

The
Robert Wood Johnson
Foundation
Annual Report 1981

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January 1, 1981 through December 31, 1981

The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, New Jersey 08540

Library of Congress Card Number 73-80807

Charts and figures by Bruce Campbell Design
Illustrations by Jeff Cornell
Printed in the United States of America
by Wm. F. Fell Company, Philadelphia

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Introduction



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

Robert Wood Johnson devoted his life to public service and to building a family-owned business into a major international corporation. An astute businessman, a statesman, soldier, and patriot, General Johnson devoted much of his life to improving the world around him. He had a tenacity of spirit that enabled him to accomplish many of his goals, but he also planned for the

long-range fulfillment of other objectives that could not be achieved in one man's lifetime.

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

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

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The
president's
statement

**Medical care and health status:
do they relate to one another?**

This year's annual report is a punctuation mark: we have just completed our tenth year as a nationally oriented foundation working in the field of health and medical affairs. The punctuation mark I have in mind is a dash—an extension of last year's report, in which I described some of the results of almost two years of staff study looking both backward and forward in our program field.

Last year I described the results of our efforts to determine how well medical care was being delivered and how medicine and health care were regarded by the public. We tried to place this information in a broader context—the economic setting in which the nation found itself, and the way Americans felt about their social institutions, their lives and their futures. Our major attention, however, was directed at using this information in an attempt to predict the problems which might face medicine and health care and those who would need it in the first half of this new decade.

From this exercise we concluded that the 1980's would be very different from the several decades preceding it. It was our belief that our medical and health care institutions were going to have to adapt to a series of significant constraints—both economic and attitudinal—to be most effective during more difficult times.

On the basis of those studies, we made some adjustments in our areas of program thrust to try and be responsive to needs as we heard and understood them. First, while maintaining our efforts to help all Americans find appropriate access to general medical care, we narrowed our focus. We are now limiting our attention to those remaining groups that have continued to lag behind during a decade in which most people made impressive improvements in their access to medical care. A growing concern here—corollary to the anticipated economic constraints nationally—is whether the ranks of these underserved groups will swell as public expenditures shrink.

Second, recognizing the overwhelming public concerns with the economy, and the general perception that health and medical care were gobbling up too many scarce and precious dollars, we indicated we would pay particular attention to programs specifically designed to make health care more efficient, effective, and less costly.

And third, we said that we would try to encourage groups that were focusing their attention on how medical care could help more people return swiftly to maximum attainable function at work, or at school, or independent living.

A year later, I believe our prognostications are still on target. However, 12 months of experience with these new objectives prompts me to address in greater detail that third area above—the focus on people's functional status. First, because, despite the simplicity of the concept, it has been difficult to articulate as clearly as we would wish. Second, because this last year's experience has convinced me that getting better answers about what personal medical care actually does or can do to decrease disability or dependency is one of the most important questions for those concerned with health and medical care to tackle during this decade.

Why is this apparently simple question so important? Isn't this what medical care is all about anyway? The answer is "yes—but . . ." for we are unable to answer it with sufficient precision to allow logical decision making about many aspects of medicine and health care.

It is now being recognized that the influence of personal physicians on a society's health cannot be measured except in the most gross sense by existing morbidity or mortality statistics. As a matter of fact, increasingly such statistics are almost wholly unrevealing as to what it is that the physician does or seeks to do most of the time. Thus, incredible as it may seem, there is no real way to measure the human benefits of most of our nation's multi-billion-dollar health expenditures. As a consequence, some critics of medicine have transmuted the absence of indicators to mean that medical care doesn't do very much.

With this sort of non-logic abroad in the land, and in a period of economic constraint and rising health costs and expenditures, the absence of adequate measures of what the personal health care system does to improve human welfare has put us in a monumental bind. We simply lack the data needed for rational discussions about the direction, magnitude, and nature of our major investments in medical and health care nationally.

What medical care does for individuals and how this is reflected in the aggregate is a principal part of the domain of the personal health care system. In the public mind, improvements in medical care have traditionally been synonymous with decreases in death rates and increased life expectancy. However, the enormous successes in controlling the major microbial killers of the past have led health professionals to shift from the prevention of death to spending most of their time on efforts to restore individuals who are physically or mentally below par to their maximum potential function.

As shown in Figure 1, between 1954 and 1968 there was a 14-year period with little change in age-adjusted death rates. However, since then, something has happened almost without us realizing it. Since 1968 we have seen a steady reduction in deaths due to a wide group of diseases as dissimilar as coronary artery disease and peptic ulcers—indeed, a drop in death rates for 11 of the 15 major killers of Americans. We do not know the reasons for this, but it has occurred.

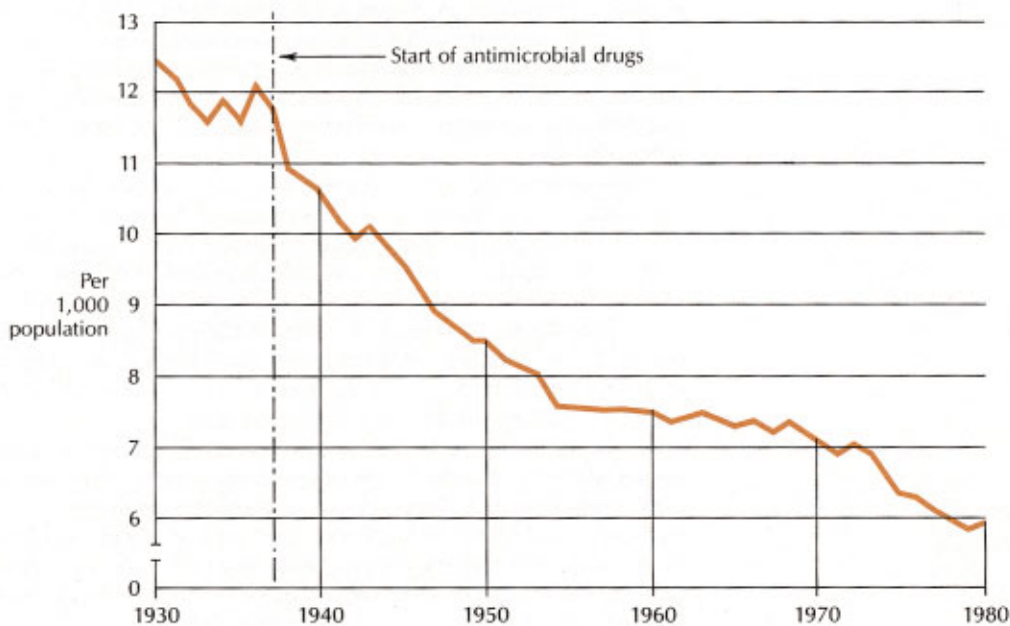
We are thus afforded the luxury of expanding our area of concern beyond simply preserving or extending life to include efforts aimed at helping individuals to use their full capacities in daily living. Yet the kind of statistics currently used to track the progress of our personal health care system do not monitor with any sensitivity the changes that are reflected by our new preoccupations. Death rates—such as we have just examined—as well as morbidity data and other sets of current statistics do not measure the impact of what physicians and other health professionals spend their time doing.

Let me give a simple example that makes my point. Thanks to modern medicine, many individuals with serious arthritis can be helped to remain or become sufficiently pain-free and mobile to lead independent, productive lives. But nowhere on the scorecard do these important gifts to suffering people, or the physician's role in making them possible, come to light. Thus it is increasingly evident that we must replace our blunt, gross statistics with more sensitive yardsticks that more accurately reflect what medical care can do to restore people to fuller functioning.

All of this has bearing on the skyrocketing costs of medical care in recent years. As shown in Figure 2, one of the most important reasons

Figure 1

Age-Adjusted Death Rates United States, 1930-78

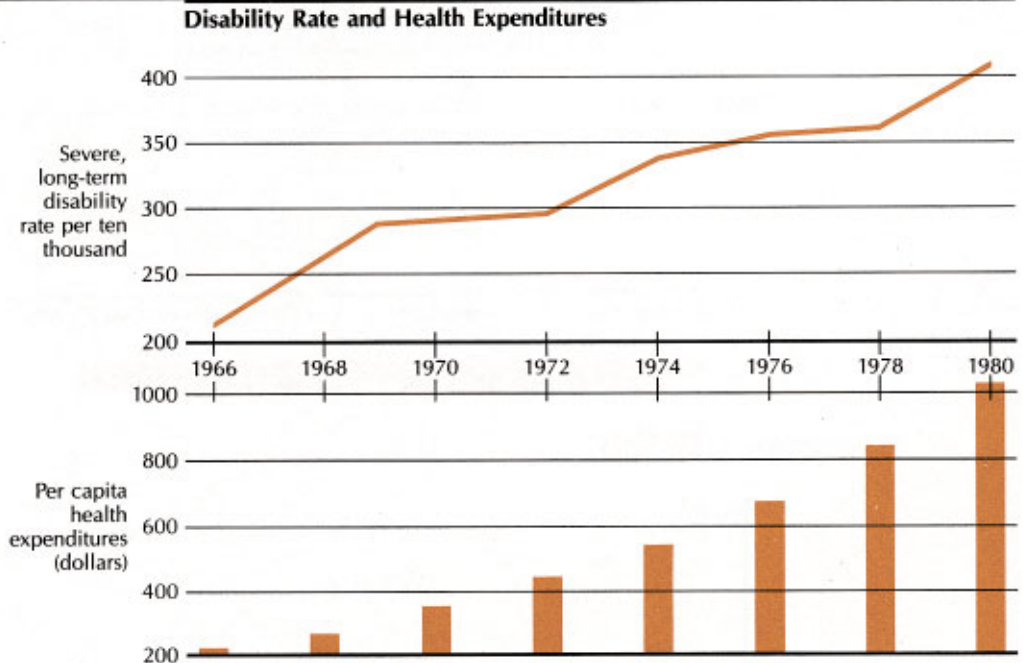


for these escalating costs is the rapidly increasing number of people with chronic problems that cripple or impair personal productivity but do not kill, or do not do so swiftly or with certainty. Physicians nowadays spend most of their time working with people with these burdens of long-term chronic illness. These problems and efforts to alleviate them account for much of the costs, both human and economic, of medical care today, and we need to know how skillful the system is in preventing disability or restoring people to independent living if we are to make wise allocation of talent and resources.

Some hold the view that this set of circumstances — lower death rates accompanied by rising numbers of people who are impaired and unable to participate fully in our society — is a clear indication of the need for more fundamental biologic answers about our major health problems. I agree with this view.

In the final analysis, our goal has to be finding ways to prevent senile dementia, or arteriosclerosis, or cancer, so that all of us can live out our full biologic life span with minimal deterioration. It is a potentially attainable goal and we should keep it ever before us and invest heavily in the fundamental sciences which may make it a reality. But in the interim,

Figure 2



and in parallel, we can also do much more for those who are the tragic losers to our present ignorance.

As shown in Figure 3, every year 75 of every 100 Americans go to see a doctor. Twelve of that 100 will be hospitalized. Less than one in that 100 will die. People who go to the doctor fall into three groups. Some (and this is the very few) go because of a serious or life-threatening event or disease. A second group—a significantly larger number—go because they are afraid that they fall in group one. It is in the management of the problems of these two groups that modern medicine plays its most visible and unambiguous role.

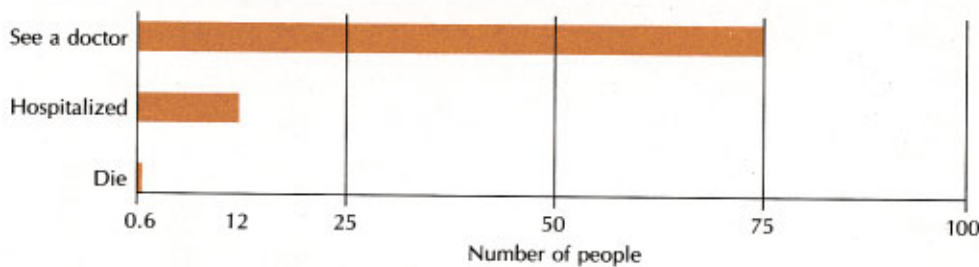
But people in the third group, who make up the vast majority, go to doctors because something has made them hurt, or weak, or excessively tired, or anxious, or they are unable to carry out their normal activities. Many have chronic diseases, minor or major, and they are asking health professionals to help them overcome limitations imposed by those diseases. They hope for cure, but will settle for freedom from pain or limitation.

We can document quite elegantly what modern medicine does for those in group one. The benefits for people in group two are also obvious—even if they simply obtain science-based reassurance that life-threatening disease is not present—but we have no way to document these latter benefits. Here is where our statistics begin to fall down: this is our first category of missing data. But of even greater importance, the bulk of our health resources, human and fiscal, are now devoted to working with group three, and here we flounder. Not only do we lack adequate measures of outcome—in terms of amelioration of pain, increased mobility, more independence, and the like—but in many instances we lack proven, effective interventions.

What do we mean by wanting to return people to maximum attainable function? As with many of the most important things in this life, the

Figure 3

Seeing a Doctor, Hospitalization, and Death—the Annual Picture



answer is simple. At the most basic level, we want people to be able to take care of themselves—to be able to arise from bed and feed and care for themselves without assistance. We want them to be mobile—to be able to get around their homes or to journey to work or school. At a higher level, we want people to be able to maintain sufficient bodily comfort and strength to develop normally as children or to fulfill the requirements of intellectual and physical work. We want them to be able to see, to hear, to walk, to climb stairs, to lift objects, to bend and tie their shoes, and to perform the other basic tasks of everyday living. At the most optimistic level, we hope they can exercise and indulge in vigorous physical effort.

Obviously there are many reasons why people can or cannot perform such activities. Physical or physiologic limitations are only part of it. How people feel about themselves, how they relate to others—mental, social, and economic factors—obviously play important roles.

How many Americans are significantly hampered by limitations in function—irrespective of their causation? Although data are regularly collected which bear on this question, they seldom are fully adequate to the need, and they receive scant attention. Perhaps the most comprehensive recent study has come from the Rand Health Insurance Study conducted over a five-year period in six quite different communities within the United States. This recently published report on the functional status of over 4,500 people between the ages of 14 and 66 is revealing. In this general population (which obviously eliminates those receiving the most intensive or institutional care, or older people), almost 14 percent indicated that health problems prevented them from doing some of the things they wished to do.

If we can generalize from these data—and there is much to suggest we can—this would conservatively indicate that over 30 million Americans have health-related functional limitations that interfere with their effectiveness. And we haven't even begun to count the elderly or those in hospitals and other institutions. This is clearly a significant segment of our population, and the problems of these people are important in both human and economic terms. Further, functional impairment obviously represents only the tip of an iceberg. The substrate of disease producing this amount of disability is manifold greater.

What are the disease problems that produce the bulk of these disabilities? There are few surprises. Results from both the Rand study and the most recent of ongoing studies by Dr. Dorothy Rice give us the picture. As shown in Figure 4, these disabilities stem from serious problems like heart disease, chronic lung disease, arthritis, asthma, and high blood pressure. But many doctor visits also result from less serious conditions like hay fever, or sinusitis, or hernias.

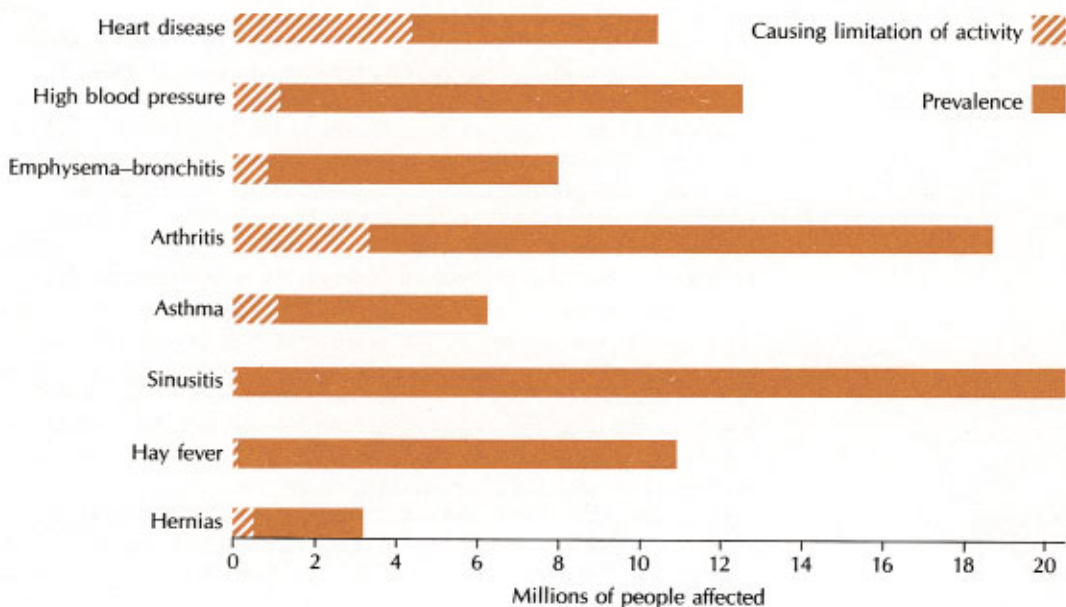
How can or how does medical care deal with these problems, and how effective are we in muting or modifying them to return people to effective functioning? This is the most crucial element of information that we need—and don't have.

Let me try and make this kind of information and what could be done with it come more alive by again using arthritis as an illustration. This is a group of diseases that rarely kills, but has a fairly high incidence and potential for crippling its victims. Over 18 million Americans are afflicted, almost 14 million of whom indicate they are bothered some or a great deal by their disease. More serious, however, over 3 million of these people—about 18 percent of those with arthritis—have significant limitations of activity.

Today a great deal of biomedical research is appropriately aimed at unraveling the mysteries of what produces these joint problems with the hope of eliminating this group of diseases, thus sparing the entire 18 million from the potential hazards of crippling. This is the hope of the future. Further, I might postulate that it has been advances in medical science of the last century and present medical care which make the actual disability rate 18 percent rather than 30 percent, but I am now guessing.

Lacking final answers, what doctors try to do and want to be able to do better today is to further reduce the disability rate. Can they identify those most at risk and concentrate their efforts on them? Can they drop the crippling to 10 percent—or 4 percent? Do some interventions do

Figure 4 **The Burden of Chronic Disease**



better at less cost? Do certain health professionals do better than others?

