

The
Robert Wood Johnson
Foundation
Annual Report 1985

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January 1, 1985 through December 31, 1985

The Robert Wood Johnson Foundation
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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.

A tribute

This year's annual report is dedicated to a man who has been a vital force in shaping The Robert Wood Johnson Foundation.

Gustav O. Lienhard, as chairman of the Board of Trustees, led the Foundation through its transition from a local to a national philanthropy. He completed his fourteenth year as chairman at the end of 1985, and in February 1986 was elected trustee emeritus.

Mr. Lienhard was asked to chair the Foundation by its founder, his old friend, General Robert Wood Johnson. The wisdom of this selection was apparent to all who knew these two men. Mr. Lienhard had worked his way through college in New York City during the 1920s. He began working for General Johnson as an accountant at Johnson & Johnson in the midst of the Great Depression, and ultimately rose to that firm's presidency and chairmanship of the executive committee. In addition, he gave generously of his time in voluntary service on the boards of a number of health and educational institutions, including Middlesex General-University Hospital and the University of Medicine and Dentistry of New Jersey. He also was a trustee of his alma mater, Pace University, where the School of Nursing is named in his honor.

In recognition of Mr. Lienhard's decades of corporate, civic, and philanthropic service in the field of health affairs, the Foundation's board of trustees has joined with the Institute of Medicine of the National Academy of Sciences to create the Gustav O. Lienhard Award for Advancement of Health Care. Consisting of a medal and cash prize of \$25,000, this award will be presented annually by the Institute to recognize outstanding achievement by a person or group in improving personal health care services in the United States.

Mr. Lienhard put his stamp on the Foundation. It is a lasting mark and one that trustees and staff alike bear proudly. We will miss his active leadership and untiring devotion to the Foundation. At the same time, we are pleased that his retirement has given us the opportunity to create an award that bears his name, and which in the years to come will encourage and honor men and women of great accomplishment who share his dedication to the improvement of health care.

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The
president's
statement

Examining the adequacy of a community's health care

The bewildering speed of change in how medical services are organized, delivered, and paid for is now apparent to even the most casual observer of the American health care scene.

As I have pointed out in several recent annual messages, rapidly rising health care costs coupled with the alarming bite that health care takes out of the national pocketbook are prompting most of these changes. Massive efforts by government, industry, labor, insurance companies, hospitals, and health professionals to control those costs are causing all kinds of new health care arrangements to emerge. A kind of alphabet soup designates new payment and cost control mechanisms and ways to align purveyors of health care and those who wish to contract for it—PROs, DRGs, HMOs, IPAs, and PPOs. So too, the locus of much of today's care is changing swiftly. New ambulatory care settings are springing up everywhere as health care providers flee from the high costs of hospitals. For-profit medical care arrangements are burgeoning and different forms of health care are now advertised like toothpaste and floor cleaners—on billboards, the radio and television across the country.

At the moment, everyone's attention is riveted on whether all of the dramatic activity will lower the sharply rising costs of health care. Clearly, this should be a relatively simple question to answer fairly quickly. But much more difficult and far more important to find out over the long run is what these new arrangements do to people—to their access to health care services, the quality and texture of those services, and their individual well-being.

In my 1982 report, I suggested that if we were indeed going to make such profound changes in how we delivered care to Americans, we owed it to them to keep careful book on how those changes, directly or indirectly, affected their health. I tentatively put forward a series of "markers" derived from national data sources which I felt could help public officials or communities monitor change and measure the effectiveness of health care by following what was happening to the recipients of care.

I received many thoughtful comments and letters from health professionals, community leaders, and public officials about that report. In most cases, the responses were enthusiastic and supportive of such an effort. But many students of American health care who were concerned with the nation's major cities, where health care arrangements are often complex and difficult to monitor, pointed out that my national "markers" fell far short of what they needed to do the job. Most identified two problems. First, that comparing national health care trends with those of

individual large cities was too far from what they needed to know. The country's major cities were just too different from the nation as a whole. Second, they felt that some of the indicators I had chosen were simply not available to them or focused on problems too rare to be meaningful for city leaders. Their overall message: find us some health care "markers" that we can use to compare our city with other cities so we can better decide where to focus our attention and our precious health care dollars.

Spurred by these comments, my colleagues and I went back to the drawing board. We have learned much in the process. We have received enormous help from the staff of the Center for Health Policy Studies at Georgetown University, and the data I will be trying out on you this year derive from these efforts.

With considerable digging, my Georgetown colleagues were able to extract some fascinating information from federal surveys and city health department reports that I think can help large cities better assess how their residents are faring as the health care system is being changed. I was startled to find that there were vast differences—sometimes as great as five-fold—between cities in certain health care measures that seem important. To dramatize these differences, I have drawn on the data for a series of charts that display only the most obvious and interesting variations for each indicator. By so doing, I hope, in a tentative way, to suggest how mayors or city health commissioners, or medical societies, or hospital associations, or groups of concerned citizens might, in medical terms, do a screening examination to detect possible health care problems in their particular communities.

But before proceeding, there are several important caveats. First, the data portrayed here are only a crude first approximation in the assessment process. As in medicine, which is my analogy, one cannot leap from the data to meaningful conclusions. There may be all kinds of reasons that have nothing to do with access to medical services or the quality of that care to explain why one city's record on a health care indicator is better or worse than that of another city. I am suggesting, however, that differences—unfavorable differences—ought to prompt a city to dig further to see what the reasons are and whether they should or should not take action to improve the situation.

Next—confirming the frustrations of many of my correspondents—despite the effort expended by a most knowledgeable group to obtain a complete data set for all the country's largest cities for each of the rather simple and straightforward indicators I will portray, the data for many of them were sadly lacking for most cities. Even when the data were available, they were often five years out of date!

This troubles me deeply, for it seems to me that few things are as important to us as our collective health. In material terms, we will spend more than one-tenth of the nation's economy—over four hundred billion dollars this year—on health care. It simply doesn't make sense to be almost totally without objective "intelligence" to show what we are getting for those health care dollars. Each day a quick glance at the newspaper tells us

the relative standing of our baseball, football, and ice hockey teams. Likewise, a myriad of data is available daily on the status of American business or the economy in our major cities. Yet in health care, even fairly simple statistics are not regularly collected, or when they are, they are processed so slowly that they are not available until two to five years after the fact.

Thus, in most communities no one knows how often individuals are seen by their doctors, or how many expectant mothers are receiving prenatal care, or whether the changes we are making in the arrangements for the delivery of care are resulting in more or less infant deaths, or deaths from heart disease, or cancer, or diabetes, or what-have-you. From even the most charitable point of view, this seems short-sighted. It does, however, explain why, as one of my correspondents stated, opinions about health care arrangements in his community ranged from being “the envy of the world” to being in a “state of crisis,” and neither side could prove its point.

I will use data from as far back as 1979 and as recent as 1985—always using the latest available. Because I have also selected cities which seem roughly comparable and for which there are interesting variations, and since the availability of data on each city varied so enormously, I have provided a table listing the cities considered in each array (see page 20). A full display of all of the obtainable data is available in a report of the Georgetown University Center for Health Policy Studies: *Health Care System Performance Indicators for Selected American Cities: Sources and Methods*.*

So with this as a preamble, let me take you through a doctor-oriented approach to trying to examine the comparative health of your large city using three questions to elicit “signs and symptoms” that bear watching.

Question 1: How well is medical and dental care being delivered to the residents of your city? What signs and symptoms should you watch?

Symptom 1: How often are the poor in your community being seen by physicians? Data on the number of visits people make to doctors do not tell us what we really want to know about access to medical care. However, they do offer one narrow window on how available medical care is for your city’s low-income population. There is abundant evidence that serious

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illness is more common among the poor. So if no barriers to receiving care exist, low-income individuals in your community should generally be making five to six visits to doctors per year. The national norm for healthy people from middle- and upper-income groups is four visits to a physician per year.

As shown in Figure 1, there is a difference of more than 40 percent in physician visits made by low-income residents in Philadelphia and Dallas.

Symptom 2: Are children in your community seeing a doctor regularly? Pediatricians recommend that children between the ages of six and twelve see a physician twice a year. Why not see how many children in your city have not seen a doctor even *once* in the last year?

As shown in Figure 2, there is more than a two-fold difference between New York and Houston in this regard, and neither of these cities seems to be doing as well as one would like.

Symptom 3: Are there signs that the residents of your city who need care may not be seeing a physician when appropriate? Two indicators can be used to shed some light on this question.

- First determine the proportion of people living in your community with a diagnosis of one of the major medical killers (cancer, heart disease, stroke, hypertension, etc.) who did not see a doctor last

Figure 1

Annual visits to a physician by low-income urban residents — an example of the variation among selected major cities (1979-1981)

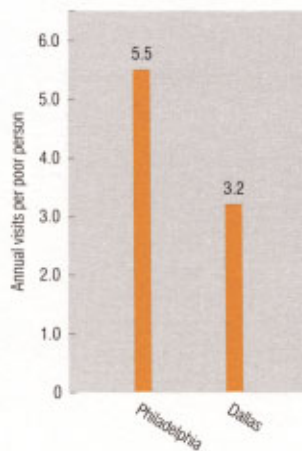
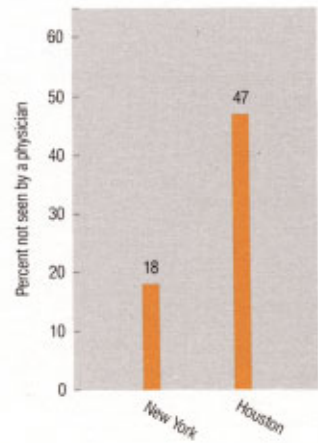


Figure 2

Percentage of children (ages 6-12) not seen by a physician in the last year — an example of the variation among selected major cities (1979-1981)



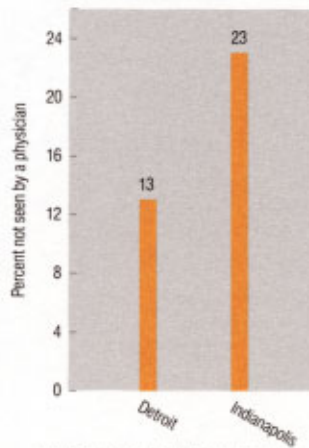
year. Physicians recommend that patients with these conditions be seen by a doctor at least once a year—and usually more frequently. As indicated in Figure 3, physician visits for patients with these diagnoses vary significantly among major cities. In Detroit, only 13 percent of those with such conditions failed to see a physician in the previous year. In Indianapolis, however, the figure was 23 percent.

- Another important indicator of an access problem is when significant numbers of expectant mothers in your community are not receiving prenatal care starting in the first trimester of pregnancy. A recent national study by the Institute of Medicine suggests that a delayed initiation of prenatal care is an important contributing factor to the nation's still-too-high infant death rate. Because black expectant mothers remain at a much higher risk of losing their infants during pregnancy, looking at the receipt of prenatal care separately for each racial group becomes important. As indicated in Figure 4, major disparities are also found here.

Symptom 4: What is the birthrate among young teenagers in your city? High rates of teenage pregnancy are indicative of poor access to family planning education and services and/or the effectiveness of these efforts. This, in turn, is a proxy marker for access to, and quality of, health care in general for youngsters in your city. In addition, high rates of births

Figure 3

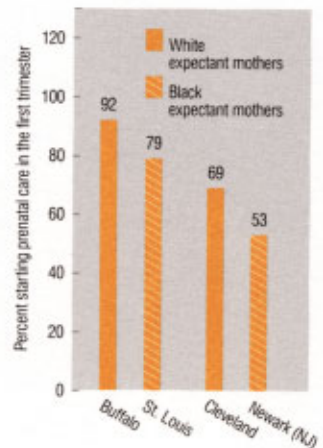
Percentage of people with serious chronic diseases* not seen by a physician for that condition in the last year — an example of the variation among selected major cities (1978-1981)



*Includes cancer, heart disease, stroke, hypertension, diabetes, arteriosclerosis, emphysema, and chronic kidney disease.

Figure 4

Percentage of expectant mothers, by race, receiving prenatal care starting in the first trimester — an example of the variation among selected major cities (1979-1980)



among very young women are associated with many other worrisome problems like significantly greater rates of infant illness and school drop-out or failure for the young mothers. As Figure 5 portrays, there is a more than six-fold difference in teenage pregnancy rates among the cities for which data are available for white and black youngsters ages 13 to 16.

Symptom 5: How accessible is dental care for children in your city?

Most authorities agree that children should see a dentist at least twice a year. Here again I suggest examining what proportion have not seen a dentist even once in the last year. As Figure 6 indicates, there exists a nearly three-fold difference between major cities.

Looking at such symptoms may tell you that your city looks quite different from others in some indicators of the adequacy of access to care. But they do not tell us why those differences exist. To find real, bottom-line answers would require further exploration—for example, examining the adequacy of your city’s public and private health insurance coverage; the general availability of “free-care” services by your hospitals, health departments, voluntary agencies, and neighborhood health centers; the adequacy of the supply of health professional practitioners in traditionally underserved neighborhoods; and whether or not cultural, language, or other barriers interfere with delivery of appropriate medical care for some of the people living in your city.

