The Robert Wood Johnson Foundation Annual Report 1982

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Annual Report 1982

January 1, 1982 through December 31, 1982

The Robert Wood Johnson Foundation
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Contents

Introduction

The Robert Wood Johnson Foundation is an independent philanthropy interested in improving health care in the United States. It was established in 1936 by General Robert Wood Johnson, who died in 1968.

Robert Wood Johnson devoted his life to public service and to building a family-owned business into a major international corporation. An astute businessman, a statesman, soldier, and patriot, General Johnson devoted much of his life to improving the world around him. He had a tenacity of spirit that enabled him to accomplish many of his goals, but he also planned for the long-range fulfillment of other objectives that could not be achieved in one man's lifetime.

Despite the intensity and determination he displayed in his role as a business leader, General Johnson had a warmth and compassion for those less privileged than he. He was always keenly aware of the need to help others, and during his lifetime, he helped many quietly and without fanfare.

The true measure of General Johnson's deep concern for the needs of others was his decision to leave virtually his entire estate to The Robert Wood Johnson Foundation. With the settlement of this bequest in December, 1971, the Foundation began its transition from a local institution active primarily in New Brunswick, New Jersey, to a national philanthropy.

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The president's statement

The challenge:
can we cut health care costs while preserving health gains?

In American society today, one domestic concern overrides all others. We are all worried about the depressed state of our economy and its impact on our lives and the lives of those around us. While most expect better times to be forthcoming, how all of us and our institutions can adapt in ways which will hurt least, or hopefully even improve our future, is a central concern.

In this climate, the problem of health costs and the ever-growing bite that they take out of our collective pocketbook has assumed an even more pressing and immediate dimension. During 1980-1981, the nation's medical bill rose more rapidly than it had during the past 15 years while our Gross National Product grew at one of the slowest rates seen in this same period (Figure 1).

These dramatically escalating expenditures coming during troublesome economic times have led industry, labor, government at all levels, indeed all sectors of our society, to initiate or plan significant restrictions on their spending for health care. What routes each of these groups will

Figure 1

National Health Expenditures and Gross National Product: Relative Changes 1966-1981

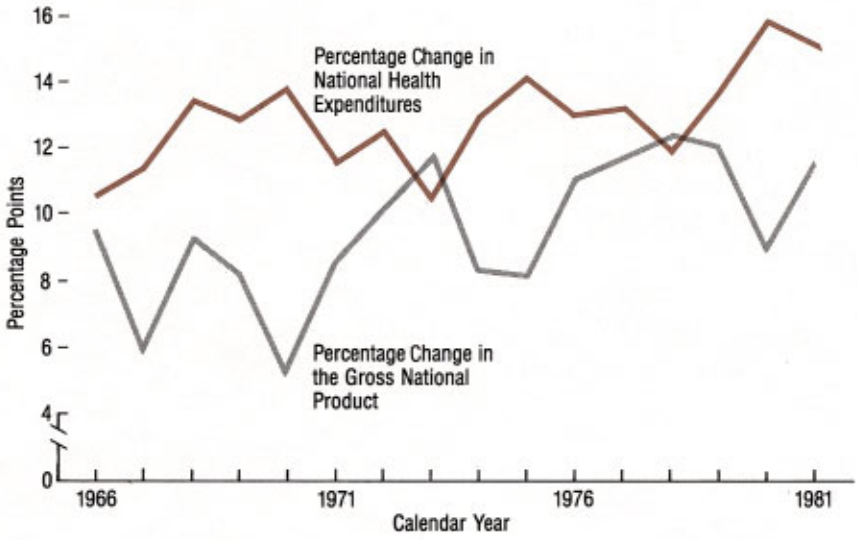
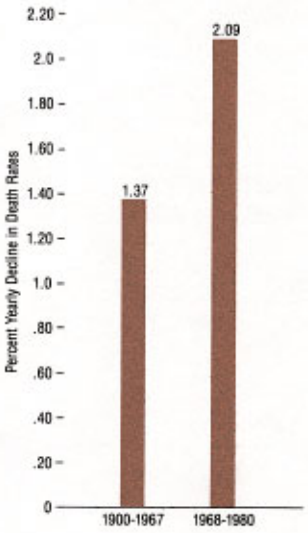


Figure 2

The Rate of Yearly Decline of U.S. Age-Adjusted Death Rates 1900-1980



choose to reduce these expenditures is not yet clear. But it *is* clear that the various approaches, when taken together, could have far-reaching implications beyond simply the cost target. The central question in the minds of many: how will reducing health and medical care expenditures affect the future health of our people?

As we have pointed out in a number of previous reports and publications,[1] this nation has made extraordinary progress in improving the health and lives of its people over the past 15 years. Prior to that—between the middle 1950s and the late 1960s—no real increase in life expectancy was achieved for any age group, leading some to wonder whether more medical care made any real difference in our well-being or survival. However, beginning in 1968, death rates began steadily decreasing at one of the fastest rates seen during this century (as shown in Figure 2). By 1980, the expectation of life at birth had grown by four years. Overall adjusted death rates for all Americans had dropped by 20 percent, and there were reductions in deaths from 10 of the 15 leading killers. In particular, overall infant and maternal death rates had fallen profoundly, and death rates for black newborns had dropped a dramatic 45 percent.

Especially reassuring were the decreases in deaths from diseases in which medical care can clearly be lifesaving. These included deaths from childbirth (down 72 percent between 1965 and 1980), pneumonia (down 53 percent), tuberculosis (down 52 percent), and diabetes (down 31 percent).[2]

These improvements have encompassed all age groups. Particularly noteworthy in greying America have been impressive changes in death rates among those over 65. From 1955 to 1967, we lagged behind most other countries in the western world in our progress toward longer lives. However, in the next decade, as shown in Figure 3, we led most others with a marked improvement in age-adjusted death rates among the elderly. While concerns about the quality of that extension of life deserve, and are receiving careful examination, the fact remains: we've made impressive progress.

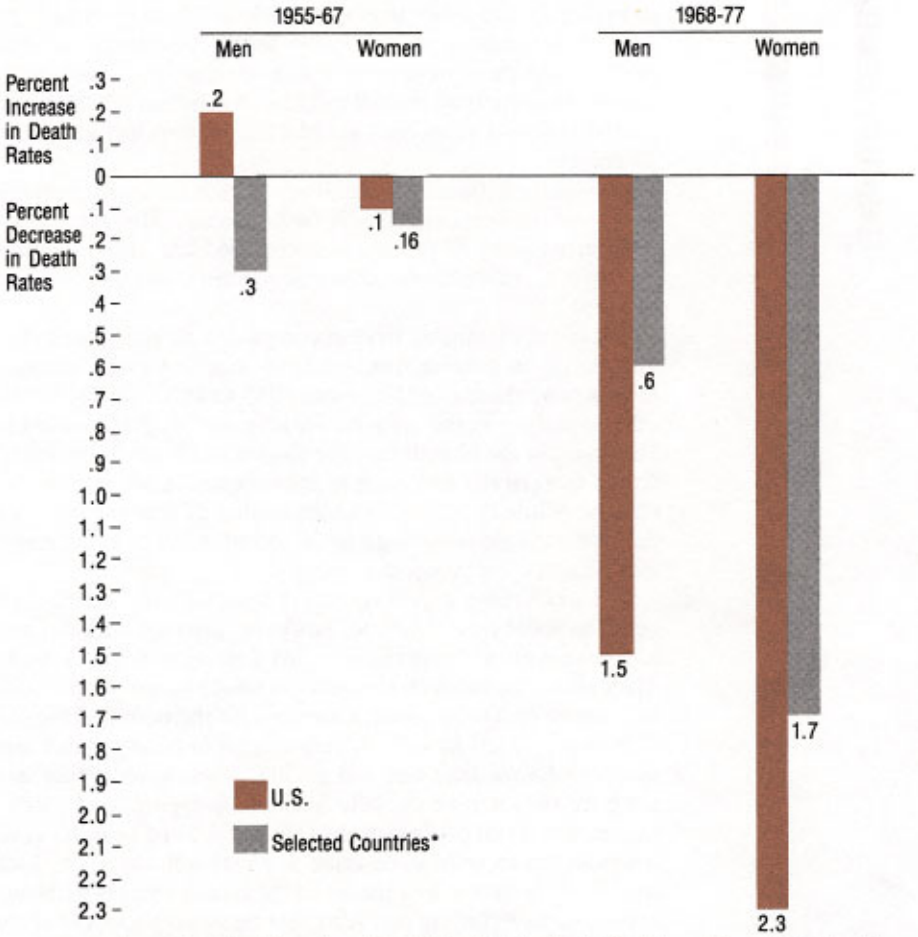
Not all of these improvements in health are due simply to more or better medical care. They do, however, coincide with the greatest public and private efforts ever made in this country to improve health care. They also coincide with the nation's most aggressive and successful effort to increase access to medical services for the poor and the elderly.

In years past, I have been very careful to point out that higher spending for medical care and greater access to physician services have not been shown to be causally linked to dropping death rates and the improving health of Americans. During the last year, however, evidence has been put forward to describe just such a linkage. Dr. Jack Hadley of the Urban Institute, in a recent study, relates increasing health expenditures to falling mortality. He marshals figures to show that for every 10 percent increase in national health expenditures per capita there has been a 1.6 percent drop in U.S. age-adjusted mortality.[3]

While one can argue about whether such high costs for these incremental advances are appropriate or necessary, if Hadley's thesis is correct, these improvements are not just numbers in a table. Each 1 percent drop in overall U.S. mortality rates means over 20,000 people are with us each year who would not have been before. And this, of course, is but the tip of the iceberg. Mortality statistics are a very blunt

Figure 3

The Average Annual Percent Change in Age-Adjusted Death Rates for People 65 Years of Age or Older for the U.S. and Selected Countries 1955-1967 and 1968-1977



*Average for Selected Countries—Includes Canada, England and Wales, France, German Federal Republic, Netherlands, and Sweden

measure of what transpires in medical care. Of each 1,000 Americans, 750 see a doctor each year, but probably very few are in any mortal peril and only 6 die. Logic suggests that many of the hundreds of others seeing their physicians have been helped and their functional abilities improved or maintained as a result of those medical encounters.

If more health expenditures do result in less morbidity and mortality, reductions in health care expenditures must be made with particular care to avoid having any untoward future effect on the nation's march toward better health for its citizens.

Obviously, the simplest and swiftest way to reduce health expenditures is to just reduce the numbers of people who are covered by insurance and other reimbursement programs, public and private, and to reduce the comprehensiveness of health benefits currently provided to recipients. But if the facts are as I have outlined, this may prove extraordinarily expensive over the long term, in both human and economic terms.

No thoughtful citizen wants to deny medical services to anyone who needs them. The question therefore becomes: how can cuts be made where they will do little or no harm and allow progress to continue? Obviously, this approach is vastly more difficult. To make wise cutbacks in expenditures takes considerable amounts of good information, a great

Figure 4

Prevalence of Serious Chronic Health Conditions by Income

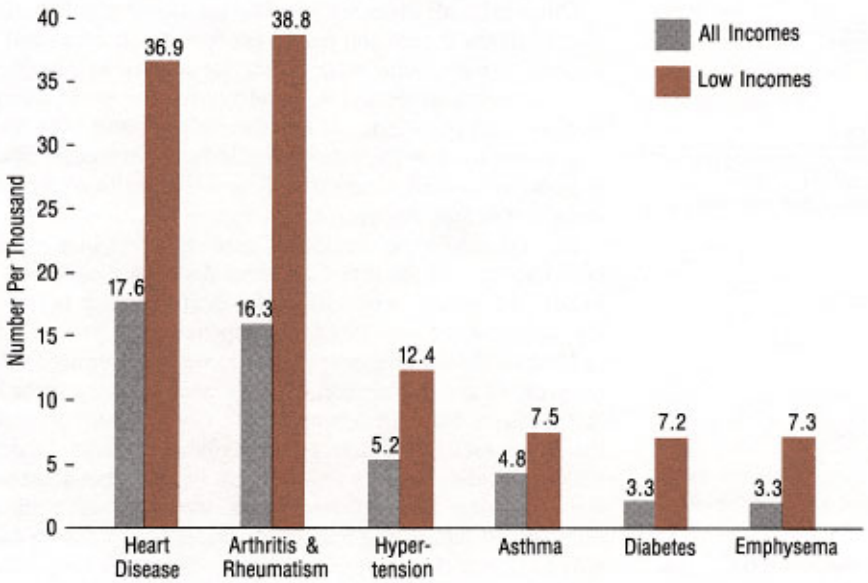


Figure 5

Per Person Physician Visits: Poor and Non-Poor 1964-1980

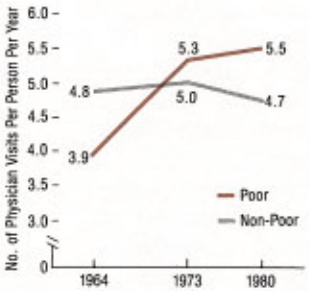
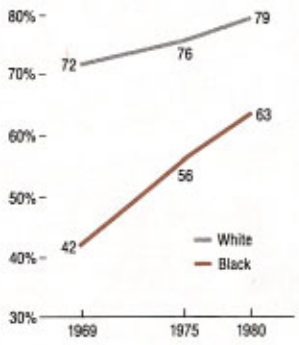


Figure 6

Hospital Discharges for the Poor and Non-Poor Elderly 1964-1978

Figure 7

Percent of Mothers who Received Prenatal Care in the First Three Months of Pregnancy 1969-1980



deal of effort, and the active participation of physicians, dentists, nurses, hospital managers — and all other health professionals — as well as government, business, labor, and the many other players on the health care scene.

A number of suggestions are already being advanced about ways to use substantially fewer resources and still provide high quality services for all who need care. Evidence to date suggests it will probably require a variety of changes in the ways we currently pay for health care and more discriminating ways of organizing and providing that care. Prospective patients as well as physicians, hospitals, and other health professionals regard these alternatives with varying degrees of enthusiasm — or a lack of it. Some plans involve replacing the fee-for-service features of current health insurance programs with agreements with specific physicians and institutions to provide health care for a predetermined yearly amount. Others involve providing people with medical care vouchers that can be used to enroll in health maintenance organizations with potential savings for enrollees and those who pay the bills alike. There are proposals to link patients exclusively with specific physicians or hospitals without altering the payment mechanisms; others have a different focus — public sector rate setting and stricter utilization review for hospitals, physicians, and nursing homes. Many suggest targeting our resources more precisely on those at greatest hazard of infirmity or death rather than broad coverage for all. Almost all of the proposals currently being advanced involve more emphasis on care in the ambulatory setting, better coordination of services, less expensive professional personnel for various tasks, and greater incentives for physicians to be more restrained and discriminating in the use of high-cost medical technologies.

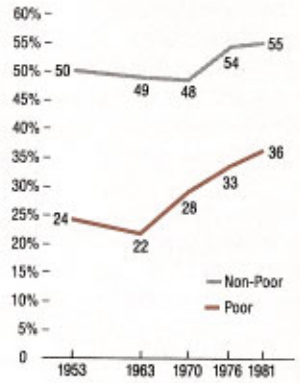
Obviously, all of us wish to choose a course which continues to offer quality medical care and health services to all who need them. Indeed, I am one of many who believe that our society will be judged in part by the attention it gives and the quality of services it delivers to its children, its poor, and its elderly. Many also believe, and I am among them, that it is possible to slow the rate of rise in health expenditures while continuing to improve overall access to care and the health of Americans if we are imaginative and innovative.

But we need to be surefooted here. Because of the pluralistic nature of our country, and the many different decision makers who will be involved in how we reduce expenditures for health care, it is important to develop ways to monitor what actually happens as this process begins.

How could we as a people decide we are keeping faith with the progress of the last several decades while making these hundreds of decisions involved in cutting costs? Could health professionals develop the data which could help guide public and private leaders who must make the calls? Clearly this will not be easy, but I am inclined to believe it can be done. To start the process, we have begun thinking about markers for measuring the effectiveness of our health care system which, while imperfect, would allow all Americans to keep book on how we are

Figure 8

Percent of People Seeing a Dentist in the Last Year 1953-1981



doing during this difficult period. They will not satisfy purists in the social sciences or epidemiology, but all such measures have rough edges. The markers I will suggest, however, have the advantage of drawing on data readily available to public officials, health professionals, and interested citizens alike.

First, we can continue to monitor how often people are seeing doctors or receiving certain kinds of care generally agreed to be important to maintain health and function. This can now be examined by income, or age, or race, or in other subsets if it is deemed helpful. Figures 4 through 8 portray these kinds of data. As shown in Figure 4, we know that the poor have greater medical needs than the non-poor. Similar data could be displayed to show larger burdens of illness among the elderly. Figures 5 and 6 show quite dramatically the advances the nation has made in recent years in getting care to the poor and elderly, and we need to keep a close eye on this measure. If statistics on use of health care begin returning to levels approaching those of 1964, it would suggest we are not doing as well as we should.

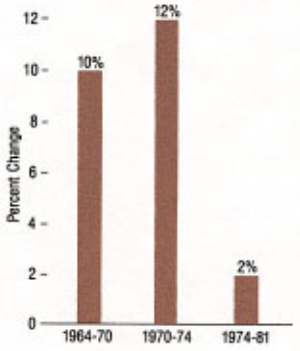
This might apply even more powerfully to access to prenatal care during the first three months of pregnancy—a period during which medical care results in lower infant mortality, lower maternal mortality, and healthier babies (Figure 7). If there is a decline in the number of pregnant women seeing doctors during the first trimester, we should worry about it.

Similar monitoring of dental care would seem appropriate (Figure 8). During the last 15 years, we have steadily increased the number of poor citizens seeing a dentist each year. Again, we might agree we should find ways to maintain or improve this access while reducing the rates of cost escalation.

Secondly, we can keep an eye on where people go for their care. A decade ago, personal physician care was harder to come by. Thus, until the mid-1970s, the number of people using emergency rooms of U.S. hospitals, where episodic care and lack of continuity are the rule, was rising at worrisome rates—10 to 12 percent per year. This has since dropped abruptly to less than 2 percent per year, as shown in Figure 9—another indication that people are finding their way to personal physicians to answer their medical needs. A rising rate in emergency room visits would suggest that access to personal physician services was again becoming more difficult.

