

The
Robert Wood Johnson
Foundation
Annual Report 1978

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The Robert Wood Johnson Foundation



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

Do Foundation-supported programs make a difference? A first look.

Seven years have hurried by since The Robert Wood Johnson Foundation moved onto the national scene as a philanthropy devoting its resources to improving the health and medical care of Americans. Our annual reports since 1972 chronicle our evolution. During this period we have made almost 1,100 awards totalling \$318.5 million. Many dedicated people using our funds are hard at work bringing their talents to bear on the problems which impede the appropriate distribution of modern medical and dental care to all who need it—particularly those not requiring hospitalization. There are many exciting new things happening in the organization and delivery of health care in the United States.

As also indicated in those same annual reports, early on we decided to underwrite objective external evaluations of our major programs to get a better understanding of how well they met their particular objectives. We are now in a position to report on the first four of these evaluations to reach completion. This report describes some of the highlights of those studies, which have closely examined one small segment of our total program.

Our decision to put substantial amounts of money and effort into objective external critiques of our programs was based on a number of considerations. Of primary importance was the belief that before new solutions would be absorbed into the mainstream of American life, a better educated and more sophisticated public would ask for objective evidence that demonstrations launched under Foundation funding were actually helping to reduce the problems at which they were directed. “What difference does it make in the lives of people?” is the tough question asked increasingly by elected officials, those working on national policy, and the public in general. Secondly, it was our belief that impartial, factual data about the effectiveness of particular programs would help answer a criticism regarding foundations as expressed in the Peterson Report of 1970:*

“Foundations apparently find the process of conceiving or making grants more satisfying and more worthy of their time and resources than evaluating success or failure of these grants, what was learned by them, and the extent to which the results were disseminated to an interested public.”

*Commission on Foundations and Private Philanthropy. *Foundations, Private Giving, and Public Policy: Report and Recommendations*. Chicago, University of Chicago Press, 1970.

Last and most obvious, having made the decision to be mission oriented rather than a general purpose foundation, our trustees and staff needed solid, objective information on the programs supported to determine the extent to which they met our hopes.

Since 1972 we have provided \$10 million for evaluations of 15 major programs which in the aggregate amount to Foundation grants of more than \$150 million. As a general ground rule, if the Foundation invests more than a million dollars in a particular program that is to be conducted at multiple sites, or by multiple groups, a simultaneous evaluation is developed and undertaken. These studies are being conducted by skilled professional groups not themselves responsible for developing or running the programs.

Four major programs launched in 1972 and 1973 have now been concluded. The full evaluation reports and subsequent papers and monographs by those conducting these studies are, or will soon be, available for those who wish to examine the findings in depth.* For now, rather than attempting a true summary of these studies, I would like to share with you the findings which caught my eye and which seem to me the most important on which to base further efforts.

As will be apparent, evaluation of complex programs involving many institutions and many people cannot yet be classified as a precise science. While we are gaining in sophistication in this field, we fully recognize there is no well-tested prescription for how these important assessments of performance should be designed or carried out, but we are attempting to make them more precise and crisp each time.

Here, then, are some of the findings, both positive and negative, which stem from careful examination of these particular Foundation efforts. We still have much to learn, but this is our first harvest. There will be more.

A nationwide program of financial aid for students enrolled in medicine and osteopathy

In 1972 The Robert Wood Johnson Foundation awarded \$10 million in grants to increase the amount of student aid monies available to young men and women entering schools of medicine and osteopathy. There was, at that time, federal legislation in place which put enormous pressures on medical schools to increase their output of physicians. However, the data then available suggested that the delivery of health services and the distribution of physicians by specialty or geographic location were not likely to be significantly affected by this increase in numbers unless serious attention was given to the selection of more students who might choose generalist careers or practice in medically underserved areas. After considerable study, we made our scholarship

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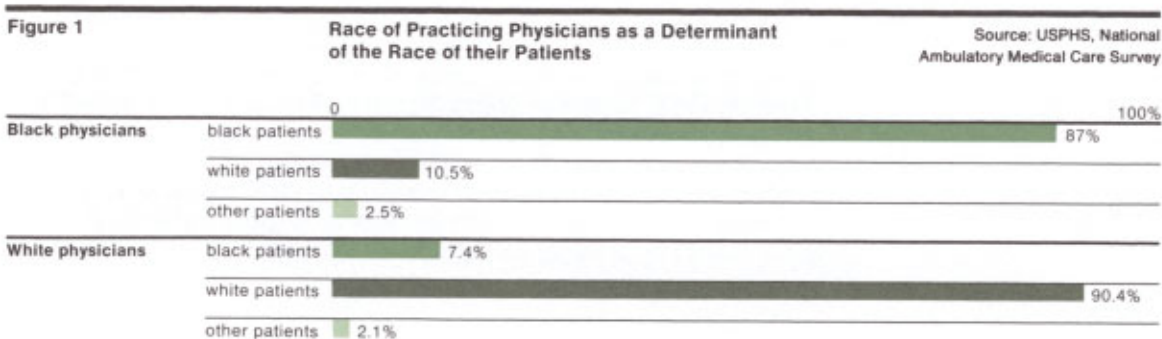
and loan funds available to students needing financial aid who came from minority backgrounds, to women students, and students from rural areas. The evidence then available suggested that these students tended to choose branches of medicine and practice locations which made it more likely that they would care for people most poorly served in urban and rural areas. Further, there were indications that a change in federal student aid policy was imminent—away from needy students to a much smaller number who would agree to serve tours in doctor-short areas following their training. Consequently, medical educators told us that the amount of student aid funds then available would be insufficient to maintain economically marginal students in school.

The evaluation was done by the National Planning Association (NPA) in Washington, D.C., which was asked to conduct a study to answer two deceptively simple questions. First, had we selected students who tended to choose generalist careers and subsequent practice in underserved areas? Second, were our funds needed? That is, were they of critical importance in placing young people from these backgrounds in medical or osteopathic schools and keeping them there?

Some of the answers were unexpected. Regarding the question, “Did we pick the right students?” the answers were mixed. Clearly the decision to support students from minority backgrounds seems to be leading to the anticipated results. Whether support awarded women students and students from rural backgrounds accomplishes a similar purpose is less clear.

In making their awards, institutions allocated over 50 percent of our funds to enroll and maintain minority students—predominantly black students—in medical school. Consequently the following findings seem of particular interest.

As shown in Figure 1, the race of office-based practicing physicians is an important determinant of the race of patients that they serve in ambulatory practices. Because medicine is a culturally sensitive area of human interaction, different ethnic groups have always tended



to seek out physicians from their own culture. But until I saw the results of this study, I was unaware of the degree to which this also occurs along racial lines.

At this point in our history, black doctors serve almost exclusively black patients. However one may feel about this characteristic of current society, it must be kept in mind in planning for medical services. If medical care is to be equitably accessible to all, enlarging the number of black physicians is clearly of critical importance to the welfare of the nation.

The study also showed that black physicians were 26 percent more likely to choose a primary care specialty—family practice, internal medicine, pediatrics—than were young white physicians. Based on knowledge from earlier studies indicating that physicians tend to practice in the same geographic areas where they complete their postgraduate training, Figures 2 and 3 offer some evidence that black physicians are settling in the South, which is a relatively underserved region medically, and are also more likely to locate in large cities where low income minority people are heavily concentrated. Thus an increased supply of black physicians can be viewed as helping to improve the geographic distribution of physicians.

The data on women are less dramatic. Women choose primary care specialties in only slightly greater numbers than physicians in general. While considerably more go into pediatrics—14.5 percent of women in contrast to 5.5 percent of all physicians—fewer go into family or general practice. There is evidence, however, that women do tend to pursue somewhat different careers than their male counterparts. More women physicians are hospital-based and more are salaried—(17 percent versus 8 percent) and a greater proportion of these are in primary care specialties. This suggests that they work in large hospitals

Figure 2 Change in Black Physicians Training in the South Compared to Black Population in the South

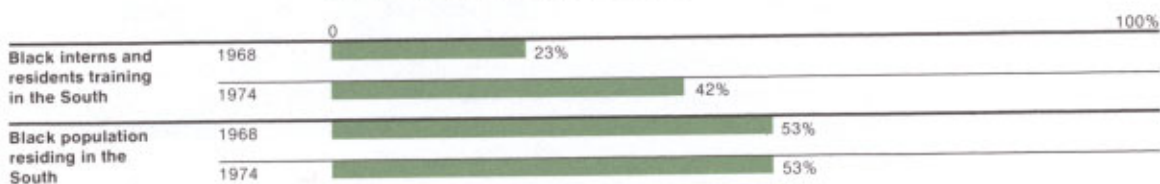


Figure 3 Recent Medical School Graduates Practicing in Central City Locations, 1975



which tend to be located in underserved areas where they deliver more general medical care to low-income patients.

The data on students from rural backgrounds are more impressive. The study indicates that over 30 percent of physicians coming from towns of less than 10,000 return to rural practice. This represents a career choice for rural America which is about three times higher than observed among choices of students originally from urban areas.

Regarding the question: "Were our funds needed?" the answer was both no and yes. As shown in Figure 4, popular perceptions to the contrary, there was actually a surplus of aid funds available to students during the first three years of our program. The full financial impact of changes in federal strategies regarding government support of students was not felt during this period. Thus the NPA study showed, in retrospect, that more funds were available than actually required to meet baseline student needs during the period 1972-1975.

However, this situation changed dramatically in 1975-1976. At that time, the federal sector substantially reduced student support on the basis of need and shifted its funds to the development of the National Health Service Corps. The resultant sharp reduction in numbers of students assisted led to a decided problem for students needing financial help. Thus in 1975, the Foundation's funds became critically important, particularly to low income and minority students. Projections shown in Figure 4 suggest the needs have grown even more serious in subsequent years.

Obviously, such aggregate data do not show the differing needs of different schools over time. Some which did not have a surplus of funds in the 1970's benefited enormously from our support, but it seems probable that during the first three years of the program, the target groups of students would have remained in professional schools without our assistance.

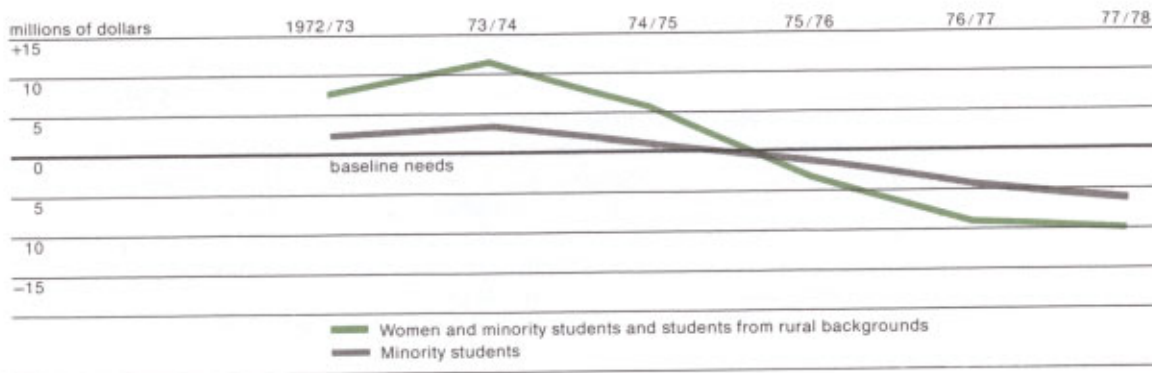
The NPA study included a careful analysis of the relative importance of several other factors in determining the enrollment in medical school for minority and women students. This analysis drew on the findings of student and financial aid officer polls, as well as the insights provided by sophisticated models of the enrollment process. For one thing, the study revealed that financial aid was of less importance than generally believed. For example, special recruitment programs, general social change, and the presence of minority faculty members within a medical school were shown to be more influential for black students than student aid funds in promoting their enrollment. For women as well, programs designed to encourage their entry into medical school coupled with the general change in social attitudes regarding the appropriateness of women engaging in professional careers were said to be of more importance than the availability of student aid.

The evaluators also examined whether the way our funds were awarded was the most efficient use of limited monies to assure student

recruitment and retention. Our program was permissive. Each school could determine both who would receive student aid and how much of that aid would be an outright scholarship gift and how much would be awarded in loans. Here, the NPA study suggests that more of our funds were awarded in scholarships and less in loans than absolutely necessary. Studies of the income production of young physicians—those under 35—show that they move swiftly to incomes of \$35,000 to \$40,000 yearly after completing training. This represents an extraordinary “return” of 22 percent per annum on the costs of a medical school education—a splendid investment in anyone’s terms. Loan pay-backs should therefore present no insurmountable financial problem to most young physicians. Further study has shown that loans can provide almost 10 times more funds than can scholarships if appropriately deployed to the same end. On the basis of these data, in this period of grave shortages of dollars for social purposes, we have moved to a guaranteed student loan program to help offset the serious shortfalls in projected student aid for the years ahead.

In designing the 1972-76 program, we had a choice between giving support to the educational institutions themselves or funding a central agency to deal with individual students. We chose the former route. However, the evaluation suggests that making the awards to student-funding agencies like the National Fund for Medical Education or the United Student Aid Fund would probably have been more appropriate. Wealthier schools with more student aid monies tended to bid up awards to students within the special groups that were already in the pool. This had the unintended side effect of having certain schools with strong recruitment programs giving almost 25 percent more aid to those students than was perhaps necessary. Thus it would appear that

Figure 4 Medical Student Aid Gaps and Surpluses Relative to Baseline Needs



student funding agencies would have been able to support larger numbers of needy students with the same philanthropic contribution.

In examining these findings, the dominating influence of federal funding decisions was brought forcefully home to us. In 10 years, federal policy regarding student aid has changed three times: from student aid based on ability, to student aid based on financial need, to the most recent decision of student aid based on subsequent service commitments. We have learned several things from this study.

First, because federal funds are such a large component of medical and osteopathic student aid, philanthropic groups must be very knowledgeable about, and up-to-date on, federal strategies, if they are to play an effective role.

Second, targeting on particular groups of students can only modestly—not dramatically—change the selection of career and practice location.

Third, external funds to support needy students in schools of medicine and osteopathy are now critically needed.

Last, funds made available through guaranteed loan programs seem to be the way of getting the greatest return for monies expended to keep economically deprived students in school, and providing such funds through a central agency dealing directly with students probably distributes philanthropic dollars most broadly and equitably.

A nationwide program to develop regional emergency medical communications systems

In focusing on barriers that Americans encountered in obtaining access to medical care, the difficulty many seemed to be having in getting immediate and appropriate help in emergency medical situations soon caught our attention. In 1973 the Foundation made almost \$15 million in awards to 44 sites in 38 states to develop regional emergency medical communications networks. A number of studies had suggested that the technical knowledge required to develop coordinated systems was available, but communities were having trouble getting beyond a variety of jurisdictional and geographic problems.

The value of emergency medical care was not an issue for us. Our concern was getting appropriate emergency services to patients, or patients to the services, with greater speed and effectiveness. We hoped to demonstrate that regionalized programs with inter-jurisdictional coordination could accomplish this objective. The Foundation's program was aimed at encouraging local communities to band together to establish well planned, regional emergency medical communication arrangements to coordinate services and dispatch ambulances throughout relatively large geographic areas or population centers.

Two quite different assessments of this program were conducted. A committee of the National Academy of Sciences composed of experts in all facets of planning and operating emergency medical service

systems, which advised us on the programs, did on-site reviews of all 44 regions. An independent study, conducted by the Rand Corporation, was planned and funded shortly after the start of the program. The Rand study of a sample of preselected sites was designed to assess the effect of full regionalization of emergency services on access to services, on speed of treatment, transfer to appropriate hospitals, and communication between hospitals and personnel in emergency vehicles. We also hoped to get some information on the lifesaving capability of such programs, although this issue was not central to the study.

When planning the Rand Corporation study, the Foundation was early in its development, and our lack of experience in service programs and evaluation alike led us to make several fundamental errors. First, our goals for full regionalization were unrealistically high. Second, the time frame for the conduct of the study was wrong—we started too early and the two-year period of the evaluation was too short. Third, the appeal of the program seemed so great and its advantages so obvious to us, that we expected good data from all programs. Thus only seven of the 44 sites were selected for the Rand study. Although we had made participation in the evaluation a precondition of the grants, neither the grantees nor we were aware how difficult and time consuming it would be to gather data from the multiple groups and organizations comprising regional emergency medical service systems. This resulted in three of the seven sites having such incomplete data that they were excluded from the final analysis. In retrospect, we expected too much, we looked too soon, and the sites were too few in number to obtain solid answers to the questions of most compelling interest to us.

Within the preselected sites studied by Rand, regionalization as measured by any rigorous criterion such as cross-county ambulance runs, or assignment of hospital destination based on matching a patient's problems with institutional capacity, simply did not occur during the period of the study. In the absence of full regionalization—perhaps an unrealistic goal—the Rand group was unable to determine whether such coordinated services could make the differences we had predicted would occur.

However, the Rand study did show that the Foundation funds had brought together the various aspects of emergency services operated under different geographic and institutional jurisdictions in new administrative arrangements. Four years later, the on-site reviews conducted by the National Academy of Sciences also indicated that by this time the majority of regions were effectively operating multi-jurisdictional programs.

The Rand study had some other interesting findings. First, it was clear in the seven regions studied that access to emergency care prior to launching the program was not as deficient as thought. Despite the complex nature of arrangements regarding notification of emergencies,

dispatch of ambulances and the like, people seemed to be getting to care more promptly than was commonly supposed. However, problems in tracking those who tried to get, but failed to receive, emergency care makes this observation less certain than one would wish, although from what we can ascertain this group is very small.

The most important finding of the Rand study with respect to planning future strategies was the critical importance of the kind and extent of medical training of those who staff ambulances. One of the hopes of the program was to improve direct communications between ambulance attendants and expert physicians in the hospital so that patients would be properly managed during the critical moments between the medical catastrophe and arrival at the hospital.

The Rand study clearly showed that it required the presence of highly trained paramedics, who can administer definitive care in the ambulance, for such communications to occur. There was far less communication with emergency medical technicians (EMT's), who receive less training and can stabilize patients but not give definitive care.

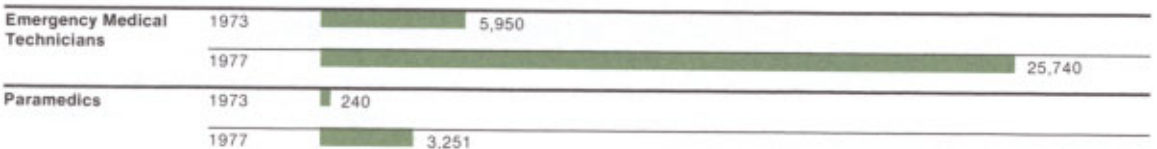
As an example, in San Bernardino County, California, where the implementation of ambulance-to-hospital communications was accompanied by training of large numbers of paramedics, physicians prescribed treatment for 65 percent of severe cases en route when a paramedic and an EMT were in the ambulance together, but in only seven percent of such cases when the lesser-trained EMT was aboard alone. These data are summarized in Figure 5. The Rand research suggests the development of paramedic-EMT teams as a possible next important step in improving emergency medical care.

The value of such communications—and notification of the hospital of the nature and the severity of the problem being brought to it—

Figure 5 Ambulance Staffing as a Determinant of Physician-Ambulance Communication When Transporting 'Severe' Medical Problems



Figure 6 Number of Trained Personnel in the 44 Regions of the Foundation's Emergency Medical Services Program



was borne out in yet other ways by the Rand study. It was shown that pre-notification increases the chances that the patient will be seen by a physician, that the physician will be present in the emergency room when the patient arrives, and sharply cuts the delay in treatment—from 27.3 minutes to 10.7 minutes in the region examined.

The National Academy of Sciences observations showed that the Foundation-supported programs trained large numbers of new emergency medical personnel. These data are shown in Figure 6. The Rand findings suggest that it may be wise to shift the emphasis of future training to include larger numbers of paramedics.

As shown in Figure 7, the first step in regionalization—progress toward centralization of responsibilities and agreement on a central telephone number—was satisfactorily accomplished in most regions by the end of four years. But while the number 911 provides the easiest telephone access to emergency services, the Rand findings underscore how difficult this changeover is to implement at the local level.