Figure 5

Births to women (ages 13-16), by race — an example of the variation among selected major cities (1979-1980)

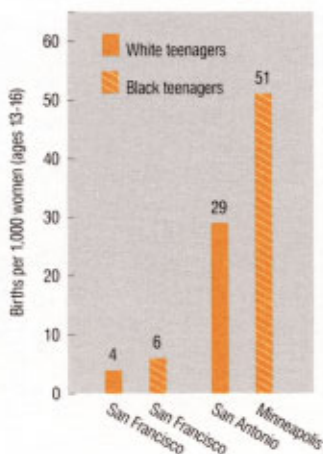
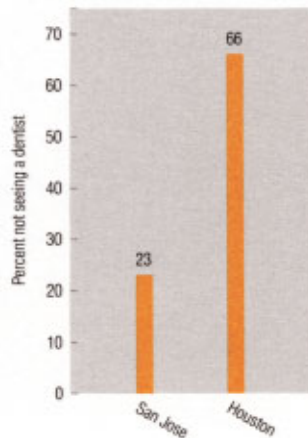


Figure 6

Percentage of children (ages 6-12) not seeing a dentist in the last year — an example of the variation among selected major cities (1979-1981)



**Question 2: How is your city doing in controlling health care costs?
What signs and symptoms might you follow?**

Symptom 1: Has the medical care component of your city's consumer price index (CPI) been rising at faster or slower rates than for other major cities? The medical care section of the CPI includes a whole market basket of health care costs, including charges for health services made by hospitals, doctors, dentists, and pharmacists in your city. Here one needs a multi-year trend to tell you what's going on. As shown in Figure 7, Baltimore had one of the slowest rates of cost increase between 1980 and 1985, while in Pittsburgh the increase was 51 percent greater.

Symptom 2: How does your city's inpatient hospital admission rate compare with that of other cities? Many illnesses can be successfully treated by physicians on either an inpatient or outpatient basis. However, in most instances, outpatient care is less expensive and generally more convenient for patients and their families. How frequently physicians choose to hospitalize their patients for particular illnesses varies greatly among communities. As indicated in Figure 8, the hospital admission rates among large cities vary enormously, even when rates have been adjusted for important demographic differences between cities. New York has been quite successful in treating patients out-of-hospital, compared to Houston, which has a much higher admission rate.

Figure 7

Escalation of the medical care component of the Consumer Price Index — an example of the variation among selected major cities (1980-1985)

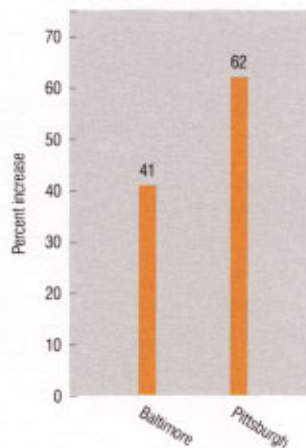
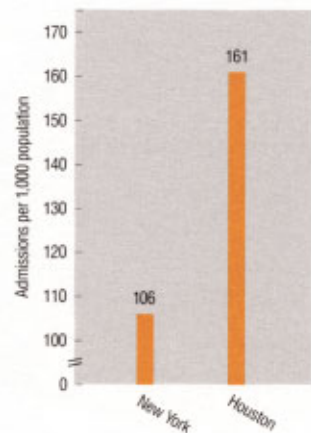


Figure 8

Hospital admissions (age, sex, and race adjusted) per year — an example of the variation among selected major cities (1979-1981)



Symptom 3: How swiftly have the costs of being a patient in hospitals in your city been rising, and how do those rates compare with other cities? Nationally, between 1978 and 1983, the average costs for a stay in the hospital rose by 89 percent. As shown in Figure 9, Buffalo did quite a bit better than this, while Phoenix saw its hospital expenses rise at double Buffalo's rate. Once again, while such comparisons may signal a problem in your city, these indicators cannot tell you why or what to do about it. This requires a much closer, in-depth investigation.

Question 3: How well is your city's overall health care system working? Is it reducing death rates appropriately?

Symptom 1: What is happening to your infant death rate? Death rates in the first year of life are one good, visible measure of the success of your city's overall health care arrangements. Deaths in children less than one year of age now account for more than half of all the deaths occurring in young people up to the age of 21! A community's infant death rate also reveals the outcome of a whole series of your community's health care activities that need coordination. For example, the quality and accessibility of: early prenatal care; regional neonatal and perinatal hospital referral centers for high-risk mothers and babies; follow-up pediatric services for the newborn; specialized social services; and nutrition counselling and actual food supply for infants.

As indicated in Figures 10 and 11, some large cities have been much more successful than others at targeting their health care resources and reducing the deaths of their infants.

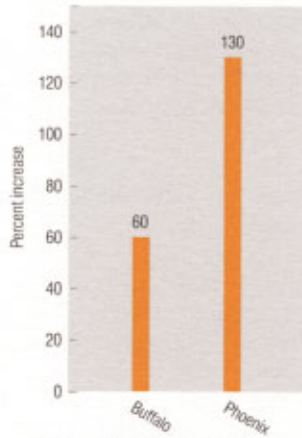
Here again, also look at rates for white and black infants separately. Over too long a period of time, black infant death rates have stayed about twice that of whites.

As indicated in Figure 12, this gap is not inevitable. The differences in death rates for infants are so great among cities that the city with the highest white infant death rate has a rate about the same as that of black infants in another city where black infant death rates are lowest. Clearly, looking across major cities, the gap between the black and white infant death rates has been narrowed in some cities while it has widened in others. Improvements here are possible in many communities.

Symptom 2: What are the death rates from heart disease for men in their most productive years in your community? As with the infant mortality rate, a community's death rate from heart attacks (acute myocardial infarction) adjusted for demographic differences — age, race, and sex — is another indicator which can help reveal how well your health care system works. While there are many personal and nonmedical factors involved, this rate can suggest something of the quality of the community's inpatient cardiac care units, the speed and quality of emergency response services, and, indirectly, public education activities related to diet and smoking. As

Figure 9

Increases in the total average expenses per adjusted inpatient admission to hospitals* — an example of the variation among selected major cities (1978-1983)



*An adjusted inpatient admission is a weighted average of inpatient admissions and outpatient visits.

Figure 10

Reductions in white infant mortality — an example of the variation among selected major cities (3-year average trends: 1974-76 and 1980-82)

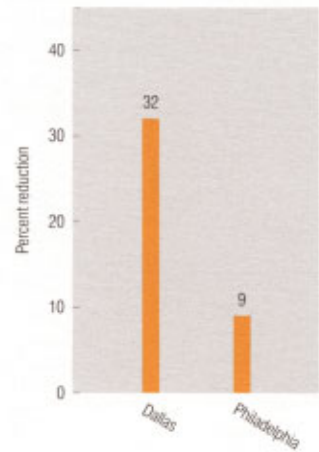


Figure 11

Reductions in black infant mortality — an example of the variation among selected major cities (3-year average trends: 1974-76 and 1980-82)

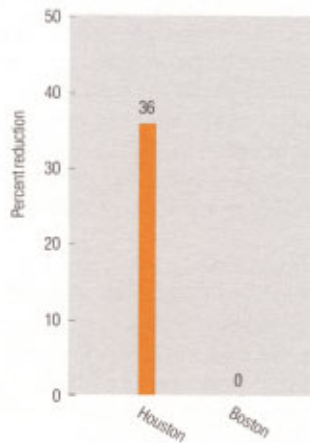


Figure 12

Similarity in infant death rates between the city with the lowest rate for black infants and the city with the highest rate for white infants (1980-1982)

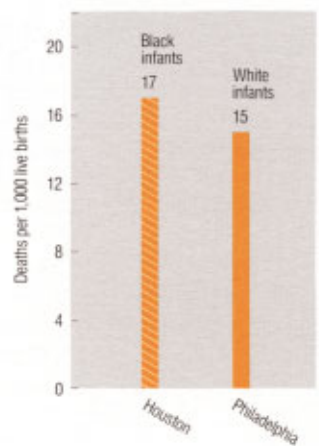


Figure 13

Death rates from acute myocardial infarction for white males (ages 45-64) — an example of the variation among selected major cities (1979-1980)

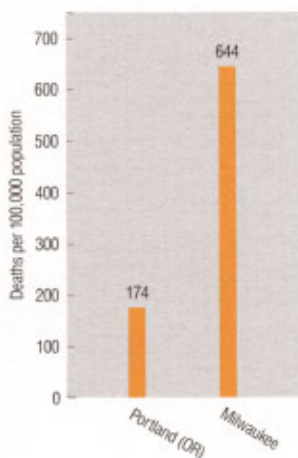


Figure 13 indicates, more than a three-fold difference in heart attack death rates exists among cities. Probably a community's lifestyle and its climate play a role in these differences, but I would want to find out if other, modifiable factors were involved.

In conclusion

Most cities for which data are available do not show signs of having multiple, serious problems. Most seem to do well on some measurement scales while looking less good on others. But careful examination of large differences from the norm may permit a community to target its precious and limited health care resources and energies on its most serious shortfalls. For example, does a city similar to yours where certain problems seem under better control have some simple way of organizing or delivering its health care in ways that lead to better outcomes?

Looking back over the last year, our foundation has attempted to assist those working on this targeting process. Our activities in 1985 can be summarized as having provided support and encouragement for a substantial number of civic leaders, health professionals, and other relevant groups that have identified one or more worrisome health care shortfalls in their communities and asked for help in resolving them. Our assistance has thus gone to a wide range of organizations and groups that have been painstakingly involved in identifying and developing approaches to improving the health care situations in their communities.

What all these groups have had in common is a commitment to making the benefits of modern medicine available as widely as possible and a belief that the best way to accomplish this in today's world of constrained resources is to target in on their communities' most critical health care problems. Clearly, we now have the necessary professional health manpower and a whole array of remarkable new technologies with which to make continuing advances in the health of Americans. What is most needed today is a sophisticated intelligence system to tell us where and how to deploy these resources in the most economical way.

Table

Cities for which data are available

	Figure												
	1	2	3	4	5	6	7	8	9	10	11	12	13
Atlanta			■	■			■						■
Baltimore	■		■	■	■		■	■	■	■	■	■	
Boston				■			■		■	■	■	■	
Buffalo				■			■		■				■
Chicago	■	■	■	■	■	■	■	■				■	■
Cincinnati							■		■				
Cleveland				■			■					■	■
Dallas	■	■		■	■	■	■	■	■	■	■	■	
Denver	■			■			■	■					■
Detroit	■	■	■	■		■	■	■		■	■	■	■
Houston	■	■	■	■		■	■	■	■	■	■	■	
Indianapolis		■	■	■		■			■				■
Jacksonville									■				
Kansas City (MO)				■			■		■				■
Los Angeles	■	■	■	■		■	■	■		■	■	■	
Memphis									■				
Miami				■			■						■
Milwaukee		■		■		■	■		■			■	■
Minneapolis				■	■		■						
Newark (NJ)				■									
New Orleans				■						■	■		
New York	■	■	■	■		■	■	■	■	■	■	■	■
Oakland				■									
Philadelphia	■	■	■	■		■	■	■	■	■	■	■	■
Phoenix				■					■				■
Pittsburgh				■	■		■						■
Portland (OR)				■			■						■
San Antonio				■	■				■	■	■		
San Diego	■	■	■	■	■	■	■	■	■				
San Francisco		■			■	■	■			■	■		
San Jose		■				■							
Seattle				■			■						
St. Louis				■	■		■						■
St. Paul				■			■						
Tampa/St. Petersburg			■										
Washington, D.C.		■				■	■						

The 1985
grant program

The 1985 grant program

During 1985 the Foundation made 272 grants totaling \$65.9 million in support of programs and projects to improve health care in the United States. The types of activity supported were:

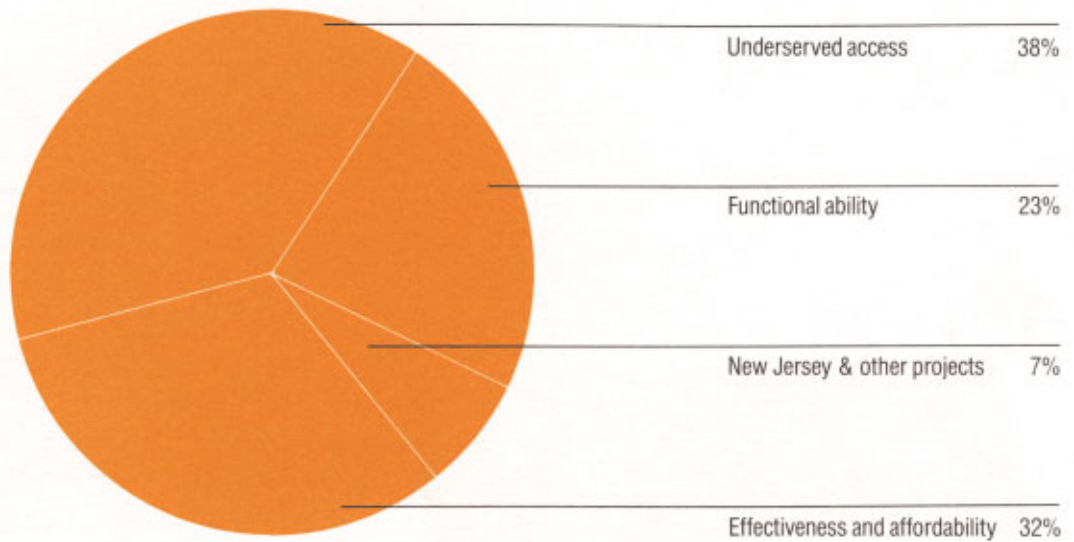
- developing and testing new ways of providing health care services, \$30.8 million, or 47 percent of the 1985 grant funds;
- helping health professionals acquire new skills needed to make health care more accessible, affordable, and effective, \$11.1 million, or 17 percent;
- conducting studies and evaluations to improve health care, \$16.7 million, or 25 percent; and
- other projects, \$7.3 million, or 11 percent.

