



The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults

**ASSESSMENT OF THE
ACCOMPLISHMENTS AND IMPACT OF
THE JOHN A. HARTFORD FOUNDATION'S
GRANTMAKING IN AGING AND HEALTH**

1983-2015

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EXECUTIVE SUMMARY

The mission of The John A. Hartford Foundation is to improve the care of older adults. Over a period of more than 30 years, from 1983 to 2015, the Foundation devoted nearly half a billion dollars to achieving its mission, primarily through faculty development and professional training in geriatric medicine, nursing and social work and through the development, testing and dissemination of innovative new models of care for older adults. This report provides an independent review of what the Foundation has done in these and related areas, how its grantmaking strategies evolved, and, especially, the impact of the almost 600 grants that it made in health and aging during these years. To carry out this task, we reviewed hundreds of available grant and evaluation reports and peer-reviewed articles, surveyed former Foundation grantees and awardees, and conducted extensive interviews with current and former Trustees, staff members, grantees, and funding partners. Wherever possible, we also examined the scope and scale of the problems that the Foundation was seeking to address in order to place the significance of its accomplishments in context.

We considered the question of the Foundation's impact on the care of older Americans from three different perspectives:

1. A quantitative assessment of the output and impact of each of the Foundation's major programs in health and aging between 1983 and 2015.
2. A qualitative assessment of the cumulative impact of the Foundation's programs in health and aging during that time, based on the views of its grantees and awardees, its staff and board members, and other foundations.
3. A combined quantitative and qualitative assessment of the extent of improvement in health care for older Americans since the early 1980's and various views of the Foundation's contribution that improvement.

Each of these approaches has its limitations, but given the extent to which the findings converge, we believe that they provide a consistent composite picture of the Foundation's impact. Perhaps not surprisingly for an effort of this magnitude and duration, its impact has played out on multiple fronts:

First, the Foundation led the way in creating a whole new field in American health care, essentially from scratch. Its sustained investments in geriatrics training for faculty in medicine, nursing and social work produced a corps of top-notch geriatrics academics who: (1) taught and mentored many thousands of students within their respective professions, thereby greatly amplifying the impact of their training; (2) conducted innovative research that advanced the care of older patients and clients; and (3) elevated the prestige and credibility of geriatrics within their professions, their home institutions, and the field at large. With regard to the scale of the impact, the Centers of Excellence alone met roughly half the national need for academic geriatricians.

Second, as it became clear that it would not be possible to produce enough practicing geriatricians, geriatric nurses or geriatric social workers to meet the health care and social service needs of the growing number of older Americans, the Foundation pushed hard to ensure that all of the nation's practicing physicians, nurses and social workers who provided care to older adults received geriatrics training in the course of their professional education. The impact of these efforts on the nation's nurses has been particularly striking, with more than 90 percent of baccalaureate nursing programs now having geriatric content integrated into their curriculum and with all baccalaureate nursing graduates expected to have geriatrics as one of their core competencies. Similarly, the widespread integration of gerontological content into social work curricula will have a lasting impact on the profession, and the incorporation of geriatrics content into many of the medical and surgical certification exams represents a major achievement that has already had a widespread impact on American medicine.

Third, a number of the models of care that the Foundation has supported have been widely adopted, including the Beers List, NICHE, the Transitional Care Model (TCM), and especially palliative care, which is now in almost 90 percent of the nation's large hospitals. Others, such as Project IMPACT, the Care Transition Intervention, GITT, PACE, Hospital

at Home, Care Management Plus, BOOST, Guided Care, ACE, and HomeMeds, have had more limited uptake so far (in the range of 5 percent or less) but could pick up steam if recent trends toward value-based care continue.

Finally, the Foundation appears to have had an impact on the stigma that has long bedeviled the field of geriatrics and aging. By lending its prestige as a pre-eminent national foundation—and backing it up with major funding for more than three decades—the Foundation has reduced, though not eliminated, a barrier that for so long has kept geriatrics on the margins of health care.

The other major barrier that has kept geriatrics on the periphery is the existing financing system, and in particular the traditional fee-for-service Medicare program. It is one of the main reasons that there aren't enough geriatricians, that non-geriatric physicians don't always apply their geriatric skills and know-how, and that many of the innovative models developed with the Foundation's support are still at the starting gate: they are either not adequately reimbursed or not viewed as cost-effective under fee-for-service Medicare. As a result, bringing geriatrics into the mainstream has been, and remains, an uphill battle.

Since the enactment of the Affordable Care Act in 2010, Medicare has begun gradually shifting towards a value-based approach to reimbursement in the hopes of containing rising costs. Despite earlier signs to the contrary, it now appears that the federal government will continue to move the program in that direction (although on a voluntary basis, which will probably limit its spread and its impact). This may help to accelerate the adoption of some of the Foundation-sponsored models of care, and could potentially even help to bring geriatricians' salaries more in line with other specialties. But the shift towards value-based care—assuming that it continues—is not necessarily a panacea for those seeking better care for older Americans. While the trend may be encouraging, it will bear close watching—and perhaps occasional intervention—to ensure that it really does support the kinds of improvements in the care of the nation's elderly that The John A. Hartford Foundation has worked so hard, and for so long, to bring about.

INTRODUCTION

The mission of The John A. Hartford Foundation is to improve the care of older adults. In keeping with this mission, over a period of more than 30 years, from 1983 to 2015, the Foundation provided major support for faculty development in geriatric medicine, nursing and social work and for the development, testing and dissemination of innovative new models of care for older adults.

In 2016, as the Foundation began to address a new set of strategic priorities, the Board of Trustees expressed interest in supporting an independent assessment of the accomplishments and impact of the Foundation's past grantmaking in these two areas. We are pleased to have been invited by the Foundation to conduct this assessment.

The assessment is designed to provide an in-depth independent review of what the Foundation has done in the areas of faculty development and model development and dissemination between 1983 and 2015, as well as related areas such as leadership development and public policy, and what the apparent impact of those investments has been. Specifically, through a review of written materials and interviews with former and current Board and staff members, we have sought to determine what the Foundation's original goals and expectations were, both for the broad program areas and for specific programs and initiatives. We then reviewed available grant and evaluation reports and conducted interviews with former staff, grantees, evaluators, and others familiar with the Foundation's programs to determine the extent to which the Foundation's stated goals and expectations were met. We also examined the scope and scale of the problems and needs that the Foundation was seeking to address in order to place the significance of its accomplishments in context.

In addition to providing a review of what the Foundation has accomplished over the past 32 years and the significance of those accomplishments, the assessment presents some key lessons that may be helpful to the Foundation's future grantmaking. The findings from the assessment also provide a baseline from which to gauge the Foundation's impact going forward.