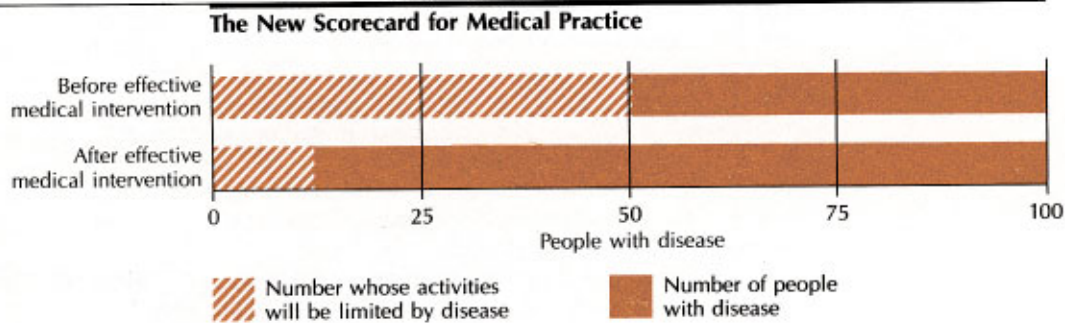
If we had this kind of information, perhaps we could then record a box score like Figure 5. This, it seems to me, should be the kind of scorecard against which we measure the personal health care system. What percentage of patients with a disease or disorder are at hazard of developing limitations? How may these people be identified and how may these limitations be prevented? Clearly it should be against this kind of informational backdrop that interventions are measured. We would then have a powerful data base against which to judge the effectiveness of our personal health care system.

It is important to emphasize that I am not talking about medical care or surveillance of just those people whose function has been impaired. These are the tragic losers to their disease. Most of the Americans who have some disease, injury, or disorder, and go to physicians each year, do so because they are trying to avoid being among those who suffer limitations. Physicians and the personal health care system are trying to get at the unknown percentage of people in this group who, left untreated, would end up poorly.

I believe better ways of identifying those who will get into trouble—which is called medical prognostication—might evolve more swiftly if we had the stimulus of the scorecard and the requisite effort of physicians in collecting the necessary data. If we could identify and spend our time with those truly at risk, this would begin to reduce the costs of medical care.

As a simple example, we must now treat, often with unpleasant medicines, 100 people with asymptomatic high blood pressure for many years to prevent serious late consequences in 17. How much more efficient and less costly if we could know in advance which 17 need our care and could encourage the other 83 to stay away from us.

Figure 5



A number of physicians are now beginning to try to address these kinds of issues. Let me cite two examples. First, a recent British study demonstrated quite conclusively the benefits of heart valve replacements by showing that most undergoing such surgery returned to work or independent living. The second involves victims of heart attacks and the observation that 20 to 50 percent of the estimated 900,000 survivors of the 1.5 million myocardial infarctions that Americans have each year failed to return to work. This led a Baltimore group to design ways to improve this outcome. Using nurses to help acutely-ill patients reduce their anxiety, build confidence, and comply with their treatment and convalescent regimens led to an increase of almost 20 percent in those returning to work. This inexpensive addition to the complex technical care of people with heart attacks obviously had enormous payoff in both human function and cost savings.

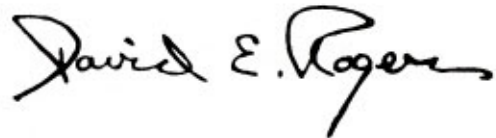
What can a foundation do in this area? Because this is a relatively new way of looking at illness and medicine's impact upon it, we have begun with some care. Under our new area of funding interest—programs to help people to maintain or regain maximum attainable function in their everyday lives—we are seeking to support a variety of studies and demonstrations aimed at improving both prognostication and intervention. Proposals which have a good potential for more effectively helping to improve mobility or relieve pain or help prevent retreat from active participation in the affairs of society will receive our major attention.

Because of the size of the task, we have set certain ground rules for our involvement. To help us make some difficult choices, we have agreed that we will try to select programs where the intervention strategy may result in a significant, not a marginal, gain in personal function. We are less concerned with the frequency of disease, more with the frequency of risk to serious limitations of human function. Those problems most likely to put people in bed or the hospital or a nursing home will be our choices if there are indications that an intervention can change this prospect. We will also ask that the proposed effort, if successful, have the potential to affect a substantial number of people and be adaptable to the mainstream of medical care.

As a modest beginning, we have launched a new program of smaller grants to encourage research and development on medical practice itself. This, we hope, will allow physicians, nurses, and other health professionals to make better uses of new knowledge coming from biomedical and behavioral science research to improve or conserve function in their patients. These grants will be directed at the kinds of problems and illnesses customarily cared for by generalists and other physicians. They are not intended to simply improve patients' access to traditional rehabilitation services.

What we are doing represents only a small step, but is a beginning. On the national scene, medicine must get a clearer idea about what ingredients—human and technical—assembled in what way, can most effectively help people to maintain maximum human function, prevent its

breakdown, or swiftly restore it. With such information, decision makers throughout the health system can surely make wiser determinations regarding health manpower needs and how we can best allocate our available health and medical care resources. Until we have such information, policy makers, medical educators, and the American public can only continue to wonder and speculate about how much we ought to spend for health care and who best serves us when a particular illness or disease strikes. It is our hope that getting a better fix on (1) how well the personal health care system is doing in helping people to maintain or regain function and (2) how people fare after encounters with the system, will become principal agenda items for those concerned with medical care during the next several years. Armed with answers in these two areas, this nation can better plan how to deliver the best of care at a price we can afford.

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

The 1981
grant program

The 1981 grant program

During 1981 the Foundation made 159 grants totaling \$40.13 million in support of programs and projects to improve health care in the United States. The types of activity supported were:

- developing and testing new ways of providing health care services, \$20.96 million, or 52 percent of the 1981 grant funds;
- helping health professionals acquire new skills needed to make health care more accessible, affordable, and effective, \$6.62 million, or 17 percent;
- conducting studies and evaluations to improve health care, \$12.07 million, or 30 percent; and
- other projects receiving support, \$488,627, or 1 percent.

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

- \$22.19 million, or 55 percent, for programs to improve access to personal health care for the most underserved population groups;
- \$8.8 million, or 22 percent, for programs to make health care arrangements more effective and care more affordable;
- \$8.5 million, or 21 percent, for programs to help people maintain or regain maximum attainable function in their everyday lives; and
- \$647,500, or 2 percent, for a variety of other purposes, principally in the New Brunswick, New Jersey area where the Foundation originated.

A series of charts analyzing the Foundation's appropriations in its first decade as a national philanthropy—from 1972 through 1981—begins on page 41.

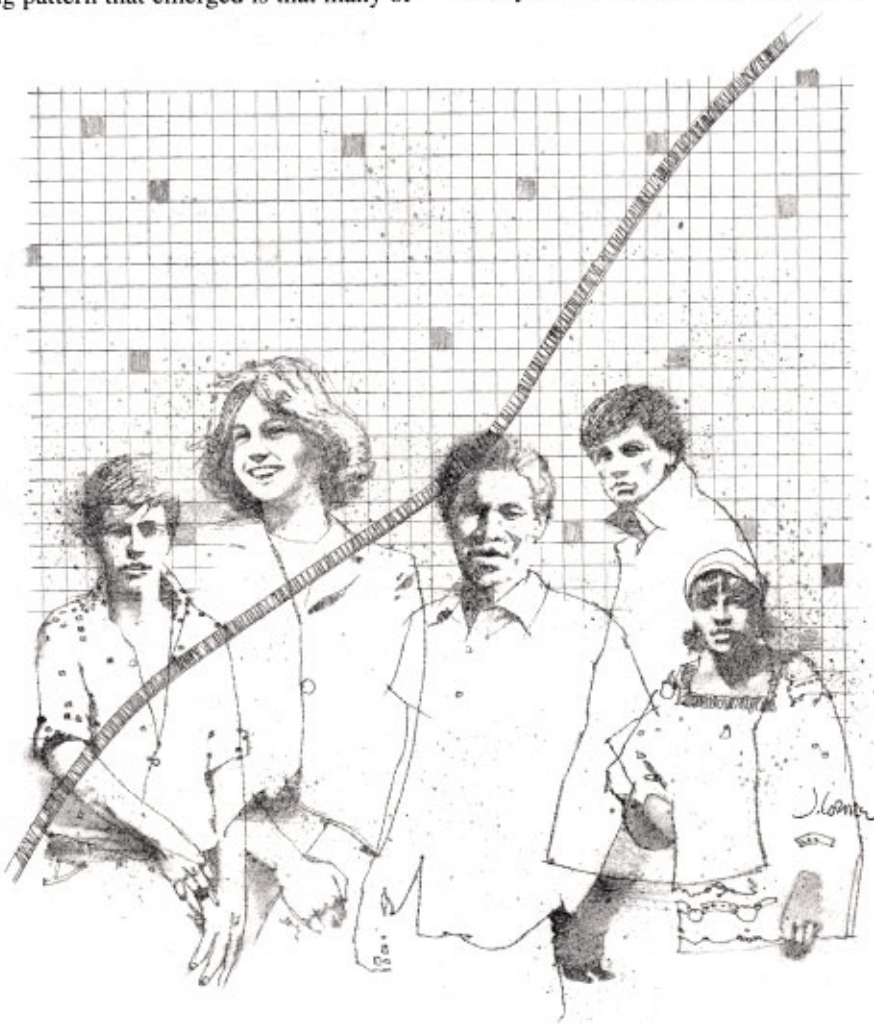
Major developments in the 1981 grant program

During this first year of changed program directions we received an impressive volume of thoughtful, responsive proposals from a wide variety of institutions and groups throughout the country. One especially gratifying pattern that emerged is that many of

these proposals simultaneously address two or even all three of our new program interests: bringing health care to groups of people with difficult access problems, making health care arrangements more effective and affordable, and helping people maintain or regain their ability to function.

Health care for young people

Most adolescents in this country are healthy, and health problems within this age group are usually transient and minor. For some,



however, this is a period of substantial risk for a group of problems whose health consequences are serious and sometimes fatal. This is mirrored in current statistics for venereal disease, teenage pregnancy, alcohol abuse, drug abuse, mental illness, and violence in the forms of accidents, homicides, and suicides. Thus, while the mortality rate of 15 to 24 year olds is relatively low, this is the only age group in our population with a rising death rate.

The Foundation's Program to Consolidate Health Services for High-Risk Young People was designed to help communities pool their resources and develop better ways to meet the needs of these young people. It was announced this year, and with the assistance of a national advisory committee, we made 20 grants in support of projects serving large inner city areas, medium-sized cities, and a network of rural communities. More than 25 teaching hospitals and their 57 co-sponsors—municipal health departments and voluntary and other agencies—are collaborating to offer more accessible, comprehensive services for young men and women. Grant recipients in this program are listed beginning on page 66.

We also joined some 15 foundations and businesses in Houston that have come together to develop and support a primary care health center for 6,000 young people in an area of the city where 40 percent of the residents have incomes below the poverty line. The center, organized by the Urban Affairs Corporation in cooperation with the Houston Independent School District, offers basic medical and related services. It is staffed and managed by faculty physicians from the Houston campus of the University of Texas Medical School.

Also in the Southwest, a consortium of public and private medical and other health professionals is preparing a sustained attack on the health problems of mothers and children living in poverty on both sides of the 1,600-mile border between the United States and Mexico. Under the auspices of the American Academy of Pediatrics—and with

support from the Foundation and other sources—the needs of this population are being defined and specific action projects to address them will be launched in six regions where 90 percent of the border population live.

Caring for the elderly

At the opposite end of the age spectrum—among the elderly—health problems become more pervasive and chronic, and access to health care and maintaining the ability to live independently become critical issues. Inextricably entwined in these issues, both for individuals and in terms of public policy, are related questions about the effectiveness and cost of health services.

One out of every five people 85 years of age and older resides in a nursing home. By the year 2000, this segment of the population will have increased almost fivefold over what it was in 1960.

Increases in the number of nursing home beds predicted several years ago have not occurred, and a significant segment of the patient population in these homes is becoming older and frailer, requiring considerably more nursing care than in the past. The institutional capacity for skilled nursing care is further challenged by the growing emphasis in hospitals on early discharge and the resulting pressures to transfer patients with complex, multiple problems to nursing homes. All of this is occurring at a time when professional staff recruiting is exceedingly difficult. Only five percent of nursing home employees are registered nurses, and most care is provided by aides with little formal training.

The Foundation's Teaching Nursing Home Program, co-sponsored by the American Academy of Nursing and announced this year, seeks to change this pattern by assisting academic nursing schools to develop clinical affiliations with nearby nursing homes. A national advisory committee has been formed and 53 applications have been reviewed. Grants to be made under this program in 1982 will be used to assist in the development of

clinical service, education, and research activities within these affiliated homes and the surrounding communities.

Outreach—another approach

Although most elderly people do not live in nursing homes, many find that poor health and impaired mobility make it difficult for them to leave their homes to seek medical care and other health services. Beth Israel Medical Center, a large voluntary hospital in New York, is responding to this challenge by establishing a satellite health service within a 230-unit public housing high-rise on Manhattan's lower east side. With our support,

this satellite will be staffed by a nurse practitioner backed up by a physician, a podiatrist, a public health nurse, and a social worker. Half the residents in the building are 75 years of age and older, and Beth Israel hopes the satellite will become a replicable prototype for improving elderly residents' access to care within the vast public housing complex in that area of the city.

Access to care in Alaska

Residents of the small villages scattered across the millions of square miles of Alaskan wilderness face extraordinary difficulties in getting health care. A remarkable, statewide



health services network, however, is meeting their basic needs despite the challenges of sparse population, rugged terrain, often forbidding weather, and distances between medical and hospital facilities measured in hundreds of miles. At the outermost point of each tendril in this network is a Rural Health Aide with a carefully stocked medical kit and a two-way radio for summoning advice or transport to the nearest hospital. For the past six years, the Foundation has supported the development of training and certification programs for these aides. The University of Alaska's Health Aide Coordinating Office will use funds from a 1981 grant to consolidate this program and implement an advanced training sequence at rural community colleges and other training sites.

Access to care in jails

The American Medical Association has documented both the enormity of medical need and the paucity of care available in this country's penal institutions, particularly local jails and correctional facilities. Over the past six years, the AMA has mounted a national effort to upgrade and accredit medical care programs for prisoners. Our grant is in support of the AMA's plans to put this program on a self-sustaining basis.

Better access via loans

While grants remain the Foundation's principal means for helping groups attempting to offer health care in underserved areas, we collaborated with the Mayo Foundation in 1981 to begin a nationwide loan guarantee program with similar objectives. The Mayo Foundation will use our funds to provide partial guarantees for bank loans of up to \$250,000 to establish satellite primary care practices in underserved communities. Participating banks must provide the loans at a negotiated, less-than-prime rate of interest. Eligible borrowing organizations include not-for-profit medical and dental group practices, hospitals, health maintenance organizations,

and medical and dental schools' faculty practice plans.

Improving long-term care

Although the elderly bear a disproportionate burden of heart disease, diabetes, arthritis, respiratory disorders, stroke, and other long-term illnesses, an estimated 100 million Americans of all ages live with one or more chronic conditions. In most instances, they do not place significant constraints on the activities of the people affected. Nevertheless, the functional abilities of many people are impaired to some degree, and these long-term conditions account for 40 percent of days people spend in hospitals and 50 percent of the nation's physician visits. Caring for the chronically ill of all ages has become one of medicine and nursing's principal challenges.

Improvements in the care of people with these chronic, disabling problems can therefore have exceptional payoffs, both economic and human. The Foundation is supporting a number of projects in this area focused on the dual challenges of making health care arrangements more effective and affordable, and helping people recover or conserve their ability to perform the important tasks of everyday life.

In one of these efforts, groups of patients with chronic diseases that are discharged from Montefiore Hospital's Loeb Center for Nursing and Rehabilitation are now receiving specialized out-of-hospital nursing care to help them maintain independent function. These patients will be carefully followed to determine how much this relatively simple, inexpensive addition to their care protects and improves their functional abilities.

For purposes of the study, these patients will be matched with others discharged from Loeb without the nursing followup and with others who are discharged from Montefiore Hospital and North Central Bronx Hospital without being referred to Loeb. Factors to be compared include levels of functioning, ability to live independently, ability to return to work,

incidence of complications, and the use of emergency rooms and inpatient services.

Heart disease is enormously expensive for the individuals affected and in the aggregate nationally. Costs in a coronary intensive care unit, for example, are often 3.5 times more than those for an average hospital bed, and an estimated one and a half million Americans suffer heart attacks each year.

A project at Massachusetts General Hospital, jointly funded with the John A. Hartford Foundation, is carefully evaluating the human value and cost savings of early discharge from the coronary care unit and hospital for patients with less severe forms of heart attacks (i.e., attacks that previous studies have shown are not life threatening).

We are also assisting a multi-hospital project in Boston in which physicians and nurses are addressing longer-term consequences. An estimated 20 to 50 percent of the survivors of heart attacks do not return to work or are underemployed, and this program is designed to extend previous, more limited studies indicating that nurse-managed interventions linked with the patients' workplaces can significantly increase the rate of return-to-work for selected patients.

Stroke is another disease where the cost of long-term treatment can be high in both dollar and human terms. A Cornell University-New York Hospital neurology team is using its grant to develop a computer-assisted diagnostic system that could lead to improved treatment and a reduction in stroke patients' costs.

Also at Cornell, Foundation funds are underwriting a project to teach physicians from across the country how to use—and to teach other physicians to use—a new approach that helps diabetic patients control their own disease. Earlier studies indicate this approach can drastically reduce, if not eliminate, the high morbidity in infants born to diabetic mothers—without the long periods of expensive inpatient hospital care that are commonly prescribed today for pregnant women who have diabetes.

Other efforts to improve care

Each year in this country, 3.6 million people suffer minor head injuries and are not hospitalized. Such injuries are generally considered acute conditions with short-term medical consequences—loss of consciousness for less than 20 minutes due to trauma and no apparent nervous-system complications.

However, a University of Virginia team studying a group of former patients three months following this kind of “minor” injury found most complained of residual effects and a third of those employed before their injury had not returned to work. The availability of health and disability insurance was not a factor, nor was a history of previous head injury or litigation.

The project has been expanded, with our support, to find ways to improve the care of people with seemingly minor head injuries, and to help those who had been employed to return more quickly to their jobs.

Information about health care outcomes is a vital ingredient in efforts to improve the clinician's ability to help individuals avoid or resolve functional disability associated with illness and injury. Paradoxically, however, funds and arrangements for collecting and using this kind of information are in short supply, despite the profound human and monetary costs of disability.