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

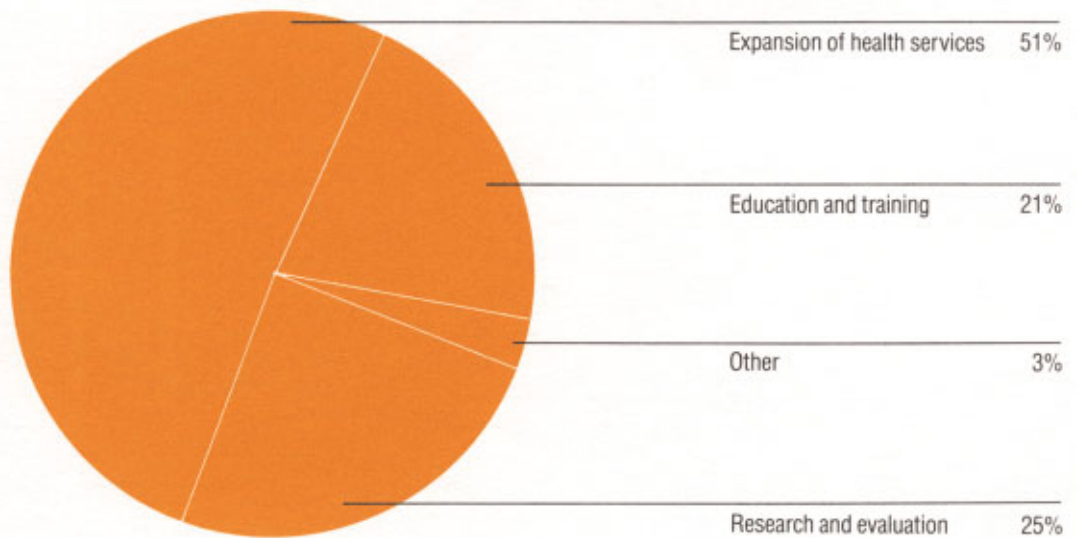
- \$29.3 million, or 44 percent, for programs to improve access to personal health care for the most underserved population groups;
- \$14.9 million, or 23 percent, for programs to make health care arrangements more effective and care more affordable;
- \$11.1 million, or 17 percent, for programs to help people maintain or regain maximum attainable function in their everyday lives; and
- \$10.6 million, or 16 percent, for a variety of other purposes, principally in the New Brunswick, New Jersey area where the Foundation originated.

Appropriations totaling \$270.9 million have been made since 1981 when the Foundation changed its principal areas of interest to those stated above. The distribution of these funds by types of activities supported as well as by areas of interest is charted on the facing page. Since becoming a national philanthropy in 1972, our appropriations have totaled \$649.0 million. A chart depicting the geographic distribution of these funds is on page 24.

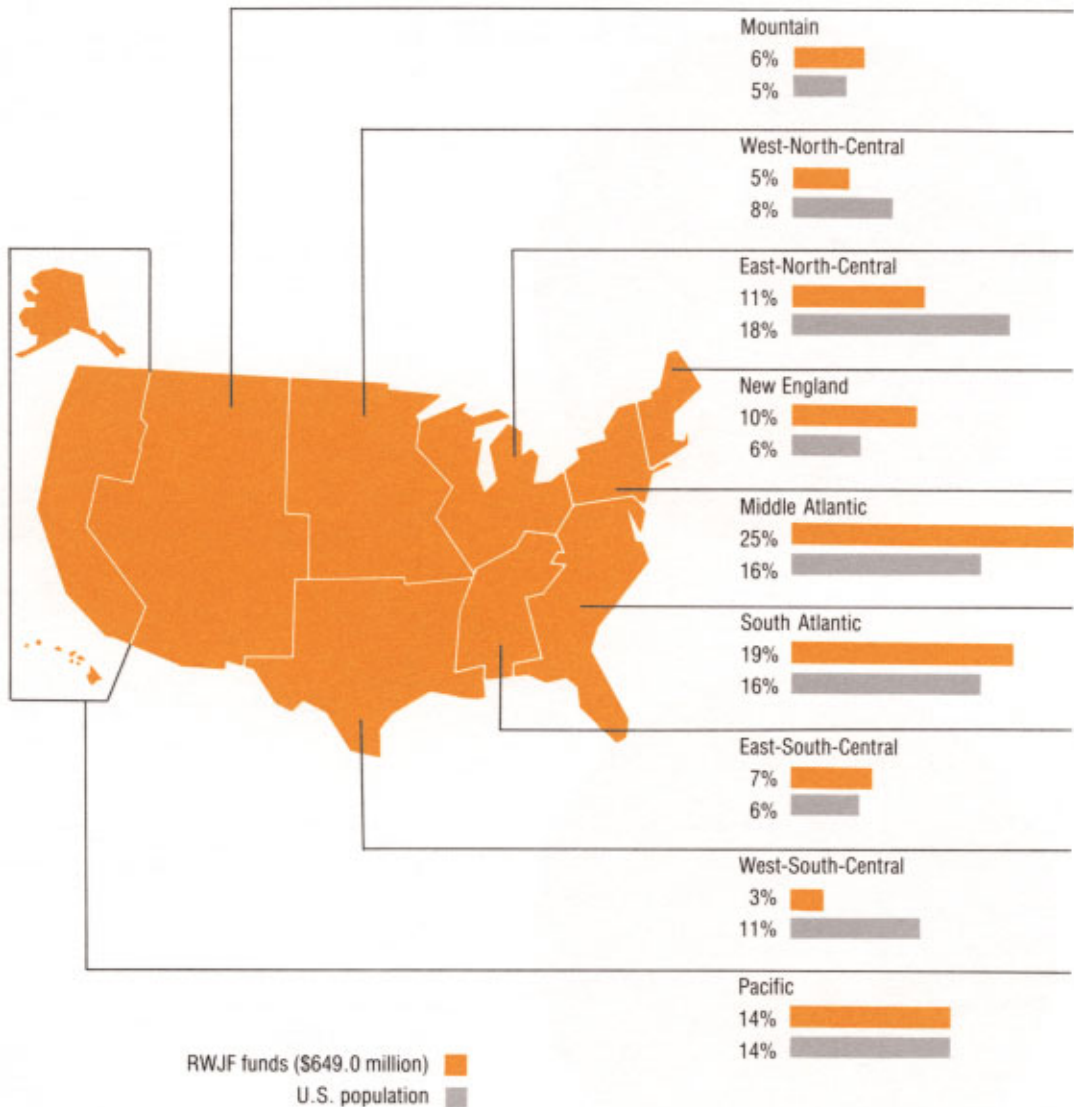
Appropriations by RWJF objectives and types of activities funded, 1981-1985



RWJF 5-year appropriations: \$270.9 million



Appropriations by geographical region compared to population, 1972-1985



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

MAJOR DEVELOPMENTS IN THE 1985 GRANT PROGRAM

The grant-supported projects and programs described in the first part of this section were selected to illustrate the Foundation's 1985 grant program. A complete list of grants made in this year begins on page 37.

In addition to the activities funded during 1985, staff of the Foundation continued to monitor and provide technical assistance to projects and programs supported by 659 other grants authorized in previous years.

Also involved in this process were 22 senior program consultants and their staffs at medical schools, teaching hospitals, and other institutions providing technical assistance and direction for the Foundation's multi-grant national programs.

ACCESS TO CARE

One of the Foundation's primary grantmaking goals is to assist projects across the country in reaching out to people isolated from the mainstream of care— isolated by geography, by age, by culture, by personal circumstances.

Program for the Chronically Mentally Ill

Over the past two decades, the locus of care for the chronically mentally ill has changed from institutional to community settings. In large part this dramatic move has come with the advent of psychotropic drugs, the increased costs of institutional care, and a belief that people ought to be in the least confining settings possible.

Unfortunately, a significant portion of deinstitutionalized individuals are functioning poorly in the community, primarily because it is difficult for them to obtain the range of health and other supportive services they need. Community systems of care are often

fragmented, riddled with gaps, and deliver services through disparate and geographically distinct agencies. Current reimbursement policies and public funding allocations favor inpatient care—with little available for out-of-hospital services. Consequently, the lives of many deinstitutionalized people are marked by chronic mental disability with intermittent hospitalization for acute episodes of illness.

This year the Foundation and the U.S. Department of Housing and Urban Development (HUD) announced the Program for the Chronically Mentally Ill, co-sponsored by the National Governors' Association, the U.S. Conference of Mayors, and the National Association of Counties. The Foundation will provide approximately \$28 million in grants and low interest loans to eight of the nation's 60 largest urban centers. These five-year grants will support citywide projects offering the continuum of health, mental health, social services, and housing options needed by chronically mentally ill people. HUD will provide rent subsidies to help grantees obtain appropriate facilities for housing. Specific awards for the Program will be announced in 1986.

Health Care for the Uninsured Program

Today, there are more than 35 million people in the United States who cannot afford or lack health insurance. Announced in 1985, the Health Care for the Uninsured Program will help state and local groups to demonstrate creative approaches—through new public and private financing and service delivery arrangements—that should help such people to get medical care. A total of \$6.5 million in grants will be provided. The Program is co-sponsored by the National Governors' Association, the National Conference of State Legislatures, the U.S. Conference of Mayors, and the National Association of Counties. Applications for the Program will be reviewed in two rounds, with round-one grant recipients announced in 1986.

Programs helping children and the elderly

In 1984, the National Council on the Aging (NCOA) in Washington, D.C., with Foundation support, initiated a project using older volunteers to help chronically ill or seriously disabled children and their families in their homes. The volunteers provide a range of services, including personal care, supplemental educational tutoring, and social and emotional support. With additional funding from the Foundation, NCOA is undertaking a multisite demonstration of this model. Appropriate institutions and voluntary agencies and organizations located in metropolitan areas with populations of at least 500,000 are eligible to apply through NCOA for Foundation funding. Up to eight four-year grants will be made under what is called the Family Friends program. The goal is to test the feasibility of the original project in different geographic locations under different types of organizational sponsorship.

This year, 24 institutions were given implementation grants under the Program for Hospital Initiatives in Long-Term Care, which was designed to serve the acute and long-term care needs of enrolled groups of elderly persons. Participating hospitals are offering, either directly or through contractual or cooperative relationships with other agencies, all traditional hospital inpatient and outpatient services plus such nontraditional services as in-home health services; homemaker or home-help services; community-based mental health services for the elderly; adult day care and/or day hospital services; congregate or supported housing and/or sheltered residential care; nursing home care; and training and support for family members and other caregivers. In addition, the hospitals themselves are providing patient assessment, placement, monitoring, and follow-up; quality assurance programs for both contracted and hospital-provided services; 24-hour emergency services seven days a week; centralized record and data systems; and leadership in community long-term care planning.

Improving access for Medicare patients

In 1983, Congress enacted a new prospective payment system for paying hospitals for care of people 65 and older under Medicare. Under this system, hospitals are reimbursed a fixed amount according to patients' diagnoses. Treatment costs in excess of that amount must be absorbed by the hospitals. Reimbursements in excess of actual costs can be retained. While much has been written about this approach, little is still known about how, in the long run, it will affect hospital behavior, especially toward certain Medicare populations that are sicker, and consequently more costly to treat. With a grant this year, researchers at Boston University are examining the incentives and disincentives for hospitals to care for very sick patients, and will be presenting a number of approaches that could improve access for Medicare patients.