In conducting the assessment, we undertook the following steps:

- Met with Foundation staff to identify: (a) available written materials, (b) current and former staff and Board members familiar with the Foundation's grantmaking between 1983 and 2015, (c) grantees who were funded during those 32 years, (d) funding partners who co-funded the Foundation's programs during this time, (e) outside experts familiar with the subject matters addressed by the Foundation's grantmaking, and (f) any available contact information for former staff, Board members, funding partners, and grantees.
- Reviewed available written materials (hard copy and/or online), including board reports, evaluation committee reports, RFPs, grantee reports, staff closed grant reports, external program evaluations, press stories, etc. This included materials specifying the Foundation's original goals and expectations, both for its program areas and for its individual grant programs.
- Designed and conducted an e-mail survey of a subset of health and aging grantees funded between 1983 and 2015, asking about the original goals and expectations for their grants, the immediate and long-term impact of their grants, and their perceptions of the Foundation's overall impact in the area of health and aging.
- Conducted in-depth telephone or in-person interviews with selected former grantees to provide more nuanced and detailed case examples of what the Foundation's grants were designed to accomplish, what they have accomplished, and some of the lessons learned. These included interviews with some of the independent evaluators funded by the Foundation to evaluate its programs.
- Conducted telephone or in-person interviews with current and former Foundation staff and Board members familiar with the Foundation's grantmaking between 1983 and 2015. They, too, were asked what the Foundation's goals and expectations were, the extent to which they believe those goals and expectations were met, and what the key lessons from those programs have been.

- Conducted interviews with former funding partners regarding their goals and expectations for The John A. Hartford Foundation initiatives in which they were involved, and the extent to which they believe those expectations were met.
- Conducted interviews with outside experts knowledgeable about geriatric medical, nursing and social work training and about models of care for older adults to help place the Foundation's accomplishments within the context of the overall fields they were designed to address.

To maximize the response rate and to encourage candid responses, all survey and interview responses were confidential. Any quotes from those survey and interview responses that are used in the report are without attribution, unless the respondent specifically authorized us to identify them. (A list of the persons interviewed for this report may be found in Appendix A.)

Beyond this introductory chapter, the remainder of this report contains the following four sections:

1. A review of the Foundation's evolving strategies and programs in aging and health between April 1983 and April 2015, including the dollar amount of the grants awarded in each area.
2. Quantitative assessments of the number of outputs (trained faculty members, replicated models, etc.) actually produced as a result of the Foundation's grants and, where possible, estimates of how much of an impact on the field as a whole those numbers represent. This is the lengthiest section of the report. It also includes a rough assessment of the Foundation's geographic impact by state, using the current location of the 3,274 Change AGENTS who have received Foundation funding in the past as a proxy measure of geographic impact.
3. Qualitative assessments of the Foundation's impact from the perspective of the Foundation's grantees, selected Board and staff members, and funding partners.

4. Our own overall assessment of the Foundation's accomplishments and impact between 1983 and 2015, based on a synthesis of the written materials, the survey responses, and the interviews with grantees, staff and Board members, and others, as well as our more than 50 years of combined experience working for and with foundations and other funders in the health care field.

ACKNOWLEDGEMENTS

Foundations are generally forward-looking institutions, and so they tend to keep their eye on the road ahead. All too often, however, they fail to take the time to check the rear-view mirror and learn from their own past experiences. This is especially true when new leaders take the wheel: they have their own agendas and feel that they have little to learn from the past. It is a great credit to the new leaders of The John A. Hartford Foundation—Board chair Margaret Wolff and president Terry Fulmer—that they have not only been willing but eager to learn from the Foundation's past three decades of grantmaking in aging and health as they and the Foundation's Trustees chart the course for its future. Moreover, they made it clear from the start that they wanted a candid assessment, not a puff piece. This report could not have happened without their visionary leadership and support. For that, we are deeply grateful.

We are also grateful to Board member John Mach and to all of the Foundation staff members who assisted us in our preparation of this report, including Amy Berman, Francisco Doll, Marcus Escobedo, Rani Snyder, George Suttles, and especially Mary Jane Koren, who provided us with unerring guidance, wit and wisdom every step of the way. Finally, we are indebted to the many former staff members and to former Board chair Norman Volk who took the time to speak openly and honestly with us about their experiences, and to all of the current and former Foundation grantees and funding partners—many of whom are recognized leaders in the field—who willingly shared their expertise, their memories, and their unvarnished views with us.

SECTION 1. GOALS, STRATEGIES AND GRANTMAKING IN AGING AND HEALTH

IN THE BEGINNING

The first mention that we found of The John A. Hartford Foundation's interest in aging and health occurs in the minutes of the June 1982 meeting of the Board of Trustees, two months after John Billings, JD, a lawyer and former grantee,¹ had been elected as the Foundation's executive director. At that time, the Foundation was working in three different program areas: health care financing, energy efficiency, and the Hartford Fellows Program, which supported young physicians interested in pursuing a career in biomedical research.² The minutes report that James Farley, at that time chairman of the Grants Committee of the Board,³ discussed two new areas in health that the Grants Committee was considering for possible future grantmaking: clinical practice patterns of physicians and the medical needs of the elderly.

Four months later, at the October 1982 Board meeting, Farley reported that the Grants Committee had heard presentations on a new program to address the problems of the elderly and on alternative roles that the Foundation might play in improving the efficiency of electricity production, and that the Committee recommended that the Foundation continue to develop a health program on the problems of the elderly.

Billings, who left the Foundation in 1985 and is now professor of health policy and population health at New York University,⁴ recalls that he recommended the focus on aging.⁵ The quality of the energy proposals was flagging and a RAND evaluation of the Hartford Fellows Program was not encouraging, so he was looking for "an important issue that other foundations were not addressing and that the Foundation could potentially catalyze without having to stay in it indefinitely." In part, he was influenced by the work of John "Jack" Wennberg, MD, of Dartmouth University, a Foundation grantee in the health care financing area who had focused on variations in the care of "very sick people at the end of life." The fact that there were significant variations across different providers suggested to Billings that "we weren't doing a good job of taking care of the elderly." Billings also discussed the issue with Robert Butler, MD, a renowned geriatrician and psychiatrist who had recently been director of the National Institute on Aging (1975-1982). Billings believed that the aging issue would appeal to the Foundation's Trustees, many of whom were themselves getting on in years. As

Billings put it, "I thought they'd be interested in it, and they were."

Norman Volk, who had joined the Board in 1979,⁶ recalls that both the Trustees and the staff were struck by "the demographic imperative": people were living longer but there was insufficient support available to them as they grew older. Despite this growing need, Volk says, geriatrics held little interest for most physicians.

At the April 1983 Board meeting, Billings presented a plan for a new program in the area of "Aging/Health," which the Trustees discussed and duly adopted. The overarching goal of the program, Billings says, was "to get the health system to take better care of the elderly."