Four projects assisted this year are targeted in this area. In the first, Beth Israel Hospital in Boston and the Medical Ambulatory Care Center at the University of California in Los Angeles are each introducing a systematic functional assessment of their patients being seen for general medical care. The objective is to improve patient outcomes by helping physicians to focus more carefully on how their patients can be more swiftly returned to productive life.

Second, a similar approach is being taken by Dartmouth Medical School group and 45 rural medical practices, all of which are linked in a network that includes a computerized management information system that collects a

common set of data on patients, expenses, and revenues. The functional status of a large group of cooperating patients will be assessed and various sub-groups will be followed to make comparisons regarding interventions used, their costs, and subsequent changes in the patients' functional status.

A team at Yale University is working with patients to develop better and more rigorous diagnostic measures and classifications for clinical problems that now are heavily dependent upon the physician's subjective observations. The aim is to use these advances to improve the precision and effectiveness of treatment.

Finally, INSURE, a not-for-profit organization established by life and health insurance companies, will conduct a geographically dispersed program in which physicians in participating medical practices will identify patients at risk for developing specific diseases, and then provide these patients with targeted preventive care. The effects of the interventions will be evaluated in terms of changes in blood pressure, weight, and other relevant physiologic measures. Plans also call for an assessment of the feasibility of introducing into medical practice the new methods of disease prevention and health promotion that will be used—principally lifestyle counseling and education tailored for specific risk groups—and an analysis of issues concerning insurance coverage and cost containment related to these services.

Medical Practice R & D

Measures to improve patient care typically begin with carefully developed ideas whose worth can be proved in small-scale testing. The Foundation's Medical Practice Research and Development Program, launched this year, seeks to encourage that kind of idea formulation and initial study. It was designed in response to the growing number of academic physicians and nurses who have expressed a desire to redirect clinical attention in medical practice to helping patients

conserve or more rapidly regain their ability to perform the commonplace, but vital, tasks of everyday life.

The 23 projects funded under this program in 1981 include such diverse proposals as:

- the use of relaxation techniques by children to reduce the frequency and severity of asthma attacks;
- an evaluation of various combinations of diagnostic and treatment techniques to speed recovery of patients with low back pain; and
- the identification and treatment of functional impairments among patients recovered from Hodgkin's disease, a form of cancer.

A complete list of the projects supported begins on page 70. They were selected with the assistance of a panel of expert consultants from more than 250 proposals submitted by medical and nursing school faculty. Plans have been made to invite a second round of proposals under this program in 1982.

Understanding health issues

A number of projects assisted this year are intended to increase national awareness and understanding in a variety of areas relevant to health care and our program interests.

Records of the Palo Alto Medical Clinic are being used in one such project to identify and evaluate factors that have resulted in increased medical care costs since 1971 for a group of specific clinical diagnoses. This type of information can be used in developing strategies for moderating future cost increases. A similar study for the period 1951-1971, for example, showed that a major contributor to rising costs was a dramatic increase in the volume of many low-cost laboratory procedures. This latest analysis is being jointly funded with the Kaiser Family Foundation and the sponsoring Palo Alto Medical Research Foundation.

The Hospital Research and Education Trust and the Institute for the Future are jointly developing an integrated data base of

demographic, financial, and other information, and then using it to make national and regional forecasts of health and medical costs, labor supply projections, and other environmental factors affecting hospitals and other elements of the health care system.

A University of Pennsylvania Wharton School group, co-funded with The Commonwealth Fund, is undertaking a comprehensive study of continuing care retirement communities. These organizations, many of which are church sponsored, offer

lifetime housing with a range of medical and social services. They are financed by one-time entry fees to residents, plus a monthly charge. This study is designed to develop information that can be used to strengthen the management and financial aspects of the communities' operations.

The Philadelphia health department is conducting a public-private sector examination of municipal health priorities. The findings should be of interest and applicable in other urban areas facing reductions in federal and



state support. This project is also being co-funded with The Commonwealth Fund.

Hospital Education and Research Foundation in Minneapolis is overseeing a study of the effects of health care competition on access to care, costs, local hospitals, physicians, third-party payers, and consumer and provider behavior in Minneapolis/St. Paul — where a substantial proportion of the population is covered by prepaid health care plans. The Hartford Foundation is funding a parallel study of another, yet-to-be selected city.

A group at The Johns Hopkins University has been funded to study and report on the relationship between the availability of capital to hospitals and their provision of services. Various policy options and their projected outcomes for the 1980's are to be included in this effort.

Grantmakers in Health began three years ago as an ad hoc effort of private and community foundations and corporate giving groups to explore major health trends and topics relevant to their philanthropic interests. Representatives of more than 50 grantmaking organizations have taken part in the group's seminars and conferences. This year we joined with several other participating organizations to support the employment of a full-time executive director to continue and expand the work of this new organization in an office under the aegis of the Foundation Center in New York City.

In addition, a major grant was made in continued support of the Institute of Medicine of the National Academy of Sciences. The Institute's members and staff develop and conduct a broad range of health policy-related studies as well as respond to government requests for consultation and for more extensive explorations of health policy.

Rural hospital 'swing beds'

The basis of the Foundation's Rural Hospital Program of Extended-Care Services is a solid example of how health care studies can lead to improvements in health arrangements.

Medicare and Medicaid clearly and dramatically increased access to health care for America's elderly and poor, but subsequent studies showed an undesirable side effect of their regulations was to stop small rural hospitals from offering long-term care as an add-on to their primary mission of acute care. Today, in many small communities, these hospitals are financially threatened by low occupancy rates, and people needing long-term care are having to enter nursing homes in larger communities and cities away from their family and friends.

A more recent study underwritten by the federal government showed that this situation can be reversed to benefit patients and rural hospitals alike. As a result, Congress has authorized changes in Medicare and Medicaid regulations to reimburse small rural hospitals for both long-term and acute care in a specified number of "swing beds" that can be used for either purpose, depending on needs.

Our Rural Hospital Program was organized this year — with the co-sponsorship of the American Hospital Association (AHA) — to encourage the diffusion of this swing-bed concept. The Program is a two-phase effort: (1) up to five state hospital associations will receive grants next year to develop technical assistance capabilities to help hospitals interested in swing-bed operations; and (2) rural hospitals in these five states will subsequently have an opportunity to apply for 25 grants to help meet start-up costs for implementing the swing-bed concept. A 1981 grant is enabling the AHA to conduct information and educational activities in support of the Program.

Medical careers for minorities

The Foundation has had a decade-long interest in efforts to encourage and assist minority students to pursue medical and related careers. Meharry Medical College, the leading educator of black physicians in the South and a past recipient of support, received a major grant in 1981 to strengthen its faculty and

management capabilities. We also provided continued assistance for National Medical Fellowships' program of scholarships for minority medical students.

Chicano Health Policy Development is using our grant for its "feeder system" to develop and encourage a cadre of well-prepared Mexican-American college students for medical and other health professional schools in Texas. In addition, similar programs of four other organizations and institutions offering educational enrichment and premedical counseling to promising minority undergraduates received continued assistance: Aspira of America, the National Fund for Medical Education, Tulane Medical Center, and the University of Medicine and Dentistry of New Jersey.

For further information

A list of all grants made in 1981 begins on page 63, followed by a list of grants made in previous years that were still active in 1981 (i.e., those with unpaid balances on January 1, 1981.) A descriptive Program Summary for most of the grants on these lists is available without charge. Requests should include the title of the grant, the institutional recipient, the grant ID number, and should be addressed to:

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



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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 1981 these reports cited 41 books, 150 book chapters, 655 journal articles, 435 reports, and 17 films, tapes and other audiovisual products.

This bibliography is a sample of citations from each category reported in 1981, and from among the publications of the Foundation's staff. These publications are available through medical libraries and/or the publishers. Copies are not available from the Foundation.

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**Analysis of
appropriations:
1972-1981**

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appropriations:
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The Robert Wood Johnson Foundation began making grants as a national philanthropy in 1972, primarily to assist groups improving people's access to general medical and dental care. In addition, improvements in the quality of care and the public policy aspects of health care were selected as areas for activity.

The areas we selected also received increasing attention from many other private and public funding sources, and by 1980 it was clear that access to health care, overall, had significantly improved. Even so, difficult problems persisted for a number of population groups, and in 1981 we refocused our efforts to target our funds on those developing health services for people with the most serious geographic, cultural, financial, and other barriers to care. At the same time we also began phasing in grants for those working in two other areas of health care. Thus, three principal interests now comprise our agenda for grants:

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

By the end of 1981 — our first decade as a national philanthropy — we had made 1,592 grants, with appropriations totaling \$447.6 million. The charts in this section show the use of these funds in relation to our objectives and the types of activities assisted in support of these objectives. They also depict the distribution of our grants by geography and type of recipient, and our grants in comparison with spending by the federal government.