Figure 9

Average Annual Change in Total Emergency Room Visits to U.S. Hospitals 1964-1981 (%)



Obviously these are proxy measures. Data on the number of visits people make to physicians and dentists do not really tell us what we wish to know. They do, however, offer one window on how medical and dental services are deployed.

Could we get closer to the bottom line? I believe we can. But in trying to do so, I believe we have to keep two important points in mind. One is that while the size of cuts made in health expenditures might be large in absolute dollars, what most concerned people are proposing would only be slowing the rate of increase in these expenditures. At this juncture,

Figure 10

Age-Adjusted Death Rates for the Soviet Union and the United States 1960-1975

there are no plans for absolute reductions in overall health expenditures. Certain groups in our society, however, may be disproportionately affected by cuts in public programs.

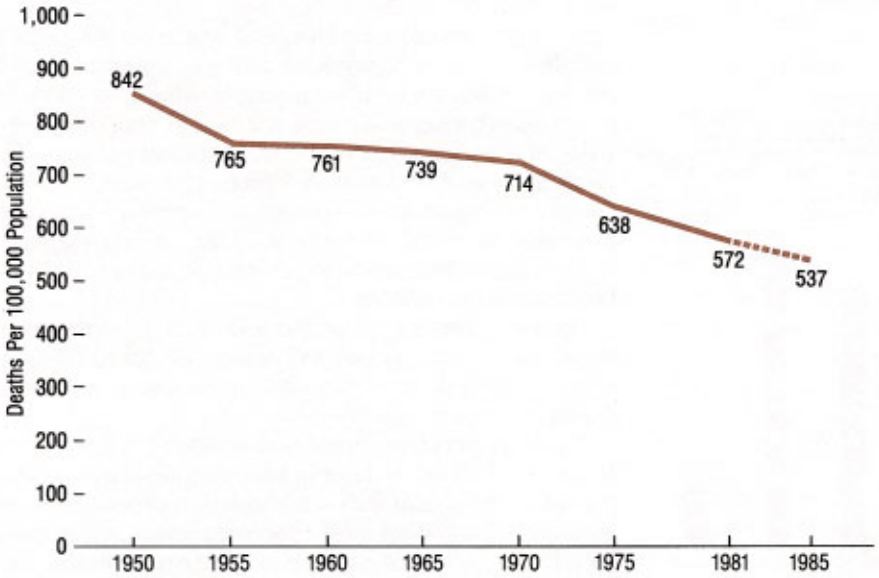
My other point is somewhat related. While only a major catastrophe could increase overall mortality rates, in aggregate statistics on 227 million Americans it is all too easy to lose sight of significant events or trends. For example: an important health measure for a small percentage of the population could deteriorate while that same measure was improving for the majority, and the decline—even if it were substantial—could be hidden in the overall population statistic.

It is of interest to note that during the last decade, despite vast differences in governmental philosophies, economic conditions, health expenditures and other fundamental characteristics, no industrialized nation except one—the Soviet Union—has seen any rise in national age-adjusted mortality rates (Figure 10).

The real question is therefore not whether the nation's death rates will rise, but whether the extraordinary health progress of recent years can be continued for everyone. I don't believe the people in this country want to slip back to the trends of the mid-1950's through 1968. Simply plateauing out at present levels of health and health care also would not be acceptable. There is every indication that present knowledge, professional skill, and technologies would permit even further

Figure 11

U.S. Death Rate (Age-Adjusted) 1950-1985



improvement — other countries have improved their health statistics using less resources. Thus, as examples, isn't it reasonable as goals for 1985 to strive for continued reductions in age-adjusted death rates (Figure 11) or infant mortality (Figure 12)?

That these improvements are seen as realistic by others is suggested by the fact that the actuaries of the Social Security Administration developed and are using these trends in their forecasts of the retirement and pension needs of the country.

Policymakers, health professionals and the public in general might also keep an eye on maternal mortality rates (Figure 13). In addition, does the nearly two-fold gap between white and black infant mortality widen or narrow in the years ahead (Figure 14)?

To be even more precise, infant mortality rates can be further subdivided into neonatal and post-neonatal rates as shown in Figure 15. Neonatal deaths (those that occur in the first month) have been shown to be a quite sensitive indicator of the adequacy of medical care. On the other hand, post-neonatal infant death rates (those that occur between one month and one year) are an indication of many other social forces influencing health, like nutrition, adequate housing, and heat, the quality of mothering and the like. Such statistics could help in tracking the effectiveness of cost reducing adjustments and where better targeting of medical efforts is needed.

Figure 12

Infant Mortality 1960-1985

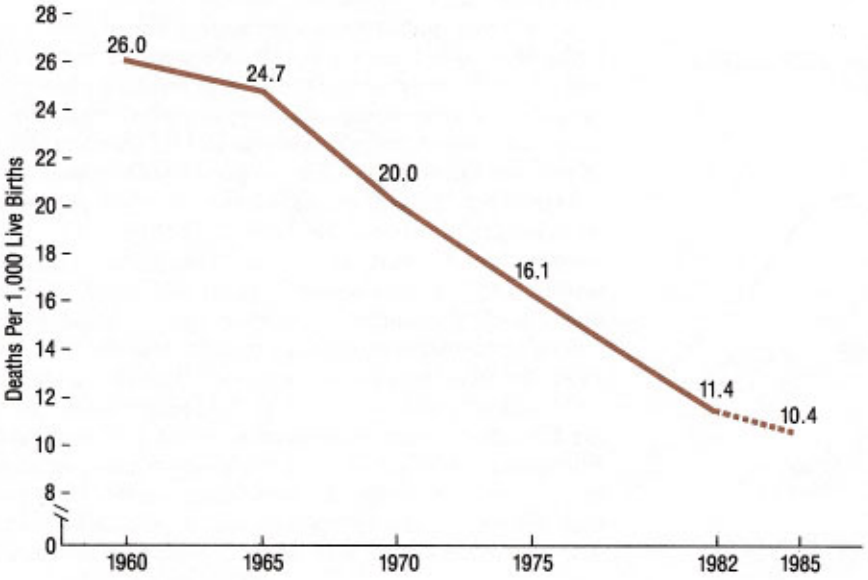
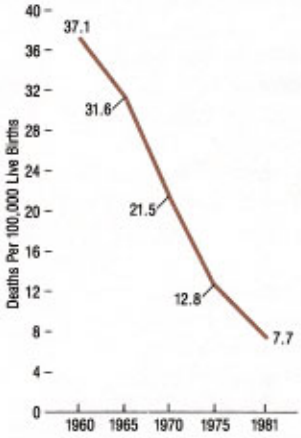


Figure 13

Maternal Mortality 1960-1981



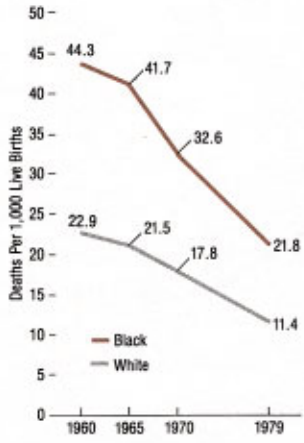
Moving beyond mortality statistics, there also are measures of common problems that could be used as indicators of whether arrangements for medical care are holding up. Let me give three examples of such markers which might serve as sensitive warning signals.

Multiple studies done in the mid-1940s show that thirty to forty cases of rheumatic fever, and risk of potentially crippling heart disease, will result from every 1,000 untreated cases of streptococcal infection in young people. As shown in Figure 16, this problem has been dramatically slashed. The incidence of serious disabling rheumatic fever as a post-streptococcal sequelae has been reduced from over 30 cases per 1,000 in 1960, to less than one in 10,000 in 1980. This is due, in no small part, to near-universal, prompt and appropriate antimicrobial treatment of acute streptococcal infections (mostly sore throats). Should the incidence of rheumatic fever plateau or again rise, it would suggest the fruits of medical knowledge are not being brought to youngsters with this and probably many other readily treatable problems.

Meningococcal infections are another case in point. Prior to the advent of antimicrobials, bloodstream meningococcal infections, or meningococcal meningitis, resulted in mortality rates ranging from 50 to 90 percent. This is a sudden and acute infection which often kills swiftly —frequently within 24 to 48 hours after the first symptoms appear. As noted in Figure 17, prompt treatment of meningococcal infections has led to a significant drop in its mortality, although we really should be doing even better—in most well-managed hospitals, mortality rates are under 10 percent. But again, a plateauing or jump in these mortality rates would serve as a warning that people are not receiving swift and appropriate medical care in general.

Figure 14

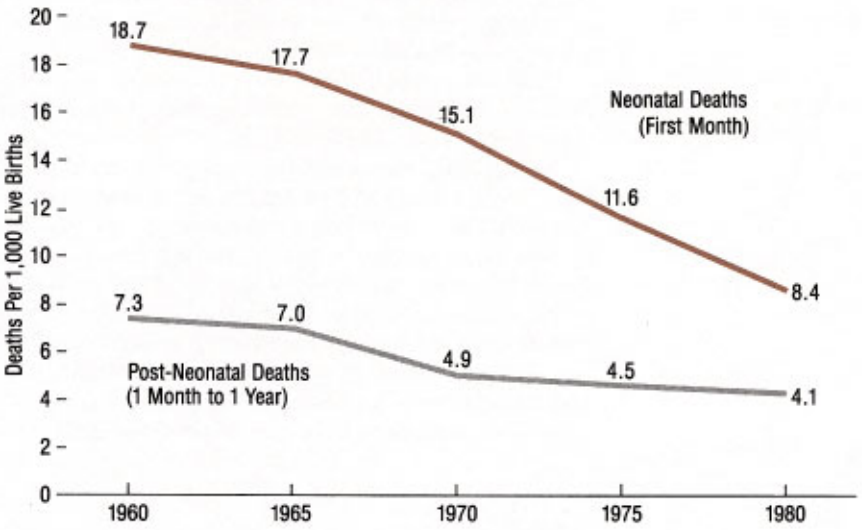
Infant Mortality Rate by Race 1960-1979



Yet another quite sensitive measure—the incidence of measles—could be used as a marker for the adequacy of childhood immunizations and pediatric preventive services in general. We have, on two previous occasions, demonstrated what happens when we let down our guard. After licensure of measles vaccine in 1963, we saw the annual incidence of measles fall from 315.2 cases per 100,000 population (1950-1962) to 1.3 cases per 100,000 in 1981, a splendid 99.6 percent decline. But look what happened between 1969 and 1971 (Figure 18). With the introduction of rubella vaccine in 1969, public funds were shifted in this direction and measles control support was curtailed. Immediately and dramatically the number of cases of measles began to rise. When direct federal immunization funds for measles vaccine were reintroduced in 1971, the trend was swiftly reversed. We did it again between 1974 and 1977 with a similar, almost three-fold jump in cases of measles before the Childhood Immunization initiative of 1977 and the Measles Elimination Program of 1978 swiftly dropped its incidence to present levels. Because the vaccine containing measles virus now routinely includes mumps and rubella vaccines as well, we could monitor all three diseases in this simple way. Indeed, Figure 18 suggests that just keeping

Figure 15

Neonatal and Post-Neonatal Infant Mortality Rates 1960-1980

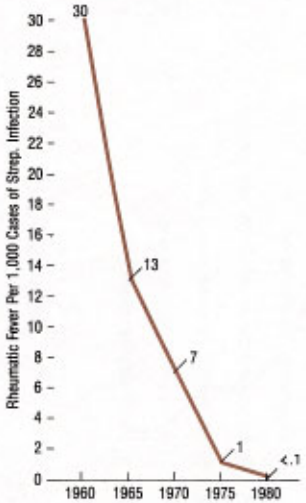


keeping track of national expenditures for vaccines alone might tell us most of what we wish to know.

Obviously, these are imperfect ways of monitoring what is happening in medical care and health affairs as the nation goes through the difficult process of reducing expenditures. They do not measure management of pain or anxiety or all the other things we seek in using the health care system. But I believe they may be a place to start. Watching these indices would allow all to keep their sights set on some important national objectives. Others may suggest yet better or more sensitive yardsticks, but these were derived from data regularly and uniformly collected nationwide, and readily available at the national, state, and local levels.

Figure 16

Rheumatic Fever as a Proportion of All Cases of Streptococcal Infection 1960-1980

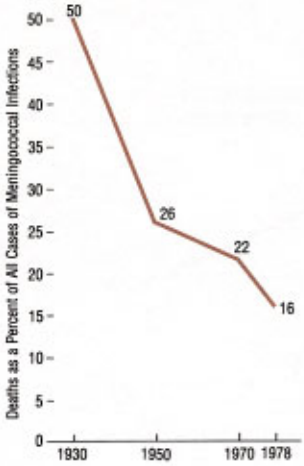


How then can private foundations help those who must make these difficult choices in the 1980s? Even the grants of a foundation as large as ours are less than 2/10,000 of what this nation will spend in health each year. Nevertheless, within the program limits that our trustees and staff together decided upon two years ago, I believe there are a substantial number of promising approaches that can and should be explored.

First, we can support private and public demonstrations which represent efforts to control health expenditures while still making quality health care equitably available. We can encourage and support those who are testing new ways of delivering basic medical services at reduced rates of increase in cost, and encourage those who are trying to target those services on those most in need. We can help medicine and the other

Figure 17

Deaths from Meningococcal Infections as a Proportion of All Cases of the Disease 1930-1978



health professions find out what clinical interventions are most effective and least costly.

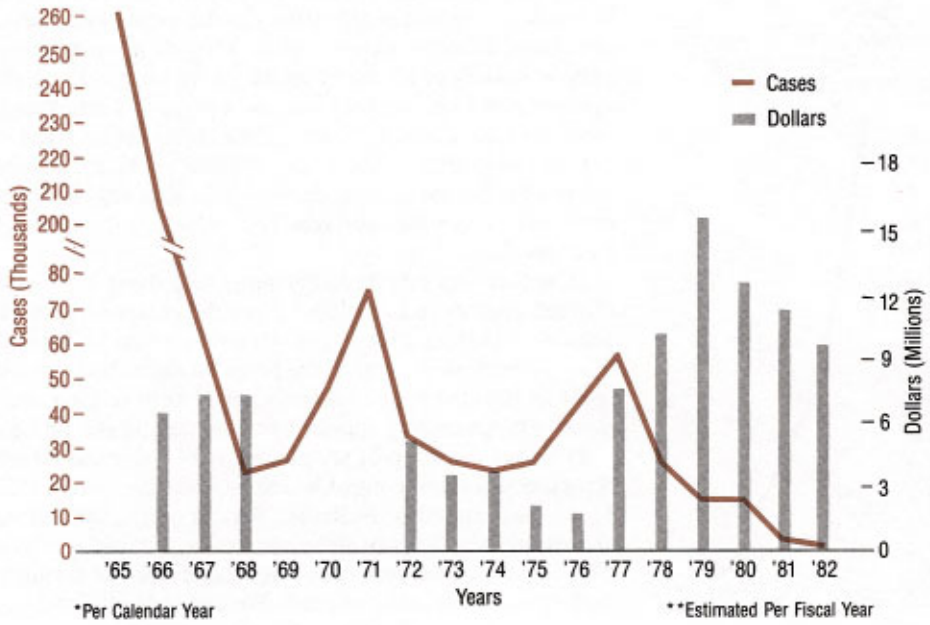
Second, during a period of economic difficulty, we can encourage groups that are focusing their attention on how medical care could help more people return swiftly to maximum attainable function at work, or at school, or independent living.

Third, we can help those who are developing independent assessments of health and health care, including both public and private services at the national, state, and local levels.

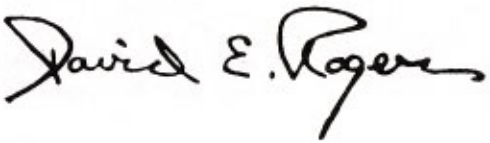
During 1982, we moved our grant programs in all three of the foregoing areas. As will be seen in succeeding sections of this Annual Report, we are supporting a number of groups and institutions that are in the process of reorganizing care, while maintaining quality and access. Similarly, we are supporting a number of groups that are continuing efforts to improve care to keep patients more functionally independent, both directly and through the training of health professionals. We are also aiding a number of groups performing studies to help the nation understand what is happening to the health of Americans—particularly those who continue to have serious problems getting the care they need.

Figure 18

Measles Cases* and Federal Grant Funds Obligated for Measles Control** 1965-1982



My final thoughts in closing this eleventh year that the Foundation has been active as a national philanthropy range outward to encompass the many people and institutions and organizations across the country that are sending us thoughtful proposals. In many ways, these requests mirror the pain the current economic situation imposes on so many. At the same time, they remind us that periods of adversity over the last two centuries have often brought forth the most imaginative and creative innovations for improving quality of life in all its dimensions. I remain hopeful that an increasing recognition of the need for sensible priorities and working more closely with one another will ultimately result in an even more responsive, equitable system for delivering health services to all who need them.



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The 1982 grant program

The 1982 grant program

During 1982 the Foundation made 228 grants totaling $53.2 million in support of programs and projects to improve health care in the United States. The types of activity supported were:

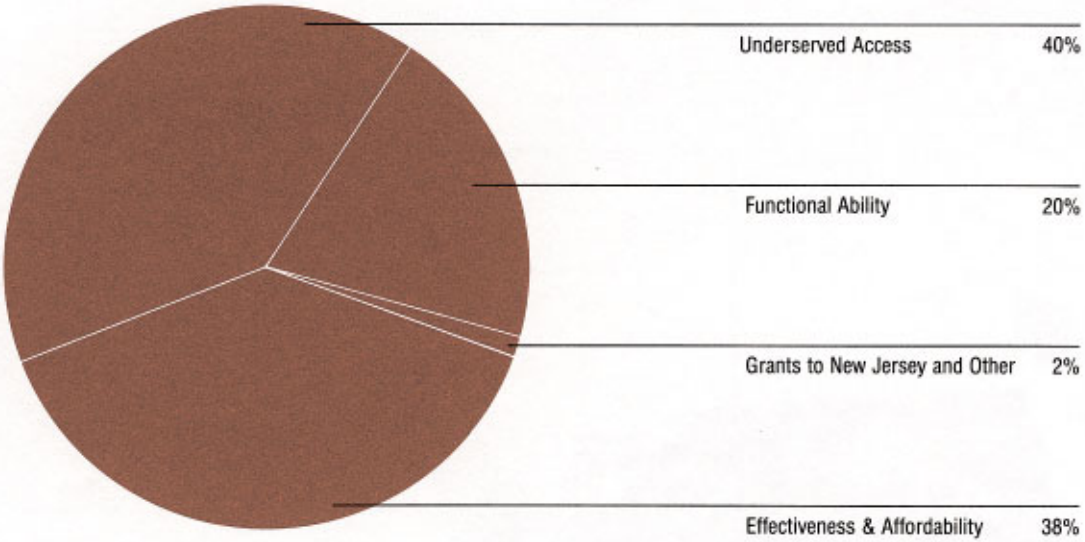
- developing and testing new ways of providing health care services, $23.5 million, or 44 percent of the 1982 grant funds;
- helping health professionals acquire new skills needed to make health care more accessible, affordable, and effective, $17 million, or 32 percent;
- conducting studies and evaluations to improve health care, $12.2 million, or 23 percent; and
- other projects received $483,219, or 1 percent.