Noting that those 65 and over constituted 11 percent of the population but accounted for 30 percent of health care costs,⁷ the plan (attached to the minutes of the April 1983 Board meeting as Exhibit G) identified four "major problems" in the area of health and aging: (1) accelerated growth in costs, (2) lack of depth in geriatric leadership, (3) limited resources available for aging-related medical research, and (4) the need to improve services for older patients. It noted that the Foundation was already working on the first problem through some of its cost-containment grants, and said the accelerated growth in costs for the care of the elderly "would continue to be addressed through our health care financing program." To address the other three problems, the plan recommended a program with three components:

- Hartford Geriatric Development Awards to provide mid-career retraining of academic physicians for geriatric specialization.
- Biomedical research grants, specifically targeted to stimulate more rapid innovation in research on the health problems of the elderly.
- A general grants program of demonstration and research projects to help improve health services for older patients.

The projected four-year budget for these three areas (1983-86) was \$7 million.

The plan called particular attention to the shortage of geriatricians, setting the stage for what was to become the largest area of the Foundation's grantmaking in the years to come. "Although their numbers are beginning to grow,"

the plan stated, “there are relatively few physicians (less than 750 nationally in 1977) with special interest and training in the care of older people. Even without the expected growth of the elderly population, a substantially larger number of geriatricians are needed to provide training in medical schools, to conduct more aging-related biomedical research, and to furnish consultative assistance to the general population.”

At that same April 1983 meeting, the Trustees approved the Foundation’s first five grants in aging and health, totaling \$190,000:

- Four \$30,000 planning grants to the schools of medicine at Harvard, Johns Hopkins, Mt. Sinai and University of California, Los Angeles (UCLA) for the Geriatric Faculty Development Awards program.
- \$70,000 to the Lenox Hill Neighborhood Association in New York City for a coordinated service demonstration program.

As it turned out, those five modest grants were the first of 577 grants in aging and health that the Foundation was to award over the next 32 years (through April 2015). Those 577 grants would include dozens of multi-million dollar awards and would ultimately total \$473,721,681—just shy of half a billion dollars.

AN EVOLVING STRATEGY

One of the themes that came up repeatedly in our interviews and in the responses to our email survey of former grantees and awardees was an appreciation for the Foundation’s unflagging commitment to aging and health over so many years. A senior officer at another foundation commented, “The Hartford Foundation? They’re wonderful! One of their most important contributions has been their attention to one area of focus and not flip-flopping around. They got into aging, they stayed in aging, they’re known for aging. That reliability is really important. And their focus has been a lot on the education of providers, which I also think is really important.” A respondent to our email survey wrote, “JAHF has been the most consistent large funder in the field of aging. It has had an enormous impact through its sustained involvement in aging. The impact has been achieved through its activities as a funder, convener, [and] thought leader in aging.”

In this respect, the Foundation has capitalized on one of the most important strengths of private philanthropy: its capacity to stay the course. Many of the greatest challenges

facing modern society are deeply rooted and do not lend themselves to quick fixes. Because foundations do not have to issue quarterly reports to shareholders or run for re-election every few years, they are uniquely positioned to take the long view and to address tough challenges of this kind. Yet relatively few foundations have exhibited the patience and persistence that it takes to stay with an issue for the long haul—certainly not for decades, as The John A. Hartford Foundation has done in the area of aging and health.

That said, the Foundation’s strategy in health and aging did not remain fixed. Rather, it evolved and matured in the years following the April 1983 Board meeting, as the result of both experience and the counsel of outside experts. For example, by 1986, having provided Hartford Geriatric Faculty Development Awards to 29 mid-career internal medicine faculty who wished to pursue advanced training in geriatrics, the Foundation realized that it would need to find a more highly leveraged approach if it hoped to make a meaningful dent in the projected need for academic geriatricians.⁸ Accordingly, with the Foundation’s support, the Institute of Medicine⁹ convened a group of leaders in the field who recommended the establishment of “centers of excellence.” The expectation was that these centers of excellence, based in medical schools with strong geriatrics programs, would attract and train larger numbers of academic geriatricians, who in turn would be able to train more geriatricians. As Richard Sharpe, the Foundation’s program director at that time, explained, “We were not focused on producing geriatricians. We wanted to produce the trainers of the geriatricians.”¹⁰

Meanwhile, the aging priorities themselves were evolving. The three priority areas identified in the original April 1983 plan soon morphed into geriatrics training, assessment of older adults, and community-based care of older adults,¹¹ and by the late 1980’s, these three priorities were consolidated into just two: increasing the supply of academic geriatricians through centers of excellence, and improving the delivery of health care services to older adults. A few years later, following another report from the Institute of Medicine, these two priorities were further massaged and restated in the 1993 Annual Report as (1) strengthening geriatrics in America’s medical schools, and (2) integrating health-related services for the elderly.

The restatement of the first priority reflected a growing awareness that, even with the establishment of more than a dozen centers of excellence, the nation’s medical schools were in fact not going to be able to produce enough

geriatricians to meet the growing need. Consequently, it made sense to broaden the Foundation's focus to include exposure to geriatrics in the training of primary care physicians, as well as medical and surgical specialists, so that they would be better prepared to meet the needs of their older patients. As Norman Volk recalls, "We realized there would never be enough pure-bred geriatricians, so we had to train internal medicine subspecialists, surgeons and other specialists." The restatement of the second priority reflected the fact that the care of older patients—especially those with complex conditions—often required a wide array of both medical and non-medical services and that the provision of those services would need to be better integrated if they were to meet patient needs.

A WATERSHED YEAR

The following year—1994—was a watershed year. James Farley, now Chairman of the Board, announced that the Trustees had "decided to curtail new grants in the area of Health Care Cost and Quality"¹² while at the same time expanding the health and aging program area by committing "up to 80 percent of the Foundation's funds to initiatives involving the elderly population."¹³ Health and aging was clearly on its way to becoming the Foundation's sole focus. At the same time, the Foundation, in collaboration with the Commonwealth Fund and the Atlantic Philanthropies, launched what was to become a signature program: the Paul Beeson Physician Faculty Scholars in Aging Research, a three-year fellowship program designed to create a new cadre of physician scientists in aging. And—in keeping with its recognition that, despite its best efforts, there were not going to be enough geriatricians to meet the growing need—the Foundation launched two new programs that would begin to expose the nation's primary care physicians and subspecialty internists to geriatric training.