As noted in Figure 8, there were also marked improvements in the communications linking ambulances to hospitals and the linking of central medical emergency dispatchers with fire departments, police

Figure 7 Simplifying Public Access to Emergency Service in the Foundation's 44-Region Program

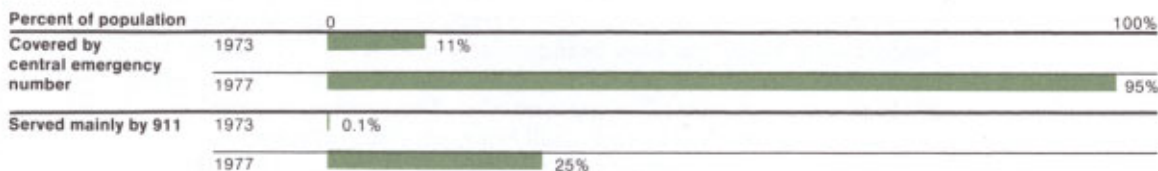


Figure 8 Improving Communication Linkages Between Ambulances and Hospitals, and Between Dispatchers in the Foundation's 44-Region Program



departments, and other dispatchers in other regions. These seem clear evidence of improvement in multi-jurisdictional linkages.

Because of the design of the Rand study and the early recognition of the complexity of such an evaluation, we are unable to answer the question of greatest interest to all: do regionalized programs save more lives? Here we have only softer data, much of it anecdotal, supplied from the regions themselves. But such as it is, it seems to point in the right direction. Data from the city of Newark, New Jersey, comparing deaths in control areas in which the coordinated system was not in place with those in which it was, suggest that deaths from accidents and those produced by motor vehicles were significantly decreased. In Newark the program was able to drop the response time from notification to on-site management of emergencies by almost 50 percent. Bits and pieces of data from other areas—Florida, East Lansing, Peoria and other regions—also suggest greater lifesaving capacity when coordinated systems are in place, but the data lack rigor and control.

There are, however, some figures emerging that deserve mention. A series of papers from the Seattle project* demonstrates the value of paramedics in saving individuals who have undergone cardiac arrest—an all too common event synonymous with death in years past.

In a two-year period in the Seattle emergency medical service region, EMT's cared for 301 individuals with cardiac arrest. Six percent of these patients were subsequently discharged alive from the hospital. In contrast, of 569 receiving treatment from paramedics, 20 percent went home and have been similarly followed. Their composite studies indicate that an individual with cardiac arrest is 4.4 times more likely to survive if treated by a paramedic. The findings suggest that paramedic services have a small but measurable effect on the community's cardiac mortality rate: a drop of 1.3 percent if managed by EMT's; a drop of 8.4 percent if a paramedic is in attendance.

Review of these papers shows quite dramatically the "why" for this striking difference in outcome. The paramedic, unlike the EMT, is trained to give definitive care for cardiac arrest, and it is the *time* which elapses between the event and (a) cardiopulmonary resuscitation, plus (b) definitive treatment (restoring normal heart rhythm or re-starting the heart) that makes the critical difference.

As shown in Figure 9, if cardiopulmonary resuscitation (CPR) was started within four minutes, and definitive treatment given within eight minutes, 51 percent of these "dead" patients were subsequently

*Eisenberg, Mickey; L. Bergner and A. Hallstrom. "Paramedic Programs and Out-of-Hospital Cardiac Arrest: I. Factors Associated With Successful Resuscitation" and "II. Impact on Community Mortality." *American Journal of Public Health*, 69(1):30-42, January, 1979.

Bergner, Lawrence; M. Eisenberg and A. Hallstrom. "Evaluating Emergency Medical Services: Quasi-Experimental Outcome Studies." *Evaluation and the Health Professions*, scheduled for publication in March, 1979.

discharged alive from the hospital. If *both* time periods were exceeded, only five percent survived to return home.

These important studies suggest all kinds of new strategies for those concerned with emergency medical care. Training laymen to administer CPR was shown to have an important positive effect on outcome, and Seattle launched a large community program to do just this. Plans for recasting the training of emergency personnel to permit earlier treatment of the arrest is suggested in communities where these skills can be appropriately utilized. We need more such studies.

So these are the results of this program to date. Not as dramatic as we had hoped, but nevertheless encouraging. Obviously our program did not start from scratch. Most American communities have ways of delivering medical services in emergencies; hence problems of access were not as great as we had believed. The voluntary efforts of communities to develop these complex systems cannot be evaluated over a short time frame, and completely regionalized systems are harder to put together than we had originally thought. Getting communities to organize central dispatching services, to share ambulance services across city, county or other political boundaries, and the myriad of other details required are long-term propositions. But the federal sector has now launched a much larger effort, and we have been the catalyst for a program which looks promising.

Most encouraging, the National Academy of Sciences report suggests a continuing commitment to the program. Over 75 percent of the regions are now self-sustaining financially and have broad public acceptance and support.

Strengthening the role of state legislatures in improving American health care

In 1973 a number of federal mandates were placing sudden, massive, and different responsibilities for health legislation at the state level. Aggregate state spending for health had risen from \$3.5 billion in 1965 to \$15.9 billion in early 1974—largely for Medicaid programs—and accounted for the largest percentage increase in any state budgetary item during this decade. Where state legislatures had previously dealt largely with public health matters, in 1973 they were playing an increasingly key role in personal health and medical affairs.

Figure 9 Percent of People Discharged Alive From the Hospital Following a Sudden, Out-of-Hospital Cardiac Arrest

Cardiopulmonary resuscitation	< 4 minutes	> 4 minutes	< 4 minutes	> 4 minutes
Definitive care	< 8 minutes	< 8 minutes	≥ 8 minutes	≥ 8 minutes
Survival to hospital discharge	51%	25%	15%	5%

The federal government, recognizing this growing and changing role of states in health was concentrating on developing new administrative structures, like planning agencies, to help states deal more effectively with health and medical issues.

On the other hand, the Citizens' Conference on State Legislatures (now named Legis 50) believed, and we agreed, that for legislators to deal intelligently with this avalanche of new responsibilities, the various committees of state legislatures dealing with specialized areas of knowledge required better staffing. It was our reasoning that with so many federal health programs being transferred to states, it would help to have competent professional staff working with policymakers to lay plans in health areas before, rather than after, public programs were implemented. This followed a trend: as shown in Figure 10, state legislatures were rapidly increasing the number of professional staff to help them make difficult and complex policy and priority decisions in all legislative areas.

In late 1973 and early 1974, the Foundation allocated \$2 million to allow selected states to recruit and hire professionally qualified health experts to staff standing committees on health. Our 15-member advisory committee tried to pick states that varied widely in the staffing patterns of their legislatures, in geography, and political outlook.

Of the eight states initially awarded grants for two years, only four were able to genuinely implement the staffing, and their support was continued for an additional two years. A group at Georgetown University undertook to study both the funded states and a series of control states to determine the impact of the program. As it turns out, this study represents the largest ever undertaken about the effects of committee staffing on state legislative processes. The study made use of state data and the results of interviews with over 600 individuals, including state legislators, state government officials, personnel in various health agencies, lobbyists for groups concerned with health issues, members of the press, and many others.

Again, we were trying to answer some deceptively simple questions.

Figure 10

**Number of Professional Staff Working With State Legislatures
in the United States**

			change
Central legislative stuffs	1968	547	
	1974	753	+ 38%
Legislative budget agencies	1968	114	
	1974	181	+ 59%
Legislative committees	1968	65	
	1974	495	+ 662%

First, did the presence of professional staff improve legislative performance in the health area? Second, was the decision-making of state legislators sounder, better informed and more independent? Third, did the public feel it had more input to the decision-making process about matters affecting health and medical care? Lastly, if the answers to the first two questions were yes, would other states adopt professional staffing for their health committees?

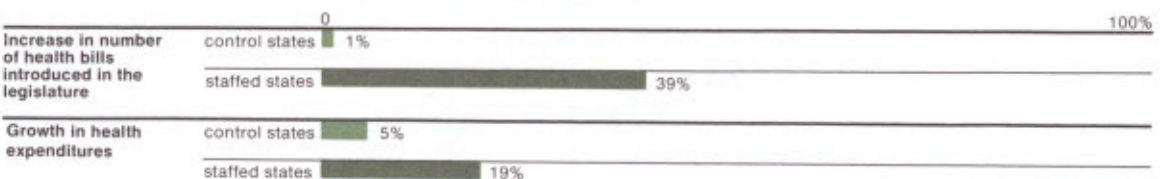
The evaluation suggests that the presence of qualified professional staff did, indeed, make a difference in overall health policy legislative performance. As shown in Figure 11, the number of legislators who rated their state legislatures' ability to handle health issues as good or very good was significantly greater in the model staffing states than in states lacking such professional assistance. Also, as shown in Figure 12, the presence of specialized staff in health markedly increased the amount of health legislation and the allocation of resources to the health area, although whether this is a plus or a minus depends on one's point of view. There was also considerable agreement that professional staff improved the capacity of the legislature for independent policy making. Ninety-three percent of state legislators in the funded states reported that the model staffing program had made them more knowledgeable about health issues, less reliant on information supplied by special interest groups, and more open to the concerns of individuals and groups who did not earn a living from working on health matters.

Clearly a professional staff increased the accessibility of the legislative process to consumers and other groups in ways that seemed both

Figure 11 'Good' and 'Very Good' Ratings Given to Legislatures for Their Ability to Handle Health Issues



Figure 12 Changes in Legislative Health Activity During Staffing Program



sound and democratic—over 60 percent of all respondents representing the public believed the programs had helped increase their access to the legislative process when compared with previous years. There was greater public input to the process brought about through greater numbers of scheduled public hearings, and greater availability of information on various bills. Even 82 percent of the press—a notably tough-minded and critical group—felt that the presence of specialized staff helped them improve their coverage of health issues. Since public confidence in being able to reach political institutions is a major tenet underlying our democracy, this finding seems gratifying.

It was also apparent that professional staff in the health area provided a different type of service to legislators than traditional generalist staffing. As noted in Figure 13, the single most important service appeared to be the provision of expert advice of an independent nature. Legislators were required to rely less on summaries of the advice of others, and this appeared to contribute to legislative independence. When asked during the final round of interviews if the quality of legislation had been improved, 87 percent of those in states receiving four-year support answered yes.

On the last question—namely, if the program appeared to be effective, would other states adopt it—the answers were mixed. None of the states supported continued it for their health committees or adopted this model of specialized committee staffing for other standing committees. Although all agreed that the program had been highly effective, it was not possible to continue staff in the health area without doing the same in others, and that was precluded by funding constraints. Be that as it may, the results suggest that providing specialized staff to state legislatures may be a powerful way of improving a state's capacity to deal with complex matters in the area of health. The program was of sufficient broad general interest that eleven other states adopted the committee-staffing concept, making use of federal and other foundations' monies to implement their new staffing programs, and the concept is of increasing interest in many states.

Figure 13 The Single Most Important Service Provided by Staff:
The Opinion of Legislators



In summary, the basic worth of offering hardworking state legislators professional assistance in an area as complex and controversial as health seemed confirmed—it worked very well. Other states paid close attention, a number adopted the concept, and it was generally agreed that legislation was improved. As with the emergency medical services program, it was clearly apparent that changes do not take place overnight, even when judged as highly effective, especially when they involve anything as fundamental as how states govern themselves. Nevertheless, it is an idea viewed very positively by state legislatures, and it is receiving continuing study.

Primary care residency training programs in internal medicine and pediatrics

As soon as agreement on the Foundation's principal objectives was reached in 1972, our attention was directed to how we might help slow or offset the dwindling supply of physicians delivering general out-of-hospital care—primary care, as we termed it. In the early 1930's, almost 70 percent of our physician population were generalists, but by 1972 this had dropped to 28 percent in a steady, continuing decline. Since 1973, in an effort to correct this trend, the Foundation has funded nine academically based primary care residency programs in internal medicine and pediatrics for a total outlay of \$10.7 million.

Physicians considered to be most involved in delivering primary care include family practitioners, internists, pediatricians and sometimes obstetrician-gynecologists. All routes appear appropriate. However, as we began our efforts, the federal sector and a number of states had made the decision to encourage growth in family practice through heavy subsidies for residency training programs in that field. The number of such programs has rapidly and steadily expanded since that time. But it was our belief that simply going this one route might not correct the national imbalance in numbers between primary care and specialty physicians. We felt that even with this expansion in family practitioners, the need for primary care could not be met in the foreseeable future by this group of physicians alone. Further, faculty required for training family practitioners were not generally available in medical schools—and we are supporting efforts to remedy this—so internal medicine and pediatrics will continue to be major sources of physicians who give generalist care. Thus the Foundation's funds for primary care training of physicians have gone to help academic centers to develop generalist training and careers in internal medicine and pediatrics, as contrasted with the traditional emphasis in these specialties on subsequent subspecialty pursuits.

In conjunction with the federal sector, we have funded two studies. One, focusing on these nine residency programs, conducted at the University of California in San Francisco (UCSF). The other is being carried out at the University of Southern California (USC).

There were three principal questions toward which the studies were directed. First, did the internists and pediatricians trained for generalist roles compare favorably in their clinical skills with more traditional internal medicine and pediatric residents headed for subspecialty training and careers? Second, did the program run the hazard of developing a shallow physician who was less able to manage patients requiring more complex in-hospital care? Third, were primary care residency graduates more likely to provide generalist types of care in places where it was most needed?

Satisfactory answers to questions one and two have been obtained by the UCSF study. A major finding of this study, based on a careful review of the performance of 163 residents in training during the years 1976 and 1977, was that residents in internal medicine and pediatrics programs emphasizing primary care are judged every bit as good as those in traditional internal medicine or pediatric residencies as measured by their National Board scores, the assessment of their peers and teachers, and the quality of the medical schools in which they had received their undergraduate training. In sum, these young men and women could have competed successfully for any kind of residencies, but chose this new and broader career route.

The study shows that the mean scores for primary care residents on national exams administered by the National Board of Medical Examiners were the same or slightly higher in the areas of basic science knowledge, clinical science information, and clinical performance. A careful survey of judgments of medical school faculty, departmental chairmen, fellow residents, and other professionals with whom they worked—nurse practitioners and physicians' assistants—yielded confirmatory information. Seventy-seven percent of these respondents thought that the primary care residents had clinical skills equal to or better than traditional internal medicine residents. They were thought to be equally or more knowledgeable in the science of medicine by 71 percent, and even equally or more interested in clinical research by 50 percent. Perhaps more gratifying, 93 percent of the respondents believed that the young men and women who received special primary care training were equally or more socially oriented than their straight internal medicine counterparts.

The last and most important question—do physicians with such training practice differently or in different sites—cannot yet be answered. They are still making their career choices. It will, however, be addressed by the USC study, which is just beginning to bear fruit. This is a careful national examination of what physicians actually do in practice. The study is documenting the number and kinds of patients cared for by over 10,000 physicians in 24 specialties in their regular practice worlds. This study will, I believe, finally give all of us real data on which to make judgments about who actually delivers primary care services. An identical follow-up study will collect similar data on

graduates of our primary care residencies after at least three years in practice. Comparison of the practice patterns of this new group with the baseline information obtained from practicing physicians who received more traditional training should determine whether those trained for primary care do opt for different practice careers or merely bear a new label.

One finding in the completed UCSF study bears watching. About one-fourth of the primary care residents indicated that they planned a fourth year of residency training in a subspecialty area. Thus it is possible that these particular individuals may be lost to primary care practice. Our ongoing study should also answer this question.

Epilogue

These, then, are the fruits of our initial forays into evaluating programs. They have given us valuable insights and have, I believe, produced some unexpected information of value to health policymakers and others working to improve our American ways of delivering general medical care. We, at least, have certainly made use of the findings in shaping our more recent programs.

The reasons such evaluations are not often carried out are also increasingly evident to us. They require extraordinary care in their design and implementation if one is to answer genuinely significant questions. The tools used in assessment of complex programs involving many people and institutions are imperfect, data collection is enormously time consuming, such studies require continuing attention and patience to keep them on track, and their costs are at first—and sometimes in the end—startling.

The evaluations also vividly illustrate that one simply cannot assess the effectiveness of many major new ideas in less than five years—and probably many new ventures require more like a decade to determine their effect. There are few institutions today which can make such long-range commitments.

In some instances, our enthusiasm, impatience, and curiosity to know whether our programs have or have not been successful have led us to try to obtain data too early. Such impatience runs the hazard of a premature “evaluation” actually being harmful to the gestation of a new idea—witness the downbeat conclusions of the Rand study based on data collected only 18 months after the grants were made.

However, despite the difficulties, we remain convinced that in today’s world, careful evaluation studies are increasingly important. The studies highlighted here have heightened our awareness that things are not always as they seem, and solid data, not anecdotes, are needed for proper decision making. They can, for example, show that individual assessments of the severity or magnitude of a problem may be grossly in error—witness the perceived desperate need for student aid funds in 1973 as viewed by the deans of individual medical schools.

Public policy decisions in health are increasingly difficult and expensive. Although there will never be *enough* information available, we must try to bridge the most important gaps in our knowledge. In addition, there are very different perceptions of the value of foundation activities or foundation-initiated programs by both the private and public sectors, and foundations need tough-minded and pragmatic documentation of the worth of their efforts carried out by trained, objective third parties. I wish we had equally rigorous evaluations of many public-sector programs.

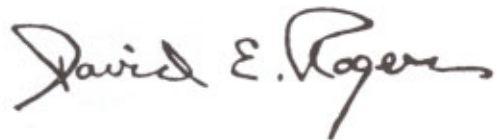
At the time of this writing, we have three fundamental perceptions about foundation efforts directed at obtaining independent evaluations of the value of particular programs foundations assist.

First, we have partially satisfied ourselves that it is feasible for private foundations to use reasonably systematic and objective techniques to evaluate their work. While the tools are often primitive and the results less definitive than one would wish, they nevertheless do permit development of better guidelines and force more critical thinking about areas where conventional belief that one is doing “the Lord’s work” can often lull one into avoiding objective assessments of performance.

Secondly, extraordinary patience and forbearance are required. Major new ideas or shifts in ways of doing things involving people and institutions take more time than logic or reason would indicate. One simply cannot expect to see shifts in arrangements which involve new groupings of people or practices at the same rapid rates than often follow the introduction of an impersonal new technology.

Lastly, we have come to the firm conclusion that foundations and others involved in major new programs designed to improve social ills or shortfalls should continue to try to determine the worth of their programs. Improvements in a society as complex as ours are never totally predictable or controllable, and that is not an altogether bad thing. Although painful to admit, conventional wisdom and obvious solutions, and the best of intentions, are sometimes wrong.

But despite the travails of unexpected or disappointing results, and the expense of such studies, there are too many demands for limited resources to permit entrenched opinions or anecdotal evidence to determine the allocation of these precious dollars. To learn by doing and by encouraging new kinds of solutions to old problems seems both right and appropriate—but the learning must be real so that subsequent decisions can be based on evidence made available for all to examine.

A handwritten signature in black ink that reads "David E. Rogers". The signature is written in a cursive, flowing style with a long, sweeping underline.

The 1978
grant program

The 1978 grant program

During 1978 the Foundation made 108 grants totalling \$47.2 million. The types of activities supported and the allocation of funds to each were as follows:

- The development of improved ways to deliver ambulatory care services, \$31.9 million, or 67.5 percent;
- The education and training of various types of health professionals needed to plan, staff, and manage ambulatory care services, \$9.8 million, or 20.9 percent;
- The evaluation of major Foundation programs, \$2.8 million, or 5.8 percent;
- The conduct of highly targeted health care research, and the development of other information intended to be useful to those formulating and evaluating public policy in health affairs, \$2.7 million, or 5.8 percent.

Viewed in terms of the Foundation's objectives, the 1978 grant funds were apportioned as follows:

- \$42.8 million, or 90.6 percent, for programs to increase access to primary care services;
- \$1.9 million, or 4 percent, for programs to improve the performance of the health care system in order to ensure quality care;
- \$1.4 million, or 3 percent, for programs to improve the formulation of public policy in health affairs;
- \$1.1 million, or 2.4 percent, for charitable institutions and programs in the New Brunswick, New Jersey area where the Foundation maintains a historic and continuing interest.

Appropriations since the Foundation became a national philanthropy in December 1971 now total \$318.5 million. A series of charts beginning on page 48 summarizes data from this seven-year period on proposals received, grants made, and a variety of analyses to portray how these funds have been allocated.

Program information

A description of selected 1978 grants concludes this section, but a list of all grants made in 1978 begins on page 71. This is followed by a list of grants made in previous years, and which were still active in 1978 (i.e., those with unpaid balances on January 1, 1978). A descriptive Program Summary for each of these grants is available free upon request. 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
P.O. Box 2316
Princeton, New Jersey 08540.