These same grant funds, viewed in terms of the Foundation's principal objectives, were distributed as follows:

- $14.8 million, or 28 percent, for programs to improve access to personal health care for the most underserved population groups;
- $27.1 million, or 51 percent, for programs to make health care arrangements more effective and care more affordable;
- $10.4 million, or 19 percent, for programs to help people maintain or regain maximum attainable function in their everyday lives; and
- $821,635, or 2 percent, for a variety of other purposes, principally in the New Brunswick, New Jersey area where the Foundation originated.

Appropriations totaling $93.3 million have been made since 1981 when the Foundation changed its principal areas of interest to those stated above. The distribution of these funds by types of activities supported as well as by areas of interest is charted on the facing page. Since becoming a national philanthropy in 1972, our appropriations have totaled $500.7 million, and a chart depicting the geographic distribution of these funds is on page 28.

Appropriations by RWJF Objectives and Types of Activities Funded, 1981-1982*



RWJF 2-year appropriations: $93.3 million

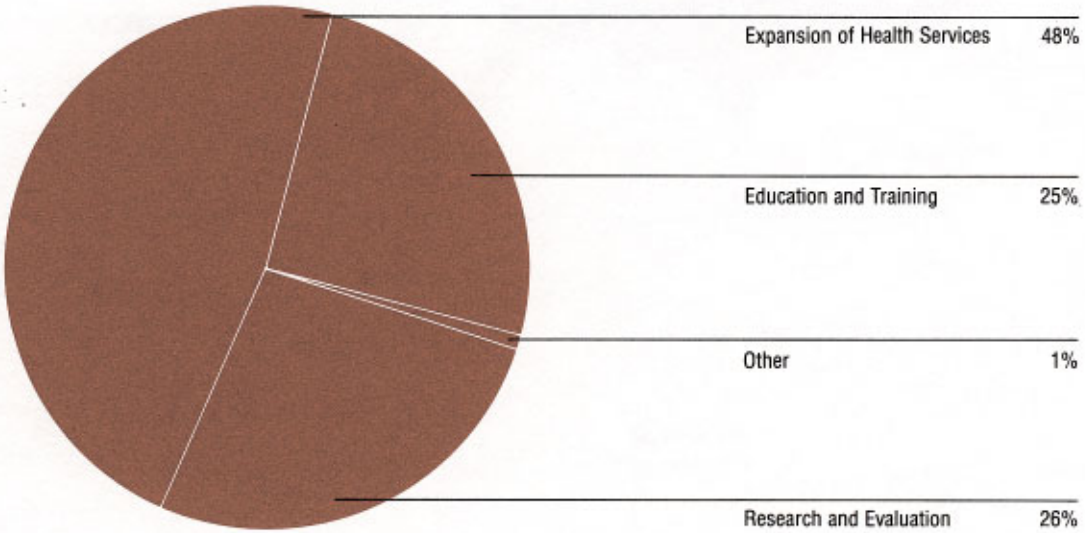
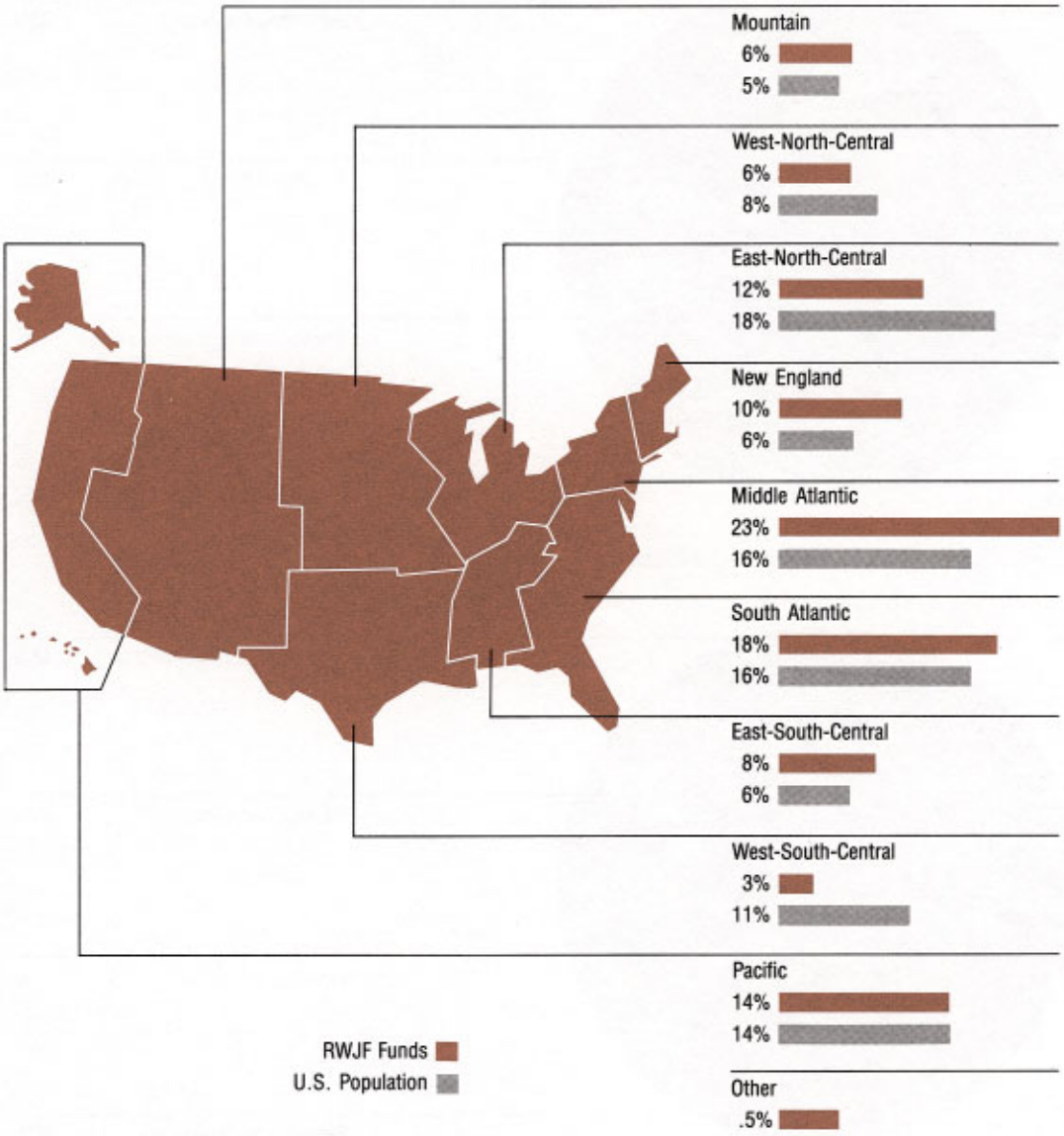


*Chart summarizing appropriations prior to 1981, when the Foundation's current program objectives were adopted, is available upon request.

Appropriations by Geographical Region Compared to Population, 1972-1982



U.S. Population figures taken from the 1980 Census of Population; Supplementary Reports, U.S. Department of Commerce, Bureau of Census, May 1981.

RWJF 10-year appropriations: $500.7 million

Major developments in the 1982 grant program

With federal and state expenditures of $32 billion in 1982, Medicaid is the primary public program paying for health care of the poor and near poor. It is jointly financed by the states and the federal government, with federal contributions ranging from 47 to 75 cents on the dollar. As Medicaid costs have soared—up 286 percent over the past 10 years—federal and state governments have sought ways to curb future increases.

Within our objectives to help improve access to care while making health care arrangements more effective and affordable, the Foundation has assisted a number of programs offering creative approaches to holding down the rate of Medicaid increases—creative in the sense that they do not rely either on cutting back the range of services or number of people covered. Grants for this purpose in 1982 include service projects in Boston and Tennessee and an effort to develop strategic options for states.

Medicaid in Boston

A consortium of more than 40 teaching hospitals, health centers and health maintenance organizations received a major grant to develop and start a program serving the 70,000 people in Boston covered by Medicaid.

The newly formed Commonwealth Health Care Corporation intends to contract with the state for a fixed budget per person on behalf of the participating health care institutions. These institutions will provide all medical and hospital services within the agreed-upon amount. Each Medicaid recipient will select a specific primary care physician in one of the participating institutions who will provide or coordinate all of the care, including specialty care and inpatient hospitalization.

...in Tennessee

The Tennessee Association of Primary Care Centers' project is similar in concept to the Boston effort. With funds from our grant and those of two other foundations, the Association is planning an umbrella contract with the state and a series of subcontracts with 22 participating primary care centers whose physicians would manage the care of Medicaid recipients. The Association proposes to pay for hospitalization and specialty care directly, but only if it is authorized by the physician case managers in the participating health centers.

Plans are to increase gradually the number of patients enrolled. Eventually it is hoped that the network will include additional centers, physicians in private practice, and hospital outpatient departments that agree to manage the care of their Medicaid patients within a fixed fee.

...and in strategic terms

The Center for the Study of Social Policy, with our assistance, is convening a group of expert state officials in a series of workshops designed to develop options for improving Medicaid arrangements within the current and anticipated social and economic climate. Results of these workshops will be communicated to those officials responsible for state Medicaid programs.

Affordable health care

Medicaid is only one component of rapidly rising health costs in this country. In broader terms, the share of personal health care expenditures for the average family in 1980 was $2,850, and that figure could be $4,917 by 1985 and more than $8,000 by 1990 if current trends are allowed to continue.

This year the Foundation announced a new grant program to help hospitals, health insurers, business, and labor join together locally to slow this rate of increase at the grass-roots level. This new effort, titled Community Programs for Affordable Health Care, co-sponsored by The American Hospital

Association and The Blue Cross and Blue Shield Associations, is intended to aid local consortiums wishing to initiate major, concrete projects to contain costs, while maintaining health-care quality and access. These approaches can include new ways to finance care as well as different arrangements for the organization and delivery of health care services in the community.

The first grants under this program will be made in 1983.

Partnerships for access to care

Almost all of the programs we support—particularly those offering health care to underserved groups—are funding partnerships in the sense that the grantees match or supplement our funds with their own resources to conduct the program.

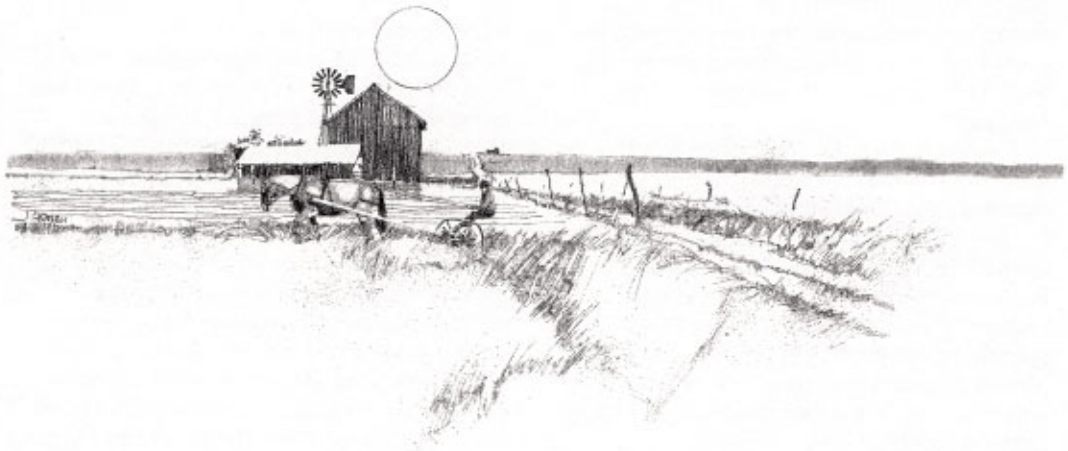
This kind of partnership is making possible the satellite health center being established in rural Amelia County by St. Mary's Hospital, 50 miles to the east in Richmond, Virginia. The Hospital is matching our 1982 grant commitment to ensure eight years of support for this center and its staff of two family physicians and support personnel.

Amelia County is a depressed, doctorless area of small farms. A major source of medical care for its 9,200 residents has been the emergency departments of Richmond's hospitals—in many instances via transportation provided by Amelia's volunteer ambulance squad. The county's infant death rate is currently 50 percent higher than that of Virginia overall.

Funding partnerships also are the basis for two other projects—both in Kansas City, Missouri—to improve access to basic medical care for specific underserved populations.

The first, operating in Paseo High School, serves high-risk adolescents among the 1,200 students of this largely black school. It is staffed by a team from Swope Parkway Comprehensive Medical Care and Mental Health Center, backed up by St. Luke's Hospital and Children's Mercy Hospital. The other project is targeted on a low-income elderly population, also largely black, using the transportation, nutrition and social services of the Seton (senior citizens') Center. This new health service is staffed and managed by the Truman Medical Center.

We are providing eight years of support for these projects with a coalition of seven foundations in the Kansas City area that identified the groups needing care and then organized the projects to meet their needs.



Programs for the elderly
Projects and programs don't often neatly address only one of the Foundation's three objectives. Most often they involve two or even all three. A number of activities assisted by this year's grants fit this pattern, yet they have one unifying characteristic: they are all seeking to improve care for elderly citizens.

The needs in this area are clear. More than four million Americans age 65 and older are severely limited in daily activities by physical or mental problems. Of these, 1.25 million live in nursing homes and another half million are completely homebound. Between 1960 and 1980, the number of people in this age group more than doubled, and in the next 20 years it will have increased by almost another third.

A role for community hospitals
The large community hospital is an obvious option in any consideration of possible bases around which the necessary range of services can be organized for our burgeoning elderly population. An encouraging sign of the interest in this new role is that more than 400 of them requested application materials for the Foundation's Program for Hospital Initiatives in Long-Term Care, which was announced this year.

The Program is co-sponsored by The American Hospital Association and the National Governors' Association. Grants to be made in 1983 will enable each of the selected hospitals to provide a comprehensive range of services for an enrolled group of at least 250 elderly people in its community.

Working with the enrolled patients' physicians and other local service agencies, the hospitals will begin offering in-home health and other supportive services; community-based mental health services; adult day care and/or day hospital services; congregate or supported housing and/or sheltered residential care; nursing home care; and training and support services for the patients' families.

Rural Hospital Program
This year, 26 small rural hospitals were funded in Kansas, Mississippi, Missouri, New Mexico, and North Dakota to begin implementing the "swing-bed" concept. This will enable them to swing designated beds from short-term care to long-term care for chronically ill, usually elderly patients and back again depending upon service needs.

The Foundation's Rural Hospital Program of Extended-Care Services, which was announced last year and is co-sponsored by The American Hospital Association, seeks to increase economically the availability of long-term care in rural communities where a shortage of nursing home beds is often paralleled by vacant hospital beds. Grants were also made under this program to the five states' hospital associations to provide technical assistance to the 26 hospitals and any others that may wish to participate on their own.

Teaching Nursing Home Program
Care of the elderly is also the focus of 11 university schools of nursing that received grants this year under another program announced last year: the Foundation's Teaching Nursing Home Program, co-sponsored by the American Academy of Nursing. The schools are developing affiliations with nearby nursing homes to demonstrate how such arrangements can enable clinical faculty to (1) participate in the ongoing care of elderly residents; (2) educate nurses, physicians, and other health professionals in the care of elderly persons; (3) undertake outreach activities serving elderly persons in the surrounding community; and (4) conduct research to improve geriatric education and care.

Other programs for the elderly
The Five Hospital Homebound Elderly Program on Chicago's north side is using our funds to expand its operations and to shift its financial base from near-total reliance on

philanthropy to one more dependent on service revenues. At the time of our grant, the Program was providing approximately 200 extremely disabled people with a range of medical and social services at roughly one-sixth the annual cost of nursing home care. A second grant, to the Northwestern University Center for Health Services and Policy Research, will permit a careful evaluation of the Program.

Beth Abraham Hospital, a 504-bed skilled nursing home in the Bronx, operates a broad range of services for the homebound elderly. It plans to test whether frail elderly people who otherwise would be admitted to nursing homes can be maintained satisfactorily and at less expense in their homes. Beth Abraham expects to contract with the state to explore various forms of financial risk sharing and incentives for appropriate patient management.

The Jewish Institute for Geriatric Care—a nursing home with a remarkably high discharge rate of 40 percent annually—is being assisted in evaluating whether its treatment approaches can be as successfully applied in its new outpatient program. These include training and support to strengthen the home-care skills of family-member caregivers, plus special clinics for senile dementia, incontinence, and other conditions that most often precipitate admissions to long-term care institutions.

The Johns Hopkins Hospital has been funded to begin a project demonstrating, in a controlled study, that hospitalized chronically ill and frail elderly patients needing skilled nursing care can be safely discharged to the care of their own families instead of a nursing home if the families are adequately prepared and supported.

Two separate, controlled studies patterned after British approaches to geriatric care were also assisted in Rochester, New York. In one, teams of physicians, nurses, social workers, and other specialists in a hospital-based geriatric assessment unit will conduct comprehensive evaluations of older patients with multiple, complex, and often interacting problems. Care is then tailored to the findings of these evaluations. The other study involves decentralized, neighborhood-based teams of nurses and social workers serving as both case managers and direct service providers for approximately 50 elderly outpatients each.