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

Chart 1

**Appropriations by RWJF Objectives,
1972-1980**

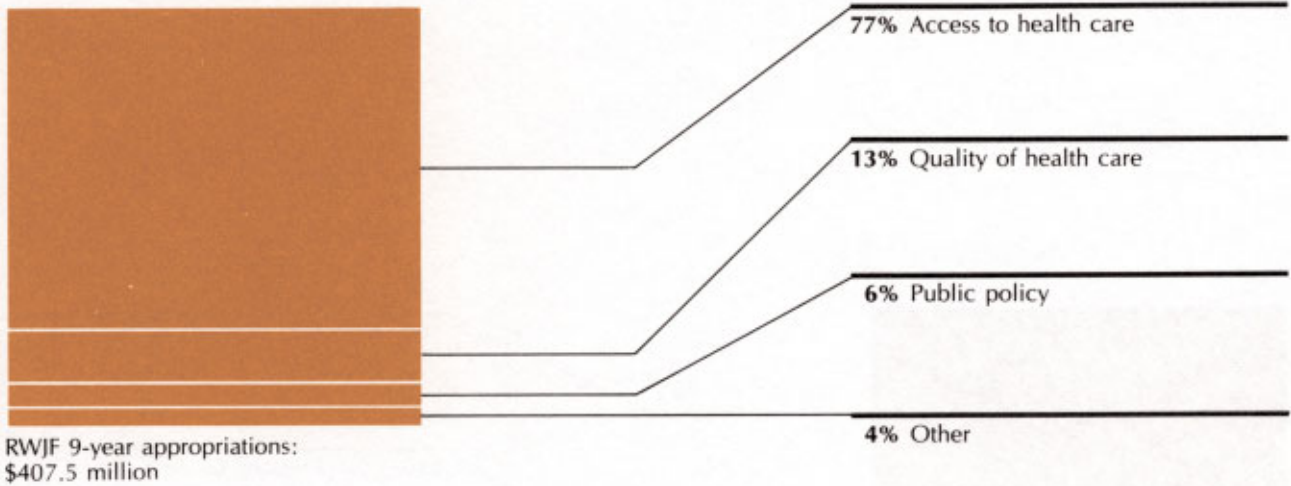


Chart 1A

**Appropriations by RWJF Objectives,
1981**

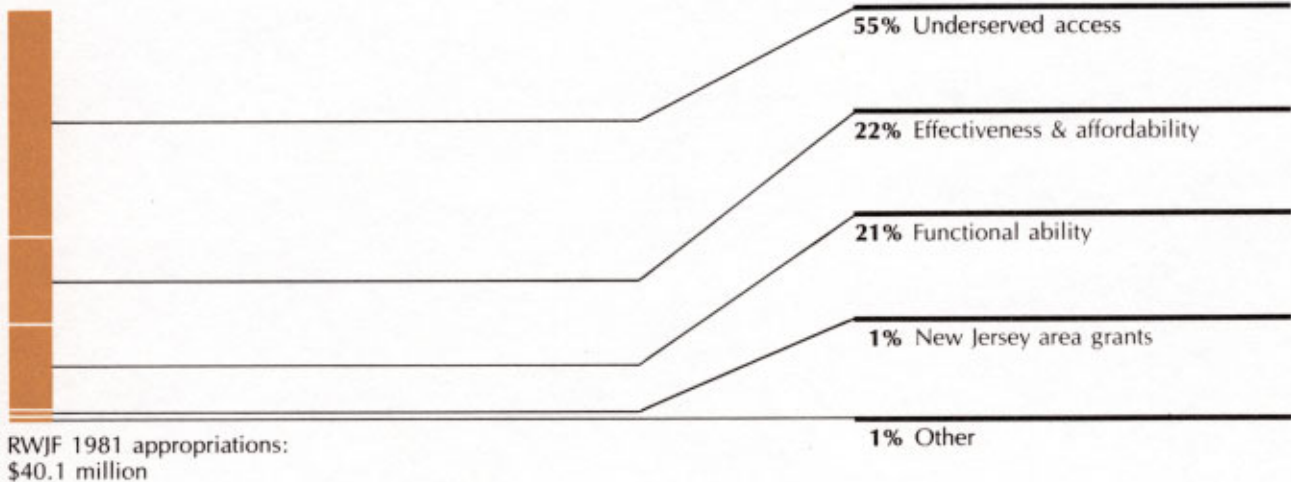


Chart 2

**Types of Activities Supported,
1972-1981**

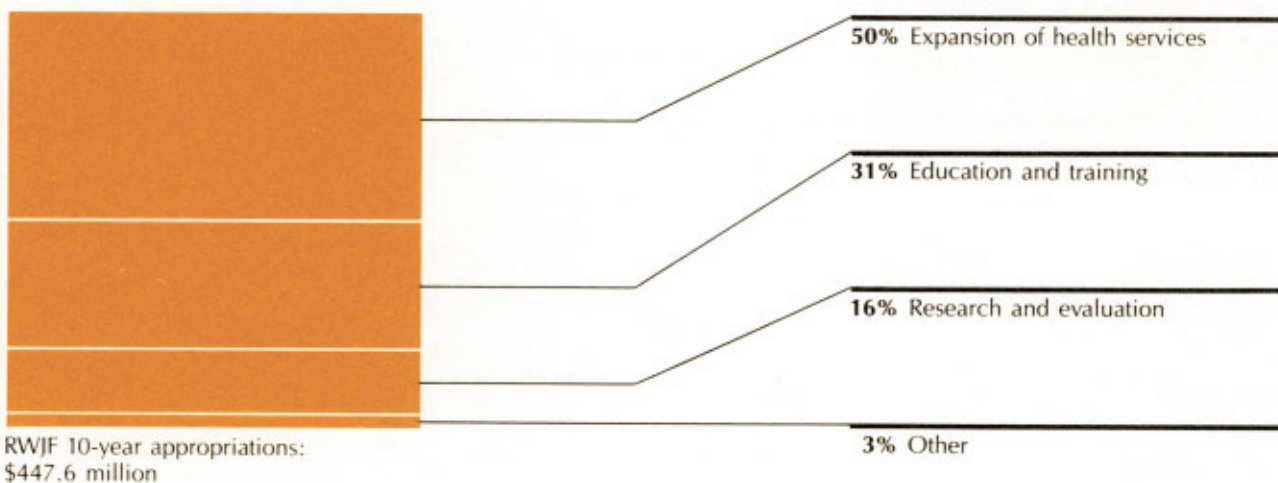


Chart 3

Types of Education and Training Programs Supported, 1972-1981

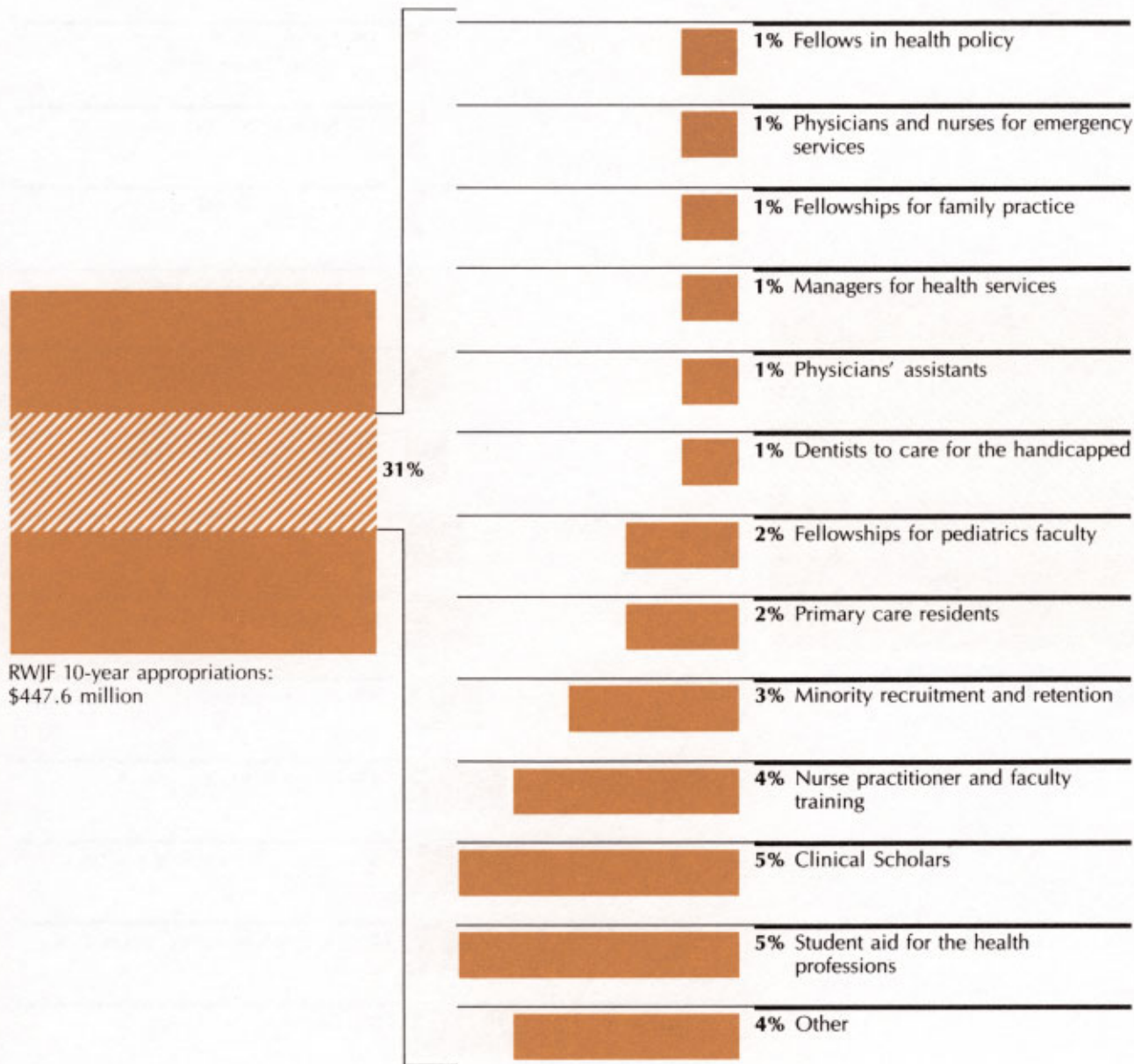


Chart 4

Types of Programs Supported to Deliver Health Services, 1972-1981

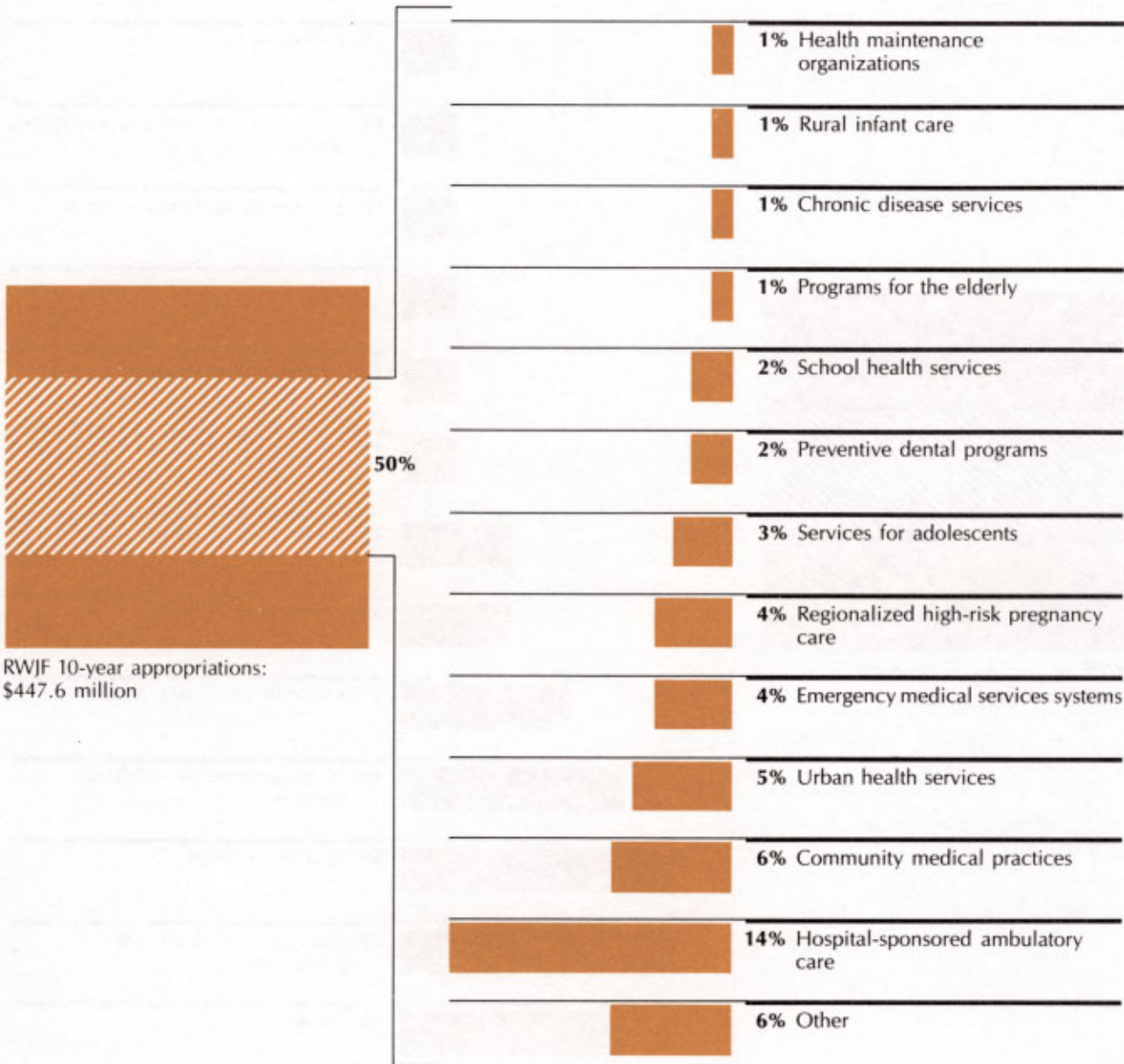


Chart 5

**Service Programs for Central-City
Minority and Rural Populations,
1972-1981**

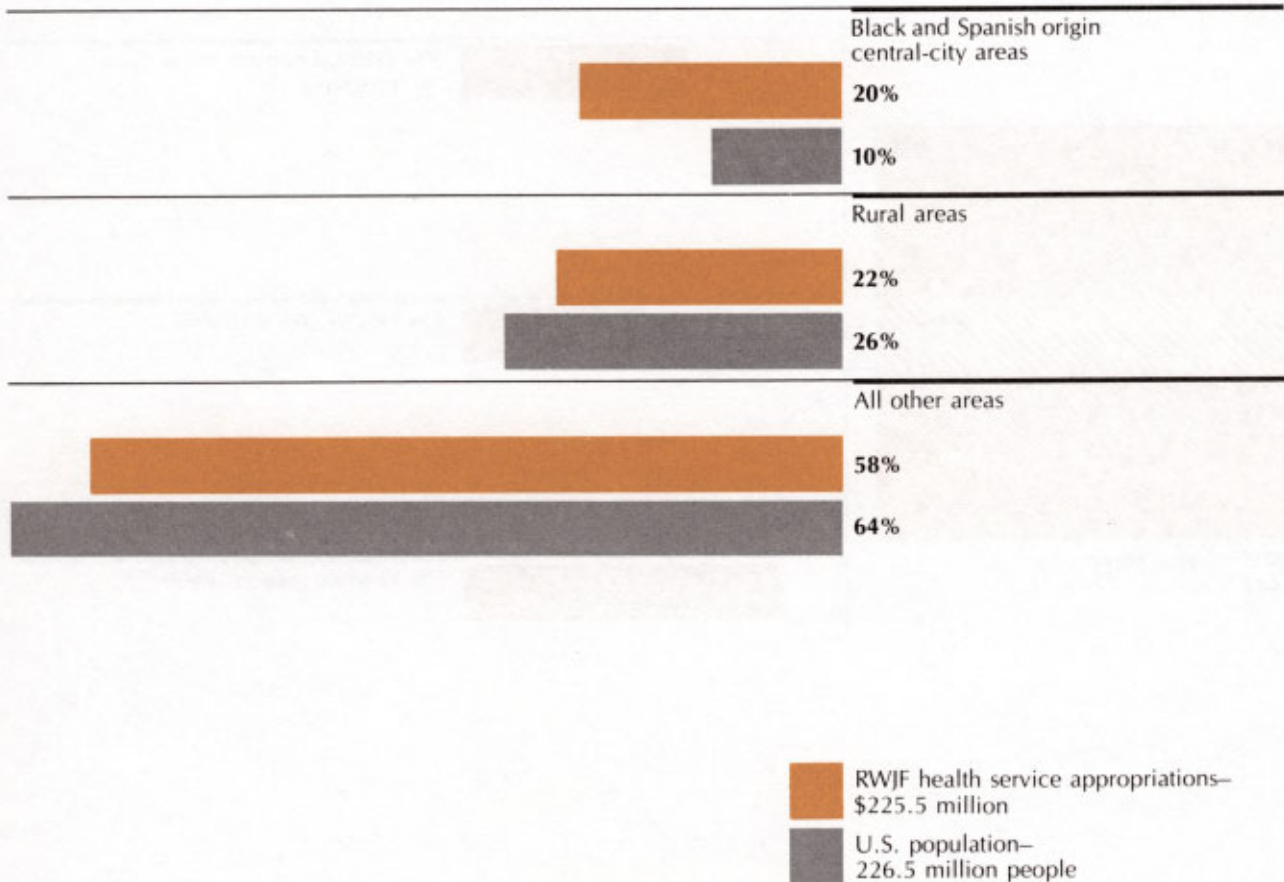


Chart 6

Types of Research and Evaluation Supported, 1972-1981

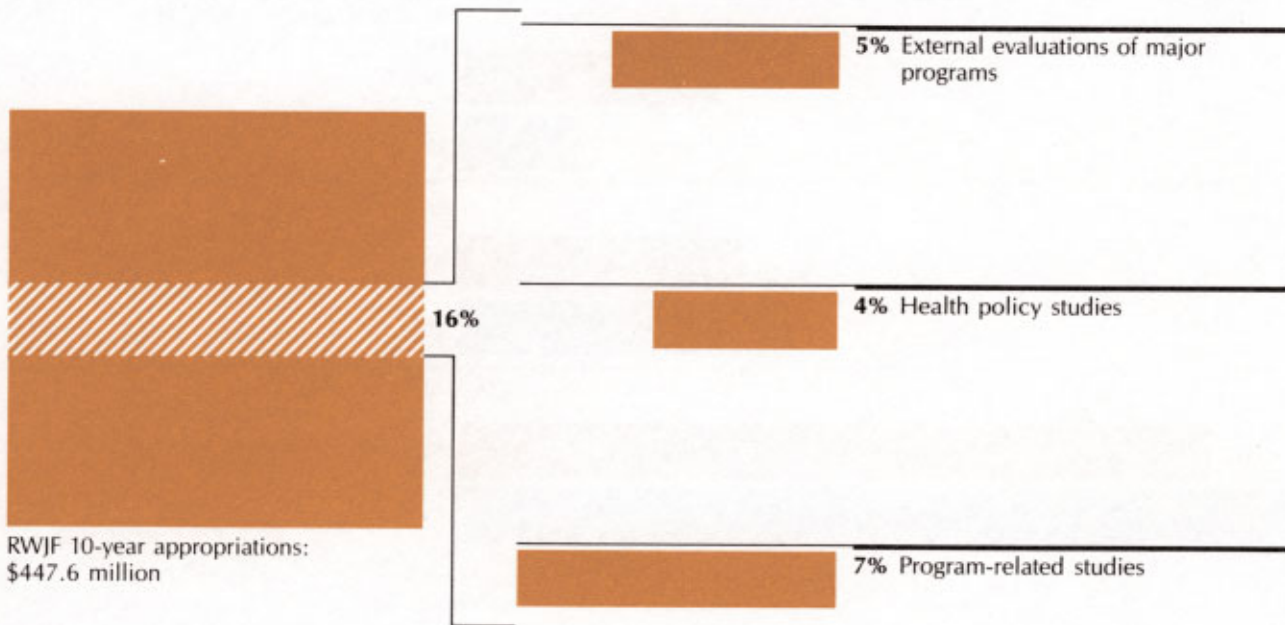
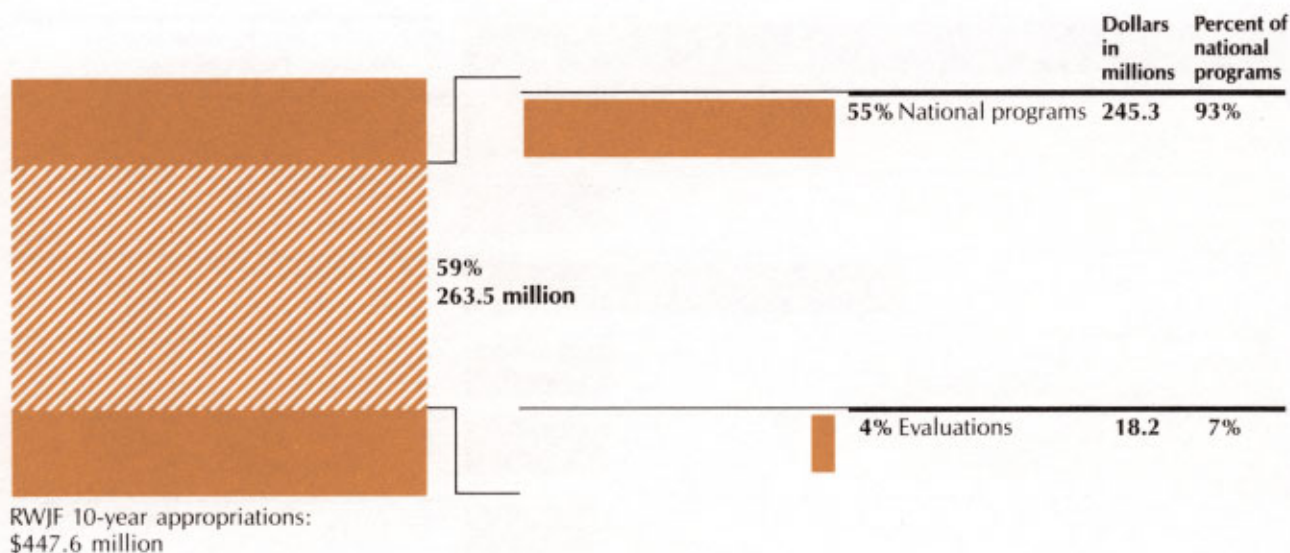


Chart 7

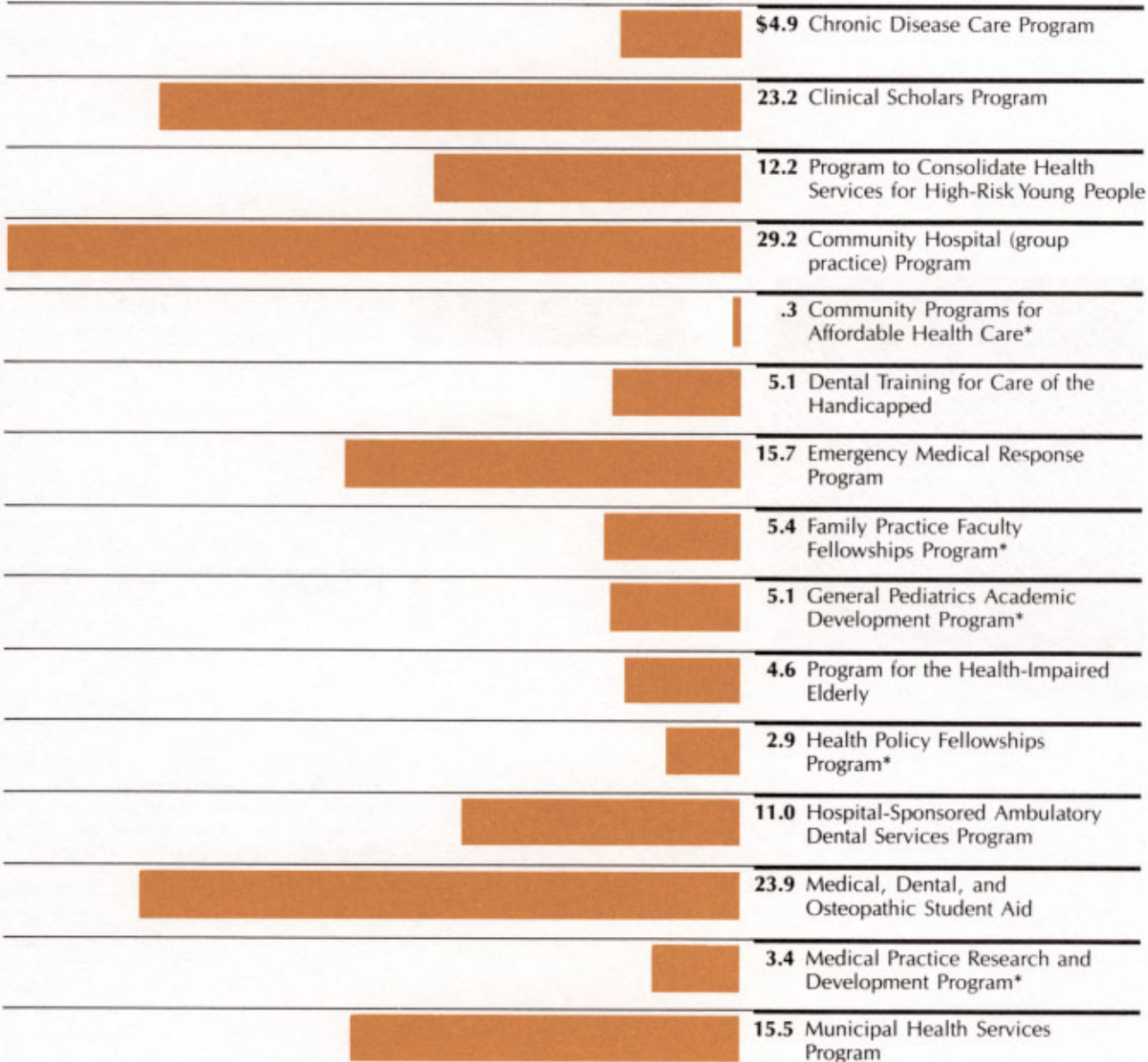
National Programs* as a Proportion of Appropriations, 1972-1981



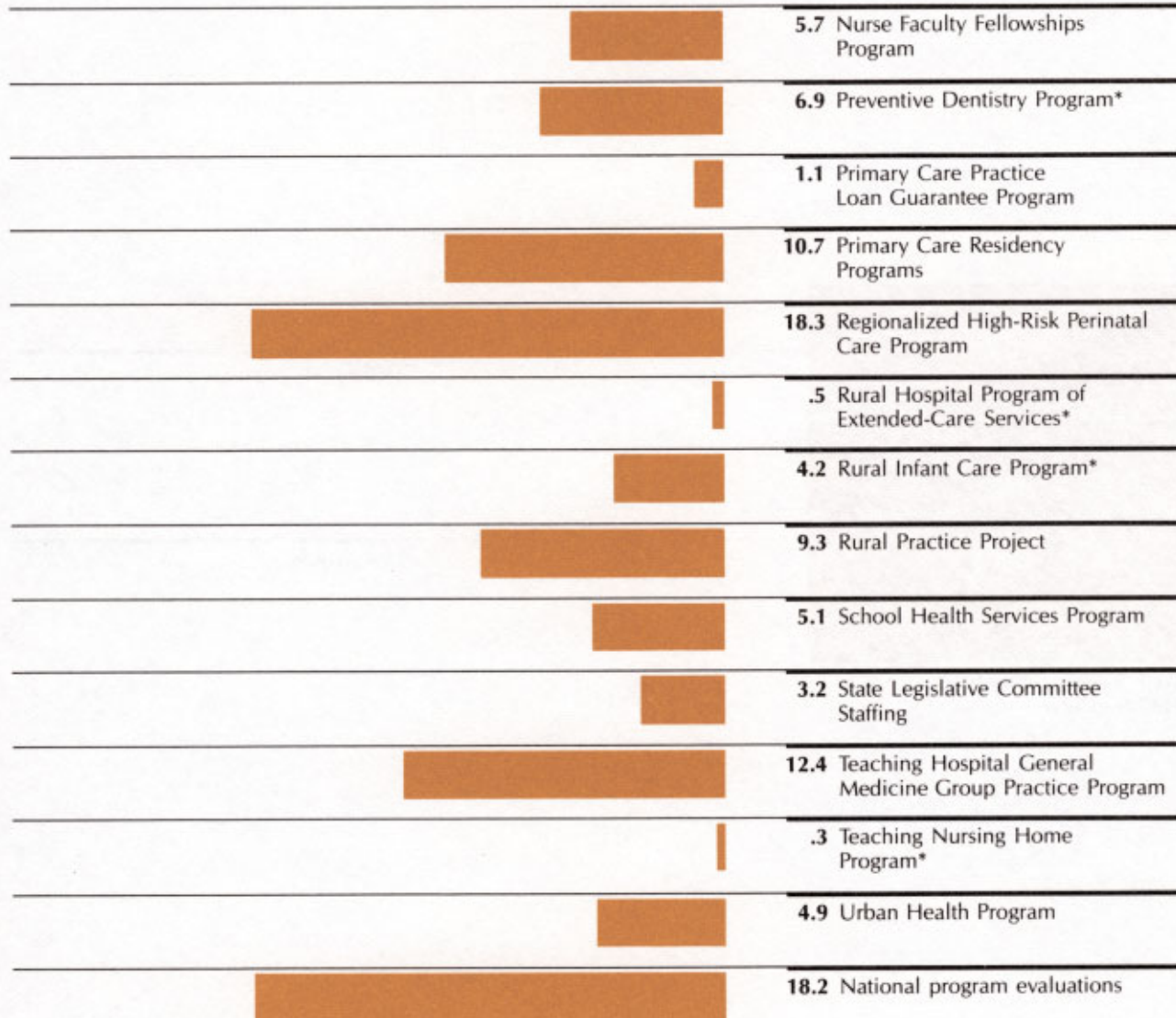
*Each of these programs comprises a series of grants assisting selected institutions or organizations addressing a specific well-defined national problem within the scope of the Foundation's objectives.