Also available without charge from the same address are copies of the following Special Reports:

- Regionalized Perinatal Services
- A New Survey on Access to Medical Care
- Emergency Medical Services
- New Roles for Nurses in Family Care; Citizen-Legislators: Coping with the Health Agenda: Unraveling the Battered Child Syndrome.

Major developments in the grant program

Evidence is accumulating that primary medical care is becoming accessible to more and more Americans. As a result, service programs and projects receiving Foundation assistance in 1978 were increasingly directed toward the remaining groups that continue to have problems getting care, especially residents of inner-city and rural areas, children of low-income families and the low-income elderly.

Municipal health services

Last year, 34 of the nation's 50 largest cities submitted detailed applications for five grants offered under the Foundation's Municipal Health Services Program, co-sponsored by the American Medical Association and the United States Conference of Mayors. This response seemed an accurate reflection of widespread concern and interest by local governments in improving primary care in inner cities. Each municipality pledged, if a grant were received, to draw upon resources of its city hospital and health department to offer primary care in at least three neighborhood locations. These medical service sites would offer underserved people an alternative to the city hospitals' outpatient clinics.

Upon recommendation of the Program's advisory committee, the Foundation made grants in 1978 to the municipal governments of Baltimore, Cincinnati, Milwaukee, San Jose, and St. Louis to implement their plans for offering care to a total of more than 650,000 people.

The federal Health Care Financing Administration has invited the selected cities to participate in a reimbursement study that includes special waivers of Medicaid and Medicare regulations to expand reimburse-

ment for general and preventive services provided through the neighborhood sites.

A group at Columbia University, under a separate grant, is conducting an evaluation of the Program.

Other urban service programs

In addition to municipal hospitals and health departments, there are relatively few other established institutions—principally large hospitals and academic medical centers—which have indicated their commitment to staying in inner cities and continuing to offer primary care services. Four such institutions are the Drew Postgraduate School of Medicine in Los Angeles; Louisiana State University School of Medicine in New Orleans; Montefiore Hospital in New York; and the Sisters of Mercy Health Corporation operating three hospitals in Detroit.

Each is prepared to expand its primary care services to reach 35,000 to 60,000 people living in areas of severe medical need—census tracts where virtually all health and social indices are among the worst in the country.

In 1978 the first grants under the Foundation's Urban Health Initiatives Program were made to these four institutions to help them develop their plans. These grants are contingent upon the availability of federal funds and National Health Service Corps personnel to meet the operating needs of the expanded primary care efforts.

Primary care group practices

In Scranton, Pennsylvania, 27,000 people live in a medically under-served area of the city that is largely one of middle-income households, although unemployment is high and incomes in many of the households are below the poverty level. In addition, there is a large proportion of children and elderly people, and illness rates are high.

In response to these circumstances, and to meet medical needs in several adjacent

communities, a board of local residents and community leaders planned and in 1978 opened the Scranton Primary Health Care Center. The Center will be staffed by physicians, nurse practitioners, and a full-time administrator. In addition to a grant from the Foundation, the Center has received substantial assistance from local charitable sources, the national Campaign for Human Development, and the Kresge Foundation.

Four grants were also made in 1978 under the Foundation's Community Hospital Program to establish primary care group practices sponsored by participating hospitals in Michigan, Georgia, Kentucky, and the District of Columbia. A total of 50 community hospitals in 35 states are now developing practices under this program. Similarly, three small-town primary care group practices—in Michigan, North Carolina, and Virginia—received grants under the Foundation's Rural Practice Project during 1978, bringing the number of these practices to 13 in 12 states. Both of these Foundation programs are scheduled to conclude their grant-making in 1979.

School health services

A number of trends over the past few years have focused national and local attention on schools as logical sites for offering primary health care for children. However, a study funded by the Foundation in 1978 shows that many states' laws and regulations for school health services now permit more extensive services than are generally being offered.

Based on several "model" projects, and months of planning that involved consultants from across the country, the Foundation's School Health Services Program was announced in 1977. Thirty states submitted applications for assistance, and in 1978, four grants were made under this program—to Colorado, New York, North Dakota and Utah. These states have now begun projects

to employ nurse practitioners in selected schools where the children lack appropriate access to primary care services. Supervised by pediatricians in the participating communities, the school nurse practitioners will:

- Care for minor injuries, manage most common childhood illnesses, and identify potentially serious conditions requiring the attention of a physician or other health professional;
- Help children and their families locate needed medical services and then follow-up to make sure those services are received;
- Work with parents and physicians in the care of chronically ill and disabled children;
- Give immunizations, physical exams, and conduct periodic screenings for health problems.

Continuing a model project

A school-based health care project in Hartford, Connecticut, begun three years ago, is one of the models for the Foundation's School Health Services Program. Ninety percent of the 800 children in grades K through 6 in the demonstration school are Medicaid-eligible, and care is provided by two nurse practitioners and two aides, with physician backup. In addition, there is a part-time dentist overseeing a hygienist and aide.

The Foundation's 1978 grant will continue this project and support an evaluation that includes a comparison school.

Initial data indicate the nurse practitioners with physician back-up have been able to handle most of the health problems presented by the children. Moreover, children in the comparison schools have increased their use of hospital emergency rooms and outpatient services, but there has been a decline in the use of such services by children in the demonstration school.

Programs for the elderly

Three programs testing new approaches for meeting the special needs of elderly persons for a variety of health care services were started in 1978 with Foundation assistance.

The National Council on the Aging and a group of collaborating universities are establishing service and learning centers using students to provide a wide variety of services to older persons. These include medical, dental, and nursing care; speech and hearing therapy; and pharmacy and nutrition services.

Students will participate as part-time employees, as volunteers, or in field clerkships offering academic credit. The participating schools are Boston University, the University of Denver, George Washington University, the University of Georgia, Hampton Institute, and Indiana's Consortium for Urban Education.

In Baltimore as in most communities, it is not unusual for indigent elderly patients to stay in the hospital longer than is medically necessary. They may have no one at home to care for them, and beds in nursing homes offering intermediate-level care are in short supply.

The Johns Hopkins Hospital is testing the feasibility of identifying and training surrogate families which, for a fee, will provide care in their homes to elderly patients discharged from the Hospital.

A physician-directed team of nurses and social workers from Johns Hopkins will serve as the patients' primary and continuing source of health care and will monitor the surrogate families' performances. A planned evaluation will seek answers to three questions:

- Is foster family care a cost-effective alternative to nursing home care?
- What improvements in the patients' health and ability to function can be achieved by such care?
- What are the characteristics of families that provide effective care of patients in the home?



The United Way of the Minneapolis Area has convened a coalition of public and private agencies in a one-year planning effort addressing the problems experienced by the elderly requiring health and related services.

In this city, 20 percent of the population, or 87,000 people, are over 60 years of age. Over half of these people have incomes near or below the poverty level, and 20 percent live alone. Moreover, the provision of health and related services for the elderly follows a national pattern of responsibility fragmented among multiple institutions and agencies with substantial variations in eligibility requirements, service content and style, sites, and cost to the individual. The Minneapolis United Way coalition's ultimate objective is to overcome these barriers and develop a coordinated system of health and related services for the elderly.

Other service projects

Continued assistance was provided in 1978 for four service activities previously supported by the Foundation: a Vanderbilt University program to help rural communities develop and improve their health services; Georgetown University's prepaid Community Health Plan; the Barrio Comprehensive Child Health Care Center in San Antonio; and the University of Tennessee's involvement in a Memphis regional primary care network that was one of the models for the Foundation's Municipal Health Services Program.

Two programs announced

During 1978 planning was completed, advisory committees formed, and two new national programs were announced. Under the Hospital-Sponsored Ambulatory Dental Services Program, hospitals with dental residency programs will be assisted to expand their outpatient activities to offer emergency, basic, and preventive dental care for people who currently lack adequate access to these services. Plans call for as

many as 25 grants of up to \$500,000 each during 1979.

The General Pediatrics Academic Development Program will assist six universities to train future faculty, to conduct clinical research, and to develop models of patient care—all centered on the medical problems commonly seen in the out-of-hospital practice of general pediatrics.

Applications for both programs have been received and reviewed, and most site visits were completed this year. Grants are expected to be made in early 1979.

Special assistance projects

The Rural Health Center Series—a six-volume set of handbooks prepared by a group of well-qualified authors for health professionals and community leaders alike—is scheduled for publication in the spring of 1979. The handbooks, prepared and published with Foundation support, are based on a study of 24 rural health centers staffed by nurse practitioners and physicians' assistants backed up by physicians.

The Series was prepared under the auspices of the University of North Carolina Health Services Research Center and the North Carolina Office of Rural Health Services. The six titles are: Rural Health Centers in the United States; Planning and Managing Rural Health Centers; Clinical Roles in Rural Health Centers; A Legal Guide for Rural Health Programs; Facility Planning, Design, and Construction for Rural Health Centers; and Medical Record and Index Systems for Community Practice.

A 1978 grant to Boston University will support a project offering developmental assistance for Individual Practice Associations (IPA's)—affiliations of independent physicians offering prepaid health care in accordance with provisions of the federal Health Maintenance Organization program. Operating out of the University's Health Policy Institute, the project will assist a



limited number of new IPA's with such tasks as attracting the initial complement of physicians, defining alternative benefit packages and master group contracts, and approaching insurance carriers to begin contract negotiations.

Nurse practitioner faculty training

Over the past seven years, the Foundation has supported nurse practitioner training to help expand access to primary health care services.

Two ingredients have made it possible for these new health practitioners to assume expanded clinical responsibilities. One is the medical skills they have acquired, such as history taking, physical examination, ordering and interpreting basic laboratory tests, and following diagnostic protocols and treatment plans. The other has been the development of systems of care in which nurse practitioners can use these and their nursing skills with appropriate physician supervision and collaboration.

To prepare nursing faculty for new careers as teacher-practitioners for the nurse practitioner profession, in 1978 the Foundation's Nurse Faculty Fellowship Program was extended two years beyond the initial three-year commitment. The new appropriations will enable a total of 100 faculty from throughout the country to complete one-year fellowships at the Program's four academic sites—the University of Colorado, Indiana University, the University of Maryland, and the University of Rochester.

Two other academic centers—the University of Washington and the University of Pennsylvania—also received grants in 1978 to implement their plans to become regional graduate centers for preparing nurse practitioner faculty.

Emergency nurse/primary care training

Last year the Foundation began a program to help a number of hospitals and schools of

nursing develop primary care training for emergency department nurses from smaller, outlying hospitals in their regions. In 1977 two such programs were initiated. This year four additional institutions received grants to complete the series: Good Samaritan Hospital in Portland, Oregon; Hermann Hospital in Houston; Maricopa County General Hospital in Phoenix; and Nebraska Methodist Hospital in Omaha.

Academic careers in family practice

In 1977 the Foundation announced a Family Practice Faculty Fellowship Program with grants to four universities. In 1978, two additional universities became participants: Case Western Reserve University and the University of Missouri-Columbia. They will offer two-year fellowships to young physicians planning academic careers involving research, teaching, and the practice of family medicine.

Training rural health aides in Alaska

Since 1975 the Foundation has assisted the development of Alaska's program to train Rural Health Aides—Eskimos and Indians providing first-line medical care for 40,000 native peoples living in 200 villages scattered across the state's vast arctic and subarctic wilderness.

Progress to date includes the establishment of a coordinating office for the training program by the University of Alaska, publication of a manual for the aides, and the development of certificate and associate degree curricula for the aides.

A 1978 grant will support the development of course and teaching materials for implementation of the curricula and further strengthening of in-service training for existing aides and their assistants.

Minority health career opportunities

Four grants in 1978 continue the Foundation's support of selected institutions assisting

minority and other disadvantaged students interested in health careers:

(1) Tulane University's program for the recruitment and retention of minority students for medical school, including a summer enrichment experience, year-round counseling and tutoring, and help for other schools developing similar programs;

(2) The National Fund for Medical Education's program of small grants for medical school summer studies for minority premedical students;

(3) The Association of University Programs in Health Administration's recruitment of minority college students for graduate programs leading to careers in the management of health institutions; and

(4) The University of Southern California School of Medicine's programs of educational enrichment, counseling, and tutorials for disadvantaged premedical students within a consortium of six area undergraduate institutions.

Guaranteed student loans

With a previous year's grant of \$500,000, a total of \$3.3 million was made available for borrowing by medical, osteopathic, and dental students under the Foundation's Guaranteed Student Loan Program administered by United Student Aid Funds, Incorporated. In 1978, a \$1 million grant for this program is expected to guarantee an additional \$7 million in loans to supplement other assistance available for students in the three health professions.

Perinatal program studies

In 1975 the Foundation began a national perinatal program to establish eight regional systems to identify and care for the 15-25 percent of pregnant women at high risk to serious complications affecting their health or their babies' health. The objective is to test the belief that the organization of such services on a regional basis would lead to a



reduction of maternal and infant deaths and birth defects.

In 1978 three grants were made for studies building further on this program. One grant to The Johns Hopkins University expands the scope and duration of the program's principal evaluation, which also began in 1975.

Two other studies—at the University of Arizona and Case Western Reserve University—will use somewhat different approaches seeking to provide further clarification of the Program's outcome by determining what proportion of high-risk infants admitted to the neonatal intensive care units (NICU's) have survived and can be classified as "normal" three years later. Included in the Case Western Reserve University study is a comparison of outcomes between infants delivered in one hospital and then transported to the hospital with an NICU and those whose mothers were transported to the hospital with the NICU before giving birth. Both projects will periodically check the children's physical, neurologic, and intellectual development and will help parents obtain any needed medical or social services.

Other program-related research

A group at the University of North Carolina has begun a national study of programs offering rural health care services. Various models have been identified—including the Foundation's Rural Practice Project—for comparison with respect to their stability; cost; effects on access to care; and physician, patient, and local community satisfaction. The federal government and the Foundation are both participating in funding this project.

Another University of North Carolina group, also receiving both Foundation and federal support, has begun a study of the new and expanded role of state and local health departments developing ambulatory care services. This study will assess the potential of these agencies for designing and

operating primary care services in underserved areas.

An inter-disciplinary group at Northwestern University will use a 1978 grant from the Foundation to study three areas of management related to ambulatory care services: (1) organizational arrangements that can reduce institutionalization of the elderly and chronically ill; (2) linkages with other health care services and providers that can increase the effectiveness of hospital emergency rooms, particularly for non-emergent problems; and (3) the use of mathematical modeling to develop optimal organization designs for ambulatory practices.

The town of Brookline, Massachusetts' research and demonstration program to detect and prevent health and learning handicaps in preschool children also received continuing support. The educational and diagnostic service elements of this program will end at the conclusion of the 1978-79 school year, and work continues to refine and validate a number of new methods that have emerged from this program to detect problems and monitor child development.

Health policy fellowships

A 1978 grant to the National Academy of Sciences, Institute of Medicine will continue the Foundation's Health Policy Fellowship Program until 1982. Under previous grants, thirty academic health center faculty members, by the end of 1979, will have completed one-year fellowships that include an intensive orientation to Washington health policy affairs and nine-month Congressional and/or executive branch staff assignments. The fellowships—six each year—serve the dual purpose of developing a cadre of academic health center faculty with firsthand knowledge of the federal health policy process, and providing federal policymakers with the assistance of competent professionals experienced in academic health affairs.

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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 1978 these reports cited 64 books, 57 book chapters, 346 journal articles, 217 reports, and 63 films, tapes and other audiovisual materials.

This bibliography is a sample of citations from each category reported in 1978, and from among the publications of the Foundation's staff.

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Analysis of
appropriations:
1972-1978

**Analysis of
Appropriations:
1972-1978**

In 1972 The Robert Wood Johnson Foundation emerged as a national philanthropy with an overall goal to assist institutions and groups that are attempting to improve the American health care delivery system to make high-quality medical care more available for non-hospitalized Americans. Toward the achievement of this goal, three major objectives were defined:

- improving access to general health care services;
- improving the quality of health care, and the methods by which quality of care can be measured;
- improving the formulation and evaluation of public policy in health affairs.

In its first seven years as a national philanthropy, the Foundation made 1,093 grants, with appropriations totalling \$318.5 million. The charts in this section show the use of these funds in relation to the Foundation's objectives, the proposals submitted to the Foundation, and the types of activities assisted in support of these objectives. The charts also depict the distribution of grants by geography and type of recipient, and the Foundation's grants in comparison with spending by other foundations and by the federal government.

All percentages and dollar amounts in the charts have been rounded.