Mothers and infants

At the other end of the life cycle from old age—in childbirth and infancy—equal health care challenges abound. They gain in urgency because health problems early in life can have consequences that exact financial, social, and personal tolls over many, many years. Like efforts to improve health care for the elderly, however, the wide variety of programs and projects for mothers and infants that we have assisted usually involves all of our program objectives.

Regionalization in Missouri

Within a context of cutbacks in public monies for health programs, the state of Missouri has given priority to expanding and reorganizing maternal and child care and for fixing responsibility on a regional basis for these services. This program is the first of its kind nationally. The University of Missouri-Columbia School of Medicine and the state's Department of Social Services, assisted by the Foundation's start-up grant, will implement a phased plan to create six regional, nonprofit corporations to plan and manage all publicly financed maternal and child care in the state. Eventually, all state and federal funds for these purposes will be distributed among these corporations in block grants to be used according to priorities set in the regions.

Teen Tot Clinic

The problems and risks that have put teenage pregnancy high on the nation's health agenda include high incidences of premature birth and associated medical consequences of low birthweight; the increased risk of lower IQs and poor school performance among children

of teenage mothers; and the likelihood of poverty for mother and child. A Philadelphia study found 8 out of 10 students who left school because of pregnancy did not return, and repeat pregnancies were common. Nationally, more than half of all Aid to Families of Dependent Children goes to women who as teenagers had their first babies. The University of Pennsylvania School of Nursing, in collaboration with Children's Hospital and with our funding, is developing a Teen Tot Clinic to provide care for teenage mothers and their children. It will focus on maintaining the health of both mother and child while allowing the child-mother to complete her education. It incorporates an array of outreach efforts at home and school that include the involvement of the infant's grandmother in the support system.

Low-birthweight infants

Under yet another grant and also at the University of Pennsylvania, a program of in-hospital and home-care follow-up is being initiated to discharge selected low-birthweight newborns more swiftly from the hospital. This program builds on evidence obtained from a variety of studies that prolonged hospitalization of these infants is deleterious because of their exposure to very high noise levels, the threat of infection, and the social deprivation that comes from being separated from their parents.

Developmental disabilities

There are 2.8-million children and young people in this country who are categorized as developmentally disabled because of mental retardation, cerebral palsy, autism, epilepsy,

learning disabilities, neuromuscular disorders, and birth defects. Compounding the effects of these problems, and confounding attempts to ameliorate them, are the fragmentation and lack of coordination of the health and social services needed by these children and their families. The University of Medicine and Dentistry of New Jersey-Rutgers Medical School, with our financial assistance, has established its Academic Center for Developmental Disabilities to see if this situation can be improved. Staff will help marshal the considerable public and voluntary resources in the surrounding six-county region to offer coordinated, comprehensive, case-managed services to all developmentally disabled children and their families in the area.

Controlling childhood injuries

Even though accidents are the leading cause of death in children and account for 500,000 children being admitted to hospitals each year, little has been done in recent years to improve the management of pediatric injuries or reduce the likelihood of injury. Further, most emergency medical services are geared to adults, and there is evidence that these systems do not serve children well.

The Johns Hopkins Hospital Regional Pediatric Trauma Center, with a 1982 grant, is working to improve performance in this area. Careful data will be collected from the 300 seriously injured children it cares for each year to gain better insights about the precise causes and nature of the injuries. The care received by approximately 13,000 other children seen in emergency rooms and admitted to other hospitals in Maryland each year will also be analyzed. All of this information will then be used to improve the training of physicians and emergency medical personnel in the state and to inform and guide groups working on accident control and injury prevention.

Child health studies

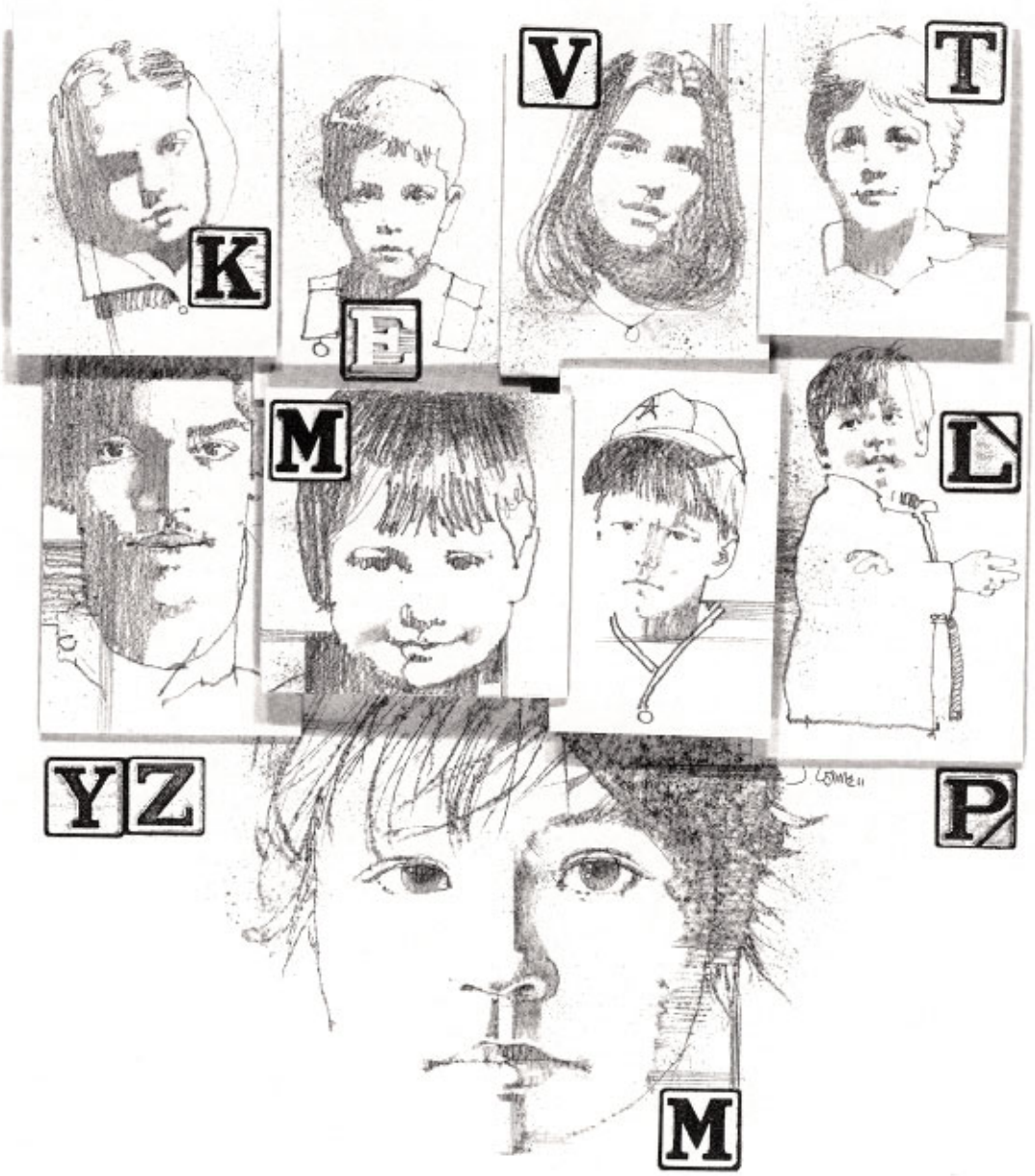
For the 12 percent of all children estimated to have handicapping conditions, the past two decades have been characterized by a national effort, albeit highly varied at the local level, to ensure they receive health care and a public education. A Children's Hospital Medical Center-Harvard University team, with a major grant from the Foundation, has begun a three-year study of school placement involving some 2,000 elementary school children with moderate to severe physical and emotional handicaps. The study addresses three broad policy questions growing out of the varied educational approaches that have been employed: (1) What types of school settings (regular or specialized) seem best for children with particular functional limitations? (2) What patterns of school-related health services are most effective in improving their performance? and (3) What school expenditures are essential to improve their health and functional outcomes?

A second medical group from Children's Hospital Medical Center, with another of our grants, is working with practicing pediatricians in selected urban and rural communities to test a series of new diagnostic techniques and management protocols for use with children aged 9 to 15 who exhibit a variety of behavioral and learning problems. Follow-up examinations will be conducted to see if the youngsters' functional abilities have been improved.

Another grant, to Harvard University, is enabling a group of health professionals and public policy analysts to develop national program strategy options for improving the health of children and youth.

Patient functional status

The second annual round of grants in our Medical Practice Research and Development Program is underwriting 21 initial or early-stage studies which focus on bettering functional outcomes for patients impaired by disease or injury. A third round of grants is planned for 1983, but under the more descriptive title: Research and Development Program to Improve Patient Functional Status.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Adult day hospital
Better outcomes for patients — in terms of satisfaction, functional effectiveness, and less expense — are also the goals of a phased study by Memorial Sloan-Kettering Cancer Center. A succession of brief but expensive hospital stays has become routine for a large and growing number of adult cancer patients nationwide who receive long-term therapy extending over months and even years. Our funds are being used to see if much of this care could be provided in the hospital during the day, with the patients going home or to a hotel at night. This approach has proved successful in the care of selected children at the Center, and Memorial Sloan-Kettering staff estimate that much of the adult care now done on an in-patient basis could be handled this way, including 2,000 to 3,000 surgical procedures annually.

Clinical Nurse Scholars Program
Specialization and the use and management of a vast array of new technologies for the care of patients who are more acutely ill than ever before have become dominant patterns in hospital nursing practice. The Foundation announced its Clinical Nurse Scholars Program this year for nurse faculty committed to meeting this growing challenge through a new emphasis on hospital-based practice and clinical research in the collegiate education of both entry-level nurses and future nurse faculty. The first group of nine Scholars will be selected in 1983 for individually tailored, two-year fellowships involving advanced patient care, clinical research, and hospital management at the University of California, San Francisco; The University of Pennsylvania; and The University of Rochester.

Dental Scholars Program
Also in 1982, the Foundation announced a new program offering two-year fellowships in health services research for dental school faculty members. Focused on systems and arrangements for providing dental care, their postdoctoral work will center around preceptorships in such disciplines as epidemiology, economics, and policy analysis. Planning grants were made this year to the Harvard School of Dental Medicine and the University of California, Los Angeles, School of Dentistry, where the Scholars will be enrolled. The first five fellowships under the Dental Services Research Scholars Program will be awarded in 1983.

Clinical Scholars Program
The Robert Wood Johnson Clinical Scholars Program offers young physicians completing their residency training two years of postdoctoral studies in a social or management science or other non-biological areas of learning. It is based on the premise that a cadre of physicians who are both skilled clinicians and versed in these additional research disciplines can make valuable contributions toward improving the organization, financing, and delivery of medical services. In 1982, grants were made to continue the Program for another three years at the University of California, Los Angeles; University of California, San Francisco and Stanford University; University of North Carolina at Chapel Hill; University of Pennsylvania; University of Washington; and Yale University.

Medical careers for minorities
Six of our grants in 1982 support projects and programs to increase the number of minority physicians and the quality of their training. One was our fourth major grant in 11 years to Meharry Medical College, which has educated more black physicians and dentists than any other institution in the country. Meharry will use this latest assistance to recruit additional faculty needed to continue to strengthen its patient care, teaching, and research programs.

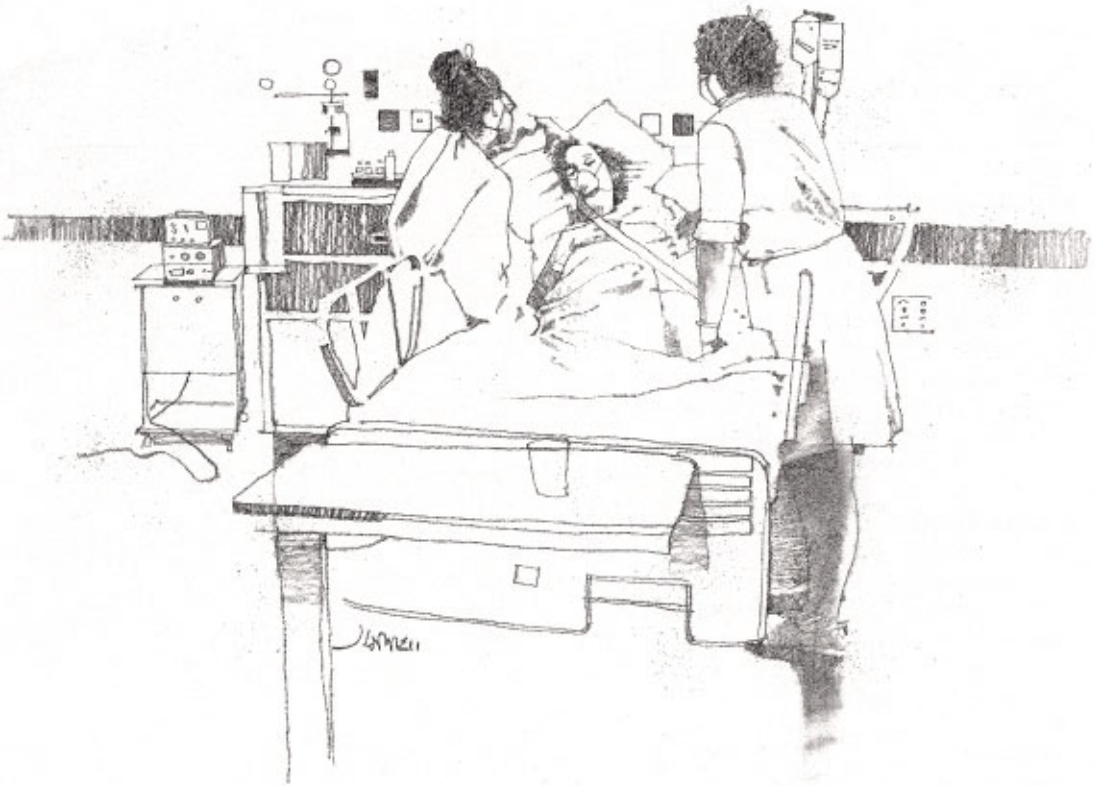
The other grants were to attract talented minority students in high schools and colleges

to medical careers and for special study programs for minority premedical and medical students. The recipients were the four-college Atlanta University Center Prehealth Profession Program administered by Morehouse College; Charles R. Drew Postgraduate Medical School; Illinois Institute of Technology; the National Fund for Medical Education; and the University of Southern California School of Medicine.

An additional grant was made to Educational Testing Service to study Foundation-supported programs seeking to increase the medical school minority applicant pool and help minority medical students achieve their academic objectives.

Student loans

A decision was also made in 1982 to continue our Guaranteed Student Loan Program for those medical, dental, and osteopathic students who received assistance prior to 1982. This is being done through a "program related investment" — a loan of monies to United Student Aid Funds (USAF), which administers the Program. USAF is using these funds as a reserve against possible defaults on the student loans it guarantees under our program.



Understanding health issues

In addition to the studies previously described, support was also given this year to a number of other projects designed to produce and disseminate information and data important to the understanding of various aspects of health affairs.

Foremost among these were grants to Louis Harris Associates and the University of Chicago to conduct a follow-up study of the Foundation-supported, 1976 national survey of access to health care.

Our aim is to track this particular measure of health care over time, and to maintain a current profile of the groups in our population that continue to have difficulty securing basic health services. Plans are to complete the analysis of data and report the results in the spring of 1983.

Other such projects include a University of Michigan study of families in the Detroit area to determine the effects of unemployment on people's health and health care utilization; an Urban Institute study of the effects of changes in public expenditures on hospitals and their care of the poor; a Harvard University study of the effects of recent federal block grants on services offered by primary care centers and local health departments; and Tufts University studies of the changing patterns of physician distribution, of care patterns for the terminally ill, and of the effects of anti-trust actions in health affairs. In addition, four grants were made in support of independent evaluations of four major programs funded by the Foundation.

Local assistance

The Foundation also strives to be a good corporate citizen in its local community, and within this context, the recipients of its grants included United Ways in Central Jersey and Princeton, the New Brunswick units of the Salvation Army and St. Vincent de Paul Society, St. Peter's Medical Center, Middlesex County College, and Middlesex General-University Hospital.

For further information

A complete list of 1982 grants begins on page 51, followed by a list of grants made in previous years that were still active in 1982 (i.e., those with unpaid balances on January 1, 1982). A descriptive Program Summary for most of the grants on these lists is available without charge. Requests should include the title of the grant, the institutional recipient, the grant ID number, and should be addressed to:

Communications Office
The Robert Wood Johnson Foundation
Post Office Box 2316
Princeton, New Jersey 08540.

Bibliography

Bibliography

Each year the Foundation's grantees report the publications and other information materials that have been produced as a direct or indirect result of their grants.

In 1982 these reports cited 28 books, 114 book chapters, 680 journal articles, 252 reports, and 18 films, tapes and other audiovisual products.

This bibliography is a sample of citations from each category reported in 1982, and from among the publications of the Foundation's staff. These publications are available through medical libraries and/or the publishers. Copies are not available from the Foundation.

Books

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Financial statements

Introduction to Statements

The annual financial statements for the Foundation for 1982 appear on pages 47 through 50, followed by a listing of grants authorized in 1982 and a summary of grants authorized in prior years which had not been paid in full as of January 1, 1982.

Grants authorized in 1982, net of cancellations and refunds of prior years' grants, totaled $49,529,839. Program development, administrative and investment expenses for the year came to $5,132,776 and federal excise tax amounted to $1,013,288, making a grand total of expenditures of $55,675,903. This total exceeded gross investment income of $50,963,458 by $4,712,445. In 1981, total expenditures were $4,676,755 less than gross investment income.

A list of investment securities held at December 31, 1982 is available upon request to the Treasurer, The Robert Wood Johnson Foundation, Post Office Box 2316, Princeton, New Jersey, 08540.

William R. Walsh, Jr.
Vice President and Treasurer

Opinion of Independent Certified Public Accountants

To the Trustees of
The Robert Wood Johnson Foundation:

We have examined the statement of assets, liabilities and foundation principal of The Robert Wood Johnson Foundation as of December 31, 1982 and 1981 and the related statement of investment income, expenses, grants and changes in foundation principal for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1982 and 1981 and the investment income, expenses, grants and changes in foundation principal for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Newark, New Jersey
January 17, 1983.