Supporting community health centers

Through the Foundation's Community Care Funding Partners Program, locally planned and conducted projects across the country have been bringing health care to groups of people lacking appropriate access to such services. In the Program, project leaders join with local foundations and corporations, which match Foundation funds, to establish primary care health centers in medically underserved areas of the community. During this past year five centers received assistance: Jeff Davis County Medical Services Center, a rural health project in a remote Georgia community; Lawndale Christian Health Center, a primary care center in west side Chicago; adolescent health care centers located in DuSable High School in Chicago and in Northeast High School, Kansas City, Missouri; and Oak Cliff Clinics, a family health center in south Dallas. Since the Program began in 1981, 13 projects in eight cities have received support.

In addition to helping establish new centers, the Foundation assisted two efforts this year designed to help existing centers maintain their services. The first was a matching grants



program aimed at improving the management capacities of small to mid-sized centers, and the second was a technical assistance program to help larger centers diversify their revenue

sources through health-related business enterprises. The National Association of Community Health Centers received a grant to participate in both efforts.

This past year, supplemental support was also provided to existing centers previously aided by the Foundation. To qualify for additional support, centers must meet criteria related to the needs of the people the centers serve, their managerial and professional performance, their financial status, and the outlook for institutional survival. During 1985, two centers meeting the needs of largely Hispanic populations received support: the Barrio Comprehensive Family Health Care Center in San Antonio, Texas, and La Clinica de la Raza in Oakland, California.

COST CONTAINMENT

Rising health care costs continue to trouble this nation. During this year, the Foundation supported various efforts targeting on ways to reduce this burden on the American people and the health care institutions and systems that serve them.

Program for Research and Development on Health Care Costs

Ten grants are supporting the development and implementation of innovative efforts to control health care costs under the second round of the Foundation's Program for Research and Development on Health Care Costs. Projects include a study of shortening hospital stays of burn patients by using expanded home care services; design and evaluation of incentives for ambulatory surgery; and an evaluation of the impact of the Medicare prospective payment system. Also this year, a call was issued for proposals for the third round of grants to be made in 1986.

Community Programs for Affordable Health Care

With grants this year to the Mecklenberg County Health Care Cost Management

Council, the Greater Atlanta Coalition on Health Care, and the Minnesota Coalition on Health Care Costs, 7 of 16 planning sites have received support to implement projects under the Community Programs for Affordable Health Care. In addition, the University of Michigan School of Public Health was given a grant to begin an evaluation of this program. The Program enables communities to develop their own cost-saving strategies for providing health care services, using the combined efforts of local hospitals, health insurers, business, labor, and other key groups. It is co-sponsored by the Blue Cross and Blue Shield Association and the American Hospital Association.

Analyzing cost-cutting options

In recent years, scores of strategies have been considered to halt the upward spiraling of health care costs. A grant to the Rand Corporation is supporting an examination of the principal options currently available to both the private and public sectors. Rand will produce a report describing each major proposal for reducing costs; calculating the likely savings from each option for business, government, and others; and estimating the impact of such changes on individuals seeking health care services.

Consumer health care

The United Seniors Consumer Cooperative (USCC) is an organization in the Washington, D.C. area helping its senior citizen members obtain affordable, comprehensive health services. Efforts include determining members' eligibility for public and private benefits, offering discounts for health and other services, and providing consumer-oriented information packages. This year, with support from the Foundation and other private grantmakers, USCC is testing its model program of consumer health information on how to select health care providers appropriate for present needs and in the event of long-term illness.

Regionalized perinatal care

In past years, the Foundation funded the development and testing of model systems of regionalized perinatal care. Such systems now exist throughout the country, organized around 385 tertiary perinatal centers. With a grant this year, researchers at the Women & Infants' Hospital of Rhode Island are conducting a multistate study to analyze the effects of recent changes in state reimbursement policies and other ongoing changes in the health care sector on these systems of regionalized perinatal care.

Managing long-term care

Long-term care takes a growing share of national health expenditures—in 1984, nursing home care alone accounted for almost \$35 billion. The management of nursing homes, home health agencies, and other long-term care services is a complex and expanding field requiring a range of specialized knowledge and skills. Unfortunately, few academic programs are available. With Foundation support, the Association of University Programs in Health Administration (AUPHA) is: developing curricula for graduate and undergraduate training programs in long-term care administration; creating a fellowship program to increase faculty expertise in long-term care administration; and organizing a national coordinating group on long-term care administrative education.

IMPROVING FUNCTIONAL STATUS

Another of the Foundation's grantmaking goals is to support projects demonstrating and studying ways to help people maintain or regain maximum attainable function in their everyday lives.

Research and development

For five years, the Research and Development Program to Improve Patient Functional Status has provided limited support for innovative approaches designed to help people maintain

or regain maximum functioning. This year, 21 projects received assistance, including: a study to improve the predictability of premature birth; an investigation of whether hearing impairment is associated with and contributes to cognitive dysfunction in Alzheimer's patients; and a demonstration to improve functional capacity after hip replacement using an outpatient rehabilitation program. More than \$12 million has been allocated to underwrite 85 projects in this program since its inception.

Helping the elderly

For elderly individuals, falls pose particular risks because they can result in permanent damage and disability. The Center for Health Research (CHR) of the Northwest Region of Kaiser Permanente is evaluating two approaches to preventing falls among the elderly: (1) changing the physical environment in the home to decrease the opportunities for accidents; and (2) teaching elderly individuals with decreased physical or mental capacities to develop adaptive responses.



Alzheimer's disease is a debilitating, progressive neurological disorder. Its occurrence is catastrophic for both the patient and the family. A grant to The National Benevolent Association of the Christian Church is supporting a model comprehensive care program designed to meet the specific needs—through the different stages of the disease—of Alzheimer's patients and their families. Located in Florida Christian Center in Jacksonville, a six-site protected living complex for the elderly, the program includes medical assessment, case management, home care, caregiver training, respite care, hospital care, and intermediate and skilled nursing care.

On Lok Senior Health Service is a community-based health center in San Francisco offering a full range of health care services for frail elderly people. On Lok's program has three main features: (1) comprehensive outpatient and inpatient care; (2) prepaid capitation financing under a single premium shared by Medicare and Medicaid; and (3) full financial risk for costs in excess of premiums. A grant this year is enabling On Lok's staff to work with general hospitals, community health centers, and other institutions interested in replicating its singular system of providing and financing long-term care. This multisite demonstration is intended to test On Lok's model in different settings and geographic locations.

Improving infant health and survival

Since the early part of this century, the United States has seen dramatic declines in infant death rates—from 85.5 per 1,000 live births in 1920 to an estimated 10.6 per 1,000 in 1984. Despite these gains, however, significant problems remain. Gaps in infant death rates persist among different population groups and among different parts of the country; a quarter of a million infants born each year are at risk of death or serious disability because of their low birthweights; and for the first time in many years, some

communities are reporting a rise in their infant mortality rates.

This past year the Foundation made five grants to examine ways of improving access to medical care for high-risk mothers and infants, and to study some of the underlying causes of infant mortality.

With additional help from the South Carolina Department of Health and Environmental Control and the March of Dimes Foundation, the Medical University of South Carolina has launched a five-site randomized clinical trial evaluating the effectiveness of using certified nurse midwives to provide intensive prenatal care services to high-risk women. Researchers are looking at the effects of prenatal nursing care on low-birthweight rates (2,500 grams or less) and on hospital use and costs associated with low birthweight in the state. South Carolina has the highest rates of low birthweight and very low birthweight (1,500 grams or less) in the country, and the second highest infant mortality rate.

In another study, Harvard Medical School is evaluating a program to improve high-risk birth outcomes in Boston. Entitled Healthy Baby, the program being evaluated is based on extensive cooperation between the Department of Health and Hospitals, the medical staffs of 13 community health centers and the maternity departments of four Boston hospitals, the Massachusetts Division of Maternal and Child Health, and the mayor's office.

The Southern Governors' Association (SGA) received support for a study to review existing state and private sector health care efforts around the country designed to lower infant death rates. From this study the SGA will develop a set of recommendations on how states could better address this problem. In addition, the University of Washington School of Medicine is conducting a study to monitor birth outcomes in low-income women as a way to target limited public funding more effectively; and Case Western Reserve University School of Medicine is developing a

research agenda for the prevention of low birthweight.

Predicting children at risk for dental caries

With support from the Foundation, researchers from the American Fund for Dental Health and the University of North Carolina are developing a low-cost predictive screen for use in identifying children at high risk for multiple dental caries. The study team is assessing the screening method, which includes innovative microbiologic saliva tests, in a sample of 5,200 school-age children drawn from two

communities known to have high rates of dental caries. This project follows up the five-year National Preventive Dentistry Demonstration Program supported by the Foundation.

OTHER RESEARCH

Evaluations and studies supported each year focus on a variety of subjects bearing on the Foundation's three main areas of concern: how to improve access to care for underserved populations; how to make health care more



effective and affordable; and how to help people maintain or regain functional abilities.

Access to care

In 1976 and 1982, the Foundation funded two national access to care studies, and subsequently published the results in issues of its *Special Report*. A grant this year to the University of California, Los Angeles, is underwriting a third access to care study, elaborating upon the earlier findings and incorporating additional questions for people with serious illnesses and those who have been refused treatment for financial reasons.

Childhood deaths

Through a grant to the Maine Department of Human Services, researchers are conducting a statewide pilot study following up reported child and adolescent deaths (from infancy to 18 years of age). A key part of the follow-up involves interviews with the children's families conducted by specially trained public health nurses. The study seeks to identify specific risk factors associated with these deaths.

Health status of black Americans

The National Academy of Sciences is conducting a study on the health and medical care status of black Americans. Since 1950, the adjusted death rate for blacks has fallen by over 35 percent. However, the gap between white and black death rates has remained the same—nearly 150 percent higher for blacks. The questions of why and what can be done to rectify this situation will be examined.

Teenage pregnancy

Teenage pregnancy and its consequences are the subjects of a study by The University of Pennsylvania and the Institute for the Study of Exceptional Children in Princeton, New Jersey. This longitudinal study builds on a study of 400 inner-city youths under age 18 who were pregnant for the first time in 1965 and sought prenatal care at Sinai Hospital in Baltimore. At that time, the teenagers and

their mothers were interviewed. In subsequent years, the children of these 400 teenagers have been periodically assessed. These children, now grown, are part of the current survey, as are their offspring. The combined information gathered from this four-generation span will be used in an attempt to identify factors associated with teenage pregnancy and the health and developmental outcomes of the children of teenage parents. The study has also received funding from the Commonwealth Fund.

Effects of Medicare changes

The Medicare program has changed significantly in the last few years. Notable among these changes is the establishment of a prospective payment system creating incentives for hospitals to discharge patients earlier. One rationale is that individuals could be cared for in the community less expensively. However, questions remain as to whether this approach works. If people are being discharged earlier, for example, they may also be sicker and more reliant on community service agencies, some of which may not be able to keep up with the increased demand for services. In addition, many services in the community are not covered under Medicare. With a grant this year, the University of California, San Francisco, School of Nursing is conducting a study of the impact of these Medicare policy changes on community services and patient care.

Looking to the future

Health care in the year 2000 is the focus of a study being conducted by The Institute for the Future in Menlo Park, California. Specifically, the study team will identify the key environmental forces that are creating change in the nation's health care system in order to forecast the health care environment of the future, assessing the likely impact of projected environmental changes on four key groups in the health care system—physicians, hospitals, academic medical centers, and



businesses/insurers. Working with representatives from these four groups, the study team will define the major issues and choices facing private- and public-sector planners and policymakers.

In the rapidly changing health care environment, the roles that not-for-profit health institutions play are becoming increasingly unclear. Particularly in the hospital field, but in other areas such as HMOs and home care, corporate restructuring and the establishment of for-profit subsidiaries are making it more difficult to define what is special or unique in the nature of the not-for-profit institutions. A grant to the United Hospital Fund of New York is assisting a group of leading experts in looking at current and future roles of voluntary health care institutions. These analyses, when completed and published, are intended to offer a framework for future public policy.

Access to research results

Over the past few years, the Foundation has invested in research and evaluation studies that have produced a variety of databases of interest to health service researchers and policymakers. While data collected have been focused on specific research questions, much additional information could also be gleaned through secondary analyses. To facilitate this, the Inter-University Consortium for Political and Social Research at the University of Michigan, with Foundation funding, is preparing public-use data tapes gathered from a group of these Foundation-supported studies and evaluations.

TRAINING

During 1985, the Foundation again supported a number of specialized training programs. These programs provide current and future health professionals the opportunities to build and enhance their skills in areas important to the health care needs of this country.

Infant communications disorders

To date, speech and language pathologists have been only marginally involved in the assessment and care of infants, including those at high risk of developmental impairments. Instead, the profession has concentrated on preschool and school-age children—when communication deficits may have already impaired development. A grant this year to Western Michigan University is enabling the establishment of a graduate program to prepare speech and language pathologists to pursue specialty careers in the treatment of infants at risk for communications disorders.