Chart 1

**Appropriations by
RWJF Objectives,
1972-1978**

RWJF 7-year appropriations: \$318.5 million

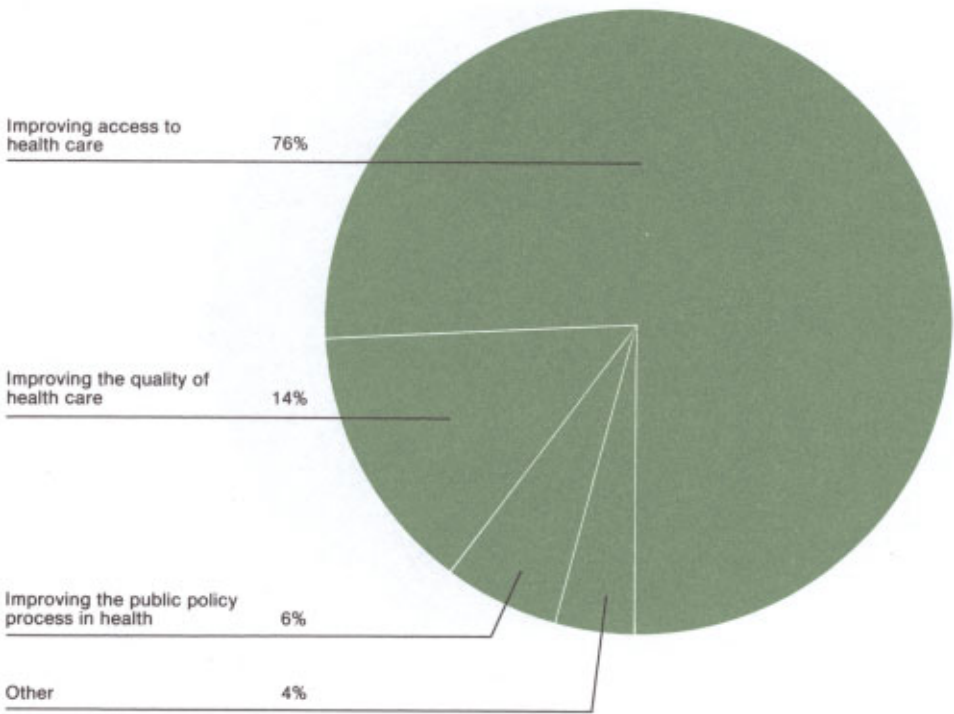


Chart 2

Types of Activities Supported, 1972-1978

RWJF 7-year appropriations: \$318.5 million

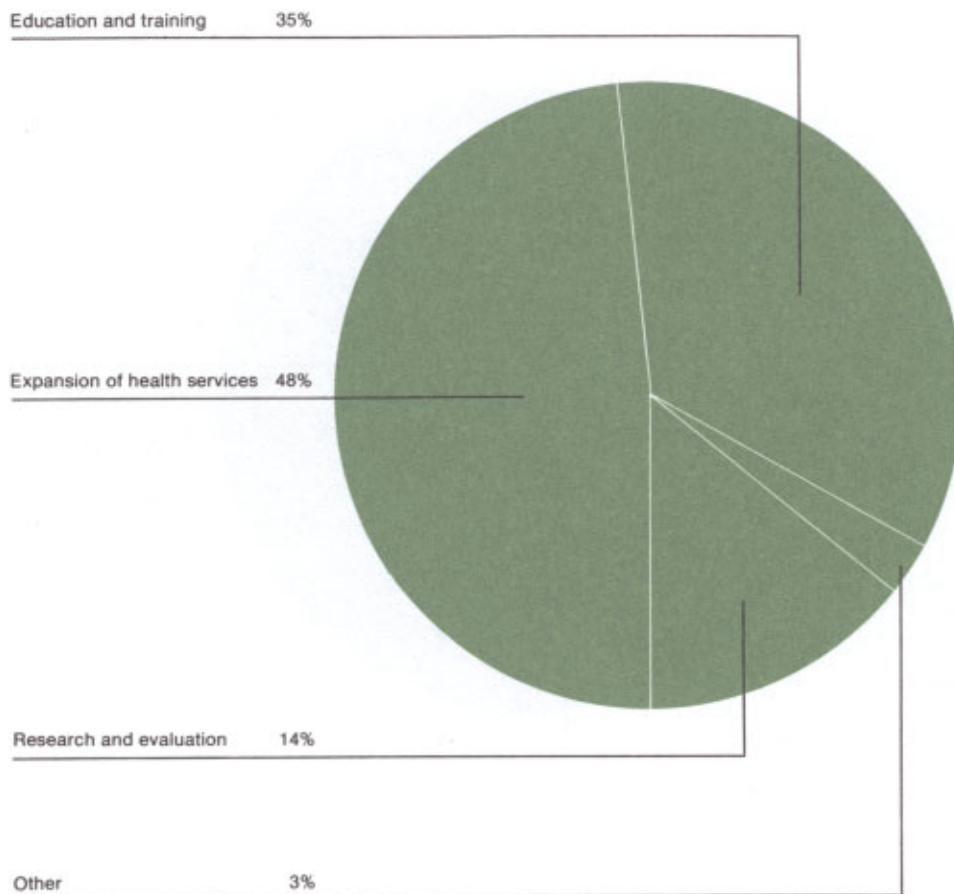


Chart 3

Types of Education and Training Programs Supported, 1972-1978

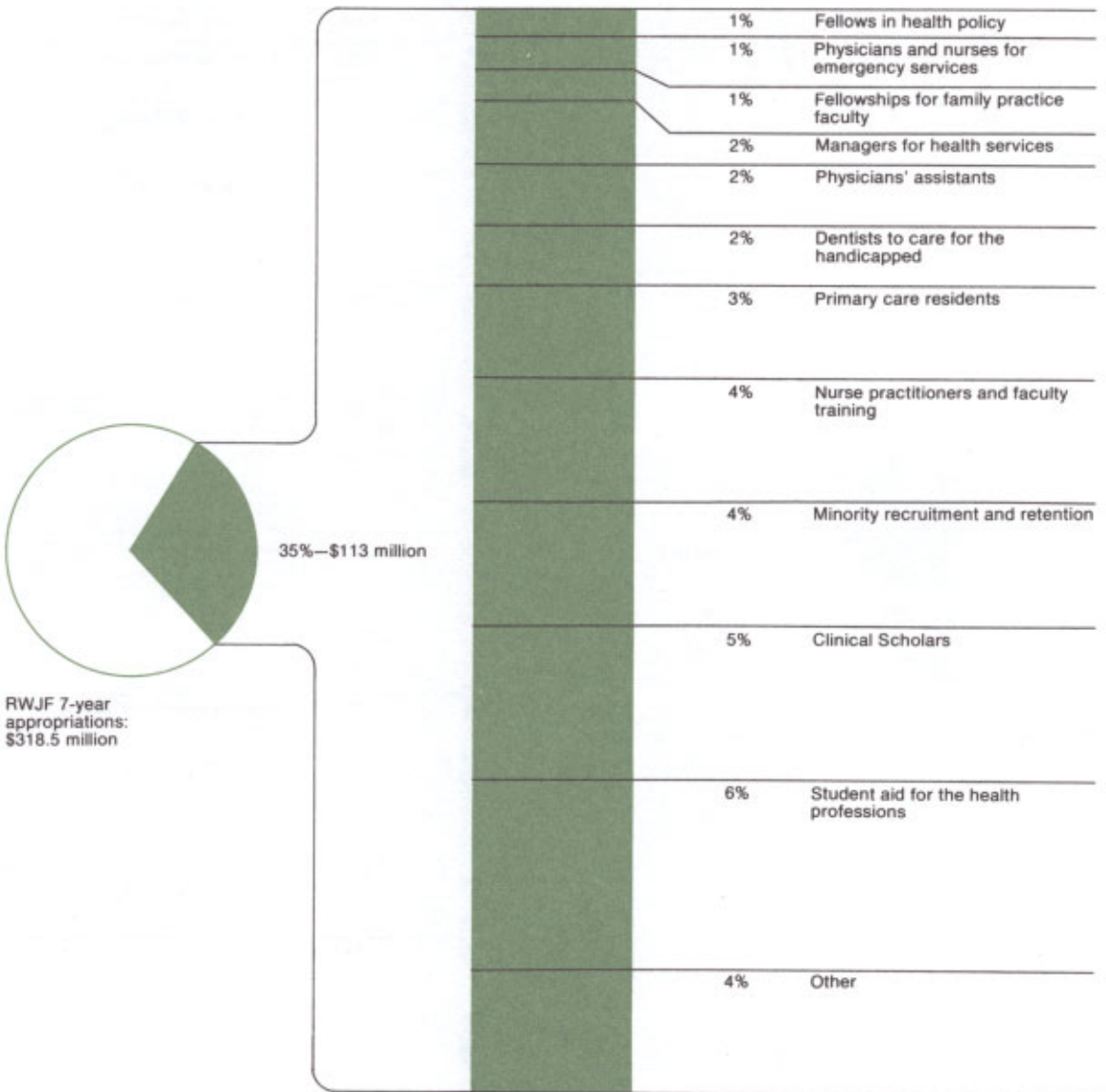


Chart 4

Types of Programs Supported to Deliver Health Services, 1972-1978

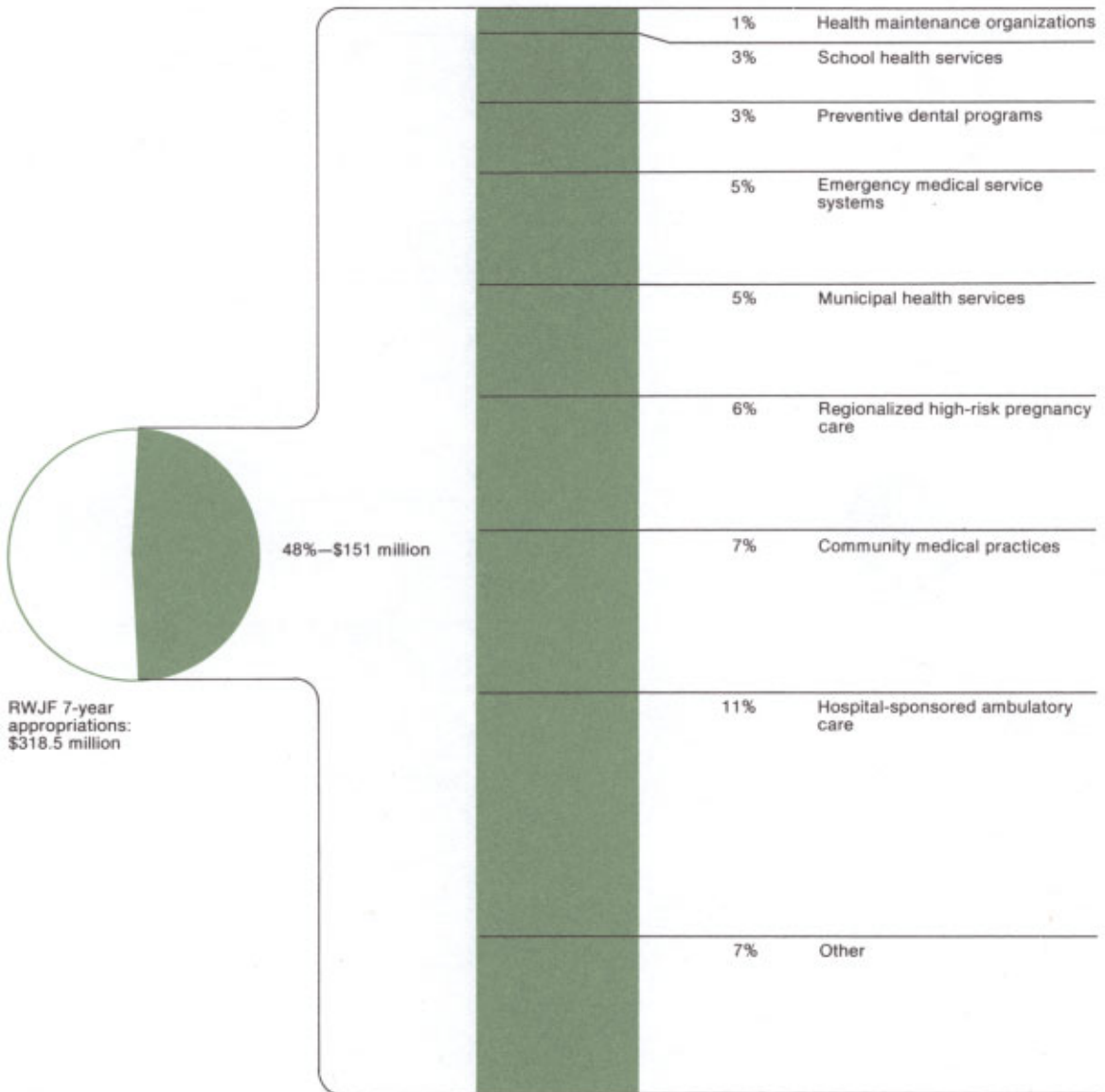


Chart 5

Types of Research and Evaluation Supported, 1972-1978

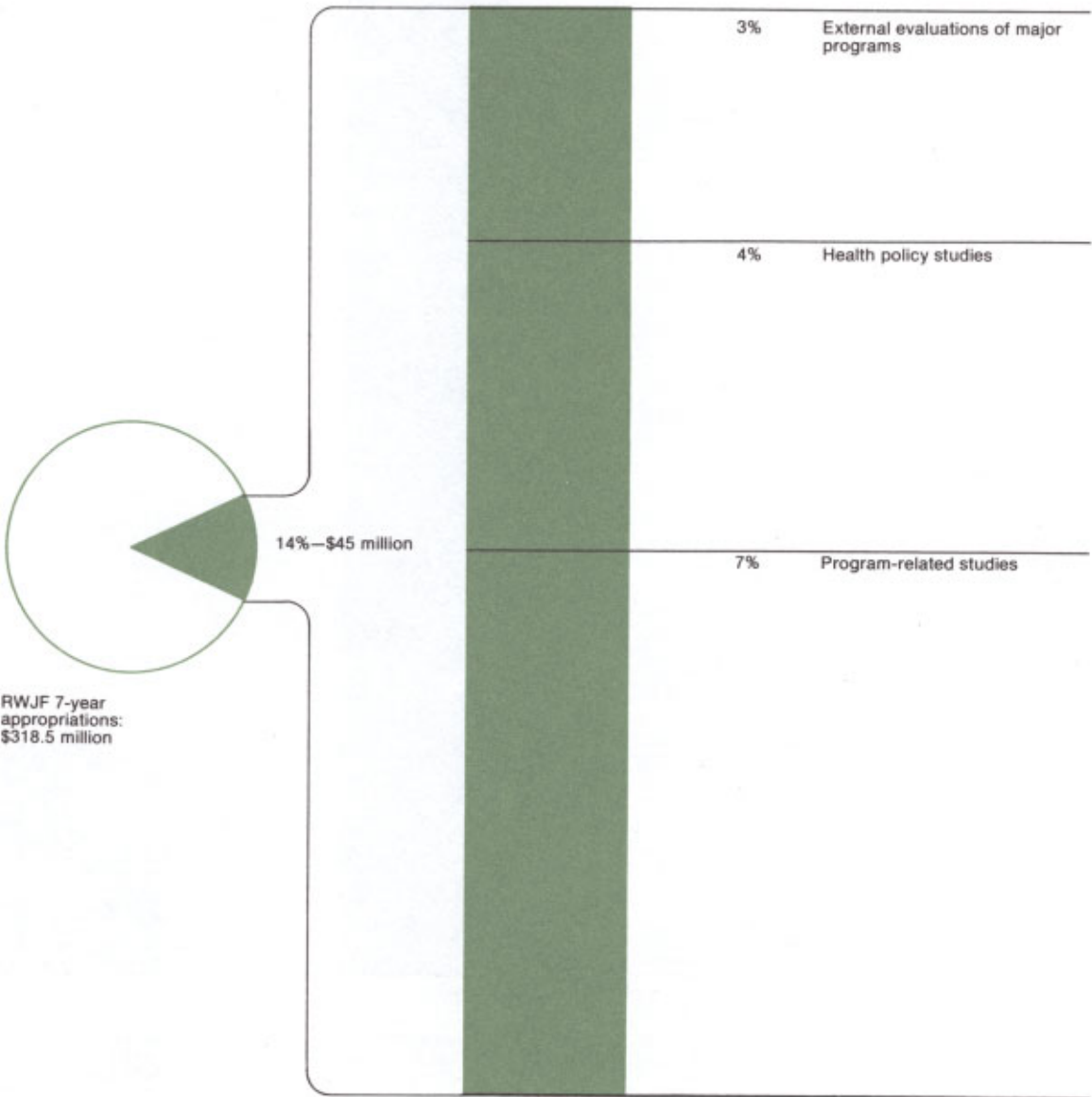


Chart 6A

**Comparison of 1972-1978
Requests Received* to
Appropriations: by
Foundation Objectives**

**Includes only those proposals for activities relevant to the Foundation's objectives.*

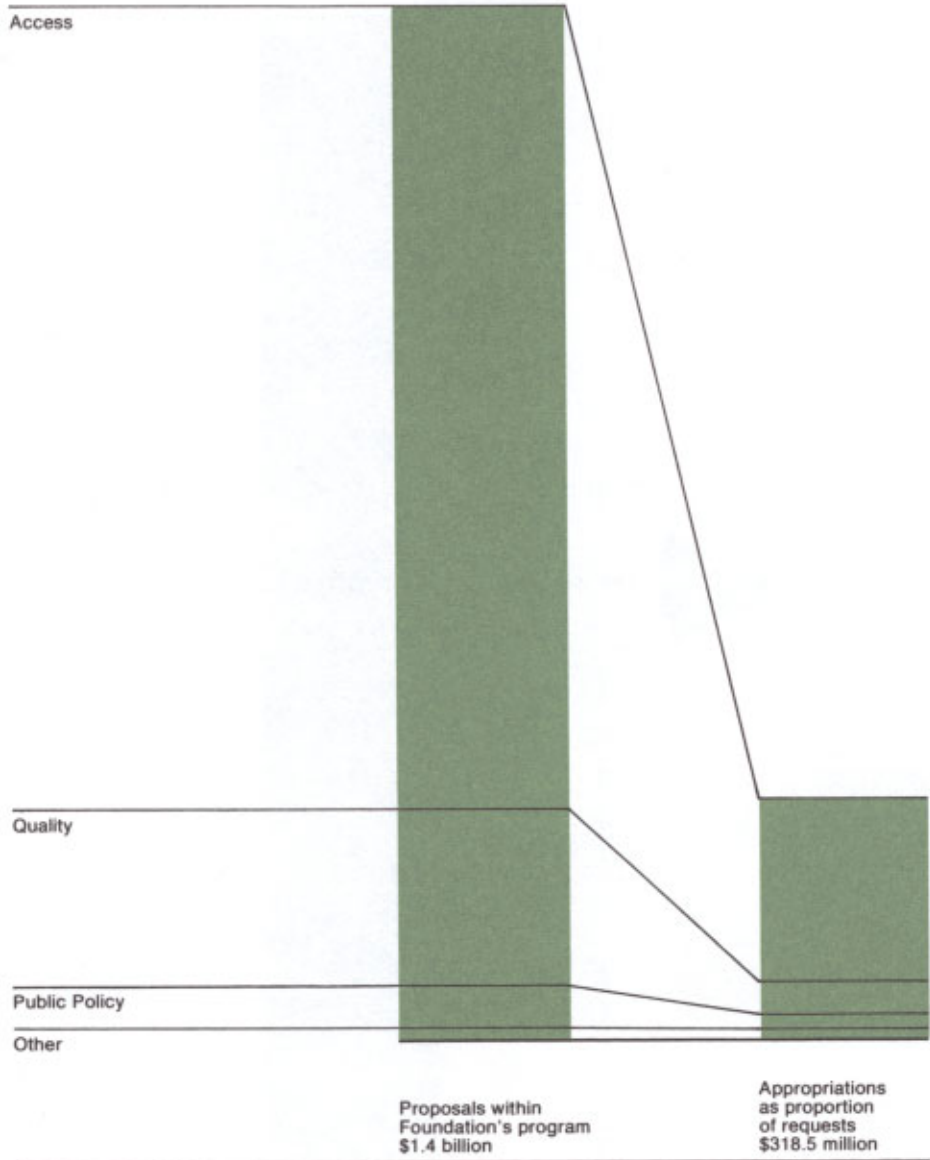


Chart 6B

**Comparison of 1972-1978
Requests Received* to
Appropriations: by Types
of Activities Funded**

**Includes only those proposals for
activities relevant to
the Foundation's objectives.*

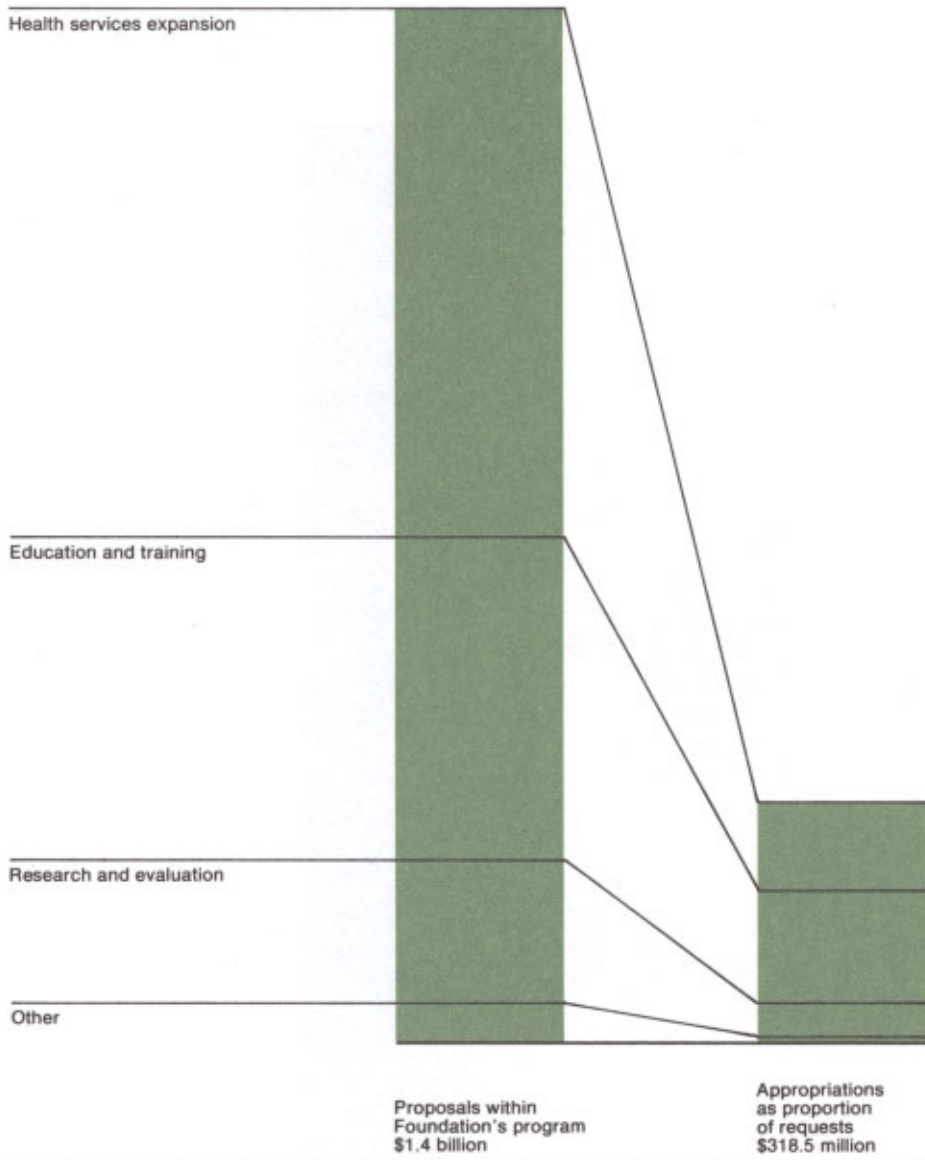


Chart 7

National Programs* as a Proportion of Appropriations 1972-1978

**Each of these programs comprises a series of grants assisting selected institutions or organizations addressing a specific, well-defined national problem within the scope of the Foundation's objectives.*