The Robert Wood Johnson Foundation
Statement of Assets, Liabilities and Foundation Principal
at December 31, 1982 and 1981

	1982	1981
Assets		
Cash	$ 236,741	$ 646,147
Investments (at cost, or market value on dates of gifts) (Note 2):		
Johnson & Johnson common stock — 22,273,258 shares in 1982, 23,283,258 shares in 1981 (quoted market value $1,105,310,428 and $864,390,953)	212,833,283	222,484,388
Fixed income investments (quoted market value $309,105,018 and $174,993,526)	289,401,406	215,629,969
Other corporate common stocks (quoted market value $48,358,838)	—	49,275,863
Program related investments	800,000	—
Land, building, furniture and equipment at cost, net of depreciation (Note 1)	5,632,807	5,818,010
	$508,904,237	$493,854,377
Liabilities and Foundation Principal		
Liabilities:		
Unpaid grants (Note 1)	$ 92,407,229	$ 83,279,574
Federal excise tax payable	1,013,288	917,536
Total liabilities	93,420,517	84,197,110
Foundation principal	415,483,720	409,657,267
	$508,904,237	$493,854,377

See notes to financial statements.

The Robert Wood Johnson Foundation
Statement of Investment Income,
Expenses, Grants and Changes in Foundation Principal
for the years ended December 31, 1982 and 1981

	1982	1981
Investment income (Note 1):		
Dividends	$ 23,025,243	$ 22,302,135
Interest	27,938,215	23,914,225
	50,963,458	46,216,360
Less: Federal excise tax	1,013,288	917,536
Investment expenses	299,081	339,579
	49,651,089	44,959,245
Expenses:		
Program development and evaluation	3,596,759	3,372,678
General administration	1,236,936	1,052,119
	4,833,695	4,424,797
Income available for grants	44,817,394	40,534,448
Grants, net of refunds and cancellations	49,529,839	35,857,693
	(4,712,445)	4,676,755
Adjustments to foundation principal:		
Net capital gains (losses) on sales of securities (Note 3)	10,412,857	(8,423,238)
Contributions received	126,041	187,908
	10,538,898	(8,235,330)
Net increase (decrease) in foundation principal	5,826,453	(3,558,575)
Foundation principal, beginning of year	409,657,267	413,215,842
Foundation principal, end of year	$415,483,720	$409,657,267

See notes to financial statements.

Notes to Financial Statements

1. Summary of significant accounting policies:

Grants are recorded as payable in the year the grant requests are authorized by the Board of Trustees. At December 31, 1982 unpaid grants are as follows:

Year Grant Authorized	Amount Unpaid at December 31, 1982
1978	$ 7,722,491
1979	4,404,276
1980	11,199,396
1981	23,424,908
1982	45,656,158
	$92,407,229

Depreciation of $227,626 in 1982 and $233,769 in 1981 is calculated using the straight-line method over the estimated useful lives of the depreciable assets.

Interest and dividend income is recorded when received and expenses are recorded, except for federal excise taxes, when paid. The difference between the cash and accrual basis for such amounts is considered to be immaterial.

2. The quoted market value of the sizeable investment in Johnson & Johnson common stock does not necessarily represent the realizable value of such investment.

3. The net capital gains (losses) on sales of securities for the years ended December 31, 1982 and 1981 were as follows:

	1982	1981
Johnson & Johnson common stock	$33,599,724	$ 7,446,205
Other securities, net	(23,186,867)	(15,869,443)
	$10,412,857	($ 8,423,238)

4. Substantially all employees of the Foundation are covered by a retirement plan which provides for retirement benefits through the purchase of individually-owned annuities. The Foundation's policy is to fund costs accrued. Pension expense approximated $254,000 and $233,000 in 1982 and 1981, respectively.

Summary of grants
authorized in the year ended December 31, 1982

	1982 grants authorized
American Nurses' Foundation, Inc. Kansas City, Missouri	
National symposium program on nursing faculty practice by the American Academy of Nursing (for 3 years). ID#7568	$ 141,113
Beth Abraham Hospital Bronx, New York	
Demonstration of a long-term care management and delivery system (for 3 years). ID#7301	450,000
Brandeis University Waltham, Massachusetts	
Research on the cost of hospital-sponsored ambulatory care (for 1 year). ID#8012	22,721
Brigham and Women's Hospital, Inc. Boston, Massachusetts	
Administration of the Foundation's Teaching Hospital General Medicine Group Practice Program (for 1 year). ID#6655	188,336
University of California, Los Angeles Los Angeles, California	
Evaluation of the Foundation's School Health Services Program (for 6 months). ID#8265	35,000
University of California, Los Angeles, School of Dentistry Los Angeles, California	
Planning for the Dental Services Research Scholars Program (for 10 months). ID#7851	48,028
University of California, San Francisco, School of Nursing San Francisco, California	
Planning for the Foundation's Clinical Nurse Scholars Program (for 1 year). ID#7990	86,788

	1982 grants authorized
Center for the Study of Social Policy Washington, D.C.	
Developing state strategies for Medicaid and related health care programs (for 15 months). ID#8154	$ 159,225
Charles R. Drew Postgraduate Medical School Los Angeles, California	
Program development for a high school in the health sciences for minority students (for 2.5 years). ID#7524	187,324
University of Chicago Chicago, Illinois	
Update on national study of access to health care (for 20 months). ID#6861	104,373
Analysis of practice profiles of physicians trained in primary care resident programs (for 1 year). ID#8016	159,000
Children's Hospital Corporation (formerly Children's Hospital Medical Center) Boston, Massachusetts	
Development of a medical program for children with impaired function (for 2 years). ID#6768	634,975
Study of the health and functional status of handicapped children in public school settings (for 3 years). ID#6908	1,000,000
The Foundation's Chronic Disease Care Program	
Development of physician-directed, nurse-managed programs providing ambulatory care for patients with chronic diseases. ID#4891	
Administrative costs (for 1.5 years). Princeton, New Jersey	62,483
The Foundation's Clinical Nurse Scholars Program	
Postdoctoral fellowships of advanced in-hospital clinical practice and research. ID#7514	
Princeton, New Jersey *Administrative costs (for 2 months).*	35,000
The Foundation's Clinical Scholars Program	
Postdoctoral fellowships for young physicians to develop research skills in non-biological disciplines relevant to medical care. ID#5109	
University of California, Los Angeles, School of Medicine Los Angeles, California *(4 years)*	1,234,508

	1982 grants authorized
University of California, San Francisco, School of Medicine San Francisco, California *(4 years)*	$ 637,987
University of North Carolina at Chapel Hill, School of Medicine Chapel Hill, North Carolina *(4 years)*	1,155,239
University of Pennsylvania, School of Medicine Philadelphia, Pennsylvania *(3 years)*	1,107,220
Stanford University, School of Medicine Stanford, California *(3 years)*	538,325
University of Washington, School of Medicine Seattle, Washington *(3 years)*	1,080,481
Yale University, School of Medicine New Haven, Connecticut *(3 years)*	1,094,284
Princeton, New Jersey *Administrative costs (for 1 year).*	60,000
Columbia University New York, New York *Public policy programs in health services and manpower (for 1 year). ID#7925*	99,505
Commonwealth Health Care Corporation Boston, Massachusetts *City-wide initiative to improve the delivery of health services under Medicaid (for 3 years). ID#7984*	1,297,653
Cornell University Medical College New York, New York	
Administration of the Foundation's Chronic Disease Care Program (for 1 year). ID#6482	88,116
Administration of the Foundation's General Pediatrics Academic Development Program (for 1 year). ID#6656	76,704
Endowment of a Walsh McDermott Scholar in Public Health. ID#7938	100,000
Evaluation of a training program in diabetes patient self-management (for 1 year). ID#7599	24,544

	1982 grants authorized
Council on Foundations Washington, D.C.	
National service and educational program on the foundation field (for 5 years). ID#8330	$ 250,000
Educational Testing Service — Education Policy Research Institute Washington, D.C.	
Study of programs to increase minority representation in medicine (for 3 years). ID#7810	184,688
The Foundation's Family Practice Faculty Fellowships Program	
Program to prepare physicians for academic careers in family practice (for 3 years). ID#3579	
Case Western Reserve University, School of Medicine Cleveland, Ohio	733,398
University of Missouri, Columbia, School of Medicine Columbia, Missouri	910,227
Five Hospital Homebound Elderly Program Chicago, Illinois	
Demonstration of a program to provide services for the homebound elderly (for 3 years). ID#7588	225,000
State of Florida, Department of Health and Rehabilitative Services Tallahassee, Florida	
Planning for a 16-county health services program (for 1 year). ID#7338	56,928
Fordham University New York, New York	
Planning for the Foundation's Interfaith Volunteer Caregivers Program (for 3 months). ID#8324	24,639
Georgetown University, School of Medicine Washington, D.C.	
Analysis of health policy issues (for 11 months). ID#6911	256,568
Greater Kansas City Community Foundation Kansas City, Missouri	
Primary Care Health Center for the Elderly (for 5 years). ID#7636	339,193
Primary Care Health Center for Adolescents (for 5 years). ID#7821	298,916

	1982 grants authorized
Harvard University Cambridge, Massachusetts	
Development of child and adolescent health policy (for 4 years). ID#7196	$ 783,000
Harvard University, Medical School Boston, Massachusetts	
Evaluation of the Foundation's Program for the Health-Impaired Elderly (for 3 years). ID#6845	598,887
Harvard University, School of Dental Medicine Boston, Massachusetts	
Planning for the Dental Services Research Scholars Program (for 10 months). ID#8159	48,050
Harvard University, School of Public Health Boston, Massachusetts	
Study of the effects of changes in health programs for the poor on primary care centers and local health departments (for 1 year). ID#7474	109,000
The Foundation's Program for the Health-Impaired Elderly	
Completion of an effort begun in 1980 to coordinate and integrate services at the community level for elderly people with health problems (for the periods indicated). ID#4884	
First Tennessee-Virginia Development District Johnson City, Tennessee *(2 years)*	396,806
Illinois State Department on Aging Springfield, Illinois *(3 years)*	299,237
Maryland State Office on Aging Baltimore, Maryland *(2 years)*	400,230
Nebraska Department on Aging Lincoln, Nebraska *(3 years)*	400,000
New York State Office for the Aging Albany, New York *(33 months)*	400,000
Ohio State Commission on Aging Columbus, Ohio *(3 years)*	399,946

	1982 grants authorized
Maine Medical Center Portland, Maine	
Postgraduate physician's assistant residency program in emergency medicine (for 2 years). ID#7227	$ 80,000
Massachusetts General Hospital Boston, Massachusetts	
Administration of the Foundation's Program of Prepaid Managed Health Care (for 1 year). ID#7861	261,009
The Foundation's Medical Practice Research and Development Program. ID#6329	
Albert Einstein Medical Center Philadelphia, Pennsylvania	
Evaluation of follow-up services for high-risk infants (for 2 years).	148,353
Beth Israel Hospital Boston, Massachusetts	
Study to improve patient function after critical illness (for 3 years).	149,512
Brown University, Program in Medicine Providence, Rhode Island	
Functional effectiveness trial involving female heart attack patients (for 3 years).	135,995
University of California, San Francisco, School of Medicine San Francisco, California	
Evaluation of a psychosocial intervention for trauma patients (for 3 years).	149,957
Improving function in chronically ill children: evaluation of an active communication model (for 2.5 years).	149,052
Case Western Reserve University, School of Medicine Cleveland, Ohio	
Evaluation of therapies for chronic pulmonary disease (for 2 years).	149,751
Columbia University, College of Physicians and Surgeons New York, New York	
Evaluation of home health record use on the function of asthmatic children (for 3 years).	150,000
Duke University, School of Medicine Durham, North Carolina	
Evaluation of hospitalization as a factor in functional disability (for 2.5 years).	149,925

	1982 grants authorized
Illinois Institute of Technology Chicago, Illinois	
Preceptorship program to prepare minorities for careers in medicine (for 3 years). ID#6538	$ 261,510
Jewish Institute for Geriatric Care Nursing Home Company, Inc. New Hyde Park, New York	
Evaluation of the Institute's new ambulatory care services program (for 3.5 years). ID#6575	510,029
John F. Kennedy Medical Center Foundation, Inc. Edison, New Jersey	
Equipment for The Robert Wood Johnson Jr. Rehabilitation Institute. ID#6914	50,000
The Johns Hopkins Hospital Baltimore, Maryland	
Program to strengthen the role of the family in the care of the frail elderly (for 3 years). ID#5741	627,109
Administration of the Foundation's Municipal Health Services Program (for 1 year). ID#6483	224,459
The Johns Hopkins University, School of Medicine Baltimore, Maryland	
Administration of the Foundation's School Health Services Program (for 14 months). ID#6658	85,694
A statewide program to study and control childhood injuries (for 3.5 years). ID#7762	403,724
Kingston Hospital Kingston, New York	
Administration of the Foundation's Program for the Health-Impaired Elderly and for other consulting services (for 1 year). ID#6653	189,019
Louis Harris and Associates, Inc. New York, New York	
Baseline survey for the Arizona health care cost containment system (for 8 months). ID#7804	150,000
Update on national study of access to health care: development and fielding of the survey (for 11 months). ID#7431	324,000

	1982 grants authorized
Maine Medical Center Portland, Maine	
Postgraduate physician's assistant residency program in emergency medicine (for 2 years). ID#7227	$ 80,000
Massachusetts General Hospital Boston, Massachusetts	
Administration of the Foundation's Program of Prepaid Managed Health Care (for 1 year). ID#7861	261,009
The Foundation's Medical Practice Research and Development Program. ID#6329	
Albert Einstein Medical Center Philadelphia, Pennsylvania	
Evaluation of follow-up services for high-risk infants (for 2 years).	148,353
Beth Israel Hospital Boston, Massachusetts	
Study to improve patient function after critical illness (for 3 years).	149,512
Brown University, Program in Medicine Providence, Rhode Island	
Functional effectiveness trial involving female heart attack patients (for 3 years).	135,995
University of California, San Francisco, School of Medicine San Francisco, California	
Evaluation of a psychosocial intervention for trauma patients (for 3 years).	149,957
Improving function in chronically ill children: evaluation of an active communication model (for 2.5 years).	149,052
Case Western Reserve University, School of Medicine Cleveland, Ohio	
Evaluation of therapies for chronic pulmonary disease (for 2 years).	149,751
Columbia University, College of Physicians and Surgeons New York, New York	
Evaluation of home health record use on the function of asthmatic children (for 3 years).	150,000
Duke University, School of Medicine Durham, North Carolina	
Evaluation of hospitalization as a factor in functional disability (for 2.5 years).	149,925

	1982 grants authorized
University of Florida, College of Medicine Gainesville, Florida	
Study of training for family caregivers of elderly patients with dementia (for 2 years).	$ 147,935
Harvard Community Health Plan, Inc. Boston, Massachusetts	
A controlled trial of three treatments for low back pain (for 3 years).	150,000
Massachusetts General Hospital — Institute of Health Professions Boston, Massachusetts	
Improving functional outcomes of elderly hip fracture patients — a clinical trial (for 3 years).	150,000
Medical Associates Research and Education Foundation (The Children's Hospital of Philadelphia — University of Pennsylvania) Philadelphia, Pennsylvania	
Neonatal intensive care follow-up study (for 29 months).	144,612
University of Missouri, Columbia, School of Medicine Columbia, Missouri	
Clinical trial of nurse intervention to strengthen social supports (for 3 years).	149,949
The Research Foundation of the State University of New York (SUNY School of Medicine at Stony Brook) Albany, New York	
Study using group therapy to improve function in nursing home patients (for 3 years).	150,000
University of Rochester, School of Medicine and Dentistry Rochester, New York	
Evaluation of timed manual function in geriatric assessments (for 3 years).	122,095
Stanford University, School of Medicine Stanford, California	
Study of early return to work for selected heart attack patients (for 3 years).	150,000
Temple University, School of Medicine Philadelphia, Pennsylvania	
Testing the effects of improved patient-physician communication (for 3 years).	149,610
University of Tennessee, College of Medicine Memphis, Tennessee	
Study to identify risk factors and outcome predictors in cataract surgery (for 2 years).	149,486

	1982 grants authorized
Wake Forest University, The Bowman Gray School of Medicine Winston-Salem, North Carolina	
Evaluation of self-assessment on control of asthma (for 3 years).	$ 117,243
Study of adjunct psychosocial therapy for rheumatoid arthritis patients (for 2.5 years).	149,993
University of Washington, School of Medicine Seattle, Washington	
Study to identify predictors of success with insulin infusion regimen (for 2 years).	149,590
Meharry Medical College Nashville, Tennessee	
Administration of the Foundation's Program to Consolidate Health Services for High-Risk Young People (for 1 year). ID#6909	221,658
Faculty Development Program (for 5 years). ID#8038	5,000,000
Memorial Sloan-Kettering Cancer Center New York, New York	
Planning for the development of an adult day hospital (for 3 years). ID#6933	527,000
University of Michigan, School of Public Health Ann Arbor, Michigan	
Study of the effects of unemployment on health and health care utilization in Detroit (for 1.5 years). ID#7816	255,104
Middlesex County College Edison, New Jersey	
Registered nurse refresher course (for 2 months). ID#6657	14,398
Middlesex County College Foundation, Inc. Edison, New Jersey	
Support for the health sciences scholarship program (for 10 months). ID#6913	28,135
Middlesex General — University Hospital New Brunswick, New Jersey	
Property acquisition ID#8246	118,500
Regional emergency medical services program with St. Peter's Medical Center (for 1 year). ID#8068	158,000
University of Minnesota, School of Nursing Minneapolis, Minnesota	
Administration of the Foundation's Clinical Nurse Scholars Program (for 1 year). ID#7519	122,238