Minority programs

During 1985, a third round of eight young physicians received four-year postdoctoral fellowships for biomedical research under the Minority Medical Faculty Development Program, bringing the total to 24. This initiative, designed to increase the number of minority medical faculty with strong potentials for achieving senior academic positions in the nation's medical schools, was also renewed for a second three-year period.

Four efforts received renewal support in 1985 to increase the number of minority physicians and other health professionals: the Illinois Institute of Technology's preceptorship program; the Aspira Health Professions Program, which operates in four states and Puerto Rico; a program by the University of Medicine and Dentistry of New Jersey (UMDNJ); and an enrichment program that includes precollegiate activities and study sponsored by a consortium of Atlanta undergraduate institutions and the Atlanta University Graduate School.

In addition, a grant this year to the University of Utah's Ethnic Minority Student Health Science Center is supporting the development of a premedical enrichment program for minority high school students, primarily Native Americans and Mexican Americans, drawn from 45 schools in a four-state area.

Other training programs

Four other Foundation-sponsored training programs that received support this year are:

- the Clinical Nurse Scholars Program, providing two-year postdoctoral fellowships in advanced, in-hospital clinical practice and research;
- the Dental Services Research Scholars Program, offering dental faculty the opportunity to develop research skills on the evolving issues affecting the

way dental care is provided in this country;

- the Health Policy Fellowships Program, providing faculty from academic health centers a year's experience in health policy development at the national level; and
- the Program for Faculty Fellowships in Health Care Finance, developing university faculty with the skills needed to teach and conduct research in the field of health care finance.



NEW JERSEY GRANTS

Each year the Foundation provides support to a number of programs in the state of New Jersey and in the city of New Brunswick, where the Foundation was established.

In Newark, a grant to the Department of Health and Welfare is supporting a health care project for homeless individuals. Developed through the efforts of a citywide coalition of 19 public and private agencies, the project is bringing health and other essential services to over 80 percent of the city's homeless population. State Medicaid funding has been made available through this initiative, and the state has also committed funds for a two-year pilot program that employs a community-based case management system for the mentally ill homeless.

In conjunction with the third national access to care study described previously, a grant to the University of California, Los Angeles, is supporting a special New Jersey profile that can be used by the Foundation, state and local governments, and voluntary groups involved in health care delivery, planning, and assessment.

The Foundation also made a major challenge grant toward a \$25-million campaign of the Foundation of the University of Medicine and Dentistry of New Jersey. Funds raised will be used to enhance and strengthen the educational, research, and clinical programs of the University.

FOR FURTHER INFORMATION

A brief, descriptive *Program Summary* is available without charge for most of the Foundation's 1985 grants, as well as for those made in prior years. When possible, requests should include the title of the grant, the institutional recipient, and the grant ID

number. This information on the 1985 grants is available from the listing beginning on the next page. Address requests to:

Communications Office
The Robert Wood Johnson Foundation
Post Office Box 2316
Princeton, New Jersey 08543-2316

Also available without charge from the same address is the Foundation's *Special Report*, a non-periodic publication that describes the progress and outcomes of some of the programs assisted by the Foundation. Titles issued in 1985 were:

- National School Health Services Program
- The Community Hospital Program
- The Perinatal Program: What Has Been Learned

**Summary of grants
authorized in the year ended December 31, 1985**

		1985 grants authorized
Albert Einstein College of Medicine of Yeshiva University New York, New York	<i>Community-based program to improve obstetrical care and reduce pre-term birth (for 3 years). ID#9103</i>	\$ 849,493
Alpha Center for Health Planning, Inc. Washington, D.C.	<i>Technical assistance for Health Care for the Uninsured Program (for 1 year). ID#10417</i>	154,868
American Fund for Dental Health Chicago, Illinois	<i>Identification of children at high risk for dental caries (for 4.5 years). ID#10112</i>	1,535,173
Aspira of America, Inc. New York, New York	<i>Program to increase minority enrollment in medical school (for 2 years). ID#8905</i>	300,000
Association of University Programs in Health Administration Arlington, Virginia	<i>Program to improve management education in long- term care (for 3.5 years). ID#10622</i>	460,491
City of Baltimore Health Department Baltimore, Maryland	<i>Primary care health services for the deaf (for 2 years). ID#9429</i>	19,940
Barrio Comprehensive Family Health Care Center, Inc. San Antonio, Texas	<i>Strengthening the Center's capacity to provide essential health services (for 3 years). ID#9117</i>	160,858
Benedictine Hospital Kingston, New York	<i>Technical assistance and direction for the Health- Impaired Elderly and Interfaith Volunteer Caregivers Programs (for 1 year). ID#9603</i>	337,825
Boston University, School of Management Boston, Massachusetts	<i>The effects of prospective payment on access to care (for 1 year). ID#10616</i>	54,074

Brandeis University Waltham, Massachusetts	<i>Technical assistance for program development (for 1 year). ID# 10531</i>	\$ 306,046
Brandeis University, Florence Heller Graduate School for Advanced Studies in Social Welfare Waltham, Massachusetts	<i>Evaluation of Program for Hospital Initiatives in Long-Term Care—Phase I (for 9 months). ID# 7914</i>	61,123
University of California, Los Angeles, Institute for Social Science Research Los Angeles, California	<i>Third national survey of access to health care (for 31 months). ID# 10343</i>	849,852
	<i>Special survey of access to health care for New Jersey (for 23 months). ID# 10797</i>	140,000
University of California, San Francisco, School of Nursing San Francisco, California	<i>Study of Medicare effects on health and social services for the elderly (for 3 years). ID# 10514</i>	312,656
Case Western Reserve University, School of Medicine Cleveland, Ohio	<i>Development of a research agenda for the prevention of low birthweight (for 1 year). ID# 10649</i>	150,000
Catholic Charities of the Archdiocese of New York New York, New York	<i>Planning for a health maintenance organization (for 9 months). ID# 9539</i>	195,000
Children's Hospital New Orleans, Louisiana	<i>Development of a jointly-sponsored regional pediatric center (for 8 months). ID# 10386</i>	75,000
Children's Hospital Corporation Boston, Massachusetts	<i>Study of health and functional status of handicapped children in school settings (for 9 months). ID# 10406</i>	224,957
The Citizens Committee on Biomedical Ethics, Inc. Summit, New Jersey	<i>Statewide program on legal and ethical issues in the care of the critically ill (for 2 years). ID# 10668</i>	86,312
Clinical Nurse Scholars Program	<i>Postdoctoral fellowships of advanced in-hospital clinical practice and research (for 1 year). ID# 7514</i>	
University of California, San Francisco, School of Nursing San Francisco, California		269,405

		1985 grants authorized
The University of Pennsylvania, School of Nursing Philadelphia, Pennsylvania		\$ 288,204
University of Rochester, School of Nursing Rochester, New York		275,357
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Clinical Scholars Program	<i>Postdoctoral fellowships for young physicians to develop research skills in non-biological disciplines relevant to medical care (for 2 years). ID#5109</i>	
University of California, Los Angeles, School of Medicine Los Angeles, California		101,489
The University of Pennsylvania, School of Medicine Philadelphia, Pennsylvania		96,198
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Committee for Economic Development New York, New York	<i>Report on the role of market incentives in improving health care (for 1 year). ID#10538</i>	74,000
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Community Care Funding Partners Program	<i>Primary care projects for underserved groups, jointly funded with local foundations and other private sources (for the periods indicated). ID#6397</i>	
Greater Kansas City Community Foundation Kansas City, Missouri (57 months)		391,517
Jeff Davis County Medical Services Center, Inc. Hazlehurst, Georgia (5 years)		308,577
Lawndale Christian Health Center Chicago, Illinois (4.5 years)		339,110
Oak Cliff Clinics, Inc. Dallas, Texas (5 years)		400,000
The Ounce of Prevention Fund Chicago, Illinois (5 years)		372,129
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Community Programs for Affordable Health Care	<i>Implementing local projects to slow the rate of health care cost increases (for the periods indicated). ID#6748</i>	
Greater Atlanta Coalition on Health Care, Inc. Atlanta, Georgia (2 years)		705,717

		1985 grants authorized
Mecklenburg County Health Care Cost Management Council, Inc. Charlotte, North Carolina (2 years)		\$ 828,569
Minnesota Coalition on Health Care Costs Minneapolis, Minnesota (2 years)		693,418
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Conference of Mayors Research and Education Foundation Washington, D.C.	<i>Technical assistance on urban health issues (for 2 years). ID# 10864</i>	102,772
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Cornell University Medical College New York, New York	<i>Technical assistance and direction for the General Pediatrics Academic Development Program (for 1 year). ID# 9601</i>	97,648
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The Council of State Governments — Southern Governors' Association Lexington, Kentucky	<i>Southern regional task force on infant mortality (for 1 year). ID# 10045</i>	120,329
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Dental Services Research Scholars Program	<i>Dental faculty fellowships in health services research (for the periods indicated). ID# 6720</i>	
University of Alabama, School of Dentistry Birmingham, Alabama (2 years)		100,800
University of California, Los Angeles, School of Dentistry Los Angeles, California (2 years)		138,092
Harvard University, School of Dental Medicine Boston, Massachusetts (2 years)		178,363
Long Island Jewish-Hillside Medical Center New Hyde Park, New York (2 years)		99,200
University of Minnesota, School of Dentistry Minneapolis, Minnesota (2 years)		96,145
University of North Carolina at Chapel Hill, School of Dentistry Chapel Hill, North Carolina (2 years)		94,400

	1985 grants authorized
University of Texas Health Science Center at San Antonio Dental School San Antonio, Texas (2 years)	\$ 101,600
Washington University, School of Dental Medicine St. Louis, Missouri (14 months)	4,211
State of Florida, Department of Health and Rehabilitative Services Tallahassee, Florida	<i>Case management program for medically dependent frail elderly (for 3 years). ID#9542</i> 382,628
University of Florida, Center for Health Policy Research Gainesville, Florida	<i>Evaluation of a program to maintain the very frail elderly in the community (for 7 months). ID# 10320</i> 46,152
Faculty Fellowships in Health Care Finance	<i>Program of study and field experience in health care finance for university faculty from related specialties (for the periods indicated). ID#8584</i>
Claremont McKenna College Claremont, California (1 year)	49,400
Columbia University, School of International and Public Affairs New York, New York (2 months)	8,574
University of Illinois-Chicago, School of Urban Planning and Policy Chicago, Illinois (11 months)	15,000
University of Michigan, School of Public Health Ann Arbor, Michigan (1 year)	44,733
University of Mississippi, School of Pharmacy University, Mississippi (1 year)	37,698
New York University Medical Center New York, New York (1 year)	49,400
University of Oregon Development Fund Eugene, Oregon (1 year)	15,000

	1985 grants authorized
Seton Hall University South Orange, New Jersey (1 year)	\$ 48,800
Tulane University, School of Medicine New Orleans, Louisiana (1 year)	44,586
Yale University, School of Medicine New Haven, Connecticut (9 months)	15,000
The Foundation Center New York, New York	<i>Data collection and analysis on the foundation field (for 3 years). ID# 8477</i>
	150,000
The General Hospital Corporation— Massachusetts General Hospital Boston, Massachusetts	<i>Technical assistance and direction for the Program for Prepaid Managed Health Care (for 1 year). ID# 9269</i>
	182,086
General Pediatrics Academic Development Program	<i>Projects to expand research and training for academic careers in general pediatrics (for the periods indicated). ID# 4610</i>
Duke University Medical Center Durham, North Carolina (2 years)	498,727
The Johns Hopkins University, School of Medicine Baltimore, Maryland (27 months)	499,782
Medical Associates Research and Education Foundation Philadelphia, Pennsylvania (2 years)	500,000
University of Rochester, School of Medicine and Dentistry Rochester, New York (2 years)	497,400
Stanford University, School of Medicine Stanford, California (2 years)	499,633
Yale University, School of Medicine New Haven, Connecticut (2 years)	499,500

George Washington University Washington, D.C.	<i>Technical assistance for program development (for 1 year). ID# 10562</i>	\$ 496,666
Georgetown University, School of Medicine Washington, D.C.	<i>Analysis of health policy issues (for 1 year). ID# 9758</i>	336,749
Harvard Medical School Boston, Massachusetts	<i>Evaluation of a program to improve high-risk birth outcomes in Boston (for 50 months). ID# 10315</i>	789,689
	<i>Technical assistance and direction for the Program for the Chronically Mentally Ill (for 11 months). ID# 10447</i>	345,331
Health Care for the Homeless Program	<i>Projects involving urban coalitions of public and private agencies in providing and coordinating health and other services to the homeless (for 2 years). ID# 8637</i>	
University of Massachusetts Amherst, Massachusetts		461,996
Health Policy Fellowships Program	<i>One-year fellowships with the federal government in Washington, D.C., for faculty from academic health science centers (for the periods indicated). ID# 4888</i>	
University of California, Berkeley, School of Public Health Berkeley, California (1 year)		49,352
Case Western Reserve University, School of Medicine Cleveland, Ohio (1 year)		49,276
University of Cincinnati, College of Medicine Cincinnati, Ohio (1 year)		50,120
University of Iowa, College of Medicine Iowa City, Iowa (1 year)		49,600
University Physicians Milwaukee Clinical Campus Practice Plan, Inc. Milwaukee, Wisconsin (1 year)		48,000