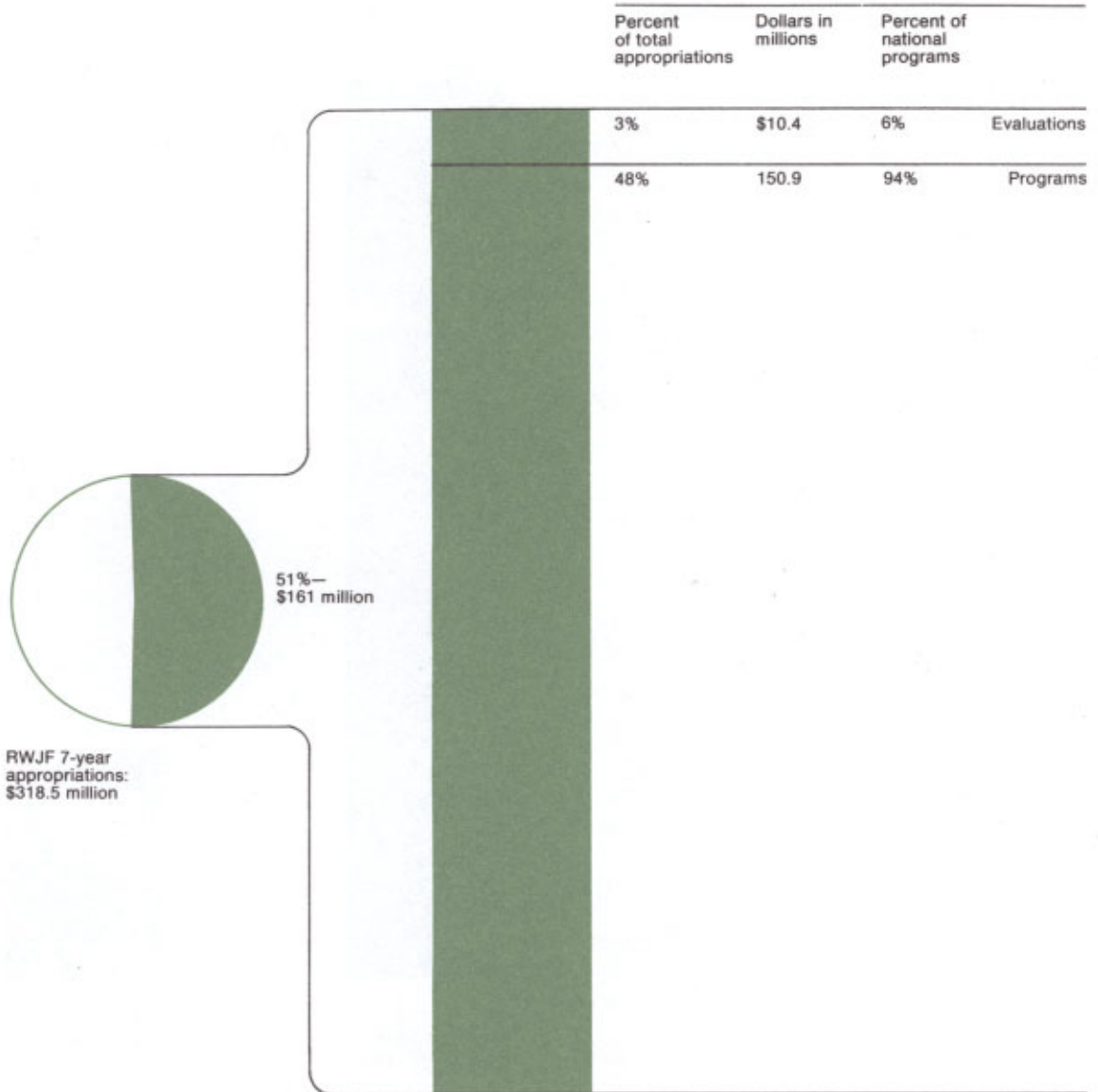


Chart 8

**National Programs,
1972-1978**

Appropriations (millions of dollars)

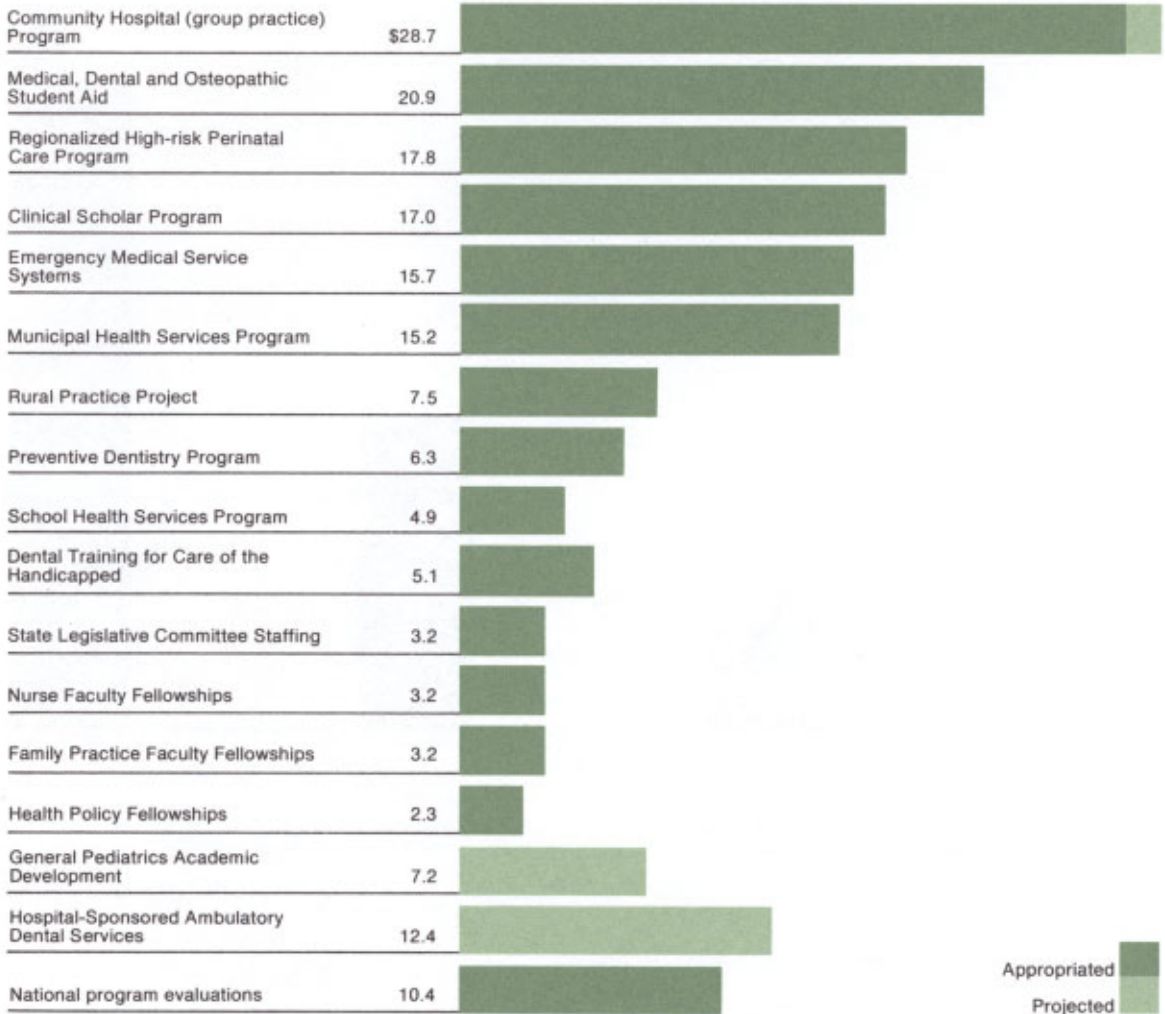
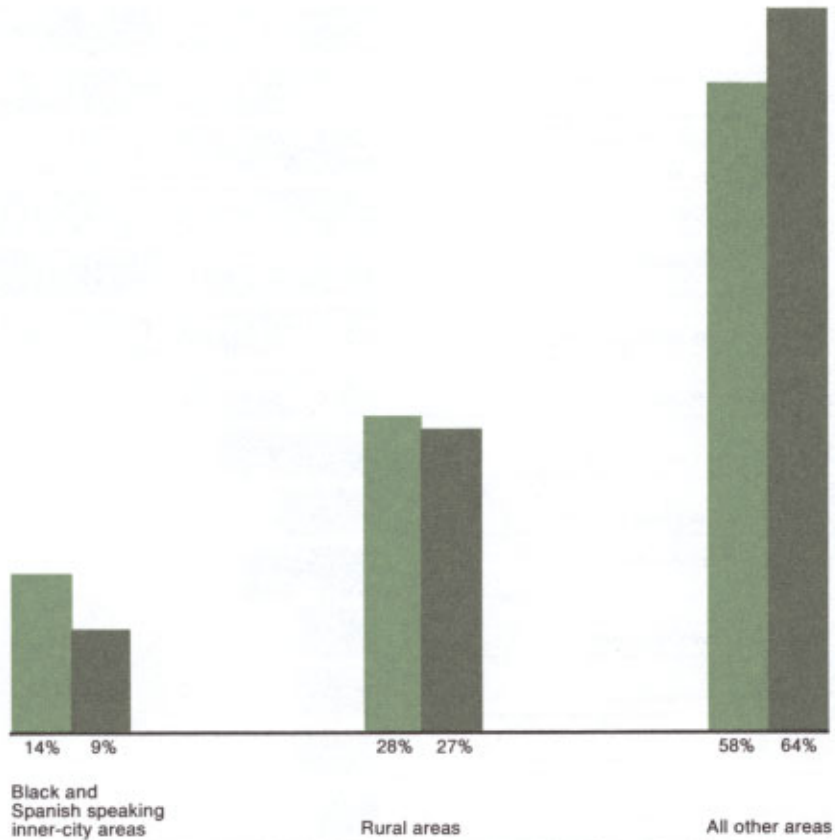


Chart 9

**Service Programs for
Inner-city Minority
and Rural Populations,
1972-1978**



 RWJF health service appropriations—\$151 million
 U.S. population—203 million people

Chart 10

1972-1978 Appropriations
by Geographical Regions
Compared to Population

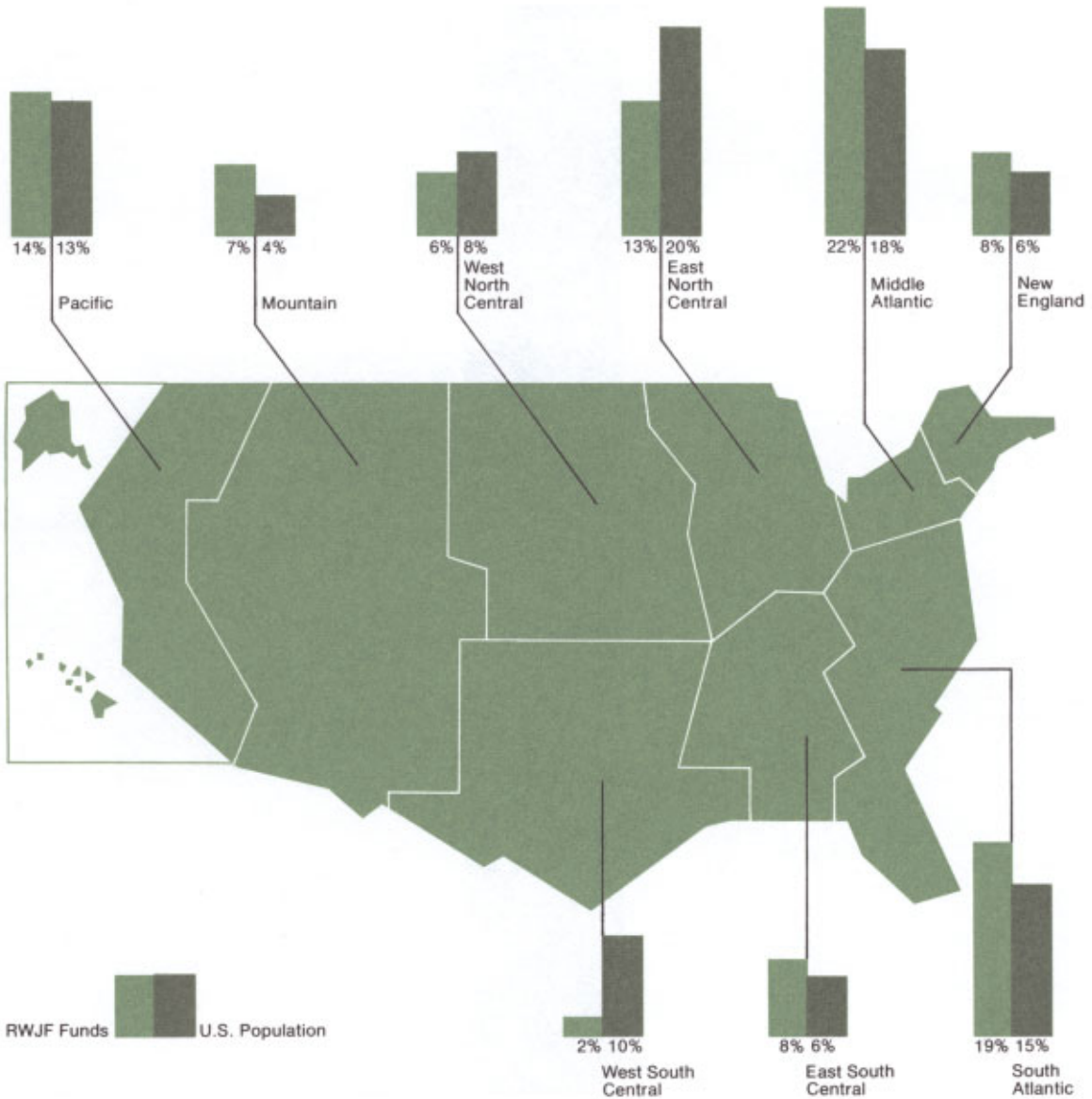


Chart 11

**Appropriations for
Programs in New Jersey,
1972-1978**

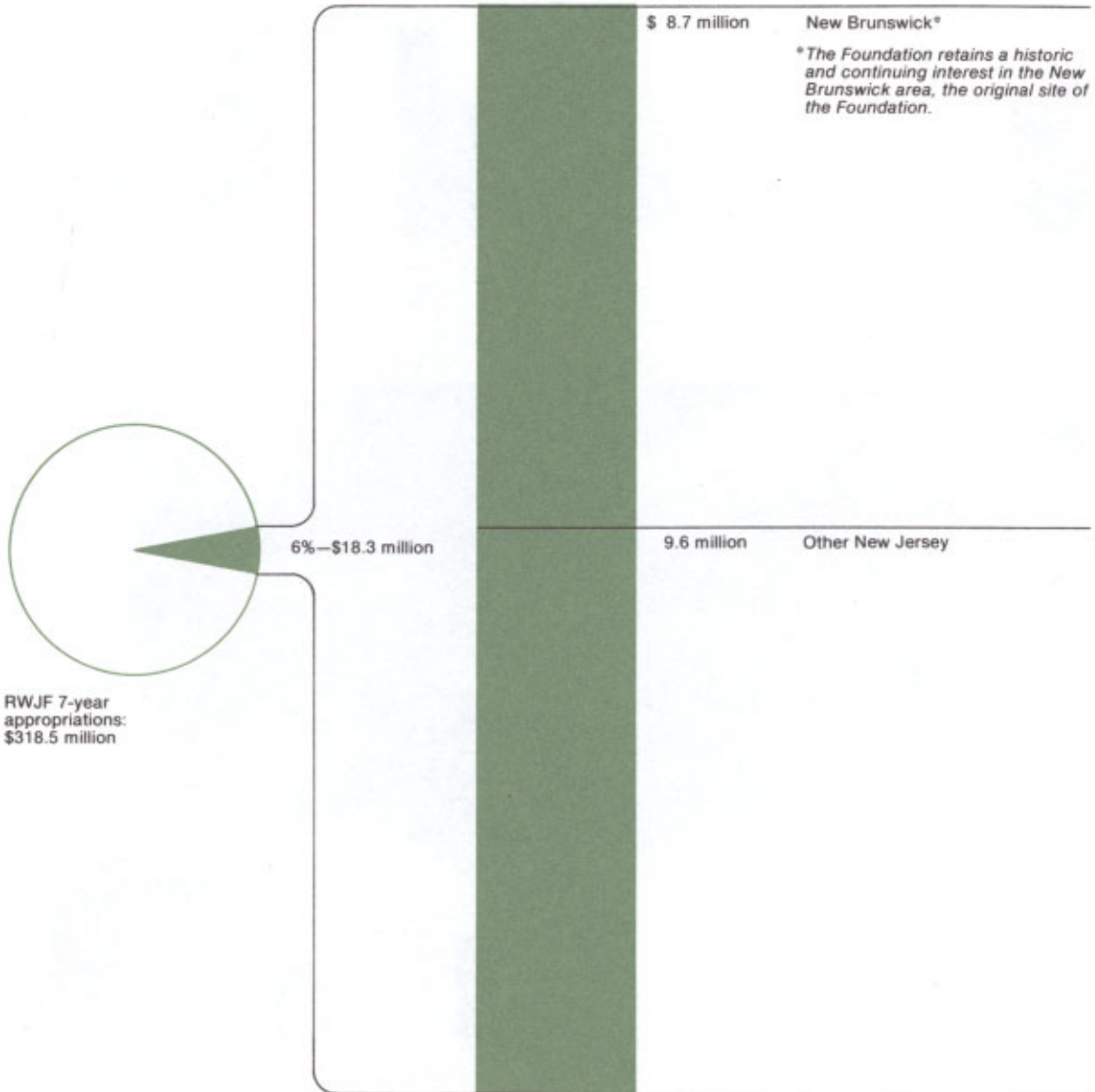


Chart 12

**Division of
Appropriations Between
Public and Private
Institutions,
1972-1978**

RWJF 7-year appropriations: \$318.5 million

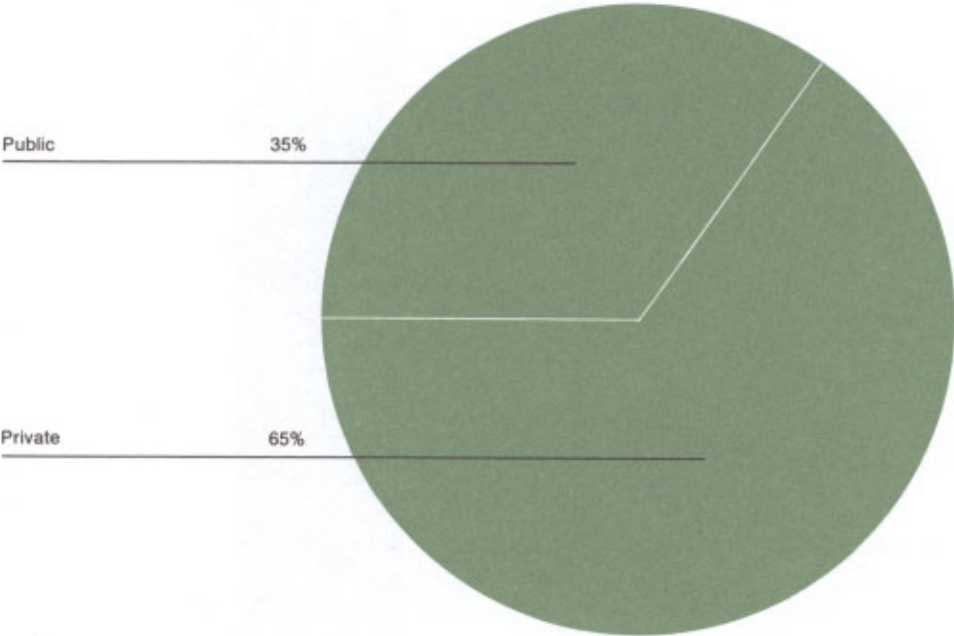


Chart 13

Types of Institutions Receiving Support, 1972-1978

	Number of institutions	Percent of dollars appropriated	RWJF 7-year appropriations: \$318.5 million
Academic health science centers	125	49%	
Community and state health agencies	78	14%	
Community hospitals	66	11%	
National organizations	36	6%	
Independent research groups	33	6%	
Community clinics	35	5%	
Other universities and colleges	22	3%	
Major teaching hospitals	17	3%	
Other	14	3%	