	1982 grants authorized
University of Missouri, Columbia, School of Medicine Columbia, Missouri	
Administration of the Foundation's Rural Infant Care Program (for 1 year). ID#6910	$ 137,544
Statewide demonstration to reorganize the financing and delivery of child and maternal health services (for 2 years). ID#7836	435,122
Monroe County Long Term Care Program, Inc. Rochester, New York	
Evaluation of alternatives in the management of care for the elderly (for 2 years). ID#7794	417,077
Montefiore Hospital and Medical Center Bronx, New York	
Service program for adolescents with chronic illness (for 3 years). ID#5438	336,590
Administration of the Foundation's Program for Hospital Initiatives in Long-Term Care (for 1 year) ID#7863	233,955
Morehouse College Atlanta, Georgia	
Four-college program to increase minority enrollment in medical schools (for 3 years). ID#7356	474,844
National Academy of Sciences, Institute of Medicine Washington, D.C.	
Administration of the Foundation's Health Policy Fellowships Program (for 3 years). ID#4850	502,617
Conference on cost-effective medical care (for 6 months). ID#8102	44,399
National Executive Service Corps New York, New York	
Development of a senior executive program to aid hospitals (for 3 years). ID#7245	500,000
National Fund for Medical Education Hartford, Connecticut	
Summer remedial programs for minority medical students (for 2 years). ID#7325	212,986
National Opinion Research Center Chicago, Illinois	
Developing state strategies for Medicaid and related health care programs (for 1.5 years). ID#6770	190,806

	1982 grants authorized
New England Medical Center, Inc. Boston, Massachusetts	
Treatment of delayed mental development in rural children (for 1 year). ID#6305	$ 136,012
University of Medicine and Dentistry of New Jersey, Rutgers Medical School Piscataway, New Jersey	
Development of a regional service system for developmentally disabled children (for 4 years). ID#6684	796,772
Clinical assistance for New Brunswick School Health Services (for 3 years). ID#7374	352,795
New York University New York, New York	
Administration of the Foundation's Rural Hospital Program of Extended-Care Services (for 1 year). ID#6480	231,866
University of North Carolina, Health Services Research Center Chapel Hill, North Carolina	
Administration of the Foundation's Dental Services Research Scholars Program (for 13 months). ID#6722	189,343
Study of rural health care initiatives (for 15 months). ID#7326	109,645
Northwestern University Evanston, Illinois	
Evaluation of a program to provide services for the homebound elderly (for 3 years). ID#7587	249,759
University of Oklahoma, College of Medicine Oklahoma City, Oklahoma	
Development of a pediatric primary care program at Oklahoma Children's Memorial Hospital (for 2 years). ID#7460	150,000
University of Pennsylvania, School of Nursing Philadelphia, Pennsylvania	
Administration of the Foundation's Teaching Nursing Home Program (for 1 year). ID#6912	198,189
Early hospital discharge program for low birthweight infants (for 3 years). ID#6742	264,297
Planning for the Foundation's Clinical Nurse Scholars Program (for 1 year). ID#7991	90,956
Program to improve health outcomes for teenage mothers and their infants (for 2.5 years). ID#7689	205,000

	1982 grants authorized
The People-To-People Health Foundation, Inc. Millwood, Virginia	
Support for the Center for Health Science Information, Research and Analysis (for 3 years). ID#7484	$ 150,000
The Foundation's Program for Research and Development on Health Care Costs. ID#7867	
Administrative costs (1 year). Princeton, New Jersey	75,000
University of Rochester, School of Medicine and Dentistry Rochester, New York	
Evaluation of specialty geriatric consultation services (for 33 months). ID#6257	300,528
Follow-up of infants in the Chemung County Home Visitor Demonstration Program (for 2 years). ID#6729	439,972
University of Rochester, School of Nursing Rochester, New York	
Planning for the Foundation's Clinical Nurse Scholars Program (for 1 year). ID#7992	59,760
The Foundation's Rural Hospital Program of Extended-Care Services	
Development of "swing bed" concept to provide long-term care in acute-care hospitals (for the periods indicated). ID#6267	
Cedar County Memorial Hospital El Dorado Springs, Missouri *(2 years)*	78,997
Community Hospital Sweet Springs, Missouri *(2 years)*	80,238
District Two Community Hospital Durant, Mississippi *(2 years)*	85,189
Dr. Dan C. Trigg Memorial Hospital Tucumcari, New Mexico *(2 years)*	116,147
Hazen Memorial Hospital Association Hazen, North Dakota *(2 years)*	94,947
Holton City Hospital Holton, Kansas (2 years)	79,276

	1982 grants authorized
Kansas Hospital Association Topeka, Kansas *(4 years)*	$ 300,000
Lexington Memorial Hospital Lexington, Missouri *(2 years)*	85,662
Linton Hospital, Inc. Linton, North Dakota *(2 years)*	111,844
Maude Norton Memorial City Hospital Columbus, Kansas *(2 years)*	96,221
Mercy Hospital — Tri County Mansfield, Missouri *(2 years)*	95,954
Mississippi Hospital Association Jackson, Mississippi *(4 years)*	300,000
Missouri Hospital Association Jefferson City, Missouri *(4 years)*	257,204
New Mexico Hospital Association Albuquerque, New Mexico *(4 years)*	297,272
Nor-Lea Hospital District Lovington, New Mexico *(2 years)*	111,950
North Dakota Hospital Association Grand Forks, North Dakota *(4 years)*	290,325
North Mississippi Medical Center — Baldwyn Satellite Unit Baldwyn, Mississippi *(2 years)*	86,750
Northern Colfax County Hospital Raton, New Mexico *(2 years)*	93,954
Northwest Kansas Medical Center Goodland, Kansas *(2 years)*	92,654
Pembina County Memorial Hospital Cavalier, North Dakota *(2 years)*	114,768
Presbyterian Medical Services — Cuba Hospital Cuba, New Mexico *(2 years)*	73,507

	1982 grants authorized
Ruidoso Hondo Valley Hospital Ruidoso, New Mexico *(2 years)*	$ 101,388
St. Andrew's Hospital Bottineau, North Dakota *(2 years)*	82,474
Scott County Hospital Scott City, Kansas *(2 years)*	94,286
Sheridan County Hospital Hoxie, Kansas *(2 years)*	83,544
Sierra Vista Hospital, Inc. Truth or Consequences, New Mexico *(2 years)*	89,298
Simpson General Hospital Mendenhall, Mississippi *(2 years)*	92,987
Stafford District Hospital No. 4 Stafford, Kansas *(2 years)*	64,061
Sullivan County Memorial Hospital Milan, Missouri *(2 years)*	85,435
Tallahatchie General Hospital Charleston, Mississippi *(2 years)*	72,179
Union Hospital Society Mayville, North Dakota *(2 years)*	79,122
The Foundation's Rural Infant Care Program	
Completion of cooperative projects begun in 1980 with state health departments to reduce infant mortality and morbidity in isolated rural counties. ID#5540	
Duke University Medical Center Durham, North Carolina *(2 years)*	270,360
Eastern Virginia Medical Authority Norfolk, Virginia *(23 months)*	311,696
Louisiana State University, School of Medicine in Shreveport Shreveport, Louisiana *(2 years)*	304,611

	1982 grants authorized
University of New Mexico, School of Medicine Albuquerque, New Mexico *(2 years)*	$ 358,839
The Ohio State University Research Foundation Columbus, Ohio *(2 years)*	371,974
University of Oklahoma, Health Sciences Center Oklahoma City, Oklahoma *(2 years)*	343,014
Medical University of South Carolina Charleston, South Carolina *(2 years)*	350,487
University of Tennessee, College of Medicine Memphis, Tennessee *(2 years)*	370,161
Tulane University, School of Medicine New Orleans, Louisiana *(2 years)*	304,507
University of Washington, School of Medicine Seattle, Washington *(3 years)*	346,374
St. Mary's Hospital of Richmond, Inc. Richmond, Virginia *Establishment of a rural health center (for 32 months). ID#6375*	130,083
St. Peter's Medical Center, School of Nursing New Brunswick, New Jersey *Support for nurse training program (for 10 months). ID#6654*	30,000
St. Vincent de Paul Society Highland Park, New Jersey *Program of assistance to the indigent (for 1 year). ID#7509*	17,000
The Salvation Army New Brunswick, New Jersey *Program of assistance to the indigent (for 1 year). ID#7294*	45,000
Seton Hall University, College of Nursing South Orange, New Jersey *Graduate program in primary care nursing (for 1 year). ID#4631*	83,044

	1982 grants authorized
University of Southern California, School of Medicine Los Angeles, California	
A college medical school eduction program for disadvantaged premedical students (for 1 year). ID#7482	$ 250,000
Stanford University, School of Medicine Stanford, California	
Administration of the Foundation's Infant Health and Development Program (for 1 year). ID#7887	309,283
The Foundation's Teaching Nursing Home Program	
Nursing home-nursing school affiliations to improve long-term care of the elderly (for 2 years). ID#6362	
Case Western Reserve University, Frances Payne Bolton School of Nursing Cleveland, Ohio	232,119
The Catholic University of America, School of Nursing Washington, D.C.	237,989
University of Cincinnati, College of Nursing and Health Cincinnati, Ohio	180,492
Creighton University, School of Nursing Omaha, Nebraska	254,133
Georgetown University, School of Nursing Washington, D.C.	276,688
The Research Foundation of the State University of New York Albany, New York	224,768
Oregon Health Sciences University, School of Nursing Portland, Oregon	236,501
Rush-Presbyterian-St. Luke's Medical Center Chicago, Illinois	206,324
Rutgers University, College of Nursing Newark, New Jersey	201,004
University of Utah, College of Nursing Salt Lake City, Utah	228,257
University of Wisconsin, Madison, School of Nursing Madison, Wisconsin	198,049
Tennessee Association of Primary Health Care Centers, Inc. Nashville, Tennessee	
Implementation of a state-wide, capitated, primary care network for Medicaid recipients (for 3 years). ID#7406	232,000

	1982 grants authorized
Tufts University, School of Medicine Boston, Massachusetts *Analysis of policy issues affecting medical care (for 2 years). ID#7629*	$ 100,000
United Way of Central Jersey, Inc. Milltown, New Jersey *Support of 1982 campaign. ID#7292*	230,000
United Way — Princeton Area Communities Princeton, New Jersey *Support of the 1982 campaign. ID#6261*	33,000
The Urban Institute Washington, D.C. *National survey of hospital care for the poor and hospital financial status (for 2 years). ID#7670*	375,000
Urban Medical Group, Inc. Jamaica Plains, Massachusetts *Development and evaluation of a managed health care system for severely disabled adults (for 3 years). ID#6925*	312,381
Virginia Commonwealth University Richmond, Virginia *Administration of the Foundation's Hospital-Sponsored Ambulatory Dental Services Program (for 1 year). ID#6652*	203,166
University of Washington Seattle, Washington *Evaluation of the Foundation's Community Hospital-Medical Staff Group Practice Program (for 6 months). ID#7558*	40,189
University of Wisconsin Medical School Madison, Wisconsin *Administration of the Foundation's Urban Health Program and consultation for the Community Care Funding Partners Program (for 1 year). ID#6915*	49,628

	1982 grants authorized
PRESIDENT'S GRANTS	
Ambulatory Pediatric Association McLean, Virginia	
Planning a study of child health status and care (for 3 months). ID#8219	$ 24,736
Association for Advancement of the Mentally Handicapped—Princeton Chapter Princeton, New Jersey	
Demonstration of a transitional funding strategy for community-based agencies (for 11 months). ID#7223	12,000
Association of American Medical Colleges Washington, D.C.	
Preparation and publication of data on underrepresented minorities in medical education (for 2 years). ID#7976	25,000
Association of Professors of Medicine, Inc. Washington, D.C.	
Support for the Association's task force on manpower needs (for 2 years). ID#6803	20,330
Billings American Indian Council Billings, Montana	
Transition of urban health care program for American Indians (for 1 year). ID#7217	24,544
Boys' Clubs of America New York, New York	
Completion of materials for a health education program (for 1 month). ID#7598	1,750
University of California, San Francisco, School of Medicine San Francisco, California	
Feasibility study on the impact of flexible employee health benefit plans (for 9 months). ID#7473	24,791
Connecticut Community Care, Inc. Bristol, Connecticut	
Study following termination of a federal program to coordinate long-term care (for 1 year). ID#7728	24,481
Educational Testing Service Princeton, New Jersey	
Evaluation of a program for the training of dentists in the care of the handicapped (for 3 months). ID#7569	5,000

	1982 grants authorized
Harvard University, Medical School Boston, Massachusetts	
Study of medical intervention and functional status in nursing homes (for 9 months). ID#7362	$ 24,997
Health Research and Educational Trust of New Jersey Princeton, New Jersey	
Assessment of communications technology in support of the homebound (for 6 months). ID#7822	10,000
The Johns Hopkins University, School of Hygiene and Public Health Baltimore, Maryland	
Feasibility study of senior volunteers in long-term care (for 6 months). ID#7667	19,021
Kingston Hospital Kingston, New York	
Technical assistance to Native American groups in planning health care projects (for 1 year). ID#8277	5,820
Mercer County Special Services School District Hamilton Square, New Jersey	
Equipment purchase for a communications center for handicapped children. ID#7506	3,219
The Morehouse School of Medicine, Inc. Atlanta, Georgia	
Study of public policy effects on predominantly black medical schools (for 3 months). ID#8214	24,990
The National Council on the Aging, Inc. Washington, D.C.	
Research to identify the structurally underserved elderly (for 4 months). ID#7675	4,862
National Governors' Conference Center for Policy Research and Analysis Washington, D.C.	
Study of developments in Medicaid reimbursement (for 8 months). ID#7645	16,000
New Jersey Association for Retarded Citizens — Warren Unit, Inc. Washington, New Jersey	
Provision and evaluation of special therapy services for handicapped children (for 1 year). ID#7620	5,000

	1982 grants authorized
Newark Day Center Newark, New Jersey	
Support of planning for improved health services for the underserved (for 8 months). ID#6449	$ 24,214
University of North Carolina, Health Services Research Center Chapel Hill, North Carolina	
Study of quality assurance issues for long-term care (for 7 months). ID#7898	18,987
University of North Carolina, School of Public Health Chapel Hill, North Carolina	
Follow-up study of selected health departments as providers of primary care (for 1 year). ID#7537	25,000
University of Pennsylvania, The Wharton School Philadelphia, Pennsylvania	
Study of home equity conversion as a source of health care funds (for 1 year). ID#8034	23,780
Rush-Presbyterian-St. Luke's Medical Center Chicago, Illinois	
Survey of the role of nurse midwives in United States health care (for 1 year). ID#6306	24,900
The Washington Hospital Center Washington, D.C.	
Public-private sector study of options in financing health care for the poor (for 5 months). ID#8094	25,000

Total 1982 grants	$53,154,197
Refunds of prior years' grants	(1,600,177)
Cancellations	(2,024,181)
Grants net for 1982	$49,529,839

Summary of grants authorized in previous years, and with unpaid balances on January 1, 1982 (year authorized and full amount of grant shown)

University of Alaska
Anchorage, Alaska
Rural health aide training program (ID#6181)
1981—$177,153; 1978—$164,694

American Academy of Pediatrics
Evanston, Illinois
Health initiative program for the U.S.-Mexican border area (ID#6586)
1981—$128,674

American College of Physicians
Philadelphia, Pennsylvania
Support of the Society for Research and Education in Primary Care Medicine (ID#4260)
1978—$129,056

Study of the practice and training of internists (ID#5239)
1979—$158,550

Program of the Society for Research and Education in Primary Care Internal Medicine (ID#4636)
1981—$25,000

American Fund for Dental Health
Chicago, Illinois
Planning and implementation of a preventive dental care program for school-age children (ID#4770)
1978—$858,289

Nationwide preventive dental care program for school-age children (ID#5527)
1981—$653,628

American Health Planning Association
Washington, D.C.
Development of area-wide planning for ambulatory services (ID#5139)
1979—$260,000

American Medical Association Education and Research Foundation
Chicago, Illinois
Accreditation program for prison health care facilities (ID#6552)
1981—$398,258

University of Arizona, College of Medicine
Tucson, Arizona
Special follow-up study of high-risk neonates (ID#4682)
1978—$563,594

Arroyo Vista Family Health Foundation (Formerly The East Los Angeles Community Union)
East Los Angeles, California
Support of a family health care center (ID#5158)
1979—$232,000

Aspira of America, Inc.
New York, New York
Program to increase minority enrollment in medical school (ID#6363)
1981—$425,000

Associated Clinics of Appalachia, Inc.
Bellaire, Ohio
Program of technical assistance to member clinics (ID#4951)
1980—$335,800

Association of American Medical Colleges
Washington, D.C.
Financial aid administration programs (ID#6393)
1981—$70,000

Association of Physician Assistant Programs
Arlington, Virginia
Support for the Association's national office (ID#4506)
1979—$225,000

Association of University Programs in Health Administration
Washington, D.C.
Summer internship program in health services management (ID#3821)
1978—$299,962

Beth Israel Hospital
Boston, Massachusetts
Study of the use of functional assessment as a systematic tool in medical practice (ID#6592)
1981—$600,000

Beth Israel Medical Center
New York, New York
Primary care service in a public housing project for the elderly (ID#6256)
1981—$119,275

Brandeis University
Waltham, Massachusetts
Support of the Committee on the Growth of Hospital-Sponsored Ambulatory Care (ID#5180)
1979—$608,881

Evaluation of the viability of Foundation-sponsored individual service programs (ID#5971)
1980—$358,081

Brown University
Providence, Rhode Island
Study of the cost and efficacy of hospice care (ID#4785)
1980—$550,000

University of California, Los Angeles
Los Angeles, California
Evaluation of the Foundation's Hospital-Sponsored Ambulatory Dental Services Program (ID#4756)
1980—$676,362

Evaluation of the Foundation's School Health Services Program (ID#6269)
1981—$248,364

Evaluation of the Foundation's Chronic Disease Care Program (ID#6302)
1981—$448,964

University of California, Los Angeles, School of Medicine
Los Angeles, California
Study of health decision making among children (ID#4126)
1977—$303,461

Evaluation of the Foundation's Teaching Hospital General Medicine Group Practice Program (ID#5318)
1980—$1,113,536

Case Western Reserve University, School of Medicine
Cleveland, Ohio
Special follow-up of high-risk neonates (ID#4789)
1978—$494,999