Chart 8

Appropriations (millions of dollars)



**National Programs,
1972-1981**



*Additional grants planned for 1982

RWJF 10-year appropriations:
\$263.5 million

Chart 9

**Division of Appropriations Between
Public and Private Institutions,
1972–1981**

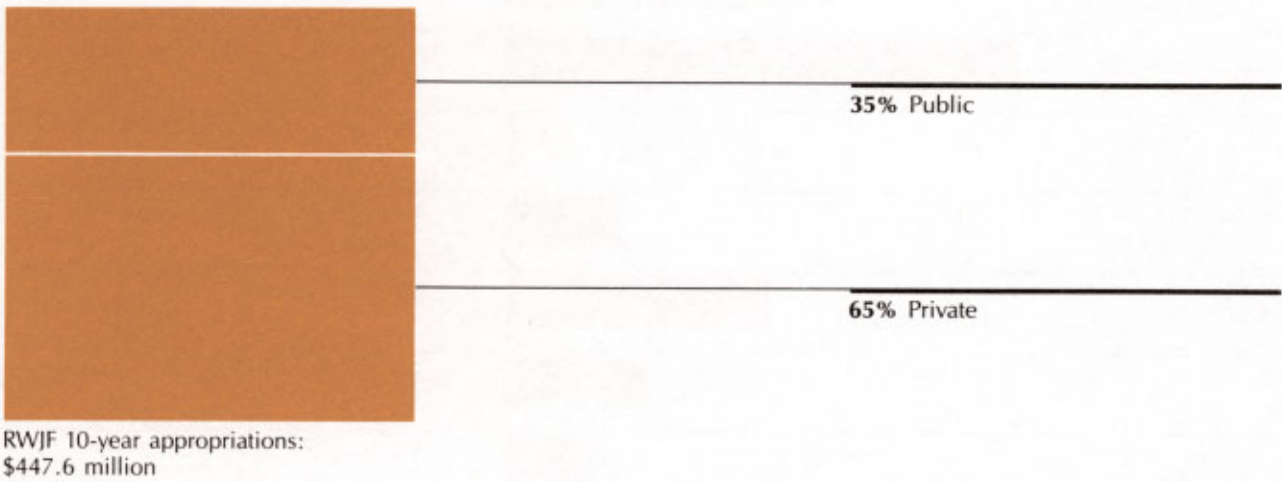
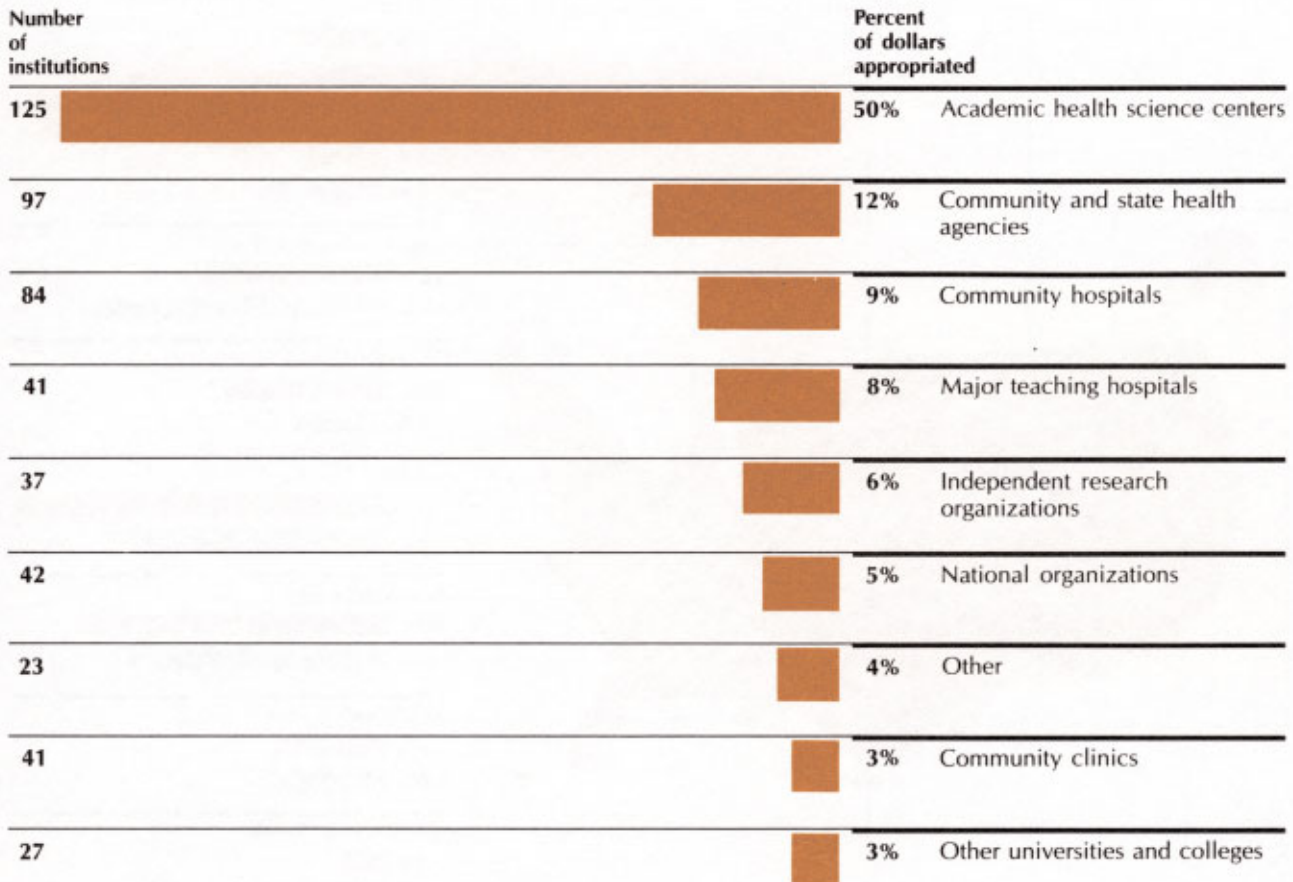


Chart 10

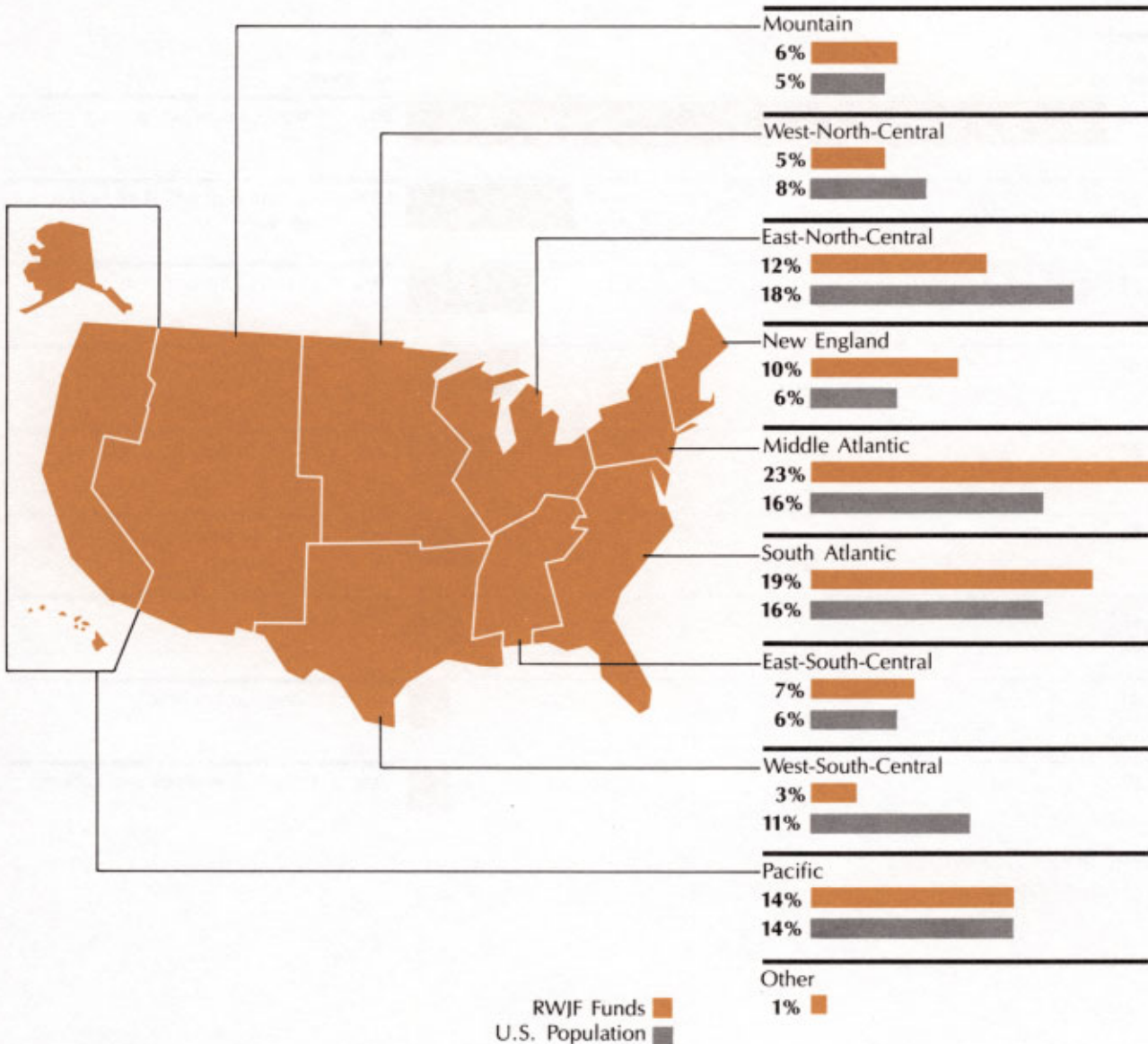
**Types of Institutions
Receiving Support,
1972-1981**



RWJF 10-year appropriations:
\$447.6 million

Chart 11

Appropriations by Geographical Region Compared to Population, 1972-1981

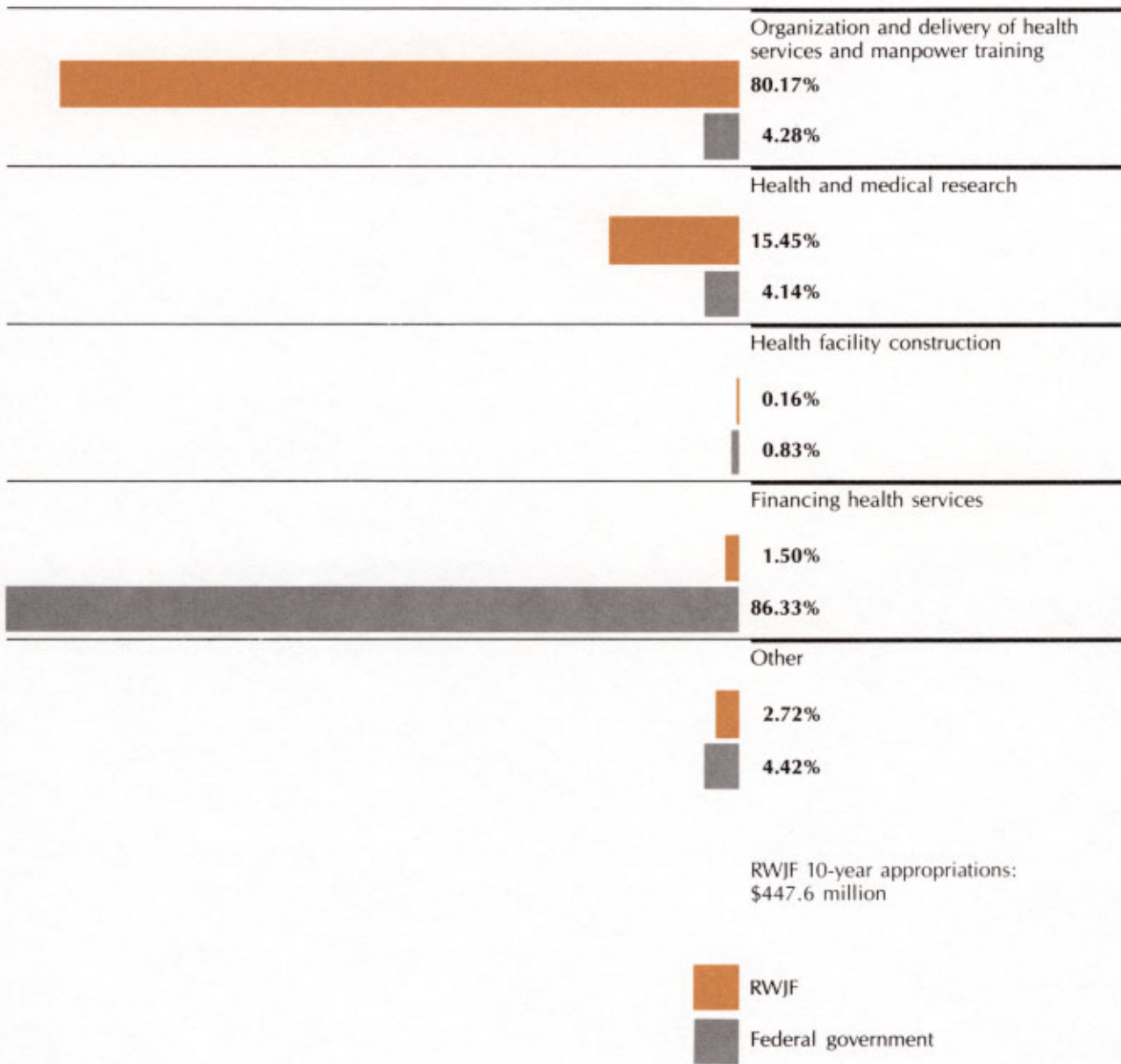


U.S. Population figures taken from the 1980 Census of Population; Supplementary Reports, U.S. Department of Commerce, Bureau of Census, May 1981

RWJF 10-year appropriations:
\$447.6 million

Chart 12

RWJF Appropriations Compared to Federal Health Expenditures by Types of Activity Supported, 1972-1981



Financial statements

Introduction to Statements

The annual financial statements for the Foundation for 1981 appear on pages 59 through 62, followed by a listing of grants authorized in 1981 and a summary of grants authorized in prior years which had not been paid in full as of January 1, 1981.

As noted earlier in this report, 1981 was the tenth year of operation of the Foundation at its present size, or as a national philanthropy. Accordingly, a review of some cumulative and comparative figures seems appropriate.

During the ten years 1972 through 1981, the Foundation made grants totaling \$435,224,561; administrative and investment expenses amounted to \$32,145,397; and excise tax paid to the Federal Government on income totaled \$8,307,218. Investment income, which has increased substantially in recent years, amounted over the ten-year period to \$288,388,161. Thus, for the ten years ended December 31, 1981 grants, expenses and taxes exceeded income by \$187,289,015. In addition to the \$8,307,218 in excise tax paid on investment income, the Foundation also paid during that ten-year period \$5,175,233 in excise taxes on capital gains from the sale or exchange of securities.

The accompanying schedule shows details for the ten-year period.

A list of investment securities at December 31, 1981 is available upon request to the Treasurer, The Robert Wood Johnson Foundation, Post Office Box 2316, Princeton, New Jersey, 08540.

William R. Walsh, Jr.
Vice President and Treasurer

Report on Excess of Grants, Expenses and Taxes Over Income 1972 through 1981

(Accrual Basis)	Investment Income	Grants (Net)	Expenses and Excise Taxes	Excess of Expenses & Grants Over Income
1972	10,510,973	44,038,974	1,417,630	34,945,631
1973	18,731,787	52,953,437	2,550,662	36,772,312
1974	23,154,399	47,791,357	3,192,244	27,829,202
1975	25,118,814	54,033,904	3,728,523	32,643,613
1976	25,411,602	43,068,376	4,688,780	22,345,554
1977	27,996,841	29,189,915	4,670,785	5,863,859
1978	33,057,604	44,775,631	4,440,076	16,158,103
1979	36,760,277	39,499,691	4,978,122	7,717,536
1980	41,429,504	44,015,583	5,103,881	7,689,960
1981	46,216,360	35,857,693	5,681,912	(4,676,755)
Totals	<u>\$288,388,161</u>	<u>\$435,224,561</u>	<u>\$40,452,615</u>	<u>\$187,289,015</u>

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, 1981 and 1980 and the related statement of investment income, expenses, grants and changes in foundation principal for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1981 and 1980 and the investment income, expenses, grants and changes in foundation principal for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Newark, New Jersey
January 15, 1982.