Chart 14

**RWJF Appropriations
Compared to Federal Health
Expenditures by Types
of Activity Supported,
1972-1978**

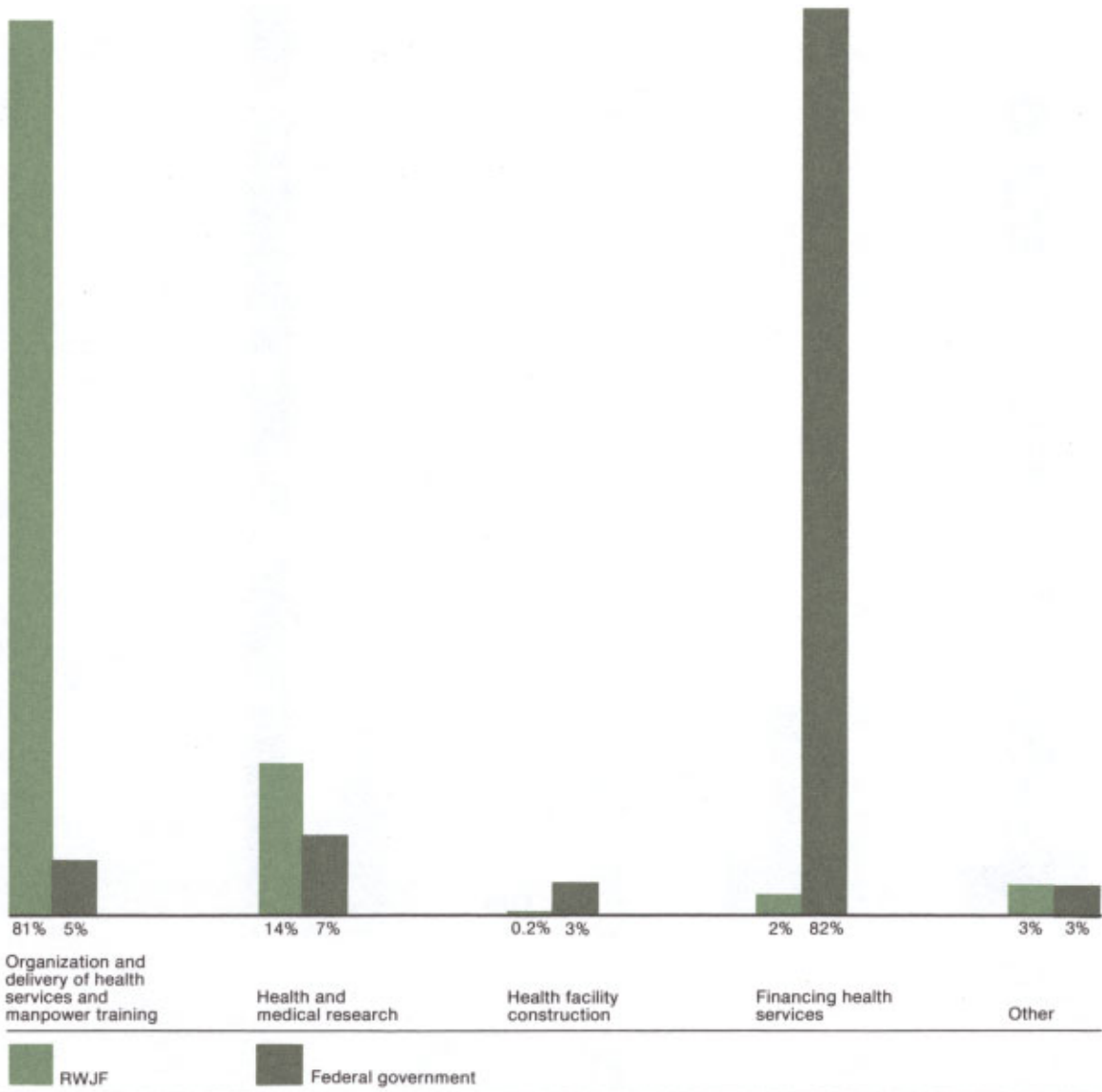
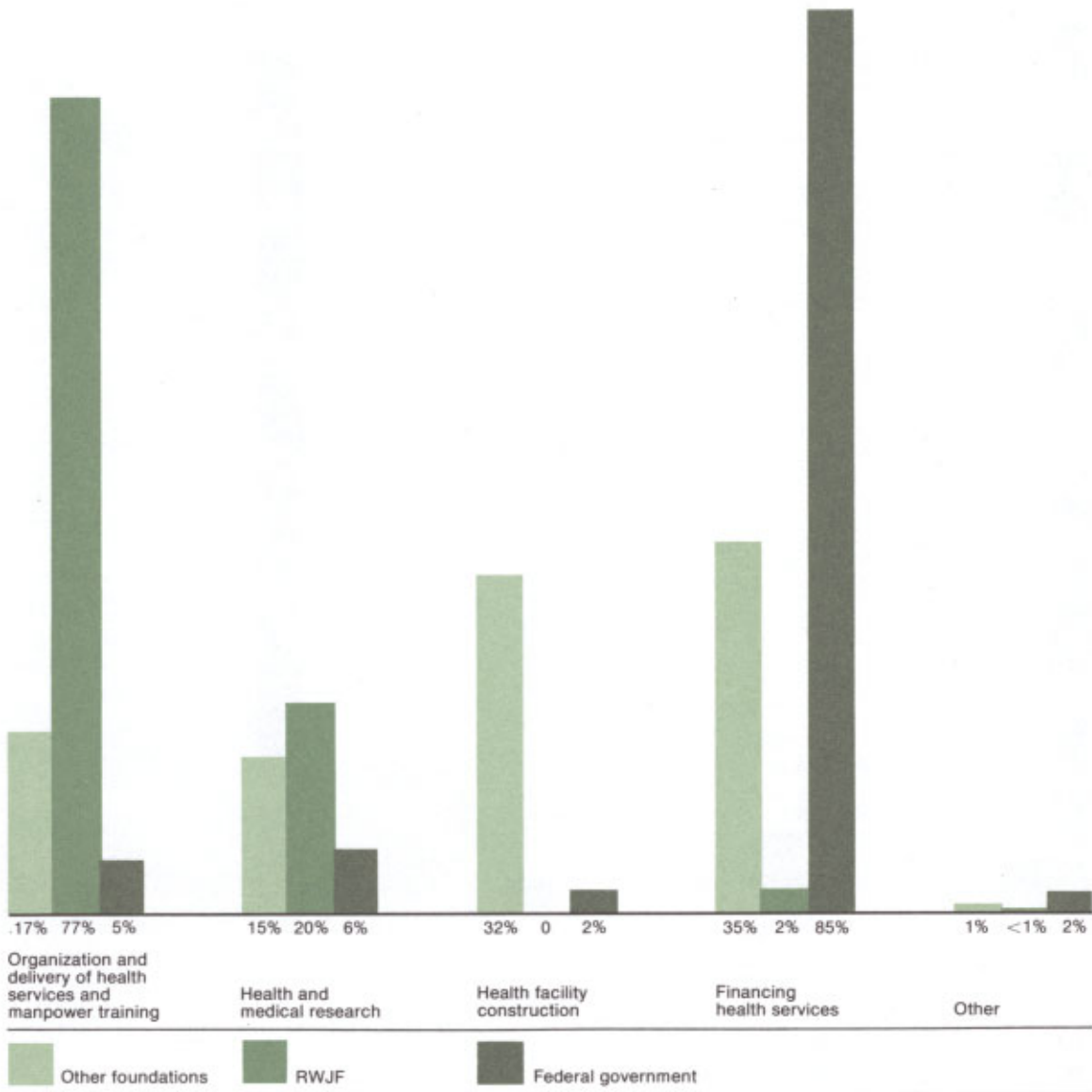


Chart 15

**RWJF Appropriations
Compared to Health
Expenditures by Other
Foundations and the
Federal Government, 1976***

*Data on other foundations' health expenditures are only available for 1976.



Financial statements

Introduction to statements

The annual financial statements for the Foundation appear on the following pages. A listing of grants authorized during 1978 appears on pages 71 through 79, and a summary of grants authorized in prior years which had not been paid in full as of January 1, 1978 appears on pages 80 through 94. A detailed list of investment securities held at December 31, 1978, although not included herein, is available upon request to: Communications Office, The Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, New Jersey 08540.

Grants authorized in 1978, net of cancellations and refunds of prior years' grants, totaled \$44,775,631. This amount, when added to investment and administrative expenses and excise taxes for the year, exceeded income by \$16,158,103. The comparable figure for 1977 was \$5,863,859, and the total by which grants, expenses and taxes exceeded income for the seven years ended December 31, 1978 was \$176,558,274.

Investment income for 1978 was \$33,057,604, an increase of 18% over the \$27,996,841 earned in 1977. Expenses in 1978 were \$3,442,856, an increase of 4% over 1977.

At the beginning of 1978, the Foundation owned 8,611,086 shares of Johnson & Johnson common stock. During the year, 200,000 shares were sold, leaving a balance in the portfolio of 8,411,086 at December 31, 1978.

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, 1978, and 1977, 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 aforementioned financial statements present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1978, and 1977, 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,
February 1, 1979.

The Robert Wood Johnson Foundation
Statement of Assets,
Liabilities and Foundation Principal
at December 31, 1978 and 1977

	<u>1978</u>	<u>1977</u>
Assets		
Cash	\$ 340,453	\$ 293,661
Investments (at cost, or market value on dates of gifts) (Note 2):		
Johnson & Johnson common stock— 8,411,086 shares in 1978, 8,611,086 shares in 1977 (quoted market value \$620,317,593 and \$660,900,851)	241,117,739	246,851,079
Other corporate common stocks (quoted market value \$42,378,982 and \$52,619,611)	47,405,401	56,786,138
Fixed income investments (quoted market value \$193,706,875 and \$196,066,055)	213,257,384	202,781,993
Land, building, furniture and equipment at cost, net of depreciation (Note 1)	6,218,146	6,117,685
	<u>\$508,339,123</u>	<u>\$512,830,556</u>
 Liabilities and Foundation Principal		
Liabilities:		
Unpaid grants (Note 1)	\$ 96,580,851	\$ 92,403,985
Federal excise tax payable (Note 3)	<u>673,592</u>	<u>1,111,732</u>
Total liabilities	97,254,443	93,515,717
Foundation Principal	<u>411,084,680</u>	<u>419,314,839</u>
	<u>\$508,339,123</u>	<u>\$512,830,556</u>

See notes to financial statements, page 70.

The Robert Wood Johnson Foundation
Statement of Investment Income,
Expenses, Grants and Changes in Foundation Principal
for the years ended December 31, 1978 and 1977

	<u>1978</u>	<u>1977</u>
Investment income:		
Dividends	\$ 16,558,812	\$ 14,915,762
Interest	<u>16,498,792</u>	<u>13,081,079</u>
	33,057,604	27,996,841
Less: Federal excise tax (Note 3)	654,294	1,109,731
Investment expenses	<u>342,926</u>	<u>253,589</u>
	<u>32,060,384</u>	<u>26,633,521</u>
Expenses:		
Program development and evaluation	2,618,498	2,581,505
General administration	<u>824,358</u>	<u>725,960</u>
	<u>3,442,856</u>	<u>3,307,465</u>
Income available for grants	28,617,528	23,326,056
Grants, net of refunds and cancellations	<u>44,775,631</u>	<u>29,189,915</u>
Excess of expenses and grants over investment income	<u>16,158,103</u>	<u>5,863,859</u>
Additions to Foundation Principal:		
Net capital gains on sale of securities (Note 4)	7,206,559	6,291,694
Less related federal excise tax (Note 3)	<u>19,298</u>	<u>2,001</u>
	7,187,261	6,289,693
Contributions received	<u>740,683</u>	<u>785,634</u>
	<u>7,927,944</u>	<u>7,075,327</u>
Net (decrease) increase in Foundation Principal	(8,230,159)	1,211,468
Foundation Principal, beginning of year	<u>419,314,839</u>	<u>418,103,371</u>
Foundation Principal, end of year	<u>\$411,084,680</u>	<u>\$419,314,839</u>

See notes to financial statements, page 70.

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, 1978, unpaid grants are as follows:

<u>Year Grant Authorized</u>	<u>Amount Unpaid at December 31, 1978</u>
1974	\$ 9,170,865
1975	9,995,347
1976	15,748,741
1977	19,660,547
1978	42,005,351
	<u>\$96,580,851</u>

Depreciation of \$169,297 in 1978 and \$151,576 in 1977 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.

- The quoted market values of investments, particularly in the case of the sizeable holding of Johnson & Johnson common stock, may be greater than the realizable values of such investments.
- The federal excise tax rate was 2% in 1978 and 4% in 1977.
- The net capital gains (losses) on sales of securities for the years ended December 31, 1978 and 1977 were as follows:

	<u>1978</u>	<u>1977</u>
Johnson & Johnson common stock	\$9,221,122	\$8,176,482
Other securities, net	<u>(2,014,563)</u>	<u>(1,884,788)</u>
	<u>\$7,206,559</u>	<u>\$6,291,694</u>

- 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 \$142,400 and \$134,500 in 1978 and 1977, respectively.

**Summary of grants
authorized in the year ended December 31, 1978**

	1978 grants authorized
University of Alaska Anchorage, Alaska <i>Rural health aide training program (ID#3790)</i>	\$ 164,694
American Academy of Pediatrics Evanston, Illinois <i>Study of pediatric training programs (ID#4643)</i>	16,626
American Association of Dental Schools Washington, D.C. <i>Develop curriculum guidelines for teaching dental care of the handicapped (ID#4529)</i>	6,470
American College of Physicians Philadelphia, Pennsylvania <i>Support of the Society for Research and Education in Primary Care Medicine (ID#4260)</i>	129,056
American Fund for Dental Health Chicago, Illinois <i>Administration of the Foundation's program to train dentists in the care of the handicapped (ID#4353)</i> <i>Program to improve dental care of the handicapped (ID#4207)</i> <i>Preventive dental care program for school-age children (ID#4770)</i>	17,294 24,900 858,289
University of Arizona, College of Medicine Tucson, Arizona <i>Special follow-up of high risk neonates (ID#4682)</i>	563,594
Association of Science-Technology Centers Washington, D.C. <i>Development of teaching materials in health (ID#4302)</i>	176,915
Association of University Programs in Health Administration Washington, D.C. <i>Summer internship program in health services management (ID#3821)</i>	299,962

	1978 grants authorized
Barrio Comprehensive Child Care Center San Antonio, Texas <i>Primary care service program for Mexican-American children (ID#3834)</i>	\$ 390,000
Boston University Boston, Massachusetts <i>Developmental assistance for independent practice associations (ID#4265)</i>	441,425
Boston University, School of Medicine Boston, Massachusetts <i>Study of child health care problems (ID#4398)</i>	5,033
Town of Brookline, Massachusetts, Public Schools Brookline, Massachusetts <i>Health program for infants and preschool children (ID#4545)</i>	387,251
Case Western Reserve University, School of Medicine Cleveland, Ohio <i>Study of child health care problems (ID#4342)</i>	4,719
<i>Special follow-up of high risk neonates (ID#4789)</i>	494,999
Center for Law and Social Policy Washington, D.C. <i>Survey of school nurse practitioner legislation (ID#4542)</i>	10,081
Child Advocacy Services Center Kansas City, Missouri <i>Establishment of a therapeutic nursery for abused children (ID#4286)</i>	25,000
Children's Hospital Medical Center Boston, Massachusetts <i>Study of child health care problems (ID#4293)</i>	21,120
<i>Administrative grant for senior program consultant services (ID#4723)</i>	122,073
Columbia University New York, New York <i>Evaluation of the Foundation's Municipal Health Services Program (ID#4027)</i>	392,026
The Community Hospital Group, Inc. Edison, New Jersey <i>Support of equipment needs of the Robert Wood Johnson, Jr. Rehabilitation Institute (ID#4627)</i>	25,000

**1978 grants
authorized**

Community Hospital-Medical Staff Group Practice Program <i>Grants for the development of hospital-sponsored primary care group practices (ID#4470)</i>	
Appalachian Regional Hospitals, Inc. West Liberty, Kentucky	\$ 483,980
Marion County Hospital Authority Buena Vista, Georgia	500,000
Providence Hospital Washington, D.C.	500,000
St. Joseph Mercy Hospital Ann Arbor, Michigan	499,910
<hr/>	
University of Connecticut Health Center Hartford, Connecticut <i>Development of a school-based health care program (ID#3835)</i>	537,225
<hr/>	
Cornell University, Medical College New York, New York <i>Assess the feasibility of improving chronic care in private practice (ID#4404)</i>	25,000
<hr/>	
Dental Training Program <i>Grants to dental schools to train dentists in the care of the handicapped (ID#3825)</i>	
University of Alabama, School of Dentistry Birmingham, Alabama	50,467
Columbia University, School of Dental and Oral Surgery New York, New York	27,121
University of Kentucky, College of Dentistry Lexington, Kentucky	133,667
University of Maryland, School of Dentistry Baltimore, Maryland	3,600
University of Washington, Seattle, School of Dentistry Seattle, Washington	21,718
<hr/>	
Family Practice Faculty Fellowship Program <i>Program to prepare physicians for academic careers in family practice</i>	
Case Western Reserve University, School of Medicine Cleveland, Ohio	538,503
University of Missouri, Columbia, School of Medicine Columbia, Missouri	654,944

**1978 grants
authorized**

University of Florida, College of Medicine Gainesville, Florida <i>Program to train physicians in primary care (ID#4808)</i>	\$ 449,794
Georgetown University, Graduate School Washington, D.C. <i>Completion of a monograph on the Legis 50 program to strengthen the role of state legislatures in health (ID#4393)</i>	3,379
Georgetown University, School of Medicine Washington, D.C. <i>Expansion of a primary care prepaid group practice program (ID#4259)</i> <i>Analysis of health policy issues (ID#4194)</i>	100,000 174,702
Good Samaritan Hospital and Medical Center Portland, Oregon <i>Primary care training for emergency nurses (ID#4512)</i>	314,459
Harvard University, Medical School Boston, Massachusetts <i>State-of-the-art paper on strategic interventions in health education (ID#4327)</i>	26,272
Health Services Foundation Chicago, Illinois <i>Design of a study of a primary care-oriented reimbursement program (ID#4351)</i>	24,994
Hermann Hospital Estate Houston, Texas <i>Primary care training for emergency nurses (ID#4078)</i>	322,211
Indiana University Foundation Indianapolis, Indiana <i>Program to prepare clinical nursing faculty in primary care (ID#3844)</i>	240,029
The Johns Hopkins Hospital Baltimore, Maryland <i>Foster family care program for the frail elderly (ID#4617)</i>	164,197
The Johns Hopkins University, Center for Health Services Research and Development Baltimore, Maryland <i>Evaluation of the Foundation's perinatal program (ID#4023)</i>	795,000

	1978 grants authorized
<hr/>	
Johns Hopkins University, School of Medicine Baltimore, Maryland	
<i>Program to prepare faculty in emergency medicine (ID#3206)</i>	\$ 713,554
<i>Joint study of surgical services in the United States (ID#4503)</i>	11,596
<i>Study of evaluation tools to select medical school applicants (ID#3811)</i>	172,483
<i>Publication of a manual on emergency medical communications systems (ID#4574)</i>	2,530
<hr/>	
The Johns Hopkins University, School of Hygiene and Public Health Baltimore, Maryland	
<i>Study of child health care problems (ID#4601)</i>	15,147
<hr/>	
Maricopa County General Hospital Research Foundation Phoenix, Arizona	
<i>Primary care training for emergency nurses (ID#3876)</i>	291,314
<hr/>	
Middlesex County College Edison, New Jersey	
<i>Refresher training to return inactive RN's to nursing service (ID#4476)</i>	18,572
<i>Health sciences scholarship program (ID#3303)</i>	15,000
<hr/>	
Middlesex General Hospital New Brunswick, New Jersey	
<i>Property acquisitions (ID#4912 and 4405)</i>	356,903
<i>Patient equipment support (ID#3822)</i>	250,000
<hr/>	
Mount Sinai School of Medicine New York, New York	
<i>Administrative grant for senior program consultant services (ID#3840)</i>	138,973
<hr/>	
Municipal Health Services Program	
<i>Program to expand municipally-sponsored inner-city health services (ID#3960)</i>	
City of Baltimore, Maryland	2,852,275
City of Cincinnati, Ohio	3,000,000
City of Milwaukee, Wisconsin	2,963,570
City of St. Louis, Missouri	3,000,000
City of San Jose, California	2,975,205
<hr/>	
National Academy of Sciences, Institute of Medicine Washington, D.C.	
<i>Support of the Institute of Medicine (ID#3836)</i>	750,000
<i>Fellowships in health policy program (ID#4496)</i>	408,430
<hr/>	