University of Chicago
Chicago, Illinois
Evaluation of the Foundation's Community Hospital-Medical Staff Group Practice Program (ID#3869)
1979—$1,419,985

Study of practice profiles of primary care physicians (ID#5970)
1980—$499,993

Evaluation of the Foundation's Municipal Health Services Program (ID#6798)
1981—$336,669

Chicano Health Policy Development, Inc.
San Antonio, Texas
Statewide program to identify and prepare Mexican-American college students for medical studies (ID#6168)
1981—$149,891

Children's Hospital Corporation
(formerly Children's Hospital Medical Center)
Boston, Massachusetts

Program to train clinical faculty in child development (ID#4546)
1979—$497,340

Planning an evaluation of emerging provisions for services for handicapped children—Phase II (ID#6328)
1981—$140,861

The Foundation's Chronic Disease Care Program

Development of physician-directed, nurse-managed programs providing ambulatory care for patients with chronic diseases (ID#4555)

Cedars of Lebanon Hospital Corporation
Miami, Florida
1979—$531,857

Daniel Freeman Hospital Medical Center
Inglewood, California
1979—$553,045

Ellis Hospital
Schenectady, New York
1979—$563,612

Henry Ford Hospital
Detroit, Michigan
1980—$570,000

Mount Auburn Hospital
Cambridge, Massachusetts
1980—$558,312

University of Oklahoma, Tulsa, Medical College
Tulsa, Oklahoma
1979—$535,074

The Staten Island Hospital
Staten Island, New York
1980—$525,428

Tufts University, School of Medicine
Boston, Massachusetts
1980—$587,449

The Foundation's Clinical Scholars Program

Postdoctoral fellowships for young physicians to develop research skills in non-biological disciplines relevant to medical care (ID#2493)

University of California, Los Angeles, School of Medicine
Los Angeles, California
1980—$946,493

University of California, San Francisco, School of Medicine and Stanford University, School of Medicine
San Francisco, California
1980—$925,288

University of North Carolina, School of Medicine
Chapel Hill, North Carolina
1980—$893,312

University of Pennsylvania, School of Medicine
Philadelphia, Pennsylvania
1981—$78,112; 1980—$913,778

University of Washington, School of Medicine
Seattle, Washington
1980—$935,494

Yale University, School of Medicine
New Haven, Connecticut
1980—$914,981

Administrative costs
Princeton, New Jersey
1981—$150,000

Columbia University
New York, New York

Public policy programs in health services and manpower (ID#5072)
1979—$423,967

Evaluation of the Foundation's Municipal Health Services Program (ID#4432)
1981—$391,848

The Foundation's Community Care Funding Partners Program

Projects offering care for the medically underserved (ID#6397)

Administrative costs
Princeton, New Jersey
1981—$199,000

The Foundation's Community Hospital-Medical Staff Group Practice Program

Grants for the development of hospital-sponsored primary care group practices (ID#4470)

Appalachian Regional Hospitals, Inc.
Lexington, Kentucky
1978—$483,980

Huron Road Hospital
East Cleveland, Ohio
1979—$500,000

Jackson Hospital and Clinic, Inc.
Montgomery, Alabama
1979—$492,214

Joint Hospital Committee for Extramural Affairs
Aberdeen, Washington
1977—$494,160

Marion County Hospital Authority
Buena Vista, Georgia
1978—$500,000

Northeast Alabama Regional Medical Center
Anniston, Alabama
1979—$500,000

Providence Hospital
Washington, D.C.
1978—$500,000

Providence Medical Center
Seattle, Washington
1977—$500,000

St. Joseph Mercy Hospital
Ann Arbor, Michigan
1978—$499,910

Scottsdale Memorial Hospital
Scottsdale, Arizona
1977—$498,103

Sisters of Mercy Health Corporation
Sioux City, Iowa
1977—$500,000

Wausau Hospitals, Inc.
Wausau, Wisconsin
1977—$456,117

Williamsburg County Memorial Hospital
Kingstree, South Carolina
1977—$485,185

Comprehensive Interdisciplinary Developmental Services, Inc.
Elmira, New York

Study of Chemung County, New York, maternal and early infant care program (ID#5263)
1979—$183,203

University of Connecticut Health Center
Hartford, Connecticut

Development of a school-based health care program (ID#3835)
1978—$537,225

The Foundation's Program to Consolidate Health Services for High-Risk Young People

Cooperative effort of teaching hospitals and public or voluntary agencies (ID#6331)

Boston City Hospital
Boston, Massachusetts
1981—$590,633

Bronx-Lebanon Hospital Center
New York, New York
1981—$600,000

University of California, San Diego, School of Medicine
San Diego, California
1981—$599,924

University of California, San Francisco, School of Medicine
San Francisco, California
1981—$600,000

Children's Hospital of Los Angeles
Los Angeles, California
1981—$599,969

Children's Hospital of Michigan
Detroit, Michigan
1981—$595,640

University of Cincinnati General Hospital
Cincinnati, Ohio
1981—$600,000

University of Connecticut, School of Medicine
Farmington, Connecticut
1981—$600,000

Cook County Hospital
Chicago, Illinois
1981—$600,000

Cuyahoga County Hospital
Cleveland, Ohio
1981—$598,199

Dallas County Hospital District, Parkland Memorial Hospital
Dallas, Texas
1981—$599,581

Howard University Hospital
Washington, D.C.
1981—$600,000

Indiana University Foundation
Indianapolis, Indiana
1981—$600,000

The Johns Hopkins Hospital
Baltimore, Maryland
1981—$599,791

University of Maryland, School of Medicine
Baltimore, Maryland
1981—$599,959

University of Mississippi Medical Center
Jackson, Mississippi
1981—$591,738

Montefiore Hospital and Medical Center
Bronx, New York
1981—$599,460

University of Oklahoma, Health Sciences Center
Oklahoma City, Oklahoma
1981—$600,000

University of Rochester, School of Medicine and Dentistry
Rochester, New York
1981—$599,763

Yale-New Haven Hospital
New Haven, Connecticut
1981—$600,000

Cooper Medical Center
Camden, New Jersey
Development of an integrated urban health system (ID#5089)
1979—$374,527

Cornell University Medical College
New York, New York
Support of a computerized neurology data bank (ID#6024)
1981—$252,503

Training physicians in the use of new technologies for patient self-management of diabetes (ID#6167)
1981—$171,388

Dartmouth Medical School
Hanover, New Hampshire
Evaluation of health care costs and patients' functional status in primary care settings (ID#6215)
1981—$149,772

The Foundation's Family Practice Faculty Fellowships Program
Program to prepare physicians for academic careers in family practice (ID#3579)

Case Western Reserve University, School of Medicine
Cleveland, Ohio
1978—$538,503

University of Iowa, College of Medicine
Iowa City, Iowa
1981—$649,168

University of Missouri, Columbia, School of Medicine
Columbia, Missouri
1978—$654,944

University of Utah, College of Medicine
Salt Lake City, Utah
1981—$847,315

University of Washington, School of Medicine
Seattle, Washington
1981—$737,498

State of Florida, Department of Health and Rehabilitative Services
Tallahassee, Florida
Improving the functional ability of children with chronic illnesses who live in rural areas (ID#6071)
1980—$597,000

The Foundation Center
New York, New York
Data collection and analysis on the foundation field (ID#5429)
1980—$150,000
Program office for Grantmakers in Health (ID#7354)
1981—$150,000

The Foundation's General Pediatrics Academic Development Program
Grants to expand research and training for academic careers in general pediatrics (ID#4610)

Duke University Medical Center
Durham, North Carolina
1979—$723,123

The Johns Hopkins University, School of Medicine
Baltimore, Maryland
1979—$800,000

Medical Associates Research and Education Foundation
Philadelphia, Pennsylvania
1979—$799,968

University of Rochester, School of Medicine and Dentistry
Rochester, New York
1979—$837,570

Stanford University, School of Medicine
Stanford, California
1979—$842,604

Yale University, School of Medicine
New Haven, Connecticut
1979—$787,165

The George Washington University
Washington, D.C.
National Health Policy Forum (ID#5209)
1979—$300,000

Georgetown University
Washington, D.C.
Completion of a project to develop a system of medically assisted self-care (ID#6947)
1981—$33,000

Georgetown University, School of Medicine
Washington, D.C.
Developing a system of medically-assisted self-care (ID#4485)
1979—$431,888
Analysis of health policy issues (ID#6097)
1981—$185,603; 1980—$188,834

Georgia Department of Human Resources
Atlanta, Georgia
Primary care health services program (ID#3830)
1979—$615,781

Good Samaritan Hospital and Medical Center
Portland, Oregon
Primary care training program for emergency department nurses (ID#4512)
1978—$314,459

Group Health Foundation
Washington, D.C.
Program to equip physicians with professional management skills (ID#4985)
1979—$151,280

Harvard University, Medical School
Boston, Massachusetts
Program to train physicians for primary medical care (ID#3089)
1977—$733,788

Evaluation of the Foundation's Program for the Health-Impaired Elderly (ID#5141)
1980—$450,000

Harvard University, School of Public Health
Cambridge, Massachusetts
Support of the School of Public Health (ID#5213)
1979—$670,000

Evaluation of the Foundation's Rural Infant Care Program (ID#5146)
1981—$588,601

The Foundation's Program for the Health-Impaired Elderly
Coordination and integration of services at the community level for elderly people with health problems (ID#4884)

First Tennessee-Virginia Development District
Johnson City, Tennessee
1980—$447,594

The Illinois Department of Aging
Springfield, Illinois
1980—$581,932

State of Maryland Office on Aging
Baltimore, Maryland
1980—$592,605

Nebraska Commission on Aging
Lincoln, Nebraska
1980—$600,000

New York State Office for the Aging
Albany, New York
1980—$600,000

Ohio Commission on Aging
Columbus, Ohio
1980—$599,860

Philadelphia Corporation for Aging
Philadelphia, Pennsylvania
1980—$600,000

South Carolina Commission on Aging
Columbia, South Carolina
1980—$548,135

Hospital Educational and Research Foundation, Inc.
Minneapolis, Minnesota
Impact of competition on Minneapolis/St. Paul metropolitan area health care services (ID#6557)
1981—$547,054

Hospital Research and Educational Trust
Chicago, Illinois
Development of a financial and administrative assistance program for hospitals attempting to improve their outpatient departments (ID#5460)
1980—$350,000

Production of educational materials for the Foundation's Rural Hospital Program of Extended-Care Services (ID#6298)
1981—$120,000

Collaborative forecasting of the health care services environment (ID#6255)
1981—$78,000

Administration of the Foundation's Community Programs for Affordable Health Care (ID#6755)
1981—$339,840

The Foundation's Hospital-Sponsored Ambulatory Dental Services Program

Programs of general and emergency dental care and oral hygiene education for dentally-underserved people (ID#4553)

Brigham and Women's Hospital, Inc.
Boston, Massachusetts
1979—$340,165

Buffalo General Hospital
Buffalo, New York
1979—$500,000

The Genesee Hospital
Rochester, New York
1979—$337,033

Highland General Hospital
Oakland, California
1979—$321,503

Illinois Masonic Medical Center
Chicago, Illinois
1979—$414,275

University of Iowa Hospitals and Clinics
Iowa City, Iowa
1979—$497,443

Loma Linda University Medical Center
Loma Linda, California
1979—$383,838

Long Island Jewish-Hillside Medical Center
New Hyde Park, New York
1979—$399,518

Lutheran Medical Center
Brooklyn, New York
1979—$499,925

Middlesex General—University Hospital
New Brunswick, New Jersey
1979—$449,366

Newark Beth Israel Medical Center
Newark, New Jersey
1979—$498,366

North Carolina Memorial Hospital
Chapel Hill, North Carolina
1979—$500,000

The Medical College of Pennsylvania
Philadelphia, Pennsylvania
1979—$444,097

Provident Hospital, Inc.
Baltimore, Maryland
1979—$343,385

Public Health Trust of Dade County, Florida—Jackson Memorial Hospital
Miami, Florida
1979—$435,390

The Richmond County Hospital Authority
Augusta, Georgia
1979—$326,966

St. Anthony Hospital
Oklahoma City, Oklahoma
1979—$210,856

St. Clare's Hospital
Schenectady, New York
1979—$401,581

St. Francis Hospital
Honolulu, Hawaii
1979—$471,387

Saint Francis Hospital and Medical Center
Hartford, Connecticut
1979—$291,794

St. Luke's Hospital
Cleveland, Ohio
1979—$336,388

University of Southern California Medical Center
Los Angeles, California
1979—$444,963

University of Tennessee Memorial Hospital and Research Center
Knoxville, Tennessee
1979—$411,796

University of Washington, School of Dentistry
Seattle, Washington
1979—$464,567

Wilmington Medical Center
Wilmington, Delaware
1979—$409,360

Indiana University Foundation
Indianapolis, Indiana
Program to prepare clinical nursing faculty in primary care (ID#3844)
1978—$240,029

Industrywide Network for Social, Urban and Rural Efforts
New York, New York
Initial study of preventive services and health (ID#6774)
1981—$400,000

Institute for the Future
Menlo Park, California
Collaborative forecasting of the health care services environment (ID#6134)
1981—$261,290

University of Iowa, College of Medicine
Iowa City, Iowa
Advanced emergency medicine for physician assistants and emergency nurses (ID#4837)
1979—$309,419

Iowa Rural Practice Development Program (ID#5745)
1980—$355,927

Follow-up program for newborns treated in intensive care units (ID#5267)
1980—$300,000

Jackson State University
Jackson, Mississippi
Program to increase minority enrollment in medical schools (ID#5342)
1979—$104,780

The Johns Hopkins Hospital
Baltimore, Maryland
Foster family care project for the frail elderly (ID#5716)
1980—$251,046

The Johns Hopkins University, School of Medicine
Baltimore, Maryland
Program to prepare faculty in emergency medicine (ID#3206)
1978—$713,554

Kingston Hospital
Kingston, New York
Administration of the Foundation's Program for the Health-Impaired Elderly and Perinatal Program (ID#5492)
1981—$187,825

La Clinica de La Raza
Oakland, California
Planning project to strengthen the health center's future financial base (ID#5904)
1981—$150,000

Maine Medical Center
Portland, Maine
Postgraduate physician assistant residency program in emergency medicine (ID#4844)
1979—$295,171

University of Maryland, School of Nursing
Baltimore, Maryland
Research on factors influencing the hospital nursing shortage (ID#5940)
1980—$325,351

Massachusetts General Hospital
Boston, Massachusetts
Study of myocardial infarction patients by the medical evaluation practice unit (ID#6265)
1981—$252,177

The Foundation's Medical Practice Research and Development Program *(ID#6329)*

University of Alabama, School of Medicine
Birmingham, Alabama

Adaptation of hypertension and smoking cessation programs to primary care practices
1981—$149,847

Albany Medical College of Union University
Albany, New York

An early detection and intervention protocol for mental impairment in the elderly
1981—$149,428

University of Arkansas, College of Medicine
Little Rock, Arkansas

Treatment trial of patients with psychosomatic illnesses in a primary care setting
1981—$149,942

University of California, San Francisco, School of Medicine
San Francisco, California

Baseline study of chronic disease care patterns
1981—$122,828

Evaluation of social isolation as a factor of functional recovery from hip fracture
1981—$149,996

Case Western Reserve University, School of Medicine
Cleveland, Ohio

Evaluation of family dysfunction as a factor in moderate infant growth failure
1981—$149,909

Cornell University Medical College
New York, New York

Program to prevent complications in diabetics undergoing surgery
1981—$148,744

The Johns Hopkins University, School of Hygiene and Public Health
Baltimore, Maryland

Program of post-trauma functional recovery
1981—$149,944

Maine Medical Center
Portland, Maine

Study of causes and interventions related to falls by elderly people
1981—$145,794

Medical Associates Research and Education Foundation
(The Children's Hospital of Philadelphia—University of Pennsylvania)
Philadelphia, Pennsylvania

Study to document and reduce problems following pediatric day surgery
1981—$69,250

Investigating and decreasing functional morbidity following head trauma in children
1981—$65,800

University of Minnesota Medical School
Minneapolis, Minnesota

Study to reduce the frequency and severity of attacks in childhood asthma
1981—$76,914

Evaluation of medical treatment in chronic otitis media with effusion
1981—$143,391

Reducing sleep reduction of high-risk infant—study of its effects on growth
1981—$149,192

New York Society for the Relief of the Ruptured and Crippled
(The Hospital for Special Surgery)
New York, New York

Assessment of total knee replacement
1981—$149,808

New York University, School of Medicine
New York, New York

Diabetes education and management at the worksite
1981—$149,662

University of North Carolina, School of Medicine
Chapel Hill, North Carolina

Study of the induction and augmentation of labor
1981—$141,604

University of Rochester, School of Medicine and Dentistry
Rochester, New York
Maintaining functional effectiveness of radiation therapy patients
1981—$149,994

Stanford University, School of Medicine
Stanford, California
Identification and evaluation of interventions to improve functional outcomes for patients recovered from Hodgkin's disease
1981—$148,524
Study of cerebellar stimulation as a means to improve the functional status of patients with cerebral palsy
1981—$149,970

University of Texas Medical School at San Antonio
San Antonio, Texas
Evaluation of strategies for reducing costs and disability from low back pain
1981—$141,831

West Virginia University, School of Medicine
Morgantown, West Virginia
Primary care test of a home-monitoring and patient education system for controlling diabetes
1981—$146,106

University of Wisconsin Medical School
Madison, Wisconsin
Study of behavioral approaches to control cancer pain and improve patients' functional abilities
1981—$147,679

Administrative costs
Princeton, New Jersey
1981—$200,000

Middlesex General—University Hospital
New Brunswick, New Jersey
Planning study on the Hospital's role in ambulatory care (ID#5792)
1980—$110,000

University of Mississippi Medical Center
Jackson, Mississippi
Program to increase minority enrollment in medical schools (ID#4632)
1979—$368,717

Montefiore Hospital and Medical Center
Bronx, New York
Development and implementation of a service program for adolescents with chronic illness (ID#4858)
1979—$338,744

Development of a child care program (ID#5390)
1980—$100,000

Montefiore Hospital and Medical Center—Loeb Center for Nursing and Rehabilitation
Bronx, New York
Program to improve outcomes for chronically ill adults (ID#6245)
1981—$586,470