	1985 grants authorized
University of Washington, School of Public Health and Community Medicine Seattle, Washington <i>(1 month)</i>	\$ 938
Heather Hill, Inc. Chardon, Ohio <i>New approach to patients with Alzheimer's and other related dementias (for 1 year). ID#9776</i>	56,750
Home Health Agency Assembly of New Jersey, Inc. Princeton, New Jersey <i>Statewide consulting services program (for 2 years). ID#9130</i>	107,294
Program for Hospital Initiatives in Long-Term Care	
	<i>Implementing comprehensive service projects for defined elderly populations (for the periods indicated). ID#7832</i>
University of California, Los Angeles, School of Medicine Los Angeles, California <i>(3 years)</i>	491,035
Craven County Hospital Corporation New Bern, North Carolina <i>(3 years)</i>	515,435
Cuyahoga County Hospital System Cleveland, Ohio <i>(3 years)</i>	500,000
Dallas County Hospital District—Parkland Memorial Hospital Dallas, Texas <i>(3 years)</i>	502,438
The General Hospital Corporation— Massachusetts General Hospital Boston, Massachusetts <i>(3 years)</i>	500,852
Geriatrics Service Complex Foundation, Inc.— South Shore Hospital Miami Beach, Florida <i>(3 years)</i>	500,000
Good Samaritan Hospital Puyallup, Washington <i>(3 years)</i>	491,381
IHC Foundation, Inc. Salt Lake City, Utah <i>(3 years)</i>	497,540

	1985 grants authorized
The Johns Hopkins Hospital Baltimore, Maryland <i>(3 years)</i>	\$ 500,219
Kuakini Medical Center Honolulu, Hawaii <i>(3 years)</i>	510,788
Lutheran Hospitals and Homes Society of America—Valley Lutheran Hospital Mesa, Arizona <i>(3 years)</i>	526,724
University of Maryland, School of Medicine Baltimore, Maryland <i>(3 years)</i>	499,996
Meharry Medical College, George W. Hubbard Hospital Nashville, Tennessee <i>(3 years)</i>	506,369
Morristown Memorial Hospital Morristown, New Jersey <i>(3 years)</i>	500,717
Mount Sinai Hospital Hartford, Connecticut <i>(3 years)</i>	497,805
Mount Sinai Medical Center, Inc. Milwaukee, Wisconsin <i>(3 years)</i>	499,999
Mount Zion Hospital and Medical Center San Francisco, California <i>(3 years)</i>	500,022
San Francisco Department of Public Health San Francisco, California <i>(3 years)</i>	497,263
Senior Health Plan, Inc. St. Paul, Minnesota <i>(3 years)</i>	500,000
St. Luke's Regional Medical Center Boise, Idaho <i>(3 years)</i>	494,818
St. Vincent's Hospital and Medical Center of New York New York, New York <i>(3 years)</i>	564,705
University Hospital Boston, Massachusetts <i>(3 years)</i>	508,285

		1985 grants authorized
University of Virginia, School of Medicine Charlottesville, Virginia (3 years)		\$ 500,339
West Virginia University Hospitals, Inc. Morgantown, West Virginia (3 years)		502,304
Hospital Research and Educational Trust Chicago, Illinois	<i>Technical assistance and direction for Community Programs for Affordable Health Care (for 22 months). ID#9270</i>	772,528
The Hospital for Sick Children Washington, D. C.	<i>Volunteer program to assist seriously disabled children and their families (for 1.5 years). ID# 10490</i>	134,991
Illinois Institute of Technology Chicago, Illinois	<i>Preceptorship program to prepare minorities for careers in medicine (for 3 years). ID# 10297</i>	256,131
Independent Sector Washington, D. C.	<i>Fund for the future (for 1 year). ID# 10667</i>	100,000
The Institute for the Future Menlo Park, California	<i>Health care projections for the year 2000 (for 2.5 years). ID#9846</i>	250,000
Interfaith Volunteer Caregivers Program	<i>Ecumenical coalitions of volunteers in projects coordinating health and other services enabling elderly and other vulnerable individuals to continue living in the community (for the periods indicated). ID# 7879</i>	
Fordham University New York, New York (2 years)		434,305
National Interfaith Coalition On Aging, Inc. Athens, Georgia (3 years)		18,150
The John F. Kennedy Medical Center Foundation, Inc. Edison, New Jersey	<i>Equipment support for The Robert Wood Johnson, Jr. Rehabilitation Institute (for 7 months). ID#9126</i>	66,343
The Johns Hopkins Hospital Baltimore, Maryland	<i>Technical assistance and direction for Faculty Fellowships in Health Care Finance (for 10 months). ID#9275</i>	214,401

The Johns Hopkins University, School of Hygiene and Public Health Baltimore, Maryland	<i>Technical assistance and direction for Faculty Fellowships in Health Care Finance (for 14 months). ID# 10204</i>	\$ 338,474
Kaiser Foundation Hospitals Oakland, California	<i>Demonstration study to prevent falls among the elderly (for 3 years). ID# 9995</i>	465,299
La Clínica de la Raza Oakland, California	<i>Strengthening the Clinic's capacity to provide essential health services (for 4 years). ID# 9115</i>	214,950
State of Maine, Department of Human Services Augusta, Maine	<i>Follow-up study of child and adolescent deaths in Maine (for 1.5 years). ID# 9791</i>	212,208
Meharry Medical College Nashville, Tennessee	<i>Technical assistance and direction for the Program to Consolidate Health Services for High-Risk Young People (for 1 year). ID# 9612</i>	257,481
University of Michigan, School of Public Health Ann Arbor, Michigan	<i>Evaluation of Community Programs for Affordable Health Care—Phase I (for 1 year). ID# 6753</i>	114,829
Middlesex County College Edison, New Jersey	<i>Registered nurse refresher course (for 2 months). ID# 9613</i>	12,932
Middlesex County College Foundation, Inc. Edison, New Jersey	<i>Financial aid program for disadvantaged students in allied health sciences (for 5 years). ID# 9760</i>	350,000
Middlesex County Recreational Council Edison, New Jersey	<i>Summer camp for children with health problems (for 8 months). ID# 10106</i>	19,540
Middlesex General—University Hospital New Brunswick, New Jersey	<i>Property acquisition (for 1 year). ID# 10107</i>	1,538,908
	<i>Research on the outcomes and costs of hospital nursing (for 2 years). ID# 10454</i>	121,400
Minority Medical Faculty Development Program	<i>Four-year program to provide two-year, biomedical, postdoctoral research fellowships (for 2 years). ID# 7854</i>	
Brigham and Women's Hospital, Inc. Boston, Massachusetts		104,426

	1985 grants authorized
University of California, San Francisco, School of Medicine San Francisco, California	\$ 240,000
Columbia University, College of Physicians and Surgeons New York, New York	120,000
Duke University Medical Center Durham, North Carolina	120,000
Foundation for Advanced Education in the Sciences Bethesda, Maryland	119,978
Harvard Medical School Boston, Massachusetts	118,211
Michael Reese Hospital and Medical Center Chicago, Illinois	120,000
University of Michigan Medical School Ann Arbor, Michigan	120,000
New England Medical Center, Inc. Boston, Massachusetts	119,809
The University of Pennsylvania, School of Medicine Philadelphia, Pennsylvania	119,946
Stanford University, School of Medicine Stanford, California	238,501
University of Washington, School of Medicine Seattle, Washington	118,000
Yale University, School of Medicine New Haven, Connecticut	239,673
Montefiore Medical Center Bronx, New York	<i>Technical assistance and direction for the Program for Hospital Initiatives in Long-Term Care (for 1 year). ID#9761</i> 257,232
Morehouse College Atlanta, Georgia	<i>Program to increase minority enrollment in medical schools (for 3 years). ID#8278</i> 239,865
Municipal Health Services, Inc. Baltimore, Maryland	<i>Primary care health services for the deaf (for 14 months). ID#10589</i> 48,660
National Academy of Sciences— National Research Council Washington, D.C.	<i>National study on the health status of black Americans (for 2 years). ID#10308</i> 250,000

National Association of Community Health Centers, Inc. Washington, D.C.	<i>Technical assistance for programs to strengthen the management of community health centers (for 3.5 years). ID# 10236</i>	\$ 451,487
The National Benevolent Association of the Christian Church St. Louis, Missouri	<i>Comprehensive care for Alzheimer's patients and their families (for 2 years). ID#9719</i>	248,210
National Council on the Aging, Inc. Washington, D.C.	<i>Technical assistance for a multisite program enabling older volunteers to assist disabled children and their families (for 38 months). ID# 10640</i>	777,029
National Governors' Association Washington, D.C.	<i>Technical assistance for the Program for the Chronically Mentally Ill (for 2 years). ID# 10865</i>	45,486
National Governors' Association Center for Policy Research Washington, D.C.	<i>Technical assistance for the Program for Prepaid Managed Health Care and Hospital Initiatives in Long-Term Care Program (for 22 months). ID# 10263</i>	231,543
National Mental Health Association, Inc. Alexandria, Virginia	<i>Development of a national consensus and plan for improving mental health care (for 1.5 years). ID# 9516</i>	198,408
New Brunswick Affiliated Hospitals, Inc. New Brunswick, New Jersey	<i>Property acquisition for a magnetic resonance imaging center (for 3 months). ID# 10101</i>	372,000
New York University New York, New York	<i>Technical assistance and direction for the Rural Hospital Program of Extended-Care Services (for 1 year). ID# 9763</i>	203,539
City of Newark, Department of Health and Welfare Newark, New Jersey	<i>Health care for the homeless (for 2 years). ID# 10251</i>	604,929
University of North Carolina at Chapel Hill Chapel Hill, North Carolina	<i>Technical assistance and development for the Infant Health and Development Program (for 1 year). ID# 10887</i>	586,013

University of North Carolina at Chapel Hill, Health Services Research Center Chapel Hill, North Carolina	<i>Technical assistance and direction for the Dental Services Research Scholars Program (for 1 year). ID#9605</i>	\$ 206,568
On Lok Senior Health Services San Francisco, California	<i>Technical assistance for the replication of its long- term care program (for 1 year). ID#10581</i>	121,773
The University of Pennsylvania Philadelphia, Pennsylvania	<i>Study of high-risk adolescents and their children (for 39 months). ID#10024</i>	459,000
The University of Pennsylvania, School of Dental Medicine Philadelphia, Pennsylvania	<i>Long-term effects of a rural dental health program (for 1 year). ID#10188</i>	35,904
The University of Pennsylvania, School of Nursing Philadelphia, Pennsylvania	<i>Technical assistance and direction for the Teaching Nursing Home Program (for 1 year). ID#9766</i>	205,205
Rand Corporation Santa Monica, California	<i>Analysis of major options for health care cost control (for 1 year). ID#9682</i>	115,856
	<i>Evaluation of the Program for Prepaid Managed Health Care—Phase I (for 10 months). ID#7859</i>	197,740
Program for Research and Development on Health Care Costs. ID#7867		
University of Alabama, School of Medicine Birmingham, Alabama	<i>Study of shortening hospital stays of burn patients by expanding home care (for 3 years).</i>	285,224
University of Michigan Medical School Ann Arbor, Michigan	<i>Physician cost-containment education and feedback program (for 38 months).</i>	266,869
University of Michigan, School of Public Health Ann Arbor, Michigan	<i>Study of private sector cost-containment approaches (for 3 years).</i>	297,217
Montefiore Medical Center Bronx, New York	<i>Cost and outcome of early hospital discharge of stroke patients to home care (for 20 months).</i>	268,130
New York City Health and Hospitals Corporation New York, New York	<i>Analysis of cost implications of pediatric protocol system (for 1.5 years).</i>	170,788

		1985 grants authorized
New York City Health and Hospitals Corporation—Harlem Hospital New York, New York	<i>Evaluation of psychiatric case management on hospital resource utilization (for 2 years).</i>	\$ 155,116
The University of Pennsylvania Philadelphia, Pennsylvania	<i>Design and evaluation of incentives for ambulatory surgery: a national study (for 2 years).</i>	201,869
The University of Tennessee, Center for the Health Sciences Memphis, Tennessee	<i>Geriatric assessment and rehabilitation unit impact on health care costs (for 3 years).</i>	199,652
The Urban Institute Washington, D.C.	<i>Analysis of changes in public and private insurance on hospital costs (for 2 years).</i>	300,000
Vanderbilt University Nashville, Tennessee	<i>Outcome evaluation of new Medicare prospective payment (for 2 years).</i>	289,755
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Research and Development Program to Improve Patient Functional Status. ID#6329		
Akron City Hospital Akron, Ohio	<i>Study of arthritic patients using noninvasive acoustical technique (for 3 years).</i>	148,539
University of California, Irvine, California College of Medicine Irvine, California	<i>Demonstration to improve functional capacity after total hip replacement (for 3 years).</i>	144,577
University of California, Los Angeles, School of Medicine Los Angeles, California	<i>Study on the use of family in the rehabilitation of traumatic head injuries (for 3 years).</i>	150,000
Case Western Reserve University, School of Medicine Cleveland, Ohio	<i>Study to improve the predictability of prematurity (for 2 years).</i>	149,946
Duke University Medical Center Durham, North Carolina	<i>Evaluation of the family as a determinant of functional health (for 2.5 years).</i>	149,698
Duke University Medical Center, School of Nursing Durham, North Carolina	<i>Relaxation training to reduce chemotherapy adverseness in children (for 3 years).</i>	146,295
University of Iowa, College of Medicine Iowa City, Iowa	<i>Study of seating systems to improve functional status for the disabled (for 1 year).</i>	33,818