The Robert Wood Johnson Foundation
Statement of Assets,
Liabilities and Foundation Principal
at December 31, 1981 and 1980

	<u>1981</u>	<u>1980</u>
Assets		
Cash	\$ 646,147	\$ 210,339
Investments (at cost, or market value on dates of gifts) (Note 2):		
Johnson & Johnson common stock— 23,283,258 shares in 1981, 23,583,258 shares in 1980 (quoted market value \$864,390,953 and \$784,143,329) (Note 5)	222,484,388	225,351,054
Other corporate common stocks (quoted market value \$48,358,838 and \$52,231,448)	49,275,863	48,120,835
Fixed income investments (quoted market value \$174,993,526 and \$184,992,796)	215,629,969	228,684,864
Land, building, furniture and equipment at cost, net of depreciation (Note 1)	5,818,010	5,952,733
	<u>\$493,854,377</u>	<u>\$508,319,825</u>
 Liabilities and Foundation Principal		
Liabilities:		
Unpaid grants (Note 1)	\$ 83,279,574	\$ 94,284,119
Federal excise tax payable	917,536	819,864
Total liabilities	84,197,110	95,103,983
Foundation principal	<u>409,657,267</u>	<u>413,215,842</u>
	<u>\$493,854,377</u>	<u>\$508,319,825</u>

See notes to financial statements.

The Robert Wood Johnson Foundation
Statement of Investment Income,
Expenses, Grants and Changes in Foundation Principal
for the years ended December 31, 1981 and 1980

	<u>1981</u>	<u>1980</u>
Investment income (Note 1):		
Dividends	\$ 22,302,135	\$ 19,978,380
Interest	<u>23,914,225</u>	<u>21,451,124</u>
	46,216,360	41,429,504
Less: Federal excise tax	917,536	819,864
Investment expenses	<u>339,579</u>	<u>436,311</u>
	<u>44,959,245</u>	<u>40,173,329</u>
Expenses:		
Program development and evaluation	3,372,678	2,990,396
General administration	<u>1,052,119</u>	<u>857,310</u>
	<u>4,424,797</u>	<u>3,847,706</u>
Income available for grants	40,534,448	36,325,623
Grants, net of refunds and cancellations	<u>35,857,693</u>	<u>44,015,583</u>
	<u>4,676,755</u>	<u>(7,689,960)</u>
Adjustments to foundation principal:		
Net capital gains (losses) on sales of securities (Note 3)	(8,423,238)	2,067,699
Contributions received	<u>187,908</u>	<u>1,140,297</u>
	<u>(8,235,330)</u>	<u>3,207,996</u>
Net increase (decrease) in foundation principal	(3,558,575)	(4,481,964)
Foundation principal, beginning of year	<u>413,215,842</u>	<u>417,697,806</u>
Foundation principal, end of year	<u>\$409,657,267</u>	<u>\$413,215,842</u>

See notes to financial statements.

Notes to Financial Statements

1. Summary of significant accounting policies:

Grants are recorded as payable in the year the grant requests are authorized by the Board of Trustees. At December 31, 1981 unpaid grants are as follows:

<u>Year Grant Authorized</u>	<u>Amount Unpaid at December 31, 1981</u>
1977	\$ 448,861
1978	15,338,499
1979	12,442,786
1980	23,525,255
1981	<u>31,524,173</u>
	<u>\$83,279,574</u>

Depreciation of \$233,769 in 1981 and \$217,841 in 1980 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 value of the sizeable investment in Johnson & Johnson common stock does not necessarily represent the realizable value of such investment.
- The net capital gains (losses) on sales of securities for the years ended December 31, 1981 and 1980 were as follows:

	<u>1981</u>	<u>1980</u>
Johnson & Johnson common stock	\$ 7,446,205	\$6,536,675
Other securities, net	<u>(15,869,443)</u>	<u>(4,468,976)</u>
	<u>(\$ 8,423,238)</u>	<u>\$2,067,699</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 \$233,000 and \$179,000 in 1981 and 1980, respectively.
- Johnson & Johnson common stock held at December 31, 1980 has been adjusted to reflect the three for one split on May 18, 1981.

**Summary of grants
authorized in the year ended December 31, 1981**

	1981 grants authorized
University of Alaska Anchorage, Alaska <i>Rural health aide training program (ID#6181)</i>	\$ 177,153
American Academy of Pediatrics Evanston, Illinois <i>Health initiative program for the U.S.-Mexican border area (ID#6586)</i>	128,674
American College of Physicians Philadelphia, Pennsylvania <i>Program of the Society for Research and Education in Primary Care Internal Medicine (ID#4636)</i>	25,000
American Fund for Dental Health Chicago, Illinois <i>Nationwide preventive dental care program for school-age children (ID#5527)</i>	653,628
American Medical Association Education and Research Foundation Chicago, Illinois <i>Accreditation program for prison health care facilities (ID#6552)</i>	398,258
American Medical Women's Association Tucson, Arizona <i>Preparing medical school faculty for leadership roles in medical education (ID#6119)</i>	25,000
Aspira of America, Inc. New York, New York <i>Program to increase minority enrollment in medical schools (ID#6363)</i>	425,000
Association of American Medical Colleges Washington, D.C. <i>Financial aid administration programs (ID#6393)</i>	70,000

Beth Israel Hospital Boston, Massachusetts <i>Study of the use of functional assessment as a systematic tool in medical practice (ID#6592)</i>	\$ 600,000
Beth Israel Medical Center New York, New York <i>Primary care service in a public housing project for the elderly (ID#6256)</i>	119,275
Trustees of Health and Hospitals of the City of Boston, Inc. Boston, Massachusetts <i>Program to increase the return-to-work rate of heart attack victims (ID#6244)</i>	589,678
Brigham and Women's Hospital Boston, Massachusetts <i>Administration of the Foundation's Teaching Hospital General Medicine Group Practice Program (ID#5497)</i>	202,530
University of California, Los Angeles Los Angeles, California <i>Evaluation of the Foundation's School Health Services Program (ID#6269)</i>	248,364
<i>Evaluation of the Foundation's Chronic Disease Care Program (ID#6302)</i>	448,964
University of California, San Francisco, School of Medicine San Francisco, California <i>Planning an evaluation of emerging provisions for services for handicapped children—Phase I (ID#6284)</i>	24,750
<i>Study of patterns of physician use among low-income chronically ill persons (ID#6374)</i>	6,165
University of Chicago Chicago, Illinois <i>Research on the consequences of teenage motherhood and implications for health policy (ID#6369)</i>	25,000
<i>Evaluation of the Foundation's Municipal Health Services Program (ID#6798)</i>	336,669

Chicano Health Policy Development, Inc. San Antonio, Texas <i>Statewide program to identify and prepare Mexican-American college students for medical studies (ID#6168)</i>	\$ 149,891
<hr/>	
Children's Hospital Medical Center Boston, Massachusetts <i>Planning an evaluation of emerging provisions for services for handicapped children— Phase II (ID#6328)</i>	140,861
<hr/>	
The Foundation's Clinical Scholar Program <i>National program to prepare young physicians for new roles in medical care (ID#5109)</i>	
University of Pennsylvania, School of Medicine Philadelphia, Pennsylvania	78,112
Administrative costs Princeton, New Jersey	150,000
<hr/>	
Columbia University New York, New York <i>Evaluation of the Foundation's Municipal Health Services Program (ID#4432)</i>	391,848
<hr/>	
The Foundation's Community Care Funding Partners Program <i>Development of programs for the medically underserved (ID#6397)</i>	
Urban Affairs Corporation Houston, Texas <i>Primary care program for adolescents (ID#5822)</i>	192,000
Administrative costs Princeton, New Jersey	199,000
<hr/>	
Community Hospital Group, Inc. Edison, New Jersey <i>Equipment support for the Robert Wood Johnson Jr. Rehabilitation Institute (ID#6101)</i>	48,500
<hr/>	
University of Connecticut, School of Dental Medicine Farmington, Connecticut <i>Analysis of the effects of dental disease on worker productivity (ID#6746)</i>	54,489

The Foundation's Program to Consolidate Health Services for
High-Risk Young People (ID#6331)*Cooperative efforts of teaching hospitals and public
or voluntary agencies*

Boston City Hospital Boston, Massachusetts	\$ 590,633
Bronx-Lebanon Hospital Center New York, New York	600,000
University of California, San Diego, School of Medicine San Diego, California	599,924
University of California, San Francisco, School of Medicine San Francisco, California	600,000
Children's Hospital of Michigan Detroit, Michigan	595,640
Children's Hospital of Los Angeles Los Angeles, California	599,969
University of Cincinnati General Hospital Cincinnati, Ohio	600,000
University of Connecticut, School of Medicine Farmington, Connecticut	600,000
Cook County Hospital Chicago, Illinois	600,000
Cuyahoga County Hospital Cleveland, Ohio	598,199
Dallas County Hospital District, Parkland Memorial Hospital Dallas, Texas	599,581
Howard University Hospital Washington, D.C.	600,000
Indiana University Foundation Indianapolis, Indiana	600,000
The Johns Hopkins Hospital Baltimore, Maryland	599,791
University of Maryland, School of Medicine Baltimore, Maryland	599,959
University of Mississippi Medical Center Jackson, Mississippi	591,738
Montefiore Hospital and Medical Center Bronx, New York	599,460
University of Oklahoma Health Sciences Center Oklahoma City, Oklahoma	600,000

	1981 grants authorized
University of Rochester, School of Medicine and Dentistry Rochester, New York	\$ 599,763
Yale-New Haven Hospital New Haven, Connecticut	600,000
<hr/>	
Cornell University Medical College New York, New York	
<i>Support of a computerized neurology data bank (ID#6024)</i>	252,503
<i>Administration of the Foundation's Chronic Disease Care Program (ID#5495)</i>	163,729
<i>Administration of the Foundation's General Pediatrics Academic Development Program (ID#5496)</i>	67,071
<i>Training physicians in the use of new technologies for patient self-management of diabetes (ID#6167)</i>	171,388
<hr/>	
Dartmouth Medical School Hanover, New Hampshire	
<i>Evaluation of health care costs and patients' functional status in primary care settings (ID#6215)</i>	149,772
<hr/>	
District of Columbia, Department of Human Services Washington, D.C.	
<i>Infant mortality study (ID#6501)</i>	23,500
<hr/>	
Educational Testing Service— Education Policy Research Institute Princeton, New Jersey	
<i>Analysis of minority enrollment in medical education (ID#6630)</i>	18,901
<hr/>	
The Foundation's Family Practice Faculty Fellowships Program <i>Program to prepare physicians for academic careers in family practice (ID#3579)</i>	
University of Iowa, College of Medicine Iowa City, Iowa	649,168
University of Utah, College of Medicine Salt Lake City, Utah	847,315
University of Washington, School of Medicine Seattle, Washington	737,498
<hr/>	
The Foundation Center New York, New York	
<i>Program office for Grantmakers in Health (ID#7354)</i>	150,000
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Georgetown University Washington, D.C. <i>Completion of a project to develop a system of medically assisted self-care (ID#6947)</i>	\$ 33,000
Georgetown University, School of Medicine Washington, D.C. <i>Analysis of health policy issues (ID#6097)</i>	185,603
Glens Falls Hospital Glens Falls, New York <i>Development of multi-hospital delivery alternatives for five hospitals in rural New York state (ID#6276)</i>	25,000
Harvard University, School of Public Health Boston, Massachusetts <i>Evaluation of the Foundation's Rural Infant Care Program (ID#5146)</i>	588,601
The Foundation's Health Policy Fellowships Program	
<i>One-year fellowships with federal government in Washington, D.C., for faculty from academic health science centers (ID#4888)</i>	
Georgetown University, School of Medicine Washington, D.C.	36,510
University of Mississippi Medical Center Jackson, Mississippi	35,400
University of North Carolina, School of Pharmacy Chapel Hill, North Carolina	35,400
University of Pennsylvania, School of Nursing Philadelphia, Pennsylvania	37,110
Washington University, School of Medicine St. Louis, Missouri	32,907
University of Wisconsin Medical School Madison, Wisconsin	35,700
Home Health Agency Assembly of New Jersey, Inc. Princeton, New Jersey <i>Establishment of a consultant services unit (ID#6444)</i>	25,000

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

Hospital Research and Educational Trust Chicago, Illinois	
<i>Production of educational materials for the Foundation's Rural Hospital Program of Extended-Care Services (ID#6298)</i>	120,000
<i>Collaborative forecasting of the health care services environment (ID#6255)</i>	78,000
<i>Administration of the Foundation's Community Programs for Affordable Health Care (ID#6755)</i>	339,840

Industrywide Network for Social, Urban and Rural Efforts New York, New York	
<i>Initial study of preventive services and health (ID#6774)</i>	400,000

Institute for the Future Menlo Park, California	
<i>Collaborative forecasting of the health care services environment (ID#6134)</i>	261,290

The Johns Hopkins Hospital Baltimore, Maryland	
<i>Administration of the Foundation's Municipal Health Services Program (ID#5494)</i>	130,749

The Johns Hopkins University, School of Medicine Baltimore, Maryland	
<i>Administration of the Foundation's School Health Services Program (ID#5493)</i>	74,735

The Johns Hopkins University, School of Hygiene and Public Health Baltimore, Maryland	
<i>Evaluation of the Foundation's Regionalized Perinatal Program (ID#6507)</i>	53,217
<i>Study of capital availability for hospitals in the 1980s (ID#6796)</i>	63,215

Kingston Hospital Kingston, New York <i>Administration of the Foundation's Program for the Health-Impaired Elderly & Perinatal Program (ID#5492)</i>	\$ 187,825
<hr/>	
La Clinica de La Raza Oakland, California <i>Planning project to strengthen the health center's future financial base (ID#5904)</i>	150,000
<hr/>	
Massachusetts General Hospital Boston, Massachusetts <i>Study of myocardial infarction patients by the medical evaluation practice unit (ID#6265)</i>	252,177
<hr/>	
Mayo Foundation Rochester, Minnesota <i>Reserves for the Foundation's Primary Care Practice Loan Guarantee Program (ID#6330)</i>	1,000,000
<hr/>	
The Foundation's Medical Practice Research and Development Program (ID#6329) University of Alabama, School of Medicine Birmingham, Alabama <i>Adaptation of hypertension and smoking cessation programs to primary care practices</i>	149,847
Albany Medical College of Union University Albany, New York <i>An early detection and intervention protocol for mental impairment in the elderly</i>	149,428
University of Arkansas, College of Medicine Little Rock, Arkansas <i>Treatment trial of patients with psychosomatic illnesses in a primary care setting</i>	149,942
University of California, San Francisco, School of Medicine San Francisco, California <i>Baseline study of chronic disease care patterns</i>	122,828
<i>Evaluation of social isolation as a factor of functional recovery from hip fracture</i>	149,996

	1981 grants authorized
Case Western Reserve University, School of Medicine Cleveland, Ohio <i>Evaluation of family dysfunction as a factor in moderate infant growth failure</i>	\$ 149,909
Cornell University Medical College New York, New York <i>Program to prevent complications in diabetics undergoing surgery</i>	148,744
The Johns Hopkins University, School of Hygiene and Public Health Baltimore, Maryland <i>Promotion of post-trauma functional recovery</i>	149,944
Maine Medical Center Portland, Maine <i>Study of causes and interventions related to falls by elderly people</i>	145,794
Medical Associates Research and Education Foundation (The Children's Hospital of Philadelphia—University of Pennsylvania) <i>Study to document and reduce problems following pediatric day surgery</i>	69,250
<i>Investigating and decreasing functional morbidity following head trauma in children</i>	65,800
University of Minnesota Medical School Minneapolis, Minnesota <i>Study to reduce the frequency and severity of attacks in childhood asthma</i>	76,914
<i>Evaluation of medical treatment in chronic otitis media with effusion</i>	143,391
<i>Reducing sleep reduction of high-risk infants—study of its effects on growth</i>	149,192
University of North Carolina, School of Medicine Chapel Hill, North Carolina <i>Study of the induction and augmentation of labor</i>	141,604

New York University, School of Medicine New York, New York <i>Diabetes education and management at the worksite</i>	\$ 149,662
New York Society for the Relief of the Ruptured and Crippled (The Hospital for Special Surgery) New York, New York <i>Assessment of total knee replacement</i>	149,808
University of Rochester, School of Medicine and Dentistry Rochester, New York <i>Maintaining functional effectiveness of radiation therapy patients</i>	149,994
Stanford University, School of Medicine Stanford, California <i>Identification and evaluation of interventions to improve functional outcomes for patients recovered from Hodgkin's disease</i>	148,524
<i>Study of cerebellar stimulation as a means to improve the functional status of patients with cerebral palsy</i>	149,970
University of Texas Medical School at San Antonio San Antonio, Texas <i>Evaluation of strategies for reducing costs and disability from low back pain</i>	141,831
West Virginia University, School of Medicine Morgantown, West Virginia <i>Primary care test of a home-monitoring and patient education system for controlling diabetes</i>	146,106
University of Wisconsin Medical School Madison, Wisconsin <i>Study of behavioral approaches to control cancer pain and improve patients' functional abilities</i>	147,679
Administrative costs Princeton, New Jersey	200,000

Meharry Medical College Nashville, Tennessee	
<i>Administration of the Foundation's Program to Consolidate Health Services for High-Risk Young People (ID#6333)</i>	\$ 227,322
<i>Strengthening management and faculty capabilities (ID#6288)</i>	1,400,000
Middlesex County College Edison, New Jersey	
<i>Registered nurse refresher course (ID#5521)</i>	10,000
Middlesex County College Foundation, Inc. Edison, New Jersey	
<i>Health sciences scholarship program (ID#5522)</i>	19,000
University of Missouri, School of Medicine Columbia, Missouri	
<i>Administration of the Foundation's Rural Infant Care Program (ID#6078)</i>	141,310
Montefiore Hospital and Medical Center Bronx, New York	
<i>Administration of the Foundation's Urban Health Program (ID#6068)</i>	117,054
Montefiore Hospital and Medical Center—Loeb Center for Nursing and Rehabilitation Bronx, New York	
<i>Planning for a demonstration to improve outcomes for chronically ill adults (ID#5986)</i>	25,939
<i>Program to improve outcomes for chronically ill adults (ID#6245)</i>	586,470
National Academy of Sciences Washington, D.C.	
<i>Publication of reports resulting from the Foundation's Emergency Medical Response Program (ID#6204)</i>	8,627
<i>Support of the Institute of Medicine (ID#6286)</i>	1,000,000
National Association of Community Health Centers Washington, D.C.	
<i>Technical assistance for the development of statewide primary care associations (ID#6157)</i>	373,151