Also in 1994, the Trustees asked a group of geriatric leaders to review the Foundation's grantmaking to date in health and aging. These leaders concluded that "by focusing solely on physician training, [the Foundation] had failed to address the need to better prepare other health professionals to care effectively for the elderly."¹⁴ This observation helped to pave the way for a gradual expansion of the Foundation's training priority to include, first, nurses, and later, social workers. It also led the Trustees to approve a Foundation-administered project "to explore the training needs of elder caregiving teams and identify opportunities for strengthening this training."¹⁵

In 1995, the Foundation took the next step in promoting interdisciplinary teamwork, awarding 13 planning grants to a range of organizations and institutions across the country to develop models of geriatric interdisciplinary team training (GITT).¹⁶ Under the direction of Terry Fulmer, PhD, RN, FAAN, at New York University, the GITT planning grants were followed by eight three-year implementation grants. The Foundation also supported Fulmer in her efforts to further develop what would prove to be a highly successful and widely adopted training and consultation program for the advancement of geriatric nursing care, entitled Nurses Improving Care to the Hospitalized Elderly (NICHE).¹⁷

A year later, in 1996, the Foundation pushed the envelope still further on geriatric nursing with a \$5 million grant to New York University to establish The Hartford Institute for Geriatric Nursing—the first geriatric nursing institute in the country. Championed by senior program officer Donna Regenstreif, PhD, led by Mathy Mezey, EdD, RN, FAAN, and co-directed by Terry Fulmer, the Institute was to "advance the art of geriatric nursing so as to provide better and more efficient care for the elderly."¹⁸ Mezey recalls that the Chairman of the Foundation's Board (James Farley) told her that he wanted the Institute to change all of nursing care, at the bedside and beyond.

EXPANDING THE FOCUS

By 1997, the language describing the Foundation's priorities had evolved yet again: from "strengthening geriatrics in America's medical schools" to "training *health professionals* to become more effective in providing elder care," and from "integrating health services for the elderly" to "*improving* and integrating the service *systems* in which [health professionals] operate" (emphases added).¹⁹ These changes in wording signaled the expansion of the Foundation's focus beyond physicians to include other health professionals, and beyond simply integrating services to improving systems of care for the elderly.

Sure enough, the following year—1998—the Foundation awarded a grant to the Council on Social Work Education as the first step in "a broad initiative to improve social work practice with older adults through better education and training programs."²⁰ And two years after that, in 2000, major grants were awarded to establish five Centers of Nursing Excellence across the country as part of an ambitious new initiative entitled Building Academic Geriatric Nursing Capacity (BAGNC). Like the physician-focused Centers of Excellence after which they

were modeled, these centers, coupled with scholarship support for pre-doctoral and post-doctoral nursing students, were intended to produce “geriatrically-qualified faculty” who could prepare their nursing students to care for the burgeoning number of older patients entering the health care system.

Even as it made these new forays into social work and nursing, the Foundation had kept the throttle wide open in its efforts to “geriatricize” the nation’s physicians. In 1997, it expanded the number of Centers of Excellence from 10 to 18, and committed another \$8 million to the Beeson Scholars program. In 1998, it renewed a program designed to attract medical students to a career in academic geriatrics. In 1999, it put still more money into the Centers of Excellence, renewed a program to integrate geriatrics into the internal medicine subspecialties, and launched a competitive grants program to beef up geriatrics education in undergraduate medical school curricula. And in 2000, the Foundation put another \$8 million into the Beeson Scholars program, added another \$6 million to its ongoing program to increase geriatrics expertise in the medical and surgical specialties, and renewed its funding to 11 of the existing Centers of Excellence while providing start-up support for two more.

Meanwhile, the Foundation had by no means neglected its second priority in health and aging: the improvement and integration of health services for older Americans. Notable programs on this side of the ledger during the 1980’s and 1990’s included development of the Beers Criteria to improve the safety of medication prescriptions for nursing home patients (1989); replication of the Program of Affordable Care for the Elderly (PACE) to enable chronically ill and disabled elderly patients to remain in their homes (1990); the Johns Hopkins Home Hospital Program to test the safety and efficacy of hospital care at home for selected elderly patients (1995); the NICHE program, mentioned earlier, to improve nursing care for the hospitalized elderly (1995); and the replication of Project IMPACT, a model program to enable primary care physicians to manage the care of depressed elderly patients (1998).

THE NEW MILLENNIUM

By the end of the 1990’s, the last of the Health Care Cost and Quality grants had been paid out, so that apart from a handful of “good citizen” grants to organizations like the Boys Club of New York and the International Rescue Committee, The John A. Hartford Foundation was finally “all in” on health and aging.

Not only that, but since the collapse of the value of its A & P shares in the late 1970’s,²¹ the value of the Foundation’s assets had climbed steadily during the 1980’s and 1990’s, from a market value of \$129 million in 1980 to \$616 million in 2000.²²

The combination of the growth of its endowment and the Trustees’ decision to focus just about all of its grantmaking on health and aging had made it possible for the Foundation to maintain its commitment to major physician training programs like the Centers of Excellence and the Beeson Scholars while at the same time expanding into new areas like nursing, social work, and interdisciplinary team training—and putting serious money behind promising model programs like Project IMPACT and NICHE.²³

Consequently, the bursting of the stock market dot-com bubble in the early 2000’s came as something of a shock to the Foundation. In 2002, Norman Volk, who had just assumed the reins as Chairman of the Board, wrote, “We navigated the first two years of the bear market with limited impact on the endowment, but there were very few places to invest productively in 2002.”²⁴ He went on to say that by year end, the Foundation’s assets had fallen to \$490 million—a 20 percent decline from \$616 million two years earlier.

Fortunately for the Foundation and its grantees, the damage was temporary. A year later, the Foundation’s assets were back up to \$561 million, leading Volk to comment wryly, “We are pleased to have fared this well in the worst investment environment since the 1970’s.”²⁵ By 2005, closing the year at \$614 million, the endowment had recovered just about all of its pre-bust value.

Through it all, despite a slump in grantmaking in 2002 and 2003 due to the decline in its endowment,²⁶ the Foundation stuck with its two-part strategy, plowing millions more into training programs such as the Centers of Excellence (which by 2005 had increased to 24 centers, including two in geriatric psychiatry); the five Centers of Nursing Excellence; a major new Gerontological Nursing Initiative that included a \$5 million renewal for the Institute at New York University; a Gerontological Social Work Initiative (described below); and the Beeson Scholars—as well as innovative models of care such as Project IMPACT, Guided Care, the Care Transition Intervention, and Transitional Care for Elders.

EXAMPLES OF THE FOUNDATION'S STRATEGIC APPROACH

It is easy to be overwhelmed by the sheer volume and complexity of the Foundation's grantmaking during this period, with so many programs (many with similar sounding titles) targeting three different professions at multiple levels. But the essential strategy as it had evolved over the past two decades remained clear: train—or influence the training of—the key groups of professionals who provide care to the elderly in the health care system, both as individual providers and as teams, and develop and promulgate effective new models and interventions for them to use in the provision of that care. Put even more simply, the strategy was to train the nation's providers to care for the elderly and give them the best possible “tools” for the job.

Both components of this strategy—the training and the models—were addressed in a variety of ways and at multiple points in their respective “pipelines.” The Foundation's approach to strengthening the geriatrics training of social workers is a good example of one of its training strategies; its support for Project IMPACT is a good example of its approach to the development and dissemination of a promising new model of geriatric care. Each is discussed below.

