a cadre of faculty trained in geriatrics depends on:

- *Recruitment into geriatrics and fellowship training*
- *Protected time for advanced fellowship training and junior faculty and fellows to train, conduct research, and pioneer new models of care.*
- *Resources in the form of salary support, lab space, equipment, computers, research expertise, and access to patient populations.*
- *Mentorship and career development support from senior faculty to guide new academics through the promotion process at their medical schools.*
- *Recruitment and preparation of fellows for career development training opportunities in the years immediately after their fellowships.*
- *Leaders at the institutional and departmental levels who prepare the structures needed for recruitment, career development and mentoring of advanced fellows and junior faculty.*
- *Point persons at divisions with significant numbers of older patients who are trained in the geriatrics issues of their specialty.*

At academic medical centers in the United States, the demand for faculty with training in geriatrics—the physicians who teach students, residents, and fellows; who conduct research to advance knowledge about aging, health services and systems; and who pioneer new models of care for the elderly—consistently outstrips supply.

Relatively little infrastructure exists to support the careers of junior faculty and fellows in geriatrics. As a result, newly minted physicians who wish to pursue careers in teaching and research in geriatrics face formidable barriers and stiff competition from other disciplines, and many abandon academics for clinical practice. But without the necessary physician and research faculty, American medical education cannot fulfill

its mission of preparing tomorrow's doctors for the practice challenges they will face. Yet many academic medical centers have training grants or other resources that can be used for geriatric enrichment with few changes in their current programming.

The JAHF Contribution

Since 1988, the John A. Hartford Foundation has awarded $31.95 million throughout the United States for advanced fellowship training in geriatrics. The Centers of Excellence program provides academic medical centers with flexible funding to strengthen their capacity to support junior faculty and fellows in geriatrics and faculty members from other disciplines interested in geriatrics. The Centers use their grants, in different proportions depending on the local institutions' resources, to fund advanced geriatric training fellowships and support junior faculty working to establish themselves in independent academic careers. The program has trained over 200 advanced fellows in geriatrics and nearly 300 faculty members in geriatrics and other

A Shared Bottom Line: Effective Geriatrics Services Improve Patient Care, Hospital Finances

www.jhartfound.org/IDEAS/businesscase

The John A. Hartford Foundation

A Shared Bottom Line: Effective Geriatrics Services Improve Patient Care, Hospital Finances

Maximizing Revenue and Quality of Care for Older Patients

Hospitals need to structure their services so that the revenues provided by older patients, almost all of whom have insurance, contribute to their systems viability.

- **Hospital-Based Geriatric Clinics Can Be Magnets for Hospital Business**
Hospitals with geriatric clinics provide good continuity of care for older patients, a potential competitive edge. They also create downstream revenue and referrals for higher-margin procedures.
- **Well-Handled Transitions Avoid DRG Bounce-Backs**
Using an interdisciplinary professional team to manage care transitions can reduce errors and avoid re-hospitalizations, saving money and improving margins.
- **Treating Co-morbidities Off DRG Periods**
Effective coordination between the inpatient and outpatient settings can allow hospital physicians to focus on the main presenting condition, while managing comorbidities in outpatient or subacute settings after discharge.
- **Geriatric Protocols, Units Can Efficiently Allocate Nurses and Auxiliary Staff to Patient Needs**
Programs such as NICHE (Nurse Improving Health System Elders) and ACE (Acute Care for the Elderly) Units bring evidence-based practices to hospital care, leading to better patient outcomes and staff retention.
- **Geriatric Consult Services, NPs Ensure Appropriate Care**
Geriatric co-attendings can shorten lengths of stay, get better clinical results, and reduce costs.

Increasingly, older adults are the central business of hospitals and health systems. Patients 65 and older already constitute the largest volume of care these facilities provide. Nevertheless, divisions and services too often opt out, by custom or inclination, from seeking higher-quality and more cost-effective care for older patients. For many CEOs and other leaders, first class geriatric care is viewed as a money loser.

This perspective cannot be sustained. In a turbulent business environment, forward-thinking CEOs are beginning to realize that better services for older patients, almost all of whom are insured, will be fundamental to their institutions' long-term vitality. Effective geriatric planning has vast implications for a hospital or health system. It can improve patient safety, bolster clinical outcomes, enhance patient satisfaction, provide a distinctive niche in the marketplace, reduce potential liability and litigation, and strengthen an academic health center's long-term financial standing. A systematic, tailored approach to the provision of medical services to older patients, therefore, should be an integral part of any academic health center's strategic plan.

The JAHF Contribution

Founded in 1929, the John A. Hartford Foundation is a committed champion of health care training, research and service system innovations to ensure the well being the well being and vitality of older adults. Our overall goal is to increase the nation's capacity to provide effective, affordable care for older Americans. Since 1982, the Foundation has provided $219 million to enhance and expand the training of doctors, nurses, social workers and other health professionals who care for elders. In addition, $68 million has been awarded to foster innovations in the integration and delivery of services for all older people and promote their widespread adoption.