		1985 grants authorized
The Johns Hopkins University, School of Medicine Baltimore, Maryland	<i>Infant screening to improve prognosis in strabismus and amblyopia (for 3 years).</i>	\$ 149,952
Louisiana State University Medical Center New Orleans, Louisiana	<i>Study of factors in initial care of spinal cord injuries for association with pressure sores (for 2 years).</i>	106,509
Medical Associates Research and Education Foundation Philadelphia, Pennsylvania	<i>Study of functional status of children after sexual abuse (for 3 years).</i>	149,581
	<i>Evaluation of risk factors for injury during adolescence (for 3 years).</i>	149,980
University of Michigan Medical School Ann Arbor, Michigan	<i>Study of insulin pump therapy on the functioning of adults with Type 1 diabetes (for 3 years).</i>	149,699
University of Nevada, School of Medical Sciences Reno, Nevada	<i>Developing predictors of family and individual function one year post-coronary (for 3 years).</i>	149,996
University of North Carolina at Chapel Hill, School of Medicine Chapel Hill, North Carolina	<i>Evaluation of timed manual function in geriatric assessments (for 1.5 years).</i>	72,067
Ohio State University Research Foundation Columbus, Ohio	<i>Reduction of urinary tract infections among the institutionalized elderly (for 2 years).</i>	150,000
Rutgers University, College of Nursing Newark, New Jersey	<i>Use of an activity scale to improve care for multiple sclerosis (for 3 years).</i>	138,579
University of Texas Medical School at San Antonio San Antonio, Texas	<i>Predicting and improving functional disability due to chronic pain (for 3 years).</i>	149,914
Jefferson Medical College of Thomas Jefferson University Philadelphia, Pennsylvania	<i>Patient monitoring after congestive heart failure and discharge from home care (for 2 years).</i>	149,994
University of Washington, School of Medicine Seattle, Washington	<i>Study of diabetic patient functioning under strict glycemetic control regimen (for 1.5 years).</i>	149,926
	<i>Exploring hearing impairment and cognitive dysfunction in senile dementia (for 3 years).</i>	150,000

Yale University, School of Medicine New Haven, Connecticut	<i>Search for psychosocial predictors of recovery in the elderly (for 3 years).</i>	\$ 149,587
University of Rochester, School of Medicine and Dentistry Rochester, New York	<i>Plan urban program of nurse home-visiting for high-risk mothers and their children (for 1 year). ID#9677</i>	83,078
Rural Hospital Program of Extended-Care Services		
	<i>Completion of projects begun in 1982 to develop "swing beds" providing long-term care in acute-care hospitals (for 2 years). ID#6267</i>	
Cedar County Memorial Hospital El Dorado Springs, Missouri		99,841
Community Hospital Sweet Springs, Missouri		109,089
District Two Community Hospital Durant, Mississippi		114,811
Dr. Dan C. Trigg Memorial Hospital Tucumcari, New Mexico		83,767
Hazen Memorial Hospital Association Hazen, North Dakota		105,053
Holton City Hospital Holton, Kansas		102,782
Board of City Hospital Trustees—Lexington Memorial Hospital, Inc. Lexington, Missouri		114,338
Linton Hospital, Inc. Linton, North Dakota		85,387
Lutheran Hospital and Homes Society of America—Pembina County Memorial Cavalier, North Dakota		85,232
Maude Norton Memorial City Hospital Columbus, Kansas		102,771
Mercy Hospital—Tri County Mansfield, Missouri		104,046
Nor-Lea Hospital District Lovington, New Mexico		88,050
North Mississippi Medical Center—Baldwyn Satellite Unit Baldwyn, Mississippi		106,970

	1985 grants authorized
Northern Colfax County Hospital Raton, New Mexico	\$ 78,471
Northwest Kansas Regional Medical Center Goodland, Kansas	107,346
Presbyterian Medical Services—Cuba Hospital Cuba, New Mexico	126,493
Ruidoso-Hondo Valley Hospital Ruidoso, New Mexico	98,612
Scott County Hospital Scott City, Kansas	101,907
Board of Trustees of the Sheridan County Hospital Hoxie, Kansas	73,227
Sierra Vista Hospital, Inc. Truth or Consequences, New Mexico	97,253
Simpson General Hospital Mendenhall, Mississippi	80,749
St. Andrew's Hospital Bottineau, North Dakota	117,526
Stafford District Hospital No. 4 Stafford, Kansas	96,925
Sullivan County Memorial Hospital Milan, Missouri	112,810
Tallahatchie General Hospital Charleston, Mississippi	119,665
Union Hospital Society of Mayville Mayville, North Dakota	116,089
St. Peter's Foundation New Brunswick, New Jersey	<i>Development of a nursing home (for 1 year). ID#10623</i> 500,000
St. Peter's Medical Center, School of Nursing New Brunswick, New Jersey	<i>Support for a nurse training program (for 10 months). ID#9768</i> 20,000
St. Vincent de Paul Society Metuchen, New Jersey	<i>Program of assistance to the indigent (for 2 years). ID#9271</i> 40,000
St. Vincent's Hospital and Medical Center of New York New York, New York	<i>Technical assistance and direction for the Health Care for the Homeless Program (for 1 year). ID#9769</i> 307,826

		1985 grants authorized
The Salvation Army New Brunswick, New Jersey	<i>Program of assistance to the indigent (for 1 year). ID# 9767</i>	\$ 57,500
Medical University of South Carolina, College of Medicine Charleston, South Carolina	<i>Evaluation of a statewide low-birthweight prevention program (for 2 years). ID# 10050</i>	192,922
Stanford University, School of Medicine Stanford, California	<i>Technical assistance and evaluation of the Infant Health and Development Program (for 1 year). ID# 9407</i>	455,144
The Statue of Liberty-Ellis Island Foundation, Inc. New York, New York	<i>Restoration of the Statue of Liberty and Ellis Island facilities (for 1 year). ID# 10299</i>	100,000
Tennessee Association of Primary Health Care Centers, Inc. Nashville, Tennessee	<i>Implementation of a statewide capitated primary care network for Medicaid recipients (for 6 months). ID# 10037</i>	150,000
Tufts University, School of Medicine Boston, Massachusetts	<i>Health policy studies of medical malpractice and physician distribution (for 3 years). ID# 10257</i>	299,987
United Hospital Fund of New York New York, New York	<i>Study assessing the future of voluntary health care institutions (for 15 months). ID# 10482</i>	110,411
United Seniors Consumer Cooperative Washington, D.C.	<i>Consumer health information program demonstration (for 3 years). ID# 10631</i>	375,069
United Way of Central Jersey, Inc. Milltown, New Jersey	<i>Support of 1985 campaign (for 1 year). ID# 10820</i>	300,000
United Way—Princeton Area Communities Princeton, New Jersey	<i>Support for the 1984 campaign (for 1 year). ID# 9272</i>	35,000
	<i>Support for the 1985 campaign (for 1 year). ID# 10208</i>	38,000
University of Medicine and Dentistry of New Jersey Newark, New Jersey	<i>Program to prepare minority students for careers in medicine and dentistry (for 4 years). ID# 6481</i>	224,100

Foundation of the University of Medicine and Dentistry of New Jersey Newark, New Jersey	<i>Research and educational enrichment program (for 5 years). ID# 10137</i>	\$ 7,000,000
University of Medicine and Dentistry of New Jersey, Rutgers Medical School Piscataway, New Jersey	<i>New Brunswick school health program (for 2 years). ID# 10334</i>	133,250
University of Utah Salt Lake City, Utah	<i>Premedical enrichment program for minority high school students (for 3 years). ID# 9771</i>	522,191
Vermont Health Policy Corporation Waterbury, Vermont	<i>Statewide program on legal and ethical issues in the care of the critically ill (for 2 years). ID# 10846</i>	68,684
Washington University, School of Medicine St. Louis, Missouri	<i>Completion of evaluation of Program to Consolidate Health Services for High-Risk Young People (for 1 year). ID# 10809</i>	137,149
University of Washington, School of Medicine Seattle, Washington	<i>Study to monitor changes in birth outcomes among low-income Americans (for 1 year). ID# 10629</i>	44,864
University of Washington, School of Nursing Seattle, Washington	<i>Technical assistance and direction for the Clinical Nurse Scholars Program (for 7 months). ID# 10654</i>	112,156
Western Michigan University Kalamazoo, Michigan	<i>Program to train speech pathologists to care for high-risk infants (for 3 years). ID# 10077</i>	196,637
Women & Infants' Hospital of Rhode Island Providence, Rhode Island	<i>Assess impact of changes in state financing on regional perinatal systems (for 3 years). ID# 10510</i>	280,916
PRESIDENT'S GRANTS		
A.C.N.M. Foundation, Inc. Washington, D.C.	<i>Study of midwifery in maternity and infant care in the United States (for 7 months). ID# 10008</i>	25,064
Baylor College of Medicine Houston, Texas	<i>Conference on educating minority high school students in mathematics and science (for 6 months). ID# 10152</i>	16,475
Brigham and Women's Hospital, Inc. Boston, Massachusetts	<i>Cost study of Teaching Hospital General Medicine Group Practice Program (for 1 year). ID# 9711</i>	14,456

		1985 grants authorized
The Brookings Institution Washington, D.C.	<i>Conference on experience and future directions for hospital swing beds (for 5 months). ID# 10662</i>	\$ 42,463
California Public Health Foundation Berkeley, California	<i>Research on the impact of access to services on health outcomes (for 1 year). ID# 9789</i>	50,000
University of California, San Francisco, School of Nursing San Francisco, California	<i>Research on the cost and burden of chronic disease (for 6 months). ID# 10706</i>	32,427
Citizens Housing and Planning Association, Inc. Boston, Massachusetts	<i>Survey of elderly people living in urban public housing (for 8 months). ID# 10266</i>	40,000
University of Colorado, Health Sciences Center Denver, Colorado	<i>Statewide program to improve child development screening (for 1 year). ID# 10072</i>	44,946
Educational Testing Service Princeton, New Jersey	<i>Survey of minority high school students' career awareness in medicine (for 9 months). ID# 9969</i>	35,565
Harvard University Medical School Boston, Massachusetts	<i>Study of the medical problems of homeless families (for 1.5 years). ID# 10428</i>	34,937
Health Research and Educational Trust of New Jersey Princeton, New Jersey	<i>Feasibility study of expanding hospital-based long-term care in New Jersey (for 1 year). ID# 9556</i>	34,050
Independent Sector Washington, D.C.	<i>Publication of a statistical profile of the not-for-profit sector (for 1 year). ID# 10544</i>	30,000
The Johns Hopkins University Baltimore, Maryland	<i>Data quality assessment for a survey of elderly people in public housing (for 10 months). ID# 10362</i>	10,900
KCTS Association Seattle, Washington	<i>To disseminate television documentary "Shelter" on the homeless (for 6 months). ID# 10113</i>	6,500
Massachusetts Health Data Consortium, Inc. Waltham, Massachusetts	<i>Study of physician practice variations for acute myocardial infarction (for 15 months). ID# 8548</i>	49,956
Medical Care Development, Inc. Augusta, Maine	<i>Program to improve hospice care in Maine (for 1 year). ID# 10163</i>	50,000
University of Michigan Ann Arbor, Michigan	<i>Preparing and archiving public-access computer tapes of research data (for 1 year). ID# 10122</i>	49,293

	1985 grants authorized
National Academy of Sciences—Institute of Medicine Washington, D.C.	<i>Study of methods to value and pay for physician services (for 8 months). ID#10079</i> \$ 45,000
New Jersey Health Care Facilities Financing Authority Trenton, New Jersey	<i>Support for a long-range facilities planning study (for 1 year). ID#9881</i> 50,000
University of North Carolina at Chapel Hill, School of Public Health Chapel Hill, North Carolina	<i>Development and dissemination of information on measures of child health (for 1 year). ID#9372</i> 50,000
Northwestern University, J.L. Kellogg Graduate School of Management Evanston, Illinois	<i>Study of ways to care for indigent in a competitive health care market (for 6 months). ID#10121</i> 25,000
Township of Plainsboro Police Department Plainsboro, New Jersey	<i>Plainsboro Township Police Department accreditation project (for 1 year). ID#10547</i> 5,600 <i>Computerization of management functions (for 1 year). ID#10664</i> 50,000
Plainsboro Rescue Squad, Inc. Plainsboro, New Jersey	<i>Purchase of equipment (for 1 month). ID#10054</i> 7,000
Provident Hospital and Training School Association Chicago, Illinois	<i>Strategic management and marketing program (for 5 months). ID#10009</i> 45,000
Scientists' Institute for Public Information, Inc. New York, New York	<i>Improving public understanding of child health and development issues (for 1 year). ID#9815</i> 29,445
St. Paul-Ramsey Hospital and Medical Center St. Paul, Minnesota	<i>Technical assistance and information project for St. Paul School-Based Adolescent Health Program (for 1 year). ID#10660</i> 20,601
University of Washington, School of Medicine Seattle, Washington	<i>Completion of primary care training program evaluation (for 1 year). ID#10300</i> 40,435
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Total 1985 grants	\$65,906,157
Refunds of prior years' grants	(555,053)
Cancellations of prior years' grants	(1,387,634)
Transfer of grants	
Balance unspent by original grantees	(511,556)
Transferred to new grantees	511,556
Grants net for 1985	<u>\$63,963,470</u>

Bibliography

Bibliography

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

In 1985 these reports cited 30 books, 191 book chapters, 1004 journal articles, 483 reports, and 42 films, tapes, and other audiovisual products.