	1978 grants authorized
National Association of School Nurses, Inc. Washington, D.C. <i>Program to improve the physical assessment and patient management skills of school nurses (ID#4427)</i>	\$ 25,000
The National Council on the Aging, Inc. Washington, D.C. <i>Expand health care services for the elderly (ID#4696)</i>	350,000
National Fund for Medical Education Hartford, Connecticut <i>Support of summer programs for minority premedical students (ID#4474)</i>	175,000
Nebraska Methodist Hospital Omaha, Nebraska <i>Primary care training for emergency nurses (ID#4689)</i>	306,113
City of New Brunswick New Brunswick, New Jersey <i>Development of a regionalized EMS system (ID#3674)</i>	200,060
University of North Carolina, School of Medicine Chapel Hill, North Carolina <i>Publication of a study of primary care health centers (ID#3817)</i> <i>Study of rural health care initiatives (ID#4080)</i>	63,706 476,927
University of North Carolina, School of Public Health Chapel Hill, North Carolina <i>Role of state and local health departments in ambulatory care (ID#4344)</i>	121,732
Northwestern University Evanston, Illinois <i>Research on the management of ambulatory care services (ID#4429)</i>	225,000
Pace University, Graduate School of Nursing New York, New York <i>Graduate program in primary care nursing (ID#3839)</i>	350,030
University of Pennsylvania, School of Medicine Philadelphia, Pennsylvania <i>Study of alternative systems for ambulatory care of the chronically ill (ID#4783)</i>	24,400

	1978 grants authorized
University of Pennsylvania, School of Nursing Philadelphia, Pennsylvania <i>Graduate program in primary care nursing (ID#4271)</i>	\$ 543,943
Princeton Area United Community Fund Princeton, New Jersey <i>Annual contribution (ID#3858)</i>	30,000
Provident Hospital and Training School Association Chicago, Illinois <i>Planning a hospital-sponsored ambulatory care program (ID#4232)</i>	45,000
The Rand Corporation Santa Monica, California <i>Evaluation of a preventive dental care program for school-age children (ID#4769)</i>	1,563,219
University of Rochester, School of Medicine and Dentistry Rochester, New York <i>Administration of the Foundation's Community Hospital Ambulatory Care Program (ID#3753)</i>	448,948
University of Rochester, School of Nursing Rochester, New York <i>Graduate program in primary nursing (ID#4350)</i>	424,560
St. Peter's Medical Center New Brunswick, New Jersey <i>Patient equipment support (ID#3823)</i>	250,000
St. Peter's Medical Center, School of Nursing New Brunswick, New Jersey <i>Support of a nurse training program (ID#4483)</i>	30,000
St. Vincent de Paul Society New Brunswick, New Jersey <i>Program of assistance to the indigent (ID#3860)</i>	15,000
Salvation Army New Brunswick, New Jersey <i>Program of assistance to the indigent (ID#3859)</i>	25,000

**1978 grants
authorized**

School Health Services Program <i>Program to improve school-based child health services (ID#3239)</i>	
Colorado Department of Health Denver, Colorado	\$ 1,177,256
New York State Education Department Albany, New York	1,200,000
North Dakota State Department of Health Bismarck, North Dakota	1,200,000
Utah State Board of Education Salt Lake City, Utah	1,200,000
Scranton Primary Health Care Center, Inc. Scranton, Pennsylvania <i>Development of a primary care group practice (ID#4171)</i>	457,931
Seton Hall University, College of Nursing South Orange, New Jersey <i>Program in clinical primary care nursing (ID#3701)</i>	455,685
South County Hospital Development Corporation East Brunswick, New Jersey <i>Planning for ambulatory care in southern Middlesex County (ID#3935)</i>	2,040
University of Southern California, School of Medicine Los Angeles, California <i>A college-medical school consortium for disadvantaged premedical students (ID#4219)</i>	637,936
University of Tennessee, College of Medicine Memphis, Tennessee <i>Development of a regional primary care network (ID#3208)</i>	480,000
Tulane Medical Center New Orleans, Louisiana <i>Program to increase minority enrollment in medical schools (ID#4478)</i>	300,000
United Student Aid Funds, Inc. New York, New York <i>Guaranteed student loan program for medical, dental, and osteopathic students (ID#3982)</i>	1,000,000

	1978 grants authorized
United Way of Central Jersey, Inc. New Brunswick, New Jersey <i>Support for the 1978 campaign (ID#3861)</i>	\$ 175,000
United Way of Minneapolis Area Minneapolis, Minnesota <i>Planning effort for coordinated health services to seniors (ID#4516)</i>	64,000
The Urban Health Initiatives Program <i>Grants to plan and develop expanded ambulatory care services (ID#4665)</i>	
Charles R. Drew Postgraduate Medical School Los Angeles, California	600,000
Louisiana State University, New Orleans New Orleans, Louisiana	633,662
Montefiore Hospital and Medical Center Bronx, New York	608,365
Sisters of Mercy Health Corporation Farmington Hills, Michigan	640,650
Vanderbilt University, Center for Health Services Nashville, Tennessee <i>Program to improve rural community health services (ID#3838)</i>	404,630
Vanderbilt University, School of Medicine Nashville, Tennessee <i>Planning for a primary care center (ID#3673)</i>	249,979
Virginia Commonwealth University Richmond, Virginia <i>Administration of the Foundation's Hospital-Sponsored Ambulatory Dental Services Program (ID#4620)</i>	237,544
University of Washington, Seattle, School of Nursing Seattle, Washington <i>Graduate program in primary care nursing (ID#3802)</i>	649,413
University of Washington, Seattle, School of Public Health and Community Medicine Seattle, Washington <i>Study of a prepaid group practice patient education program (ID#4531)</i>	16,895
	<u>\$47,187,875</u>

**Summary of grants
authorized in previous years,
and with unpaid balances on January 1, 1978**

Adelphi University
Garden City, New York
Study of the role of nurses in primary care
1974—\$290,299

University of Alabama, School of Nursing
Birmingham, Alabama
*Primary care training program for emergency
department nurses (ID#4077)*
1977—\$235,966

Alderson-Broaddus College
Philippi, West Virginia
Physician's assistants program in primary care
(ID#2471)
1976—\$267,986

Allegheny General Hospital
Pittsburgh, Pennsylvania
*Primary care training program for emergency
department nurses (ID#3036)*
1977—\$268,409

American Fund for Dental Health
Chicago, Illinois
*Planning and implementation of a preventive
dental care program for school-age children*
(ID#3218)
1976—\$5,405,721

American Group Practice Foundation
Alexandria, Virginia
*Program to equip physicians with professional
management skills for group practices*
(ID#2128)
1976—\$499,825

American Health Planning Association
Alexandria, Virginia
*Technical assistance for health planning
agencies*
1975—\$360,000

American Medical Student Association
Foundation
Schaumburg, Illinois
*Field service in community health for health
science students (ID#2200)*
1976—\$318,840

Appalachian Regional Hospitals, Inc.
Hazard, Kentucky
*Outreach service for the care of mothers,
infants, and young children (ID#3040)*
1977—\$195,000; 1974—\$623,619

Arizona State University, College of Nursing
Tempe, Arizona
*Rural emergency medical care training program
with Maricopa County Hospital (ID#0944)*
1976—\$294,540

Aspira of America, Inc.
New York, New York
*Program to increase minority enrollment in
medical schools (ID#3041)*
1977—\$323,308

Association of American Medical Colleges
Washington, D.C.
*Program to strengthen the management
capabilities of academic medical centers*
(ID#3164)
1977—\$539,732

*Workshops on financial-aid programs for
medical students (ID#3804)*
1977—\$73,000

Association of Physician Assistant Programs
Washington, D.C.
*Program with the American Academy of
Physician's Assistants to foster training of
new health practitioners (ID#2485)*
1976—\$225,000

Association of Science-Technology Centers
Washington, D.C.

*Development of teaching materials in health
(ID#2635)*
1976—\$475,440

Association of University Programs in Health
Administration
Washington, D.C.

*Summer internship program in health services
management*
1975—\$332,817

Barrio Comprehensive Child Care Center
San Antonio, Texas

*Primary care service program for Mexican-
American children*
1975—\$526,791

Bedford-Stuyvesant Family Health Care
Center, Inc.
Brooklyn, New York

*Establishment of a primary care service
program in the inner city (ID#2787)*
1977—\$584,709

Bedford-Stuyvesant Restoration Corporation
Brooklyn, New York

Planning for a primary care health center
1975—\$138,100

Beth Israel Hospital
Boston, Massachusetts

*Development of a research capability in
ambulatory care*
1974—\$512,337

Boston City Hospital
Boston, Massachusetts

*Program to prepare physicians and nurses for
careers in general medical care*
1975—\$1,189,677

Boston University
Boston, Massachusetts

Studies in the quality of patient care
1975—\$519,729

Boys' Clubs of America
New York, New York

*Health services and education program
(ID#0953)*
1977—\$498,138

Town of Brookline, Massachusetts, Public
Schools
Brookline, Massachusetts

*Health program for infants and preschool
children (ID#2486)*
1976—\$712,058

Cabin Creek Health Association
Cabin Creek, West Virginia

*Community primary care health services
(ID#3039)*
1977—\$176,551

University of California, Davis
School of Medicine
Davis, California

*Program for the preparation and placement of
rural nurse practitioners (ID#2487)*
1976—\$455,323

University of California, Los Angeles
Los Angeles, California

*Planning and conducting an evaluation of the
Foundation's school health services program
(ID#3133)*
1976—\$619,715

University of California, Los Angeles
School of Medicine
Los Angeles, California

*Program to prepare physicians in primary care
(ID#2177)*
1976—\$547,625

*Study of health decision making among children
(ID#4126)*
1977—\$303,461

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

*Establishment of a health policy center
(ID#2455)*
1976—\$1,000,000

Program to prepare physicians and nurses in primary care
1975—\$656,344

Program to prepare faculty in emergency medicine
1975—\$715,917

Evaluation of the Foundation's Clinical Scholars Program
1975—\$207,403

Analysis of programs to prepare physicians for careers in primary medical care (ID#2378)
1976—\$149,417

Center for Research in Ambulatory Health Care Administration
Denver, Colorado

Financial management assistance program (ID#3057)
1977—\$353,094

University of Chicago
Chicago, Illinois

Study of the implementation of a national health insurance program
1975—\$252,422

Evaluation of the Foundation's Community Hospital Ambulatory Care Program (ID#3163)
1977—\$1,151,689

Children's Hospital Medical Center
Boston, Massachusetts

Training clinical faculty in child development (ID#2424)
1976—\$450,000

Children's Research Institute of California
Sacramento, California

Study of the California child health care program (ID#2788)
1976—\$286,750

Christian Action Ministry
Chicago, Illinois

Development of a community-wide health program
1975—\$295,200

La Clinica de la Raza
Oakland, California

Program to improve community health services (ID#3124)
1977—\$267,185

La Clinica del Pueblo de Rio Arriba
Tierra Amarilla, New Mexico

Development of a mother and infant care training program
1974—\$134,765

Clinical Scholars Program

National program to prepare young physicians for leadership roles in medical care (ID#2493)

University of California, Los Angeles,
School of Medicine
Los Angeles, California
1977—\$714,232; 1974—\$856,103

University of California, San Francisco,
School of Medicine and Stanford
University, School of Medicine
San Francisco, California
1977—\$799,673

Columbia University, College of Physicians
and Surgeons
New York, New York
1977—\$187,745; 1974—\$829,343

George Washington University, School of
Medicine
Washington, D.C.
1977—\$194,502; 1974—\$860,670

Johns Hopkins University, School of
Medicine
Baltimore, Maryland
1977—\$225,217

McGill University, McIntyre Medical
Sciences Center
Montreal, Quebec
1977—\$799,997

Clinical Scholars Program (*continued*)

University of North Carolina, School of
Medicine
Chapel Hill, North Carolina
1977—\$800,000

University of Pennsylvania, School of
Medicine
Philadelphia, Pennsylvania
1977—\$799,478

University of Washington, Seattle, School of
Medicine
Seattle, Washington
1977—\$600,147; 1974—\$798,230

Yale University, School of Medicine
New Haven, Connecticut
1977—\$799,792

Educational development funds
1974—\$770,647

University of Colorado, School of Medicine
Denver, Colorado

*Center for the Prevention and Treatment of
Child Abuse and Neglect*
1975—\$1,162,655

*Planning of a new medical curriculum to
prepare non-M.D. primary care practitioners*
1974—\$155,400

Columbia University
New York, New York

*Public policy program in health services and
manpower by the Center for the Conservation
of Human Resources (ID#2889)*
1976—\$333,773

Community Hospital-Medical Staff Group
Practice Program

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

Bethesda Lutheran Hospital
St. Paul, Minnesota
1976—\$499,790

Community Hospital-Medical Staff Group
Practice Program (*continued*)

Crittenden Memorial Hospital
West Memphis, Arkansas
1976—\$494,029

Durham County Hospital Corporation
Durham, North Carolina
1976—\$499,916

Griffin Hospital
Derby, Connecticut
1976—\$500,000

Hadley Memorial Hospital
Washington, D.C.
1976—\$457,006

Hollywood Presbyterian Hospital—
Olmsted Memorial
Los Angeles, California
1976—\$499,981

Holston Valley Community Hospital
Kingsport, Tennessee
1976—\$466,197

Holy Cross Hospital
Salt Lake City, Utah
1976—\$443,308

Humboldt General Hospital
Winnemucca, Nevada
1977—\$500,000

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

La Crosse Lutheran Hospital
La Crosse, Wisconsin
1977—\$244,547

Lakewood Hospital
Lakewood, Ohio
1976—\$498,020

Lovelace Center for the Health Sciences
Albuquerque, New Mexico
1976—\$374,853

Community Hospital-Medical Staff Group
Practice Program (*continued*)

Lutheran Charities Association of
St. Louis, Missouri
St. Louis, Missouri
1976—\$475,105

Lutheran General and Deaconess Hospitals
Park Ridge, Illinois
1976—\$500,000

Lutheran Hospital and Medical Center
Wheat Ridge, Colorado
1976—\$500,000

Lutheran Hospital of Maryland, Inc.
Baltimore County, Maryland
1976—\$496,170

The Memorial Hospital
Worcester, Massachusetts
1976—\$475,00

Memorial Hospital of Alamance County, Inc.
Burlington, North Carolina
1976—\$487,944

Memorial Hospital of Phoenix
Phoenix, Arizona
1976—\$498,942

Mercy Hospital
Springfield, Massachusetts
1976—\$490,000

Mercy Hospital
Watertown, New York
1977—\$500,000

Mercy Hospital, Inc.
Baltimore, Maryland
1976—\$499,985

Nashua Hospital Association
Nashua, New Hampshire
1977—\$500,000

Community Hospital-Medical Staff Group
Practice Program (*continued*)

New York Infirmery
New York, New York
1977—\$500,000

Portland Adventist Hospital
Portland, Oregon
1976—\$492,658

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

Richmond Memorial Hospital
Richmond, Virginia
1976—\$497,000

St. Aloisius Hospital
Harvey, North Dakota
1976—\$499,533

St. Francis Hospital
Honolulu, Hawaii
1976—\$491,030

St. Francis Hospital
Topeka, Kansas
1976—\$446,296

St. Joseph Hospital
Lancaster, Pennsylvania
1976—\$497,620

St. Joseph's Hospital and
Medical Center
Paterson, New Jersey
1976—\$500,000

St. Lawrence Hospital
Lansing, Michigan
1977—\$491,993

St. Luke's Hospital
Aberdeen, South Dakota
1976—\$498,169

St. Margaret Memorial Hospital
Pittsburgh, Pennsylvania
1976—\$401,944

Community Hospital-Medical Staff Group
Practice Program (*continued*)

St. Vincent Hospital and Medical Center
Portland, Oregon
1977—\$499,727

St. Vincent's Hospital
Billings, Montana
1976—\$499,709

San Bernardino County Medical Center
San Bernardino, California
1977—\$499,967

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

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

Herbert J. Thomas Memorial Hospital
Association
South Charleston, West Virginia
1976—\$485,456

Waterville Osteopathic Hospital
Waterville, Maine
1977—\$467,994

Wausau Hospital, Inc.
Wausau, Wisconsin
1977—\$456,117

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

Charles S. Wilson Memorial Hospital
Johnson City, New York
1976—\$469,361

University of Connecticut Health Center
Hartford, Connecticut
*Development of a school-based health care
program*
1975—\$618,557

Cornell University, Medical College
New York, New York

Planning for ambulatory care
1973—\$499,000

*Study of doctor-patient communications
(ID#2473)*
1976—\$243,091

*Administration of the Foundation's Municipal
Health Services Program (ID#3791)*
1977—\$208,390

Dartmouth College, Medical School
Hanover, New Hampshire

*Development of a primary care service and
training program*
1974—\$1,154,685

Dental Training Program

*Grants to dental schools to train dentists in the
care of the handicapped*

University of Alabama, School of Dentistry
Birmingham, Alabama
1973—\$432,651

University of California, Los Angeles,
School of Dentistry
Los Angeles, California
1973—\$435,351

Columbia University, School of Dental and
Oral Surgery
New York, New York
1973—\$357,842

University of Kentucky, College of Dentistry
Lexington, Kentucky
1973—\$420,746

University of Maryland, School of Dentistry
Baltimore, Maryland
1973—\$466,992

University of Michigan, School of Dentistry
Ann Arbor, Michigan
1973—\$394,481

University of Nebraska, School of Dentistry
Lincoln, Nebraska
1973—\$466,930

Dental Training Program (*continued*)

New York University, College of Dentistry,
The Brookdale, Long Island Dental Center
New York, New York
1973—\$415,940

University of Tennessee, College of Dentistry
Memphis, Tennessee
1973—\$469,876

University of Washington, Seattle,
School of Dentistry
Seattle, Washington
1973—\$441,509

Duke University, School of Medicine
Durham, North Carolina

*Faculty training and research program in family
medicine*
1975—\$802,885

East Kentucky Health Services Center, Inc.
Hindman, Kentucky

Expansion of a nonprofit rural group practice
1975—\$344,050

ECCO Family Health Center
Columbus, Ohio

*Expansion of an ambulatory health care services
program (ID#2911)*
1976—\$392,987

Educational Testing Service
Princeton, New Jersey

*Planning and development of a program to
evaluate the Foundation's dental training
program for the care of the handicapped*
1974—\$300,530

Emergency Medical Response Program

*Grants to communities developing regional
systems*

Hunterdon County Board of Chosen
Freeholders
Flemington, New Jersey
1974—\$319,453

Emergency Medical Response Program
(*continued*)

Idaho Department of Environmental and
Community Services
Boise, Idaho
1973—\$399,851

King County Board of Commissioners
Seattle, Washington
1973—\$362,000

The Navajo Health Authority
Window Rock, Arizona
1973—\$388,577

New Jersey State Department of Health
Trenton, New Jersey
1973—\$399,340

San Francisco, Department of Public Health
San Francisco, California
1973—\$338,330

Municipality of San Juan
San Juan, Puerto Rico
1973—\$212,640

University of Utah
Salt Lake City, Utah
1973—\$340,432

University of Virginia
Charlottesville, Virginia
1973—\$322,626

Family Practice Faculty Fellowship Program

*Program to prepare physicians for academic
careers in family practice*

University of Iowa, College of Medicine
Iowa City, Iowa
1977—\$781,051

University of Utah, College of Medicine
Salt Lake City, Utah
1977—\$587,601

University of Washington, Seattle,
School of Medicine
Seattle, Washington
1977—\$623,832

University of Florida, College of Medicine
Gainesville, Florida

Primary care training and service program
1975—\$870,371

The Foundation Center
New York, New York

*Data collection and analysis on the foundation
field (ID#3486)*
1977—\$150,000

Foundation for Comprehensive Health Services
Sacramento, California

*Primary care delivery for rural California
(ID#3789)*
1977—\$475,000

Frontier Nursing Service
Wendover, Kentucky

Expansion of a nurse-run primary care network
1975—\$508,360

Fund for the City of New York
New York, New York

*Program to improve the quality of care in
municipal hospitals (ID#2708)*
1976—\$150,000

Genesee Hospital
Rochester, New York

Expansion of an ambulatory care program
1973—\$187,000

George Washington University
Washington, D.C.