Morehouse College
Atlanta, Georgia
Program to increase minority enrollment in medical schools (ID#4977)
1979—$384,995

The Foundation's Municipal Health Services Program
Program to expand municipally-sponsored inner-city health services (ID#3960)

City of Baltimore, Maryland
1978—$2,852,275

City of Cincinnati, Ohio
1978—$3,000,000

City of Milwaukee, Wisconsin
1978—$2,963,570

City of St. Louis, Missouri
1978—$3,000,000

City of San Jose, California
1978—$2,975,205

National Academy of Sciences, Institute of Medicine
Washington, D.C.
Fellowships in health policy program (ID#4496)
1978—$408,430

National Association of Community Health Centers
Washington, D.C.
Technical assistance for the development of statewide primary care associations (ID#6157)
1981—$373,151

National Association of School Nurses
New York, New York
Training for school nurses in health and development (ID#5095)
1980—$150,950

National Bureau of Economic Research
Cambridge, Massachusetts
Studies of productivity in the health sector (ID#5437)
1980—$257,933

National Foundation for Dentistry for the Handicapped
Denver, Colorado
Program to increase dental services for the handicapped (ID#5064)
1979—$272,402

National Fund for Medical Education
Hartford, Connecticut
Support of summer programs for minority premedical students (ID#6598)
1981—$101,552

Nebraska Methodist Hospital
Omaha, Nebraska
Primary care training program for emergency department nurses (ID#4689)
1978—$306,113

University of Nevada, School of Medical Sciences
Reno, Nevada
Enhancement of rural health care in the state (ID#4703)
1979—$400,073

New Brunswick Development Corporation
New Brunswick, New Jersey
Redevelopment program for New Brunswick, New Jersey (ID#6037)
1980—$1,500,000

University of Medicine and Dentistry of New Jersey
Newark, New Jersey
Program to prepare minority students for careers in medicine and dentistry (ID#6180)
1981—$199,559

University of Medicine and Dentistry of New Jersey, Rutgers Medical School
Piscataway, New Jersey
Planning and development of improved educational and training programs for Rutgers Medical School (ID#5436)
1981—$487,305

University of North Carolina, School of Medicine
Chapel Hill, North Carolina
Study of rural health care initiatives (ID#4080)
1978—$476,927

Northwestern University
Evanston, Illinois
Research on the management of ambulatory care services (ID#4429)
1978—$225,000

The Foundation's Nurse Faculty Fellowships Program
Program to equip nursing faculty with primary clinical skills (ID#4694)

University of Colorado Medical Center, School of Nursing
Denver, Colorado
1979—$534,320

Indiana University Foundation
Indianapolis, Indiana
1979—$537,254

University of Maryland, School of Nursing
Baltimore, Maryland
1979—$536,646

University of Rochester, School of Nursing
Rochester, New York
1979—$505,930

Ohio Presbyterian Homes
Columbus, Ohio
Planning and organizing services for the non-institutionalized elderly (ID#6170)
1981—$173,800

University of Oklahoma, College of Medicine
Oklahoma City, Oklahoma
Development of a pediatric primary care program (ID#4325)
1979—$399,146

Oregon Health Sciences University, School of Nursing
Portland, Oregon
Data collection and analysis of the Foundation's Nurse Faculty Fellowships Program (ID#3682)
1979—$201,667

Pace University, Graduate School of Nursing
New York, New York
Graduate program in primary care nursing (ID#6226)
1981—$480,095; 1978—$350,030

Palmetto Family Health Care Center
Pacolet, South Carolina
Evaluation of a health-related data system (ID#6535)
1981—$55,420

Palo Alto Medical Research Foundation
Palo Alto, California
Study of the changes in medical costs of selected illnesses, 1951–1981 (ID#6266)
1981—$100,000

Pennsylvania State Department of Health
Harrisburg, Pennsylvania
A statewide program to improve school health services (ID#4744)
1979—$404,360

The Pennsylvania State University, College of Human Development
University Park, Pennsylvania
Support of a program to assist seven rural group practices (ID#4472)
1979—$343,107

University of Pennsylvania, School of Dental Medicine
Philadelphia, Pennsylvania
Dental care program for school-age children in rural Pennsylvania (ID#3837)
1977—$547,000

University of Pennsylvania, School of Nursing
Philadelphia, Pennsylvania
Graduate program in primary care nursing (ID#4271)
1978—$543,943

University of Pennsylvania, The Wharton School
Philadelphia, Pennsylvania
Nationwide study of life care communities (ID#6162)
1981—$144,838

City of Philadelphia, Department of Public Health
Philadelphia, Pennsylvania
A public-private examination of municipal health priorities (ID#6420)
1981—$250,000

The Foundation's Primary Care Practice Loan Guarantee Program
Development of satellite care operations in medically underserved areas (ID#6410)
Administrative costs
1981—$53,320

The Rand Corporation
Santa Monica, California
Planning and conducting the evaluation of a preventive dental care program for school-age children (ID#4769)
1978—$1,563,219

Evaluation of a nationwide preventive dental care program for school-age children (ID#5882)
1981—$949,185

Rio Grande Federation of Health Centers, Inc.
San Antonio, Texas
Support of a technical assistance program (ID#4826)
1979—$332,108

University of Rochester, School of Medicine and Dentistry
Rochester, New York
Administration of the Foundation's Community Hospital-Medical Staff Group Practice Program (ID#5491)
1981—$196,863; 1980—$278,573

The Foundation's Rural Infant Care Program
Cooperative projects with state health departments to reduce infant mortality and morbidity in isolated rural counties (ID#5540)

Duke University Medical Center
Durham, North Carolina
1980—$429,640

Eastern Virginia Medical Authority
Norfolk, Virginia
1980—$388,304

Louisiana State University School of Medicine in Shreveport
Shreveport, Louisiana
1980—$395,389

University of New Mexico, School of Medicine
Albuquerque, New Mexico
1980—$341,161

Ohio State University Research Foundation
Columbus, Ohio
1980—$328,026

University of Oklahoma, Health Sciences Center
Oklahoma City, Oklahoma
1980—$356,986

Medical University of South Carolina, School of Medicine
Charleston, South Carolina
1980—$349,513

University of Tennessee, College of Medicine
Memphis, Tennessee
1980—$329,839

Tulane University, School of Medicine
New Orleans, Louisiana
1980—$395,493

University of Washington, School of Medicine
Seattle, Washington
1980—$353,037

Rural Practice Network, Inc.
Jackson, North Carolina
Development of a self-sustaining affiliation of rural practice projects (ID#6006)
1981—$100,000

Rutgers University
New Brunswick, New Jersey
Studies in the organization of health care services (ID#5074)
1979—$185,576

St. Vincent de Paul Society
Highland Park, New Jersey
Program of assistance to the indigent (ID#5505)
1981—$17,000

The Foundation's School Health Services Program
Program to improve school-based child health services (ID#3239)

Colorado Department of Health
Denver, Colorado
1978—$1,177,256

New York State Education Department
Albany, New York
1978—$1,200,000

North Dakota State Department of Health
Bismarck, North Dakota
1978—$1,200,000

Utah State Board of Education
Salt Lake City, Utah
1978—$1,200,000

Scranton Primary Health Care Center, Inc.
Scranton, Pennsylvania
Development of a primary care group practice (ID#4171)
1978—$457,931

Seton Hall University, College of Nursing
South Orange, New Jersey
Program in clinical primary care nursing (ID#3701)
1978—$455,685

University of Southern California, School of Medicine
Los Angeles, California
A college-medical school consortium for disadvantaged premedical students (ID#4219)
1978—$637,936

The Foundation's Teaching Hospital General Medicine Group Practice Program
Improvement of ambulatory services for adult patients using medical clinics and emergency rooms as their regular source of care (ID#5554)

Albany Medical Center Hospital
Albany, New York
1980—$799,594

University of California, Los Angeles, Center for Health Sciences
Los Angeles, California
1980—$799,948

University of California, San Francisco, Hospitals and Clinics
San Francisco, California
1980—$798,362

University of Colorado Health Sciences Center
Denver, Colorado
1980—$769,443

Georgetown University, School of Medicine
Washington, D.C.
1980—$735,409

The Johns Hopkins Hospital
Baltimore, Maryland
1980—$768,402

The Mount Sinai Hospital
New York, New York
1980—$799,330

New England Medical Center, Inc.
Boston, Massachusetts
1980—$799,922

University of Medicine and Dentistry of New Jersey
Newark, New Jersey
1980—$800,000

North Carolina Memorial Hospital
Chapel Hill, North Carolina
1980—$798,200

St. Louis University, School of Medicine
St. Louis, Missouri
1980—$765,041

Vanderbilt University
Nashville, Tennessee
1980—$798,158

Virginia Commonwealth University, Medical College of Virginia
Richmond, Virginia
1980—$797,867

West Virginia University, School of Medicine
Morgantown, West Virginia
1980—$783,578

Yale-New Haven Hospital
New Haven, Connecticut
1980—$788,852

Trustees of Health and Hospitals of the City of Boston, Inc.
Boston, Massachusetts
Development of urban health program for adolescents and young families (ID#5446)
1980—$931,146

Program to increase the return-to-work rate of heart attack victims (ID#6244)
1981—$589,678

Tufts University, School of Medicine
Boston, Massachusetts
Analysis of policy issues impacting on the future of medical care (ID#4851)
1979—$179,998

Tulane Medical Center
New Orleans, Louisiana
Program to increase minority enrollment in medical schools (ID#6597)
1981—$349,995; 1978—$300,000

Tuskegee Institute
Tuskegee Institute, Alabama
Development of a primary care health service program in rural Alabama (ID#3850)
1979—$347,722

United States Conference of Mayors
Washington, D.C.
Dissemination of health services information (ID#4911)
1980—$133,790

United Student Aid Funds, Inc.
New York, New York
The Foundation's Guaranteed Student Loan Program for medical, dental and osteopathic students (ID#6316)
1981—$500,000

United Way of Central Jersey, Inc.
Milltown, New Jersey
1981 campaign (ID#5520)
1981—$200,000

Urban Affairs Corporation
Houston, Texas
Primary care program for adolescents (ID#5822)
1981—$192,000

The Foundation's Urban Health Program
Planning and developing expanded ambulatory care services (ID#5331)

Case Western Reserve University, School of Medicine
Cleveland, Ohio
1979—$609,079

Charles R. Drew Postgraduate Medical School
Los Angeles, California
1978—$600,000

Montefiore Hospital and Medical Center
Bronx, New York
1978—$608,365

Newark Beth Israel Medical Center
Newark, New Jersey
1980—$681,999

Sisters of Mercy Health Corporation
Farmington Hills, Michigan
1978—$640,650

University of Southern California, School of Medicine
Los Angeles, California
1979—$596,130

The University of Texas, Southwestern Medical School at Dallas
Dallas, Texas
1980—$625,924

University of Utah, College of Medicine
Salt Lake City, Utah
Development of a network of rural health programs (ID#5184)
1980—$352,822

Vanderbilt University, Center for Health Services
Nashville, Tennessee
Program to improve rural community health services (ID#6237)
1981—$150,000; 1978—$404,630

University of Virginia, School of Medicine
Charlottesville, Virginia
A program to help people disabled by a minor head injury to maintain or regain normal function (ID#6240)
1981—$479,817

University of Washington
Seattle, Washington
Evaluation of the Foundation's Community Hospital-Medical Staff Group Practice Program (ID#4189)
1979—$387,639

University of Washington, School of Medicine
Seattle, Washington
Analysis of the practice profiles of family and general practitioners (ID#5991)
1980—$93,204

University of Washington, School of Nursing
Seattle, Washington
Graduate program in primary care nursing (ID#3802)
1978—$649,413

Yale University, School of Medicine
New Haven, Connecticut
Assessment of clinical strategies in patient care (ID#6309)
1981—$499,934

Secretary's report

Secretary's report*

Staff changes

At its December meeting the Board of Trustees voted promotions for three Foundation officers. Andrew R. Greene was elected assistant treasurer for monitoring; Ruby P. Hearn, vice president; and J. Warren Wood, III, was elected a vice president in addition to his role as general counsel and secretary.

In October 1982 Barbara Kehrer, Ph.D., joined the Foundation as a senior program officer. Before joining the Foundation Dr. Kehrer worked as a senior economist at Mathematica Policy Research, Princeton, New Jersey. She received her Ph.D. in economics from Yale University.

In January 1983 Robert H. Ebert, M.D., president of the Milbank Memorial Fund in New York City, joined the Foundation as special advisor to the president. Dr. Ebert was formerly dean of the Harvard Medical School and continues as chairman of the board of the Harvard Community Health Plan.

Also in January 1983 Saul Kilstein joined the Foundation staff as program officer. Mr. Kilstein previously worked as a social science research analyst at the Health Care Financing Administration Office of Legislation and Policy, Washington, D.C. He holds a master's degree in public administration from the Harvard University Kennedy School of Government and graduated from the State University of New York at Stony Brook.

Martita Marx, Dr.P.H., senior program officer, departed in April 1982, having served on the staff since the fall of 1978. During her tenure at the Foundation Dr. Marx was a key participant in our research and evaluation efforts.

Distinguished outside professionals play important roles in the development and management of our multi-site national programs. During 1982 a number of new people joined us in this capacity as senior program consultants.

J. Robert Buchanan, M.D., was appointed to administer the Foundation's Prepaid Managed Health Care Program. Dr. Buchanan is general director of Massachusetts General Hospital, Boston, Massachusetts.

Mitzi L. Duxbury, Ph.D., was appointed to administer the Foundation's Clinical Nurse Scholars Program. Dr. Duxbury is professor of nursing at the University of Minnesota School of Nursing.

**To present as up-to-date a picture of staff changes as possible, this report covers the period through February 15, 1983.*

Carl Eisdorfer, Ph.D., M.D., was appointed to administer the Foundation's Program for Hospital Initiatives in Long-Term Care. Dr. Eisdorfer is president of Montefiore Medical Center, Bronx, New York and professor, Departments of Psychiatry and Neurosciences, Albert Einstein College of Medicine, Bronx, New York.

Ruth T. Gross, M.D., was appointed to administer the Foundation's Infant Health and Development Program. Dr. Gross is a professor of pediatrics, Stanford University School of Medicine.

Raymond P. White, Jr., D.D.S., Ph.D., was appointed to administer the Foundation's Dental Services Research Scholars Program. Dr. White is a professor in the School of Dentistry and the Health Services Research Center, University of North Carolina at Chapel Hill.

Wendy Everett Watson, Sc.D., vice president for ambulatory and community health services at Brigham and Women's Hospital, Boston, Massachusetts, was appointed to administer the Foundation's Teaching Hospital General Medicine Group Practice Program. Dr. Watson succeeds H. Richard Nesson, M.D., who had served as senior program consultant administering this program since 1979. Dr. Nesson resigned to become president of Brigham and Women's Hospital.

Jeffrey C. Merrill, M.P.H., was appointed a senior program consultant for data research and analysis. Mr. Merrill is director of the Center for Health Policy Research Studies at Georgetown University. Mr. Merrill succeeds Clifton R. Gaus, Sc.D., who joined the Foundation as senior program consultant in 1979.

Four other senior program consultants who have made important contributions to the success of our programs completed their tenures of service during 1982.

James A. Block, M.D., completed his assignment directing the Foundation's largest national program to date—the Community Hospital-Medical Staff Sponsored Primary Care Group Practice Program. Dr. Block joined the Foundation as senior program consultant in 1974.

Ingeborg G. Mauksch, Ph.D., completed her assignment directing the Foundation's Nurse Faculty Fellowship Program. Dr. Mauksch was appointed senior program consultant in 1976.

David A. Kindig, M.D., and Mo Katz, M.P.H., completed their assignments directing the Foundation's Urban Health Initiatives Program. Dr. Kindig and Mr. Katz joined the Foundation as senior program consultants in 1979.

Board activities

The Board of Trustees met six times in 1982 to conduct business, review proposals and appropriate funds. In addition, the Policy, Finance, and Audit Committees met as required to consider and prepare recommendations to the Board.

J. Warren Wood, III
Vice President, General Counsel and Secretary

Application for grants

Application for grants

The Robert Wood Johnson Foundation is a private philanthropy interested in improving health in the United States. We are concentrating our resources on three well-defined needs in health:

- the need to improve access to personal health care for the most underserved population groups;
- the need to make health care arrangements more effective and care more affordable;
- and the need to help people maintain or regain maximum attainable function in their everyday lives.

To increase the potential impact of our grant funds within our three areas of interest, we have further defined our role to assist:

- development and testing of new and previously untried approaches to health care problems;
- demonstrations to objectively assess the operational effectiveness and value of selected new health care arrangements and approaches which have been shown to be effective in more limited settings; and
- projects designed to promote the broader diffusion of programs that have been objectively shown to improve health status or to make health care more affordable.

We give priority to proposed programs and projects that address regional or national problems. The one exception to this and our other guidelines is support for a small number of activities in New Brunswick, New Jersey where the Foundation originated.

Policy guidelines established by our board of trustees will normally preclude support for the following types of activities: (1) on-going general operating expenses; (2) endowment, construction, or equipment; (3) basic biomedical research; (4) international activities or programs and institutions in other countries; and (5) direct support to individuals.

Also, we do not support programs concerned solely with a specific disease or with broad public health problems, except as they might relate to our three areas of interest. The decision not to support such programs,

worthy though they are, in no way implies a failure to recognize their importance. It is simply a consequence of the conviction that progress in the areas we have selected depends in large measure on our ability to concentrate our funds. Unfortunately, even within our program interests and guidelines, requests have always exceeded our resources, and thus we are unable to support many deserving proposals.

There are no formal grant application forms. Applicants should prepare a letter which states briefly and concisely the proposed project as well as its objectives and significance; the qualifications of the organization and the individuals concerned; the mechanisms for evaluating results; and a budget. This letter should be accompanied by a copy of the applicant institution's tax exempt status under the Internal Revenue Code. Ordinarily, preference will be given to organizations which have qualified for exemption under Section 501(c)(3) of the Internal Revenue Code, and which are not "private foundations" as defined under Section 509(a). Public instrumentalities performing similar functions are also eligible.

Proposal letters should be addressed to:

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