Social work training

In developing its geriatric training strategy for social workers, the Foundation consulted dozens of experts, commissioned white papers, and appointed an advisory panel. There was widespread agreement that although there were many reasons why social work students did not choose to work with old people—including a lack of strong leadership in universities and professional societies, limited funding for geriatrics, and an inherent bias against working with the elderly—the most important, according to the experts, was the shortage of faculty members at schools of social work who could champion geriatrics, serve as role models and mentors, and conduct and oversee scholarly research. Accordingly, the experts advised the Foundation to address that problem.

Heeding this advice, the Foundation embarked on an ambitious effort to revolutionize social work education. Called the Geriatric Social Work Initiative, its purpose was to “enhance the geriatric capacity of social work education, including faculty, curriculum, students, and training.”²⁷

Focusing on three interrelated components of social work education, the Initiative was designed to:

1. Incorporate geriatrics into the social work curriculum and accreditation standards. Three consecutive programs administered by the Council for Social Work Education addressed curriculum and accreditation: (1) Strengthening Aging and Gerontology in Social Work; (2) the Geriatric Enrichment in Social Work Education Project (GeroRich); and (3) the National Center for Gerontological Social Work (Gero-Ed Center). Since 1998, the Foundation has allocated roughly \$14 million (\$14,185,020) to these three programs.
2. Increase the number and capabilities of social work faculty committed to geriatrics by attracting and supporting junior faculty and doctoral students who would pursue careers in academic geriatric social work. Two programs, both administered by the Gerontological Society of America, addressed this component: the Hartford Geriatric Social Work Faculty Scholars Program and the Hartford Doctoral Fellows in Geriatric Social Work Program. Since 1999, the Foundation has devoted almost \$35 million (\$34,530,777) to these two programs.
3. Strengthen geriatrics content and experience in the field placements (practicums) of master's-level social work students. The Practicum Partnership Program,²⁸ administered by the New York Academy of Medicine, tested a model in which social work students interested in geriatrics rotated among different aging agencies and organizations for their field placements. Since 2000, the Foundation has committed almost \$11 million (\$10,984,493) to this program.

In all, then, over the past 20 years the Foundation has devoted almost \$60 million (\$59,700,290) to the implementation of its Geriatric Social Work Initiative, so that social work students at all levels will be better prepared to assist the nation's elderly.

Project IMPACT

In 1998, Jürgen Unützer, MD, a psychiatrist and former Beeson Scholar now at the University of Washington, approached The John A. Hartford Foundation about a new way of treating older adults with depression. The key to Unützer's approach was to pair a primary care practitioner (a physician, nurse, clinical psychologist, or social worker)

who cared for the patient with a psychiatrist who trained and advised the primary care practitioner. Because of the severe shortage of psychiatrists trained in the care of geriatric patients, this model had the potential to greatly increase the availability of treatment for older patients suffering from depression. The Foundation responded by awarding a five-year grant—the first of many—to test the model, called Project IMPACT (Improving Mood-Promoting Access to Collaborative Treatment for Late-Life Depression).

The results of the randomized controlled trial conducted between 1999 and 2003, published in the *Journal of the American Medical Association*, found that Project IMPACT more than doubled the effectiveness of the usual treatment of depressed older adults in primary care practices. It also saved money.²⁹ After these results were reported, Kaiser Permanente of Southern California adopted the model, and it received support from the California HealthCare Foundation, the Hogg Foundation, and the Robert Wood Johnson Foundation, among others. The President's New Freedom Commission on Mental Health recommended Project IMPACT as a model treatment program; the Agency for Healthcare Research and Quality and the National Council for Community Behavioral Health endorsed the approach; and the Federal Corporation for National and Community Service awarded a Social Innovation grant to the Hartford Foundation to expand the program. Under this grant, Unützer has trained 5,000-6,000 primary care practitioners in roughly 1,000 practices.

Although the model is of great interest to the geriatrics and mental health communities, its replication has been hindered by lack of reimbursement. In response, Unützer worked with the Centers for Medicare & Medicaid Services (CMS) in 2016 to develop new billing codes to pay for coordinated care. Those billing codes have now been implemented, so that any primary care physician in the country who provides coordinated care for his or her Medicare patients can now bill Medicare for that care. Unützer is now working with state Medicaid plans to do the same. Meanwhile, CMS is funding the American Psychiatric Association to train psychiatrists to work with primary care physicians.

In all, since 1998 Unützer has received over \$8 million from The John A. Hartford Foundation—including \$2.4 million in Social Innovation grant support—for his work on Project IMPACT.

SOWING THE SEEDS

The third and final decade of the 32-year period under review for this report was a period of continuing evolution in the Foundation's grantmaking, punctuated (and almost punctured) by the severe economic recession of 2008-2009. During this period, the Foundation decided to begin raising its public profile through some sizeable investments in communications training for its staff and grantees, and took some initial steps towards a more proactive approach to public policy through its support for advocacy groups such as the Eldercare Workforce Alliance, Change AGENTS, and Community Catalyst.

Also during this period, the Foundation expanded the scope of its training strategy by giving attention to direct care workers and pre-licensure nurse training.³⁰ And it began sowing the seeds for what were to become its new, post-2015 priorities through grants to improve care for patients with complex chronic conditions, expand the availability of palliative care, and enhance support for family caregivers.

But these shifts in focus and emphasis did not occur overnight, and in the meantime the Foundation continued to provide generous support to its established geriatric training programs for physicians, nurses, and social workers. These included, in 2006, renewal grants for the Beeson Scholars, the Centers of Excellence, and the Hartford Geriatric Social Work Faculty Scholars; and in 2007—a banner year in which the Foundation awarded 32 new grants totaling \$47.7 million—renewal of the Geriatrics for Specialty Residents program; additional renewals (and expansions) of the Centers of Excellence; more Beeson Scholars; additional support (for “Try This”) to the geriatric nursing institute at NYU; funding for four more Centers of Geriatric Nursing Excellence; renewal support for the Hartford Doctoral Fellows in Geriatric Social Work and the National Center for Gerontological Social Work Education; and to top it off, a major grant to the New York Academy of Medicine for the new Practicum Partnership Program.

Yet even in 2006 and 2007, change was in the air. In 2006, the Foundation began supporting Diane Meier, MD, at Mt. Sinai Medical Center in her campaign to develop the field of palliative care, and together with nine other funders,³¹ it provided support for a new consensus report by the Institute of Medicine entitled *Retooling for an Aging America: Building the Healthcare Workforce*—a report that would help to pave the way for the Foundation's subsequent foray into public policy. In 2007, the

Foundation supported the expansion of Care Management Plus, a care management program for older patients with complex chronic conditions, into 32 primary care clinics, and it provided a grant to the AARP Foundation for a symposium on family caregiving.