This bibliography is a sample of citations from each category reported in 1985, and from among the publications of the Foundation's staff. These publications are available through medical libraries and/or the publishers. Copies are not available from the Foundation.

Books

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Dornbrand, Laurie, et al. *Manual of Clinical Problems in Adult Ambulatory Care*. Boston: Little, Brown & Company, 1985.

Feinstein, Alvan R. *Clinical Epidemiology: The Architecture of Clinical Research*. Philadelphia: W.B. Saunders Company, 1985.

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Financial statements

Introduction to financial statements

The annual financial statements for the Foundation for 1985 appear on pages 67 through 70. A listing of grants authorized in 1985 begins on page 37.

Grants authorized in 1985, net of cancellations and refunds of prior years' grants totaled \$63,963,470. Program development, evaluation, administrative and investment expenses for the year came to \$7,615,865; and federal excise tax on income amounted to \$1,546,997, making a grand total of expenditures of \$73,126,332. This total was \$4,637,618 less than gross investment income of \$77,763,950. In 1984, total expenditures were \$9,839,822 less than gross revenue.

A list of investment securities held at December 31, 1985 is available upon request to the Executive Vice President—Finance, The Robert Wood Johnson Foundation, Post Office Box 2316, Princeton, New Jersey 08543-2316.

William R. Walsh, Jr.
Executive Vice President—Finance

Opinion of 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, 1985 and 1984 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, 1985 and 1984 and the investment income, expenses, grants and changes in foundation principal for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Newark, New Jersey
January 17, 1986

The Robert Wood Johnson Foundation
Statement of assets,
liabilities and Foundation principal
at December 31, 1985 and 1984

	<u>1985</u>	<u>1984</u>
Assets		
Cash	\$ 162,646	\$ 336,821
Investments (at cost, or market value on dates of gifts) (Note 2):		
Johnson & Johnson common stock 18,284,000 shares in 1985, 19,000,000 shares in 1984 (quoted market value \$962,195,500 and \$686,375,000)	174,713,727	181,555,501
Fixed income investments (quoted market value \$572,265,640 and \$478,391,830)	526,371,177	471,839,399
Program related investments	2,675,000	2,550,000
Land, building, furniture and equipment at cost, net of depreciation (Note 1)	6,117,963	6,182,684
	<u>\$710,040,513</u>	<u>\$662,464,405</u>
 Liabilities and Foundation principal		
Liabilities:		
Unpaid grants (Note 1)	\$104,779,201	\$106,413,521
Federal excise tax payable	2,291,174	1,631,602
Total liabilities	107,070,375	108,045,123
Foundation principal	602,970,138	554,419,282
	<u>\$710,040,513</u>	<u>\$662,464,405</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, 1985 and 1984

	1985	1984
Investment income (Note 1):		
Dividends	\$ 23,992,300	\$ 22,775,328
Interest	53,771,650	52,805,721
	<u>77,763,950</u>	<u>75,581,049</u>
Less: Federal excise tax	1,546,997	1,504,229
Investment expense	414,106	369,558
	<u>75,802,847</u>	<u>73,707,262</u>
Expenses:		
Program development and evaluation	5,154,397	4,492,739
General administration	2,047,362	1,637,457
	<u>7,201,759</u>	<u>6,130,196</u>
Income available for grants	68,601,088	67,577,066
Grants, net of refunds and cancellations	<u>63,963,470</u>	<u>57,737,244</u>
	<u>4,637,618</u>	<u>9,839,822</u>
Adjustments to Foundation principal:		
Capital gains on sale of securities		
less related federal excise tax		
(Note 3)	43,913,223	10,228,266
Contributions received	15	1,100
	<u>43,913,238</u>	<u>10,229,366</u>
Net increase in Foundation principal	48,550,856	20,069,188
Foundation principal, beginning of year	<u>554,419,282</u>	<u>534,350,094</u>
Foundation principal, end of year	<u>\$602,970,138</u>	<u>\$554,419,282</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, 1985 unpaid grants are as follows:

<u>Year grant authorized</u>	<u>Amount unpaid at December 31, 1985</u>
1981	\$ 3,040,940
1982	6,276,596
1983	15,181,655
1984	31,936,075
1985	48,343,935
	<u>\$104,779,201</u>

Depreciation of \$288,176 in 1985 and \$228,547 in 1984 is calculated using the straight-line method over the estimated useful lives of the depreciable assets.

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

2. The quoted market value of the sizeable investment in Johnson & Johnson common stock does not necessarily represent the realizable value of such investment.
3. The net capital gains on sales of securities for the years ended December 31, 1985 and 1984 were as follows:

	<u>1985</u>	<u>1984</u>
Johnson & Johnson common stock	\$26,587,963	\$ 9,767,461
Other securities, net	17,325,260	460,805
	<u>\$43,913,223</u>	<u>\$10,228,266</u>

4. Substantially all employees of the Foundation are covered by a retirement plan which provides for retirement benefits through the purchase of individually-owned annuities. The Foundation's policy is to fund costs accrued. Pension expenses were \$425,604 and \$343,304 in 1985 and 1984, respectively.

Secretary's
report

Secretary's report *

The Foundation lost a valued trustee emeritus with the death of Wayne J. Holman, Jr., in 1985. During his 22 years as a trustee and trustee emeritus, Mr. Holman gave generously of his time and energy. We are indebted to him for his loyal and distinguished service to the Foundation.

At the Foundation's annual meeting in February 1986, Robert H. Myers, who has been a member of the board since 1983 and vice chairman since 1985, was elected chairman of the Board of Trustees of the Foundation. He succeeds Gustav O. Lienhard, who was elected trustee emeritus. Mr. Lienhard had served as chairman of the board since 1971. His contributions to the Foundation are described under a special section on page 5 of this annual report.

At the February 1986 meeting of the board, William McC. Martin, Jr., was elected to the office of trustee emeritus of the Foundation, having served as trustee of the Foundation for 14 years. Upon his election as trustee emeritus, Mr. Martin was cited by the board for the breadth of his vision and experience, the balance and keenness of his judgment, and for his many contributions to the work of the board and Foundation.

In July 1985, the Foundation elected four new trustees. They are Frank J. Hoenemeyer, formerly vice chairman of the Prudential Insurance Company in Newark, New Jersey; John J. Horan, formerly chairman of the board of directors and chief executive officer of Merck & Co. in Rahway, New Jersey; Jack W. Owen, executive vice president of the American Hospital Association in Washington, D.C.; and Ian M. Ross, president of AT&T Bell Laboratories in Holmdel, New Jersey.

Mr. Hoenemeyer joined Prudential in 1947, and served in various capacities in the corporate finance department. In his most recent position, he had overall responsibility for administering the company's investment activities. Mr. Hoenemeyer serves on the boards of Xavier University, Purolator Courier Corporation, and Hambros PLC of London, England. He holds a bachelor's degree from Xavier and a master's degree in business administration from The Wharton School of The University of Pennsylvania.

Mr. Horan, an attorney by training, has been associated with Merck since 1952 and currently serves as vice chairman of the board of directors. His work with the company has encompassed the legal department, public relations, marketing, and research administration. He had earlier served as

**To present as up-to-date a picture of staff changes as possible, this report covers the period through February 21, 1986.*

president and chief operating officer, and prior to that, as executive vice president. Mr. Horan is also the former chairman of the board of the Pharmaceutical Manufacturers' Association. He is a graduate of Manhattan College and The Columbia Law School.

Mr. Owen, prior to assuming his current position, served as president of the New Jersey Hospital Association from 1963 to 1983. Mr. Owen was awarded the American Hospital Association's trustee award in 1982. He received his bachelor's degree from Western Michigan University and a master's degree in business administration from the University of Chicago.

Dr. Ross, a native of Southport, England, was educated at Cambridge University, from which he holds a Ph.D. in electrical engineering. He joined Bell Laboratories in 1952 and was elected president in 1979. Dr. Ross was elected to the National Academy of Sciences in 1982. He also is a member of the board of trustees of the Foundation of the University of Medicine and Dentistry of New Jersey.

Staff changes

In May 1985, the board elected William R. Walsh, Jr., the Foundation's treasurer, to the additional office of executive vice president for finance. In December 1985, the board elected James R. Tesone, the Foundation's portfolio manager, to the post of assistant treasurer for investment.

Connie F. Mullinix joined the staff in February 1986 as program associate. Ms. Mullinix is a graduate of the University of North Carolina where she received a degree in nursing from the School of Nursing and a master's degree in public health from the School of Public Health.

Marcia M. Sass, Sc.D., program officer, left the Foundation in October to assume a position at Children's Hospital in Philadelphia as executive director for the Follow-Up Study of Low-Birthweight Infants. Dr. Sass came to the Foundation in 1983 and was involved in research and evaluation activities.

Senior program consultants

James J. Callahan, Jr., Ph.D., was appointed a senior program consultant for a planned program to provide supportive services for the elderly. Dr. Callahan is lecturer and senior research associate at the Heller School, Brandeis University.

Donald R. Cohodes, Sc.D., was appointed a senior program consultant to direct the Foundation's Community Programs for Affordable Health Care. Dr. Cohodes is the executive director for policy at the Blue Cross/Blue Shield Association in Chicago.

Rheba de Tornyay, Ed.D., was appointed a senior program consultant to direct the Foundation's Clinical Nurse Scholars Program. Dr. de Tornyay is a professor in the department of community health care systems at the School of Nursing, University of Washington, Seattle.

Julia Graham Lear, Ph.D., and Philip J. Porter, M.D., were appointed senior program consultants for a planned program to provide school-based health services for adolescents. Dr. Lear is currently deputy director of the

Foundation's Program to Consolidate Health Services for High-Risk Young People at Georgetown University School of Medicine. Dr. Porter is on the faculty of Harvard Medical School where he directs Healthy Children, a national effort to assist community groups to improve health care for children.

Miles F. Shore, M.D., was appointed a senior program consultant to direct the Foundation's Program for the Chronically Mentally Ill. Dr. Shore is Bullard Professor of Psychiatry and head, department of psychiatry at Harvard Medical School, and the area director and superintendent at the Massachusetts Mental Health Center.

Mervyn F. Silverman, M.D., was appointed a senior program consultant to direct the Foundation's AIDS Health Services Program. Dr. Silverman is professor of health policy and community health at the Institute for Health Policy Studies at the University of California, San Francisco.

Three other senior program consultants completed their assignments during 1985.

Mitzi L. Duxbury, Ph.D., completed her assignment directing the Foundation's Clinical Nurse Scholars Program. Dr. Duxbury was appointed a senior program consultant in 1982.

Stanley N. Graven, M.D., completed his assignment directing the Foundation's Rural Infant Care Program. Dr. Graven was appointed to this position in 1979.

Robert M. Sigmond completed his assignment directing the Foundation's Community Programs for Affordable Health Care. Mr. Sigmond was appointed a senior program consultant in 1981.

Board activities

The Board of Trustees met six times in 1985 to conduct business, review proposals, and appropriate funds. In addition, the Policy, Finance, and Audit Committees met as required to consider and prepare recommendations to the board.

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

Application
for
grants

Application for grants

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

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

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

- development and testing of new and previously untried approaches to health care problems;
- demonstrations to objectively assess the operational effectiveness and value of selected new health care arrangements and approaches that 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) ongoing 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 that 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 that have qualified for exemption under Section 501(c)(3) of the Internal Revenue Code, and that 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
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Princeton, NJ 08543-2316.

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