*Seminar program for government health staff
professionals (ID#3117)*
1977—\$575,000

George Washington University, School of
Medicine
Washington, D.C.

*Program to train physicians and nurses in
primary care (ID#2474)*
1977—\$24,492; 1973—\$600,000

Georgetown University, Graduate School
Washington, D.C.

*Planning and development of a health policy
center*
1974—\$1,328,734

*Completion of a monograph on the Legis 50
program to strengthen the role of state
legislatures in health (ID#4132)*
1977—\$14,350

Georgetown University, School of Medicine
Washington, D.C.

*Administrative grant for senior program
consultant services (ID#3903)*
1977—\$157,985

Analysis of health policy issues (ID#3805)
1977—\$163,364

Group Health Foundation
Washington, D.C.

*Program with the University of Pennsylvania to
prepare managers for prepaid group practices*
1974—\$48,000

*Program to equip physicians with professional
management skills for HMOs (ID#2107)*
1976—\$299,585

Harvard University, Medical School
Boston, Massachusetts

*Program to train physicians for primary medical
care (ID#3089)*
1977—\$733,788; 1973—\$337,644

Harvard University, School of Public Health
Cambridge, Massachusetts

*Support of the School of Public Health
(ID#3107)*
1976—\$1,000,000

Health Care Institute, Inc.
Detroit, Michigan

*Development of a primary care service and
education program (ID#2042)*
1977—\$176,820

- Health Care Management Systems, Inc.
La Jolla, California
Development of information systems for ambulatory care
1974—\$396,152
- Hospital Research and Educational Trust
Chicago, Illinois
Study of the role of public hospitals in ambulatory care (ID#2412)
1976—\$325,000
- Hyde Park-Kenwood Community Health Center, Inc.
Chicago, Illinois
Development of a primary care health services program (ID#3269)
1977—\$238,825
- Indiana University Foundation
Bloomington, Indiana
Program to prepare clinical nursing faculty in primary care (ID#3844)
1975—\$297,653
- The Johns Hopkins Hospital
Baltimore, Maryland
Administration of the Foundation's Municipal Health Services Program (ID#4323)
1977—\$189,000
- The Johns Hopkins University
Baltimore, Maryland
School of health services training program
1975—\$3,000,000
- The Johns Hopkins University, Center for Health Services Research and Development
Baltimore, Maryland
Evaluation of the Foundation's perinatal program
1974—\$2,013,220
- The Johns Hopkins University, School of Medicine
Baltimore, Maryland
Program to prepare faculty in emergency medicine
1974—\$754,272
- Study of evaluation tools to select medical school applicants (ID#2714)*
1976—\$130,473
- Joint Commission of Accreditation of Hospitals
Chicago, Illinois
Ambulatory health care services accreditation program (ID#2428)
1976—\$338,165
- Lake Erie College
Painesville, Ohio
Program with the Cleveland Clinic to train physician's assistants
1975—\$526,853
- Massachusetts Institute of Technology, Alfred P. Sloan School of Management
Cambridge, Massachusetts
Program to improve primary care team skills
1974—\$440,449
- University of Massachusetts
Worcester, Massachusetts
Program to improve methods for evaluating the quality of health care services
1975—\$225,191
- Mayo Foundation
Rochester, Minnesota
Development of a primary care satellite network (ID#3809)
1977—\$350,000
- The Medical Center at Princeton
Princeton, New Jersey
Facility expansion (ID#4303)
1977—\$20,000
- Medical Center of Gary, Inc.
Gary, Indiana
Program to train family health practitioners
1975—\$300,000
- Medical Mission Sisters
Philadelphia, Pennsylvania
Program of primary care services for rural and urban communities (ID#3119)
1977—\$257,920

Meharry Medical College
Nashville, Tennessee

Faculty development program (ID#3216)
1977—\$2,500,000

University of Michigan, School of Public Health
Ann Arbor, Michigan

Program on health manpower development
(ID#2479)
1976—\$424,911

Middlesex General Hospital
New Brunswick, New Jersey

Support for the Hospital's Family Health Center
(ID#4063)
1977—\$144,200

University of Mississippi Medical Center
Jackson, Mississippi

Program to increase minority enrollment in
medical schools (ID#2296)
1976—\$433,705

University of Missouri, Kansas City,
School of Medicine
Kansas City, Missouri

Program to prepare physicians and nurses for
careers in general medical care
1974—\$901,670

Montefiore Hospital and Medical Center
Bronx, New York

Training physicians and other professionals in
team practice
1975—\$584,877

Development of a child care program with the
Martin Luther King Health Center
1975—\$579,530

Morehead Clinic
Morehead, Kentucky

Development of primary care satellite clinics in
northeast Kentucky
1974—\$245,860

Morehouse College
Atlanta, Georgia

Program to increase minority enrollment in
medical schools (ID#2716)
1976—\$471,225

Mount Sinai School of Medicine
New York, New York

Program to develop primary care services for
children (ID#3792)
1977—\$150,000

Administrative grant for senior program
consultant services (ID#3235)
1977—\$183,803

National Academy of Sciences, Institute of
Medicine
Washington, D.C.

Fellowships in health policy program
1975—\$1,215,040

Support of the Institute of Medicine
1975—\$850,000

National Academy of Sciences, National
Research Council
Washington, D.C.

Administration of the Foundation's regional
emergency medical response program
1975—\$360,000

Support of the Academy's Emergency Medical
Services Committee
1975—\$274,200

National Association of Health Services
Executives
New York, New York

Program to assist minority health administrators
1975—\$232,862

National Board of Medical Examiners
Philadelphia, Pennsylvania

Program to complete the development of a
computer-based license examination
(ID#2576)
1977—\$475,000

National Bureau of Economic Research
New York, New York

Research and training program in health economics (ID#3081)
1976—\$274,091

National Chamber Foundation
Washington, D.C.

Program to study national health care issues (ID#3964)
1977—\$5,000

National 4-H Council
Chevy Chase, Maryland

Health education program development (ID#2754)
1977—\$201,308

National Fund for Medical Education
Hartford, Connecticut

Support of summer programs for minority premedical students (ID#2583)
1976—\$160,000

National League for Nursing
New York, New York

Summer study program in health policy (ID#3121)
1977—\$145,684

National Medical Fellowships
New York, New York

Scholarship program for minority medical students (ID#2929)
1976—\$1,000,000

National Rural Center
Washington, D.C.

Analysis of the financial needs of service programs in rural areas (ID#3362)
1977—\$234,951

New Brunswick Tomorrow
New Brunswick, New Jersey

City of New Brunswick redevelopment program (ID#3614)
1977—\$1,500,000

New England Medical Center Hospital
Boston, Massachusetts

Study of decision making in the health care system
1975—\$149,880

College of Medicine and Dentistry of
New Jersey
Newark, New Jersey

Planning for training and service programs
1973—\$493,000

Program to prepare minority students for preprofessional careers in medicine and dentistry (ID#2795)
1976—\$264,592

College of Medicine and Dentistry of New
Jersey, Rutgers Medical School
Piscataway, New Jersey

Program to strengthen family physician training in New Jersey (ID#2636)
1976—\$450,340

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

Administration of the Foundation's rural community practice models program
1975—\$2,074,081

Administrative grant for senior program consultant services (ID#3634)
1976—\$82,465

Study of rural health care initiatives (ID#4230)
1977—\$20,369

Nurse Faculty Fellowships Program

Program to equip nursing faculty with primary clinical skills

University of Colorado Medical Center,
School of Nursing
Denver, Colorado
1975—\$675,000

Indiana University Foundation
Indianapolis, Indiana
1975—\$675,000

Nurse Faculty Fellowships Program (*continued*)

University of Maryland, School of Nursing
Baltimore, Maryland
1975—\$675,000

University of Rochester, School of Nursing
Rochester, New York
1975—\$665,054

Vanderbilt University, School of Nursing
Nashville, Tennessee
Administration of the Program
1975—\$282,236

University of Oregon Health Sciences Center,
School of Nursing
Portland, Oregon

*Data collection and analysis of the Foundation's
Nurse Faculty Fellowships Program
(ID#3296)*
1976—\$123,947

Pace University, Graduate School of Nursing
New York, New York

*Graduate program in primary care nursing
(ID#2029)*
1977—\$162,550

University of Pennsylvania
Philadelphia, Pennsylvania

*Study of chronic care, in association with
Middlesex General Hospital, New Brunswick,
New Jersey (ID#3217)*
1977—\$310,105

University of Pennsylvania, School of
Dental Medicine
Philadelphia, Pennsylvania

*Dental care program for school-age children in
rural Pennsylvania (ID#3837)*
1977—\$547,000; 1975—\$2,023,854

University of Pennsylvania, School of Medicine
Philadelphia, Pennsylvania

*Program to train physicians for careers in
primary care (ID#1499)*
1977—\$401,765

Perinatal Program

*Grants for the development of regional high-risk
pregnancy networks*

Arizona Medical Association Foundation
Phoenix, Arizona
1974—\$2,200,000

Case Western Reserve University,
School of Medicine
Cleveland, Ohio
1974—\$2,225,000

Columbia University, College of
Physicians and Surgeons
New York, New York
1974—\$2,199,925

Charles R. Drew Postgraduate
Medical School
Los Angeles, California
1974—\$2,200,000

Professional Staff Association of Los Angeles
County—Harbor General Hospital
Torrance, California
1974—\$2,200,000

University of Southern California
Los Angeles, California
1974—\$2,198,721

State University of New York,
Upstate Medical Center
Syracuse, New York
1974—\$2,176,354

University of Texas, Health Sciences Center
Dallas, Texas
1974—\$2,200,000

University of Pittsburgh, School of Medicine
Pittsburgh, Pennsylvania
Expansion of a child care program (ID#2738)
1977—\$35,568

Posen-Robbins School District
Oak Park, Illinois
*Planning and development of a school-based
health care system (ID#3305)*
1977—\$467,527

Princeton Area United Community Fund
Princeton, New Jersey
Annual contribution (ID#3434)
1977—\$27,500

The Rand Corporation
Santa Monica, California
*Evaluation of regional emergency medical
response systems (ID#3122)*
1977—\$197,824
*Planning and conducting the evaluation of a
preventive dental care program for school-
age children (ID#2890)*
1976—\$771,611

Rio Grande Federation of Health Centers
San Antonio, Texas
*Support of a technical assistance program
(ID#2538)*
1976—\$243,180

University of Rochester, School of
Medicine and Dentistry
Rochester, New York
*Program to train physicians for careers in
primary care (ID#3090)*
1977—\$643,760; 1973—\$1,395,000
*Administration of the Foundation's Community
Hospital Ambulatory Care Program
(ID#3751)*
1977—\$567,637

Roxbury Dental and Medical Group
Roxbury, Massachusetts
Support of an urban group practice (ID#3649)
1977—\$106,000

Rural Health Care Association
Denver, Colorado
*Strengthening rural primary care practices in
Colorado (ID#4100)*
1977—\$95,868

Rural Practice Project
*Program to develop nonprofit group medical
practices in rural areas*

Associated Community Action of the North
East Adirondack Region, Inc.
Willsboro, New York
1975—\$480,463

Bakersville Community Medical Clinic, Inc.
Bakersville, North Carolina
1975—\$288,269

Dunes Family Health Care, Inc.
Reedsport, Oregon
1975—\$460,457

Family Health Care, Inc.
Tooele, Utah
1975—\$443,897

Mille Lacs Family Health Foundation, Inc.
Onamia, Minnesota
1975—\$483,970

Mission Valley Health Services Center, Inc.
St. Ignatius, Montana
1975—\$471,616

New River Health Association, Inc.
Scarbro, West Virginia
1975—\$412,331

Northeast Washington County Community
Health, Inc.
Plainfield, Vermont
1975—\$403,682

Palmetto Family Health Care Center, Inc.
Pacolet, South Carolina
1975—\$394,075

Peninsula Family Practice, Inc.
Leland, Michigan
1975—\$463,062

Roanoke-Amaranth Community Health
Group, Inc.
Jackson, North Carolina
1975—\$499,500

Rural Practice Project (*continued*)

- Southern Indiana Community Health Care, Inc.
Paoli, Indiana
1975—\$398,932
- Surry County Family Health Group, Inc.
Surry, Virginia
1975—\$499,406
- Balance of appropriation
1975—\$1,300,340
- University of Southern California,
School of Medicine
Los Angeles, California
Study of the role of medical specialists in primary care
1975—\$1,403,644
- Stanford University Medical Center
Stanford, California
Support of a research and training program in ambulatory pediatrics (ID#3229)
1977—\$272,498
Study of the training of new health practitioners in primary care, with the University of California, Davis (ID#2944)
1976—\$198,573
- County of Suffolk, New York
Hauppauge, New York
Study of a regionalized emergency medical response system (ID#4160)
1977—\$146,317
- Tennessee Department of Public Health
Nashville, Tennessee
Development of a primary care center in Hamilton County
1975—\$417,346
- University of Tennessee, College of Medicine
Memphis, Tennessee
Development of a regional primary care network
1974—\$801,504
- University of Texas, Austin
Austin, Texas
Study of rural health service programs (ID#2285)
1976—\$499,709
- University of Texas Medical Branch at Galveston
Galveston, Texas
Primary care services for school-age children (ID#2763)
1976—\$1,171,960
Program to increase minority enrollment in medical schools (ID#2422)
1976—\$339,268
- Tulane Medical Center
New Orleans, Louisiana
Program to increase minority enrollment in medical schools
1974—\$618,492
- Tuskegee Institute
Tuskegee, Alabama
Development of a primary care health service program in rural Alabama
1975—\$1,419,880
- United States Conference of Mayors
Washington, D.C.
Dissemination of health services information (ID#4069)
1977—\$75,000
Analysis of the financial needs of service programs in inner-city areas (ID#3994)
1977—\$234,951
- Vanderbilt University, Center for Health Services
Nashville, Tennessee
Program to improve rural community health services
1975—\$312,780

Vanderbilt University, School of Nursing
Nashville, Tennessee

*Administrative grant for senior program
consultant services (ID#3641)*

1976—\$99,991

*Administration of the Nurse Faculty Fellow-
ships Program (ID#3787)*

1977—\$94,100

Washington University, School of Medicine
St. Louis, Missouri

*Development of an ambulatory care teaching
practice (ID#2484)*

1976—\$495,400

University of Washington, Seattle
Seattle, Washington

*Evaluation of the Foundation's Community
Hospital Ambulatory Care Program
(ID#4016)*

1977—\$287,438

University of Washington, Seattle,
School of Medicine
Seattle, Washington

Study of the training of new health practitioners
1975—\$520,351

*Program to train physicians for careers in
primary care (ID#4272)*

1977—\$554,636; 1976—\$96,073

University of Wisconsin
Madison, Wisconsin

*Study of new health practitioners in
ambulatory care*

1976—\$269,230

*Study of new health practitioners in
ambulatory care*

1974—\$217,760

Yale University, School of Medicine
New Haven, Connecticut

*Research on the structure and quality of
primary pediatric care (ID#4170)*

1977—\$21,965; 1973—\$376,000

Secretary's
report

Secretary's report 1978*

Staff Changes

During 1978, three senior advisers completed their assignments with the Foundation: John C. Beck, M.D., Director of The Robert Wood Johnson Clinical Scholars Program; Ann A. Bliss, Senior Program Consultant; and Robert H. Kalinowski, M.D., Senior Program Consultant.

Dr. Beck joined the Foundation in 1973 and had primary responsibility for developing and operating the Foundation's Clinical Scholars Program. He has accepted a faculty appointment at the University of California, Los Angeles, School of Medicine. Mrs. Bliss came to the Foundation in 1973 and played a major role in advising on the development of the Foundation's service and training programs involving nurses in expanded roles for patient care. She is a Clinical Associate Professor, Department of Medicine, Yale University School of Medicine. Dr. Kalinowski also began his service to the Foundation in 1973 and was of enormous assistance in the development of university-related primary care service and training programs. He is practicing anesthesiology in Atlanta, Georgia.

Marilyn C. Farray, Program Officer, resigned her position with the Foundation to enter law school at Yale University. Ms. Farray joined the Foundation staff in 1975 and was active in the development of the Foundation's Municipal Health Services Program.

Charles R. Buck, Jr., Sc.D., was appointed in January of 1978 to be Director of the Municipal Health Services Program. He guided this program through its initial stage of making grants to five of the nation's largest cities to help them in providing needy urban neighborhoods with a ready source of general medical care. Dr. Buck left the Foundation in January 1979 to become Secretary of Health of the State of Maryland. Succeeding Dr. Buck as Senior Program Consultant directing the Municipal Health Services Program is Carl J. Schramm, Ph.D., J.D. Dr. Schramm is an Assistant Professor in the Department of Health Services Administration, School of Hygiene and Public Health of The Johns Hopkins University. He received his doctorate from the University of Wisconsin and his law degree from Georgetown University Law Center.

M. Alfred Haynes, M.D., was appointed Coordinator of the Foundation's Clinical Scholars Program in March 1978. Dr. Haynes is President of Instudhess, Inc. and has previously served as Chairman, Department

**To present as up-to-date a picture of staffing as possible, this report covers the period through February 15, 1979.*

of Community Medicine, and Associate Dean, Charles R. Drew Post-graduate Medical School, Los Angeles, California.

Joining the Foundation in June 1978 as a Senior Program Consultant was Robert J. Haggerty, M.D. Dr. Haggerty will direct the Foundation's General Pediatrics Academic Development Program. He is a Visiting Professor of Pediatrics, Harvard Medical School, Professor of Public Health, Harvard School of Public Health, and Senior Associate in Medicine, Children's Hospital Medical Center, Boston, Massachusetts.

In June 1978 John J. Salley, D.D.S., Ph.D., was appointed Senior Program Consultant to administer the Foundation's hospital-sponsored dental program. Dr. Salley is Associate Vice President for Research and Graduate Affairs and Professor of Oral Pathology, School of Dentistry and School of Medicine at Virginia Commonwealth University, Richmond, Virginia.

Martita M. Marx, Dr.P.H. joined the staff as a Program Officer in the fall of 1978. Dr. Marx received her doctoral degree from the University of California, Los Angeles and previously served as a consultant in applied research with Practical Concepts, Inc. of Washington, D.C.

Marc E. Voyvodich came to the Foundation as a Program Officer in October from the Blue Cross Association in Chicago, Illinois, where he worked as Assistant to the President. Mr. Voyvodich is a graduate of Colgate University and received his Master of Arts in Health Care Administration from George Washington University.

Eleanor O'D. Nealon joined the Foundation's Communications Office in May as an Information Services Officer. Ms. Nealon previously worked as a freelance writer in Washington, D.C., and is a former Director of Public Relations for the Georgetown University Medical Center.

Board Activities

The Board of Trustees met six times in 1978 to conduct business, review proposals, and appropriate funds for the implementation of new programs. In addition, the Policy, Finance, and Audit Committees met as required to consider and prepare recommendations to the Board.

J. Warren Wood, III
Secretary and General Counsel

Application for grants

The Robert Wood Johnson Foundation is a private philanthropy interested in improving health in the United States. It is concentrating its resources on a few well defined needs in health: the need to improve access to health care; the need to improve the performance of health care services in order to ensure quality care; and the need to develop mechanisms for the objective analysis of public policies in health.

The Foundation will encourage and support only those projects and programs which show promise of having significant regional and national impact, with one exception, which will be local projects in the New Brunswick, New Jersey area, where the Foundation was established.

The initial policy guidelines that have been established by the Foundation's board of trustees will normally preclude support for the following types of activities:

1. Endowment, construction, equipment, or general operating expenses.
2. Biomedical research.
3. International activities or programs and institutions in other countries.
4. Direct support to individuals.

Also, the Foundation will not be able to support programs concerned with a particular disease or with broad public health problems such as drug abuse, alcoholism, mental health, population dynamics, or the effects of environmental contamination on health. The Foundation's inability to support such programs in no way implies a failure to recognize their importance, but is simply a consequence of the conviction that to make significant progress in the three problem areas described will depend in large measure on the Foundation's ability to concentrate its resources on them.

There are no formal grant application forms. Applicants should prepare a letter which states briefly and concisely the objectives and significance of the project, the program design, 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:

Miss Margaret E. Mahoney, Vice President
The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, New Jersey 08540.

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