NEGATIVE 26 PERCENT

Then came 2008, the sudden collapse of Lehman Brothers, and the onset of the Great Recession. By year-end, the value of the Foundation's assets had fallen to \$456 million, a staggering 33 percent decline from what it had been a year earlier (\$684 million) and well below the close of 2002 (\$490 million).³² In search of a silver lining, Chairman of the Board Norman Volk gamely noted that "the investment return of negative 26.0 percent outperformed the broad equity indices, both here and abroad," but added that "unfortunately, [it] was very similar to the experience of most endowments and foundations."³³ Accordingly, the Foundation awarded only \$23.4 million in new and renewal grants that year, less than half the amount it had awarded in 2007.

Yet despite the sharply reduced payout, the Foundation forged ahead, adding another \$9.4 million to the national coordinating center for its Centers of Geriatric Nursing Excellence (including support for 60 geriatric nursing scholarships and fellowships) and putting another \$5 million into seven Centers of Excellence. The Foundation also continued its support for model development and dissemination with a \$1.2 million grant to support the replication of the Care Transition Intervention model developed by Eric Coleman, MD, another former Beeson Scholar.

In addition, the Foundation took another cautious step towards involvement in the public policy arena with a grant to the Meridian Institute (matched by the Atlantic Philanthropies) to create a coalition of aging organizations—later named the Eldercare Workforce Alliance—that would actively promote the recommendations of the Institute of Medicine's *Retooling* report.³⁴ And perhaps most notably, in a departure from a longstanding institutional reticence that could be traced all the way back to the Hartford brothers themselves,³⁵ the Foundation made a substantial (\$876,000) grant to a communications firm to help its staff and its grantees "successfully communicate the importance and characteristics of strong training and research programs for improved quality of care for older adults"³⁶—in other words, to get the word out to a much broader audience

about what The John A. Hartford Foundation was doing and what it was learning.

By the end of 2009, the value of the Foundation's endowment had edged up slightly, from \$456 million the previous year to \$472 million, but it had made only \$14 million in new grants, the same as in 2003 following the dot.com crash. Most of the new grants were renewals of training programs—the Beeson Scholars, Geriatrics for Specialists, and the Social Work Faculty Scholars program—but about \$2 million went into some of the Foundation's newer ventures: \$262,000 to a partnership between the National League of Nursing and the Community College of Philadelphia to promote geriatric training at the pre-licensure level of nursing education; \$500,000 to renew its support for Diane Meier's palliative care center at Mt. Sinai; almost \$700,000 to the AARP Foundation to improve the capacity of nurses and social workers to support family caregivers; and \$400,000 for the Eldercare Workforce Alliance (again co-funded by the Atlantic Philanthropies) to promote the policy recommendations of the IOM *Retooling* report.

In addition, in a move to improve operational efficiency that John A. Hartford himself would probably have applauded, the Foundation reallocated \$8.4 million from its sprawling Centers of Excellence program—which by now had grown to 27 centers—to the American Federation for Aging Research to establish a national program office for the Centers of Excellence that would "consolidate the programmatic and financial operations under one roof."³⁷

A CERTAIN RESTLESSNESS

Over the course of the next three years—2010 to 2012—the Foundation's endowment continued its gradual recovery, finally re-crossing the half-billion dollar mark in 2012 with a year-end value of \$514 million. But its new grantmaking remained anemic until 2012,³⁸ when it finally bounced back to \$34.6 million. As before, the lion's share of the funding that *was* awarded went to the major training programs, with most of the remainder going to the dissemination of model programs (Project IMPACT and the Care Transition Intervention) and to public policy initiatives such as the Eldercare Workforce Alliance and the National Health Policy Forum at George Washington University, which the Foundation had been supporting for the past 15 years.

But by 2012, a certain restlessness appears to have set in. The 2012 Annual Report, which provided an illuminating overview of the Foundation's grantmaking in health and

aging to date, proudly declared that “the Foundation has strengthened the field of academic geriatrics, transforming the education of physicians, nurses, and social workers—who now leave training better prepared than ever to deliver excellent care to older adults. The Foundation has also supported models of health care delivery that have been proven to provide the highest quality of care for older adults, funding innovations long before they became accepted in the mainstream.”³⁹

So far, so good. But, the report went on to say, “with 10,000 baby boomers now turning 65 every day, and a rapidly changing health care system... it is time to harness the expertise and passion of the grantees and scholars funded by the Foundation over the past 30 years and to work with old and new partners who are ready to meet the urgent need for delivering better health care to older adults.”⁴⁰ Or, as Christopher Langston, PhD, the Foundation’s program director at that time, put it in a sidebar on the following page, “It is time to shift from our ‘upstream’ theory of change—building academic infrastructure in preparation for aging (i.e., ‘enhancing the nation’s capacity for effective and efficient care’)—to a ‘downstream’ theory, focusing more on practice and more directly on improving the health of older Americans.”⁴¹

In other words, the scenario for which the Foundation had been preparing all these years had finally arrived, and so now it was time to move from preparation to action. But how?

A NEW STRATEGIC FRAMEWORK

One answer came the following year, with a three-year \$5 million grant—the biggest grant made in 2013—to the Gerontological Society of America for an ambitious new national initiative entitled Change AGENTS. “This interdisciplinary effort,” Board chair Norman Volk and executive director Corinne Rieder explained in the Foundation’s 2013 Annual Report, “will harness the talents and energy of more than 3,000 scholars and health systems leaders the Foundation has supported during the last three decades and encourage them to work directly on changes in practice and service delivery that improve the health of older patients.”⁴² After 30 years of preparation and training, the Foundation was at last deploying its army of geriatrically competent professionals—fully armed with tested interventions—in the field.

In fact, Change AGENTS was not an isolated program. It was part of a larger five-part strategic framework that the Foundation had been working on since 2011 and that it unveiled in its 2014 Annual Report. With a focus on

“putting geriatric expertise to work, investing in more direct ‘downstream’ efforts to redesign systems and care, [and promoting] needed policy change on behalf of older adults and their families,”⁴³ the new strategic framework contained five interconnected grantmaking “portfolios”:

1. Building the leadership capacity of geriatrics experts in medicine, nursing and social work to drive practice change.
2. Educating current and future practitioners in best geriatric practices.
3. Developing and supporting new, evidence-based models of care to lower costs and improve outcomes.
4. Promoting measures, standards, and health information technology that support appropriate care for older adults.
5. Advancing the Foundation’s nonpartisan mission and the work of grantees through communication, advocacy, and research that inform the development of effective health and aging policies.⁴⁴

With its emphasis on driving practice change, Change AGENTS fit neatly into the first portfolio, although many of the Foundation’s training programs had also been designed to build leadership capacity. And certainly the Foundation had supported a wealth of programs that fit into the second and third portfolios. The fourth portfolio broke newer ground, but even here, one could point to the development of the Beers Criteria and Care Management Plus as examples that fell within its scope. That said, the absence of any clear, agreed-upon measures of the quality or effectiveness of care for older persons was—and remains—a huge void in the field, and a subject that we will return to later in this report.