	1981 grants authorized
National Fund for Medical Education Hartford, Connecticut <i>Support of summer programs for minority premedical students (ID#6598)</i>	\$ 101,552
National Medical Fellowships, Inc. New York, New York <i>Scholarships for minority medical students (ID#6601)</i>	300,000
University of Medicine and Dentistry of New Jersey Newark, New Jersey <i>Program to prepare minority students for careers in medicine and dentistry (ID#6180)</i>	199,559
University of Medicine and Dentistry of New Jersey, Rutgers Medical School Piscataway, New Jersey <i>Planning and development of improved educational and training programs for Rutgers Medical School (ID#5436)</i>	487,305
The New Jersey Historical Society Newark, New Jersey <i>Restoration and maintenance of the gubernatorial mansions (ID#7290)</i>	100,000
New Jersey State Department of Health Trenton, New Jersey <i>Evaluation of statewide access to medical care (ID#6573)</i>	19,000
New York University New York, New York <i>Administration of the Foundation's Rural Hospital Program of Extended-Care Services (ID#6297)</i>	331,962
Ohio Presbyterian Homes Columbus, Ohio <i>Planning and organizing services for the non-institutionalized elderly (ID#6170)</i>	173,800
Pace University, Graduate School of Nursing Pleasantville, New York <i>Graduate program in primary care nursing (ID#6226)</i>	480,095

Palmetto Family Health Care Center Pacolet, South Carolina <i>Evaluation of a health-related data system (ID#6535)</i>	\$ 55,420
<hr/>	
Palo Alto Medical Research Foundation Palo Alto, California <i>Study of the changes in medical costs of selected illnesses, 1951-1981 (ID#6266)</i>	100,000
<hr/>	
University of Pennsylvania, School of Nursing Philadelphia, Pennsylvania <i>Administration of the Foundation's Teaching Nursing Home Program (ID#6437)</i>	249,410
<hr/>	
University of Pennsylvania, Wharton School Philadelphia, Pennsylvania <i>Nationwide study of life care communities (ID#6162)</i>	144,838
<hr/>	
City of Philadelphia, Department of Public Health Philadelphia, Pennsylvania <i>A public-private examination of municipal health priorities (ID#6420)</i>	250,000
<hr/>	
Plainsboro Rescue Squad, Inc. Plainsboro, New Jersey <i>Training equipment (ID#6688)</i>	5,000
<hr/>	
Plainsboro Township Plainsboro, New Jersey <i>Contribution toward capital needs (ID#6873)</i>	30,000
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Plainsboro Volunteer Fire Company No. 1, Inc. Plainsboro, New Jersey <i>Equipment for aerial pumper truck (ID#6682)</i>	5,000
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The Foundation's Primary Care Practice Loan Guarantee Program <i>Development of satellite care operations in medically underserved areas (ID#6410)</i> Administrative costs Princeton, New Jersey	53,320

Project Info Port Angeles, Washington <i>Development of a county-wide, health resources information and referral service (ID#6401)</i>	\$ 16,050
The Rand Corporation Santa Monica, California <i>Evaluation of a nationwide preventive dental care program for school-age children (ID#5882)</i>	949,185
University of Rochester, School of Medicine and Dentistry Rochester, New York <i>Administration of the Foundation's Community Hospital-Medical Staff Group Practice Program (ID#5491)</i>	196,863
Rural Practice Network, Inc. Jackson, North Carolina <i>Development of a self-sustaining affiliation of rural practice projects (ID#6006)</i>	100,000
Salvation Army New Brunswick, New Jersey <i>Program of assistance to the indigent (ID#5510)</i>	43,000
St. Peter's School of Nursing New Brunswick, New Jersey <i>Nurse training program (ID#6069)</i>	30,000
St. Vincent de Paul Society Highland Park, New Jersey <i>Program of assistance to the indigent (ID#5505)</i>	17,000
Society of Teachers of Family Medicine Kansas City, Missouri <i>Study of interrelationships between family and preventive medicine (ID#6800)</i>	20,000
Tulane Medical Center New Orleans, Louisiana <i>Program to increase minority enrollment in medical schools (ID#6597)</i>	349,995

United States Council on the International Year of Disabled Persons Washington, D.C. <i>National public education on the needs and potential of disabled Americans (ID#6254)</i>	\$ 25,000
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United Student Aid Funds, Inc. New York, New York <i>The Foundation's Guaranteed Student Loan Program for medical, dental and osteopathic students (ID#6316)</i>	500,000
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United Way of Central Jersey, Inc. Milltown, New Jersey <i>1981 campaign (ID#5520)</i>	200,000
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United Way—Princeton Area Communities Princeton, New Jersey <i>1981 campaign (ID#5509)</i>	30,000
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Vanderbilt University, Center for Health Services Nashville, Tennessee <i>Program to improve rural community health services (ID#6237)</i>	150,000
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Vanderbilt University, School of Nursing Nashville, Tennessee <i>Administration of the Foundation's Nurse Faculty Fellowships Program (ID#5478)</i>	79,442
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Virginia Commonwealth University Richmond, Virginia <i>Administration of the Foundation's Hospital-Sponsored Ambulatory Dental Services Program (ID#5489)</i>	202,218
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Virginia Commonwealth University, School of Dentistry Richmond, Virginia <i>Dental fellowship feasibility study (ID#7171)</i>	24,983
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University of Virginia, School of Medicine Charlottesville, Virginia <i>A program to help people disabled by a minor head injury to maintain or regain normal function (ID#6240)</i>	479,817

**1981 grants
authorized**

University of Washington, School of Medicine Seattle, Washington	
<i>Publication on access to medical care (ID#6527)</i>	\$ 11,195
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Yale University, School of Medicine New Haven, Connecticut	
<i>Feasibility study of reorganized, statewide maternal and child health programs (ID#5950)</i>	24,643
<i>Assessment of clinical strategies in patient care (ID#6309)</i>	499,934
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Total 1981 grants	\$40,133,260
Refunds of prior years' grants	(252,984)
Cancellations	<u>(4,022,583)</u>
Grants net for 1981	<u>\$35,857,693</u>

**Summary of grants
authorized in previous years,
and with unpaid balances on January 1, 1981**

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

University of Alaska
Anchorage, Alaska
Rural health aide training program (ID#3790)
1978—\$164,694

Allegheny General Hospital
Pittsburgh, Pennsylvania
*Primary care training program for emergency
department nurses (ID#5426)*
1980—\$89,599

American College of Physicians
Philadelphia, Pennsylvania
*Support of the Society for Research and
Education in Primary Care Medicine
(ID#4260)*
1978—\$129,056
*Study of the practice and training of internists
(ID#5239)*
1979—\$158,550

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

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

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

Aspira of America, Inc.
New York, New York
*Program to increase minority enrollment in
medical schools (ID#5191)*
1979—\$365,203

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

Association of American Medical Colleges
Washington, D.C.
*Financial aid administration programs
(ID#4657)*
1979—\$130,000

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

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

Barrio Comprehensive Child Care Center
San Antonio, Texas
*Primary care service program for Mexican-
American children (ID#3834)*
1978—\$390,000

Boston City Hospital
Boston, Massachusetts
*Development of urban health program for
adolescents and young families (ID#5446)*
1980—\$931,146; 1979—\$95,075

*Program to train physicians in primary care
(ID#5011)*
1979—\$100,000

Boston University
Boston, Massachusetts
*Developmental assistance for independent
practice associations (ID#4265)*
1978—\$441,425

Boys' Clubs of America
New York, New York
*Health services and education program
(ID#0953)*
1977—\$498,138

Brandeis University
Waltham, Massachusetts
*Support of the Committee on the Growth of
Hospital-Sponsored Ambulatory Care
(ID#5180)*
1979—\$608,881
*Evaluation of the viability of Foundation-
sponsored individual service programs
(ID#5971)*
1980—\$358,081

Brigham and Women's Hospital, Inc.
Boston, Massachusetts
*Administration of the Foundation's Teaching
Hospital General Medicine Group Practice
Program (ID#5332)*
1980—\$203,322

Town of Brookline, Massachusetts, Public
Schools
Brookline, Massachusetts
*Health program for infants and preschool
children (ID#5181)*
1979—\$519,392

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

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#4832)*
1980—\$302,690; 1976—\$594,835
*Evaluation of the Foundation's Hospital-
Sponsored Ambulatory Dental Services
Program (ID#4756)*
1980—\$676,362

University of California, Los Angeles, School of
Medicine
Los Angeles, California
*Study of health decision making among children
(ID#4126)*
1977—\$303,461
*Evaluation of the Foundation's Teaching
Hospital General Medicine Group Practice
Program (ID#5318)*
1980—\$1,113,536

University of California, San Francisco, School
of Medicine
San Francisco, California
*Establishment of a health policy center
(ID#2455)*
1976—\$1,000,000

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

University of Chicago
Chicago, Illinois
*Evaluation of the Foundation's Community
Hospital-Medical Staff Group Practice
Program (ID#3869)*
1979—\$1,419,985; 1977—\$1,151,689
*Study of practice profiles of primary care
physicians (ID#5970)*
1980—\$499,993

Children's Hospital Medical Center
Boston, Massachusetts
*Program to train clinical faculty in child
development (ID#4546)*
1979—\$497,340

The Foundation's Chronic Disease Care Program
*Development of physician-directed, nurse-
managed programs providing ambulatory care
for patients with chronic diseases (ID#4555)*

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

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

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

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

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

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

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

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

La Clinica de la Raza
Oakland, California
*Program to improve community health services
(ID#3124)*
1977—\$267,185

The Foundation's Clinical Scholar Program
*National program to prepare young physicians
for new roles in medical care (ID#2493)*

University of California, Los Angeles, School
of Medicine
Los Angeles, California
1980—\$946,493; 1977—\$714,232

University of California, San Francisco,
School of Medicine and Stanford
University, School of Medicine
San Francisco, California
1980—\$925,288; 1977—\$799,673

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

McGill University, Faculty of Medicine
Quebec, Canada
1980—\$147,331

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

University of Pennsylvania, School of
Medicine
Philadelphia, Pennsylvania
1980—\$913,778

Stanford University, School of Medicine
Stanford, California
1980—\$56,342

- University of Washington, Seattle, School of
Medicine
Seattle, Washington
1980—\$935,494; 1977—\$600,147
- Yale University, School of Medicine
New Haven, Connecticut
1980—\$914,981; 1977—\$799,792
- Administrative costs
Princeton, New Jersey
1980—\$150,000
- Columbia University
New York, New York
*Evaluation of the Foundation's Municipal Health
Services Program (ID#4027)*
1978—\$392,026
*Public policy programs in health services and
manpower (ID#5072)*
1979—\$423,967; 1976—\$333,773
- Columbia University, School of Public Health
New York, New York
*Study of utilization of medical services by urban
black youths (ID#5420)*
1980—\$62,158
- The Foundation's Community Hospital-Medical
Staff Group Practice Program
*Grants for the development of hospital-sponsored
primary care group practices (ID#4470)*
- Appalachian Regional Hospitals, Inc.
Lexington, Kentucky
1978—\$483,980
- Bethesda Lutheran Hospital
St. Paul, Minnesota
1976—\$499,790
- 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
- Humboldt General Hospital
Winnemucca, Nevada
1977—\$500,000
- Huron Road Hospital
East Cleveland, Ohio
1979—\$500,000
- Jackson Hospital and Clinic, Inc.
Montgomery, Alabama
1979—\$492,214
- Joint Hospital Committee for Extramural
Affairs
Aberdeen, Washington
1977—\$494,160
- Lakewood Hospital
Lakewood, Ohio
1976—\$498,020
- Lutheran Charities Association of St. Louis,
Missouri
St. Louis, Missouri
1976—\$475,105
- Lutheran Hospital and Medical Center
Wheat Ridge, Colorado
1976—\$500,000
- Lutheran Hospital of Maryland, Inc.
Baltimore, Maryland
1976—\$496,170
- Marion County Hospital Authority
Buena Vista, Georgia
1978—\$500,000
- The Memorial Hospital
Worcester, Massachusetts
1976—\$475,000

Memorial Hospital of Alamance County, Inc. Burlington, North Carolina 1976 — \$487,944	St. Joseph's Hospital and Medical Center Paterson, New Jersey 1976 — \$500,000
Memorial Hospital of Phoenix Phoenix, Arizona 1976 — \$498,942	St. Lawrence Hospital Lansing, Michigan 1977 — \$491,993
Mercy Hospital Springfield, Massachusetts 1976 — \$490,000	St. Luke's Hospital Aberdeen, South Dakota 1976 — \$498,169
Mercy Hospital Watertown, New York 1977 — \$500,000	St. Vincent Hospital and Medical Center Portland, Oregon 1977 — \$499,727
Nashua Hospital Association Nashua, New Hampshire 1977 — \$500,000	San Bernardino County Medical Center San Bernardino, California 1977 — \$499,967
New York Infirmary New York, New York 1977 — \$500,000	Scottsdale Memorial Hospital Scottsdale, Arizona 1977 — \$498,103
Northeast Alabama Regional Medical Center Anniston, Alabama 1979 — \$500,000	Sisters of Mercy Health Corporation Sioux City, Iowa 1977 — \$500,000
Providence Hospital Washington, D.C. 1978 — \$500,000	Herbert J. Thomas Memorial Hospital Association South Charleston, West Virginia 1976 — \$485,456
Providence Medical Center Seattle, Washington 1977 — \$500,000	Waterville Osteopathic Hospital Waterville, Maine 1977 — \$467,994
Richmond Memorial Hospital Richmond, Virginia 1976 — \$497,000	Wausau Hospital, Inc. Wausau, Wisconsin 1977 — \$456,117
St. Francis Hospital Honolulu, Hawaii 1976 — \$491,030	Williamsburg County Memorial Hospital Kingstree, South Carolina 1977 — \$485,185
St. Francis Hospital Topeka, Kansas 1976 — \$446,296	Comprehensive Interdisciplinary Developmental Services, Inc. Elmira, New York <i>Study of Chemung County, New York, maternal and early infant care program (ID#5263)</i> 1979 — \$183,203
St. Joseph Mercy Hospital Ann Arbor, Michigan 1978 — \$499,910	

University of Connecticut Health Center
Hartford, Connecticut
*Development of a school-based health care
program (ID#3835)*
1978—\$537,225

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

Cornell University Medical College
New York, New York
*Administration of the Foundation's Chronic
Disease Care Program (ID#5183)*
1980—\$127,814
*Administration of the Foundation's General
Pediatrics Academic Development Program
(ID#5333)*
1980—\$55,450

The East Los Angeles Community Union
East Los Angeles, California
*Support of a family health care center
(ID#5158)*
1979—\$232,000

Educational Testing Service
Princeton, New Jersey
*Evaluation of the Foundation's program to train
dentists in the care of the handicapped
(ID#4890)*
1979—\$81,029

The Foundation's Family Practice Faculty
Fellowship Program
*Program to prepare physicians for academic
careers in family practice (ID#3457)*

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

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

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

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

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

University of Florida, College of Medicine
Gainesville, Florida
*Program to train physicians in primary care
(ID#4808)*
1978—\$449,794

The Foundation Center
New York, New York
*Data collection and analysis on the foundation
field (ID#5429)*
1980—\$150,000

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

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

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

- Medical Associates Research and Education Foundation
Philadelphia, Pennsylvania
1979 — \$799,968
- University of Rochester, School of Medicine and Dentistry
Rochester, New York
1979 — \$837,570
- Stanford University, School of Medicine
Stanford, California
1979 — \$842,604
- Yale University, School of Medicine
New Haven, Connecticut
1979 — \$787,165
- The George Washington University
Washington, D.C.
National Health Policy Forum (ID#5209)
1979 — \$300,000
- Georgetown University, School of Medicine
Washington, D.C.
Developing a system of medically-assisted self-care (ID#4485)
1979 — \$431,888
Analysis of health policy issues (ID#5483)
1980 — \$188,834
- Georgia Department of Human Resources
Atlanta, Georgia
Primary care health services program (ID#3830)
1979 — \$615,781
- Good Samaritan Hospital and Medical Center
Portland, Oregon
Primary care training program for emergency department nurses (ID#4512)
1978 — \$314,459
- Group Health Foundation
Washington, D.C.
Program to equip physicians with professional management skills (ID#4985)
1979 — \$151,280
- Harvard University, Medical School
Boston, Massachusetts
Program to train physicians for primary medical care (ID#3089)
1977 — \$733,788
Evaluation of the Foundation's Program for the Health-Impaired Elderly (ID#5141)
1980 — \$450,000
- Harvard University, School of Public Health
Cambridge, Massachusetts
Support of the School of Public Health (ID#5213)
1979 — \$670,000
Planning the evaluation of the Foundation's Rural Infant Care Program (ID#5320)
1980 — \$23,918
- The Foundation's Program for the Health-Impaired Elderly
Coordination and integration of services at the community level for elderly people with health problems (ID#4884)
- First Tennessee-Virginia Development District
Johnson City, Tennessee
1980 — \$447,594
- The Illinois Department of Aging
Springfield, Illinois
1980 — \$581,932
- State of Maryland Office on Aging
Baltimore, Maryland
1980 — \$592,605
- Nebraska Commission on Aging
Lincoln, Nebraska
1980 — \$600,000
- New York State Office for the Aging
Albany, New York
1980 — \$600,000
- Ohio Commission on Aging
Columbus, Ohio
1980 — \$599,860
- Philadelphia Corporation for Aging
Philadelphia, Pennsylvania
1980 — \$600,000

- South Carolina Commission on Aging
Columbia, South Carolina
1980—\$548,135
- Hermann Hospital Estate
Houston, Texas
Primary care training program for emergency department nurses (ID#4078)
1978—\$322,211
- Hospital Research and Educational Trust
Chicago, Illinois
Development of a financial and administrative assistance program for hospitals attempting to improve their outpatient departments (ID#5460)
1980—\$350,000
- The Foundation's Hospital-Sponsored
Ambulatory Dental Services Program
Programs of general and emergency dental care and oral hygiene education for dentally-underserved people (ID#4553)
- The Brigham and Women's Hospital, Inc.
Boston, Massachusetts
1979—\$340,165
- Buffalo General Hospital
Buffalo, New York
1979—\$500,000
- The Genesee Hospital
Rochester, New York
1979—\$337,033
- Highland General Hospital
Oakland, California
1979—\$321,503
- Illinois Masonic Medical Center
Chicago, Illinois
1979—\$414,275
- University of Iowa Hospitals and Clinics
Iowa City, Iowa
1979—\$497,443
- Loma Linda University Medical Center
Loma Linda, California
1979—\$383,838
- Long Island Jewish-Hillside Medical Center
New Hyde Park, New York
1979—\$399,518
- Lutheran Medical Center
Brooklyn, New York
1979—\$499,925
- Middlesex General Hospital
New Brunswick, New Jersey
1979—\$449,366
- Newark Beth Israel Medical Center
Newark, New Jersey
1979—\$498,366
- North Carolina Memorial Hospital
Chapel Hill, North Carolina
1979—\$500,000
- The Medical College of Pennsylvania
Philadelphia, Pennsylvania
1979—\$444,097
- Provident Hospital, Inc.
Baltimore, Maryland
1979—\$343,385
- Public Health Trust of Dade County, Florida
— Jackson Memorial Hospital
Miami, Florida
1979—\$435,390
- The Richmond County Hospital Authority
Augusta, Georgia
1979—\$326,966
- St. Anthony Hospital
Oklahoma City, Oklahoma
1979—\$210,856
- St. Clare's Hospital
Schenectady, New York
1979—\$401,581
- St. Francis Hospital
Honolulu, Hawaii
1979—\$471,387
- Saint Francis Hospital and Medical Center
Hartford, Connecticut
1979—\$291,794

- St. Luke's Hospital
Cleveland, Ohio
1979—\$336,388
- University of Southern California
Medical Center
Los Angeles, California
1979—\$444,963
- University of Tennessee Memorial Hospital
and Research Center
Knoxville, Tennessee
1979—\$411,796
- University of Washington, School of
Dentistry
Seattle, Washington
1979—\$464,567
- Wilmington Medical Center
Wilmington, Delaware
1979—\$409,360
- Indiana University Foundation
Indianapolis, Indiana
*Program to prepare clinical nursing faculty in
primary care (ID#3844)*
1978—\$240,029
- Institute for Prepayment Studies, Inc.
Newark, New Jersey
*Evaluation of a primary care oriented
reimbursement system (ID#4352)*
1979—\$498,923
- University of Iowa, College of Medicine
Iowa City, Iowa
*Advanced emergency medicine for physician
assistants and emergency nurses (ID#4837)*
1979—\$309,419
*Iowa Rural Practice Development Program
(ID#5745)*
1980—\$355,927
*Follow-up program for newborns treated in
intensive care units (ID#5267)*
1980—\$300,000
- Jackson State University
Jackson, Mississippi
*Program to increase minority enrollment in
medical schools (ID#5342)*
1979—\$104,780
- The Johns Hopkins Hospital
Baltimore, Maryland
*Foster family care project for the frail elderly
(ID#5716)*
1980—\$251,046; 1978—\$164,197
*Administration of the Foundation's Municipal
Health Services Program (ID#5187)*
1980—\$104,592
- The Johns Hopkins University, Center for Health
Services Research and Development
Baltimore, Maryland
*Evaluation of the Foundation's Perinatal
Program (ID#4023)*
1978—\$795,000
- The Johns Hopkins University, School of
Medicine
Baltimore, Maryland
*Program to prepare faculty in emergency
medicine (ID#3206)*
1978—\$713,554
*Administration of the Foundation's School
Health Services Program (ID#5334)*
1980—\$68,215
- Kingston Hospital
Kingston, New York
*Administration of the Foundation's Program for
the Health-Impaired Elderly and Perinatal
Program (ID#5335)*
1980—\$180,448
- Lake Erie College
Painesville, Ohio
*Program with the Cleveland Clinic to train
physician assistants (ID#5013)*
1979—\$182,242
- Maine Medical Center
Portland, Maine
*Postgraduate physician assistant residency
program in emergency medicine (ID#4844)*
1979—\$295,171

Maricopa County General Hospital Research
Foundation
Phoenix, Arizona
*Primary care training program for emergency
department nurses (ID#3786)*
1978 — \$291,314

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

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

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

University of Missouri, Columbia, School of
Medicine
Columbia, Missouri
*Administration of the Foundation's Rural Infant
Care Program (ID#5490)*
1980 — \$147,416

Montefiore Hospital and Medical Center
Bronx, New York
*Development and implementation of a service
program for adolescents with chronic illness
(ID#4858)*
1979 — \$338,744
Development of a child care program (ID#5390)
1980 — \$100,000
*Administration of the Foundation's Urban
Health Program (ID#5481)*
1980 — \$178,020

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

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

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

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

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

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

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

National Academy of Sciences, Institute of
Medicine
Washington, D.C.
Fellowships in health policy program (ID#4496)
1978 — \$408,430
Support of the Institute of Medicine (ID#3836)
1978 — \$750,000

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

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

National Council on the Aging, Inc.
Washington, D.C.
*Expanded health services for the elderly
(ID#5811)*
1980 — \$70,000

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

National Fund for Medical Education
Hartford, Connecticut
*Summer programs for minority premedical
students (ID#5826)*
1980—\$100,000

National Medical Fellowships, Inc.
New York, New York
*Scholarship program for minority medical
students (ID#5479)*
1980—\$300,000

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

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

New Brunswick Board of Education
New Brunswick, New Jersey
*Program to study school health services
(ID#5594)*
1980—\$65,000

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

University of Medicine and Dentistry of
New Jersey
Newark, New Jersey
*Program to prepare minority students for
preprofessional careers in medicine and
dentistry (ID#2795)*
1976—\$264,592

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

University of North Carolina, School of Public
Health
Chapel Hill, North Carolina
*Role of state and local health departments in
ambulatory care (ID#4344)*
1978—\$121,732

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

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

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

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

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

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

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

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

Pace University, Graduate School of Nursing
New York, New York
*Graduate program in primary care nursing
(ID#3839)*
1978—\$350,030

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

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

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

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

University of Pittsburgh, Graduate School of
Public Health
Pittsburgh, Pennsylvania
*Development of a guide for financing,
organizing, and staffing pre-hospital
emergency medical service (ID#5140)*
1979—\$171,569

Posen-Robbins School District
Posen, Illinois
*Implementation of a school-based health care
program (ID#4420)*
1980—\$113,256

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

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

University of Rochester, School of Medicine and
Dentistry
Rochester, New York
*Program to train physicians for careers in
primary care (ID#3090)*
1977—\$643,760
*Administration of the Foundation's Community
Hospital-Medical Staff Group Practice
Program (ID#3757)*
1980—\$278,573; 1979—\$406,242

University of Rochester, School of Nursing
Rochester, New York
*Graduate program in primary nursing
(ID#4350)*
1978—\$424,560

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

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

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

- Louisiana State University, School of
Medicine
Shreveport, Louisiana
1980—\$395,389
- Medical University of South Carolina, School
of Medicine
Charleston, South Carolina
1980—\$349,513
- University of New Mexico, School of
Medicine
Albuquerque, New Mexico
1980—\$341,161
- Ohio State University Research Foundation
Columbus, Ohio
1980—\$328,026
- University of Oklahoma, Health Sciences
Center
Oklahoma City, Oklahoma
1980—\$356,986
- University of Tennessee, College of Medicine
Memphis, Tennessee
1980—\$329,839
- Tulane University, School of Medicine
New Orleans, Louisiana
1980—\$395,493
- University of Washington, School of
Medicine
Seattle, Washington
1980—\$353,037
- Rutgers University
New Brunswick, New Jersey
*Studies in the organization of health care
services (ID#5074)*
1979—\$185,576
- The Foundation's School Health Services
Program
*Program to improve school-based child health
services (ID#3239)*
- Colorado Department of Health
Denver, Colorado
1978—\$1,177,256
- New York State Education Department
Albany, New York
1978—\$1,200,000
- North Dakota State Department of Health
Bismarck, North Dakota
1978—\$1,200,000
- Utah State Board of Education
Salt Lake City, Utah
1978—\$1,200,000
- Scranton Primary Health Care Center, Inc.
Scranton, Pennsylvania
*Development of a primary care group practice
(ID#4171)*
1978—\$457,931
- Seton Hall University, College of Nursing
South Orange, New Jersey
*Program in clinical primary care nursing
(ID#3701)*
1978—\$455,685
- University of Southern California, School of
Medicine
Los Angeles, California
*A college-medical school consortium for
disadvantaged premedical students (ID#4219)*
1978—\$637,936
*Study of practice profiles of graduates of
primary care residency programs (ID#4690)*
1979—\$364,243
- The Foundation's Teaching Hospital General
Medicine Group Practice Program
*Improvement of ambulatory services for adult
patients using medical clinics and emergency
rooms as their regular source of care
(ID#5554)*
- Albany Medical Center Hospital
Albany, New York
1980—\$799,594
- University of California, Los Angeles, Center
for Health Sciences
Los Angeles, California
1980—\$799,948

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

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

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

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

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

New England Medical Center Hospital
Boston, Massachusetts
1980—\$799,922

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

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

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

Vanderbilt University
Nashville, Tennessee
1980—\$798,158

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

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

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

University of Tennessee, College of Medicine
Memphis, Tennessee
Development of a regional primary care network
(ID#3208)
1978—\$480,000

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

Tulane Medical Center
New Orleans, Louisiana
Program to increase minority enrollment in
medical schools (ID#4478)
1978—\$300,000

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

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

United Way—Princeton Area Communities
Princeton, New Jersey
1980 campaign (ID#5508)
1980—\$30,000

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

Bexar County Hospital District
San Antonio, Texas
1979—\$600,000

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

- District of Columbia General Hospital
Washington, D.C.
1980 — \$646,307
- Charles R. Drew Postgraduate Medical School
Los Angeles, California
1978 — \$600,000
- Hahnemann Medical College and Hospital of
Philadelphia
Philadelphia, Pennsylvania
1980 — \$649,057
- Louisiana State University, New Orleans
New Orleans, Louisiana
1978 — \$633,662
- Montefiore Hospital and Medical Center
Bronx, New York
1978 — \$608,365
- Newark Beth Israel Medical Center
Newark, New Jersey
1980 — \$681,999
- Sisters of Mercy Health Corporation
Farmington Hills, Michigan
1978 — \$640,650
- University of Southern California, School of
Medicine
Los Angeles, California
1979 — \$596,130
- The University of Texas, Southwestern
Medical School at Dallas
Dallas, Texas
1980 — \$625,924
- University of Utah, College of Medicine
Salt Lake City, Utah
*Development of a network of rural health
programs (ID#5184)*
1980 — \$352,822; 1979 — \$177,778
- Vanderbilt University, Center for Health
Services
Nashville, Tennessee
*Program to improve rural community health
services (ID#3838)*
1978 — \$404,630
- Vanderbilt University, School of Medicine
Nashville, Tennessee
Planning for a primary care center (ID#3673)
1978 — \$249,979
- Vanderbilt University, School of Nursing
Nashville, Tennessee
*Administration of the Foundation's Nurse
Faculty Fellowships Program (ID#5337)*
1980 — \$135,613
- Virginia Commonwealth University
Richmond, Virginia
*Administration of the Foundation's Hospital-
Sponsored Ambulatory Dental Services
Program (ID#5338)*
1980 — \$205,203
- University of Washington, Seattle
Seattle, Washington
*Evaluation of the Foundation's Community
Hospital-Medical Staff Group Practice
Program (ID#4189)*
1979 — \$387,639
- University of Washington, Seattle, School of
Medicine
Seattle, Washington
*Analysis of the practice profiles of family and
general practitioners (ID#5991)*
1980 — \$93,204
- University of Washington, Seattle, School of
Nursing
Seattle, Washington
*Graduate program in primary care nursing
(ID#3802)*
1978 — \$649,413

Secretary's
report

Secretary's report*

The trustees and staff lost a valued colleague on October 17, 1981, with the death of Walsh McDermott, M.D., who had served as special advisor to the president since 1972. This loss was memorialized by the Board of Trustees in a resolution that stated in part:

Walsh McDermott was an elder statesman of American medicine when he came to us, and we drew deeply on his experience, insight, and vision in guiding the Foundation through its first decade as a national philanthropy. His conviction that all people should have access to the best of what he termed the "science and samaritanism" of medical care is mirrored in the Foundation's goals and in hundreds of projects and programs across the country that we have assisted.

Walsh McDermott will be missed, daily and keenly, by everyone at the Foundation. At the same time, his life and work will serve to remind us, individually and as a Foundation, of our ability to set and attain impossible goals.

Trustee elected

In March 1981, Richard B. Sellars, a member of the Foundation's Board of Trustees from 1959 to 1971, was elected a trustee. Mr. Sellars retired three years ago as chairman of the board and chief executive officer of Johnson and Johnson after 40 years with that corporation. Mr. Sellars is active in many voluntary, civic, and business organizations nationally and in New Jersey. He brings a broad range of experience in financial and public affairs to our board, and we are extremely pleased to welcome his return.

Staff changes

John W. Murphy left the Foundation in the spring of 1981 to become executive director of The Flinn Foundation in Phoenix, Arizona. Mr. Murphy joined the Foundation in 1972 and was one of its first members. He served as both a program and information services officer as he participated in the growth and development of the Foundation.

Catherine McDermott left in December to serve as executive director of Grantmakers in Health, an organization she helped found, that is now under the auspices of the Foundation Center in New York City.

**To present as up-to-date a picture of staff changes as possible, this report covers the period through January 31, 1982.*

Ms. McDermott joined the Foundation in 1976 as director of personnel and subsequently served, in addition, as a staff officer.

Four individuals joined the professional staff this year. In April 1981, Drew E. Altman joined the Foundation as assistant vice president. Mr. Altman previously served as special assistant to the deputy administrator, Health Care Financing Administration. He is a Brandeis University graduate and received his master's in political science from Brown University.

In May, Andrew R. Greene became assistant to the treasurer. Before joining the Foundation, Mr. Greene was assistant to the president of the New York City Health and Hospitals Corporation. He received his B.A. from Ohio State University in Columbus, and his M.H.C.A. from Trinity University, San Antonio, Texas.

James Firman joined the staff as program officer in September. He previously worked as project coordinator for the National Council on Aging. Dr. Firman holds a B.A., M.B.A., and Ed.D from Columbia University.

In January 1982, Bruce C. Vladeck, Ph.D., was appointed assistant vice president. Before joining the Foundation staff Dr. Vladeck was assistant commissioner of health for the State of New Jersey. Prior to his health department appointment Dr. Vladeck served five years on the public health, medical and political science faculties of Columbia University.

Linda H. Aiken, Ph.D., was elected vice president for research in December 1981. Dr. Aiken has been responsible for the Foundation's evaluation activities since she joined the staff as a program officer in 1974. She was elected an assistant vice president in 1979.

Martita M. Marx and Douglas H. Morgan were promoted to senior program officer in April 1981. Dr. Marx joined the staff in 1978 and Mr. Morgan in 1980.

Five senior program consultants were appointed in 1981.

— In April, Anthony R. Kovner, Ph.D., was appointed to administer the Rural Hospital Program of Extended-Care Services. Dr. Kovner is professor and director of the Program in Health Policy Planning and Administration of the New York University Graduate School of Public Administration.

— In June, Mathy D. Mezey, Ed.D., was appointed director and Joan E. Lynaugh, Ph.D. was appointed associate director of the Teaching Nursing Home Program. Dr. Mezey is an associate professor and director of the Gerontological Nurse Clinician Program, University of Pennsylvania School of Nursing. Dr. Lynaugh is assistant professor and director of the Primary Care/Family Nurse Clinician Program, University of Pennsylvania School of Nursing.

— In August, Henry R. Foster, M.D., was appointed to administer the Program to Consolidate Health Services for High-Risk Young People. Dr. Foster is professor and chairman, Department of Obstetrics and Gynecology, George W. Hubbard Hospital of Meharry Medical College, Nashville, Tennessee.

— In November, Robert M. Sigmond was appointed to administer the Community Programs for Affordable Health Care. Mr. Sigmond is special advisor on hospital affairs, Blue Cross and Blue Shield Associations, Chicago, Illinois. He is also an adjunct professor of health administration, School of Business Administration, Temple University, and lecturer— medical and hospital administration, the Graduate School of Public Health, University of Pittsburgh.

Departing as a senior program consultant was Donald L. Madison, M.D., associate professor, University of North Carolina School of Medicine. Dr. Madison, appointed a senior program consultant in 1973, assisted the staff in developing the Foundation's early activities in support of medical service programs and subsequently directed the Rural Practice Project.

Board activities

The Board met six times in 1981 to conduct business, review proposals, and appropriate funds. In addition, the Policy, Finance, and Audit Committees met as required to consider and prepare recommendations to the Board.

J. Warren Wood, III
Secretary and General Counsel

Application for grants

The Robert Wood Johnson Foundation is a private philanthropy interested in improving health in the United States. We are concentrating our resources on a few well defined needs in health: the need to improve access to personal health care for the most underserved population groups; the need to make health care arrangements more effective and care more affordable; and the need to help people maintain or regain maximum attainable function in their everyday lives.

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

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

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

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

Also, we do not support programs concerned solely with a specific disease or with broad public health problems, except as they might relate to our three areas of interest. The decision not to support such programs, worthy though they are, in no way implies a failure to recognize their importance. It is simply a consequence of the conviction that progress in the areas we have selected depends in large measure on our ability to concentrate our funds. Unfortunately, even within our program interests and guidelines, requests have always exceeded our resources, and thus we are unable to support many deserving proposals.

There are no formal grant application forms. Applicants should

prepare a letter which states briefly and concisely the proposed project as well as its objectives and significance; the qualifications of the organization and the individuals concerned; the mechanisms for evaluating results; and a budget. This letter should be accompanied by a copy of the applicant institution's tax exempt status under the Internal Revenue Code. Ordinarily, preference will be given to organizations which have qualified for exemption under Section 501(c)(3) of the Internal Revenue Code, and which are not "private foundations" as defined under Section 509(a). Public instrumentalities performing similar functions are also eligible.

Proposal letters should be addressed to :

Edward H. Robbins, Proposal Manager
The Robert Wood Johnson Foundation
Post Office Box 2316
Princeton, New Jersey 08540

The Robert Wood Johnson Foundation—Princeton, New Jersey