It was the fifth portfolio that—despite its careful and somewhat cumbersome wording—represented probably the most substantive departure from the Foundation’s previous strategies. While the Foundation had cautiously been tiptoeing towards public policy for some years now through its support of the Institute of Medicine, the Health Policy Forum, and more recently the Eldercare Workforce Alliance, the Board had long ago concluded that there was little the Foundation could do to influence public policy. Norman Volk remembers face-to-face meetings that Foundation Board members had with various United States Senators years ago. The meetings were cordial enough but led nowhere. “It was heavy lifting at the time,” he recalls.

According to Christopher Langston, the Foundation’s decision to revisit the policy question was prompted in large part by the difficulty of applying many of the skills and interventions in which the Foundation had invested for so many years under existing reimbursement policies. “People learned to do stuff that the real world wouldn’t let them do,” Langston says bluntly. “If you can’t squeeze it into an 11-minute visit, it’s not happening.”

The Foundation’s emerging interest in public policy was reflected in some of the grants that it awarded in 2013 and 2014, including a \$584,000 grant to Community Catalyst, a non-profit organization whose mission “to organize and sustain a powerful consumer voice to ensure that all individuals can influence the local, state and national decisions that affect their health,”⁴⁵ and a \$1.6 million grant in support of the Health and Aging Policy Fellows Program, which had been funded by the Atlantic Philanthropies since 2008.

Other grants of note during these years included another \$2 million for the Center to Advance Palliative Care; another \$1.6 million to the Paraprofessional Health Institute to improve care of the elderly by direct care workers; \$400,000 for an Institute of Medicine report on family caregiving and support services for older adults; almost \$500,000 to Yale University to improve the care of persons with complex health needs; \$2 million to the Partners in Care Foundation to improve care for older adults using integrated networks of medical care and social services; and another \$2 million for the Foundation’s ongoing communication and dissemination initiative. Notably, there were no grants in either year to any of the Foundation’s longstanding training programs.

WHERE THE MONEY WENT

As we noted earlier, during the 32 years from April 1983 to April 2015, The John A. Hartford Foundation made 577 grants in health and aging totaling \$473,721,681—almost half a billion dollars. When one recalls that the initial four-year budget presented to the Board of Trustees by John Billings in April 1983 was for only \$7 million, this truly represents a staggering commitment.⁴⁶

In looking at how this money was allocated within the health and aging priority area, we considered five categories: training, models, policy, research/evaluation, and “other.” We further divided the training category into four subcategories: physicians, nurses, social workers, and geriatric interdisciplinary teams (GITT). The results are presented in Table 1.⁴⁷

As indicated in Table 1, the largest share of the total (71 percent) went to training, and of that amount, just over half (51 percent) went to physician training. This means that more than a third of the Foundation’s total grantmaking in health and aging between April 1983 and April 2015 (36 percent) supported physician training.

The Foundation spent \$86,998,370 on the training of nurses—just over half of what it spent on physician training and slightly less than it spent on model development and dissemination (\$88,273,784). And it spent \$64,415,333 on the training of social workers, almost three-quarters (74 percent) of what it spent on the training of nurses.

The Foundation spent almost four (3.8) times as much on training as it did on model development and dissemination, and it spent almost 15 (14.4) times as much on training as it did on policy.

TABLE 1: Allocation of JAHF aging grants awarded from 4/83 to 4/15, by category and profession

CATEGORY/PROFESSION	DOLLAR AMOUNT, PER CATEGORY	DOLLAR AMOUNT, PER PROFESSION	% OF TRAINING	% OF TOTAL
TRAINING (total)	\$335,578,471		100	71
Training (MDs)		\$171,823,313	51	
Training (Nurses)		\$86,998,370	26	
Training (SWs)		\$64,415,333	19	
Training (GITT)		\$12,341,455	4	
MODELS	\$88,273,784			18
POLICY	\$23,330,191			5
RESEARCH/EVAL	\$18,011,068			4
OTHER	\$8,528,167			2
TOTAL	\$473,721,681			100

SECTION 2. BY THE NUMBERS: QUANTITATIVE OUTPUT AND IMPACT

As discussed in the previous section, between April 1983 and April 2015, The John A. Hartford Foundation awarded almost half a billion dollars in grants in the area of health and aging in an effort—as John Billings succinctly put it—“to get the health system to take better care of the elderly.” Did it succeed in this effort?

Perhaps not surprisingly, there is no simple answer to this question. First of all, the Foundation never specified a particular outcome measure or metric with which to gauge how well the health care system was taking care of the elderly, and indeed, when we spoke with a range of experts in the field—including a number of prominent Foundation grantees—about how one would measure how well the health care system is taking care of the elderly, we got a range of responses. There is, in other words, no clear consensus on how to measure how well the health care system is taking care of the elderly, and it is not an issue to which the Foundation gave much attention.⁴⁸

But even if there were to be broad agreement on how to measure how well the health care system is taking care of the elderly, there would be the question of attribution. That is, assuming that the agreed-upon indicator had improved since 1983, how much of that improvement—if any—could actually be attributed to the Foundation’s grantmaking in the field? There might, for example, be a reduction in the average length of hospitalizations for patients age 65 and over. While improvements in care of the kind that the Foundation promoted through its geriatric training programs and models of geriatric care might have contributed to that reduction, the reductions might also have been driven by changes in hospital reimbursement policies or by changes in health-related behaviors of the patients themselves.

We will return to this “big picture” question later in this report, but fortunately there are additional ways to get at the impact question. One way, of course, is simply to ask knowledgeable individuals for their impressions of the Foundation’s impact. And indeed, in our interviews we asked current and former staff and Board members, current and former grantees, and staff from other foundations to share their impressions of the Foundation’s impact. We also asked this question in our email survey of past and current Foundation grantees. Those qualitative assessments will be presented in Section 3.

Another way to get at the question of the Foundation’s impact, which we will address in this present section—a way that uses “hard” quantitative measures—is to look program by program at measures such as the number of individuals trained, the number of places or institutions that have adopted a particular model that the Foundation supported, and the number of older adults served by those model programs. While measures of this kind are not available for every program, the numbers that are available can provide a general sense of the level of impact that many of the Foundation’s individual programs have had. To place these numbers in context and to provide a better sense of each program’s relative impact on the problem or need that it was designed to address, we will also present information on the “denominator”—for example, the number of hospitals that potentially *could* have adopted a particular model program—whenever possible.

The programs will be presented by type (for example, training), category (for example, physician training), and in some cases by strategy within a category (for example, creating a corps of academic geriatric scholars). A grid summarizing these program-by-program measures for the Foundation’s major investments in training and models of care can be found in Appendix B.

As we have discussed, throughout most of the 32 years that are the focus of this report, the Foundation’s grantmaking strategy for improving the care of older Americans had two major components. First, the Foundation sought to train those who provided the care—initially just physicians, then nurses and social workers—by creating a cadre of geriatrics faculty in each of the professions and by infusing geriatrics content into their curricula and certification examinations. And second, the Foundation supported the testing and dissemination of new models of care that could improve the care of older adults. The Foundation supplemented these two primary areas of activity with programs to improve public policy and nurture leadership in the field. We use this broad strategic framework in presenting and discussing the Foundation’s many initiatives and programs in the remainder of this section.

In addition, in response to a question raised by the Foundation’s Board chair, Margaret Wolff, Esq., we present information regarding the current geographic distribution of the Foundation’s past and current grantees and awardees.

PHYSICIAN TRAINING PROGRAMS

The Foundation employed three strategies to increase the number of physicians who were trained and prepared to provide appropriate care to older patients:

1. Create a corps of academic geriatric scholars to conduct research and serve as mentors and role models.
2. Educate and train non-geriatrician physicians in the care of older adults.
3. Incorporate geriatrics into the education and training of medical students and residents.

As we will show, in terms of numbers, the Foundation did what it said it would. It trained a great many teachers and mentors, promoted pioneering research, and advanced the incorporation of geriatrics content into the medical school curriculum and the training of specialists and subspecialists. The major programs that fall under each strategy will be discussed in turn.

Creating a corps of academic geriatric scholars

The first program to be funded under the health and aging area was the **Geriatric Faculty Development Awards** program (1983-87). Over its four-year life, this \$2.5 million program provided a year of geriatric training to 29 midcareer faculty at four leading medical schools (Harvard, Johns Hopkins, Mt. Sinai, and UCLA). Of the 29, 26 awardees went on to devote a significant amount of time to the training of others in geriatrics. Given the estimate cited in the Foundation's 1983 Annual Report that there would be a need for 2,000 academic geriatricians by the year 1990 and that the number of academic geriatricians then teaching in the nation's medical schools was no more than 200,⁴⁹ the addition of 26 more active academic geriatricians represented probably about a 10-15 percent increase the national total, still far short of the 2,000 reportedly required to meet the need. However, the point of the program was to engage four of the most prestigious medical institutions in the country, thereby giving credibility to the Foundation's efforts to strengthen geriatrics and easing the way for other schools to give higher priority to geriatrics—and in this, it succeeded.

In an effort to scale up its impact, the Foundation in 1988 committed \$6.4 million to the **Academic Geriatrics Recruitment Initiative** to establish “Centers of Excellence” at 10 medical schools across the country. Over the years, the number of Centers of Excellence would grow to 28 (including two centers in geriatric psychiatry), and by 2015 the Foundation had devoted \$52 million to the

Centers of Excellence, plus \$19.5 million to the American Federation for Aging Research to manage and coordinate the program—a total of \$71.5 million, or about 40 percent of its total expenditures for physician training. According to an evaluation of the program published in 2017 by David Reuben, MD (a recipient of one of the original 29 Geriatric Faculty Development Awards), from 1988 to 2015 the Centers of Excellence supported 1,164 fellows and junior faculty in geriatric medicine, geriatric psychiatry and related specialties and subspecialties.⁵⁰ Almost all (97 percent) have remained in aging, and in response to a survey, 90 percent reported having taught in the prior year. In all, according to Reuben's evaluation, the fellows and faculty supported by the Centers of Excellence taught or mentored 55,500 trainees each year.⁵¹

To put this figure in context, as of 2016 there were almost a million (953,695) actively licensed physicians in the United States.⁵² Assuming that all 55,000 trainees taught or mentored by Centers of Excellence fellows and faculty were or later became physicians and that they all went on to practice in the United States (which may not be the case), this would mean that each year the program is impacting the equivalent of about 6 percent of all actively licensed physicians.⁵³

Another way to look at the quantitative impact of the Centers of Excellence is in terms of the need for 2,000 academic geriatricians by 1990 cited in the Foundation's 1983 Annual Report. If the survey results can be generalized to all 1,164 fellows and junior faculty supported by the Centers of Excellence—meaning that 90 percent of them taught in the previous year—then it would appear that the program has single-handedly met roughly half the national need for academic geriatricians (at least as it was projected for 1990).⁵⁴ This is a genuine achievement.

Finally, it is worth noting that the Foundation's investment in the Centers of Excellence leveraged substantial additional resources (although probably some of the resources raised would have been raised without the Centers of Excellence funding). The respondents to Reuben's survey—who represented only 29 percent of the 1,164 Center of Excellence awardees—obtained more than \$1.1 billion in federal, state, philanthropic, and private sector research grants.⁵⁵ This alone represents a return on investment of more than 15 to 1.⁵⁶

Besides the Centers of Excellence, the other major initiative by the Foundation to create a corps of academic geriatric scholars has been its funding of

the **Paul B. Beeson Career Development Awards in Aging Research**. Launched in 1994 with joint funding from The Commonwealth Fund and the Atlantic Philanthropies, the Beeson Awards provided up to \$150,000 a year for up to three years to junior and mid-career faculty committed to careers in academic geriatrics. The program continues to the present day and is jointly funded by The John A. Hartford Foundation and the National Institute on Aging.⁵⁷

Since its inception, the Foundation has committed \$39 million to the program, and so far the program has sponsored 219 Beeson Scholars (including 8 overseas).⁵⁸ While this is only about one-fifth (19 percent) the number of faculty and fellows sponsored through the Centers of Excellence, the purpose of the Beeson Awards program is different.⁵⁹ Its focus is on strengthening the field of aging research as well as the geriatric medicine programs at the recipients' institutions. A 2011 evaluation of the program by Elizabeth Bragg, PhD, RN, et. al., found that the program is achieving these goals. The evaluation compared 36 medical schools that had Beeson Scholars with a matched sample of 34 similar medical schools that did not have Beeson Scholars, and found that "Beeson Scholars are more likely than a matched sample of non-Beeson [National Institutes of Health (NIH)] K awardees to study important geriatric syndromes such as falls, cognitive impairment, adverse drug events, osteoporosis, and functional recovery from illness."⁶⁰ Moreover, they were more likely than their matched comparisons to stay in the institution where they had trained during their Beeson award, and many were playing leadership roles on research projects in their institutions.

While these aren't the kinds of "hard" quantitative outcomes that one can point to in other kinds of training and service delivery programs, the case can be made that the research and leadership contributions of the Beeson Scholars are playing an important role in establishing the value and legitimacy of geriatrics within the academic mainstream. The following response to our email survey from a former Beeson Scholar who is now the director of a university geriatrics program provides an example of the program's impact: "The Beeson award came to me at a critical juncture in my career. In the short term, it made me excited about aging research. In the long term, it helped me redirect my research focus, combining my interest in inflammation and aging, and build a research career based on this. The Beeson program has been critical in helping me develop a network of national colleagues, and also mentees. It has even helped me in my faculty

recruitment efforts." Another respondent told us: "I feel the Beeson Scholars program remains the single most important and successful aspect of academic workforce development I have ever witnessed."

Educating and training non-geriatrician physicians

As it became clear that despite its initial efforts to increase the number of academic geriatricians, there would not be enough geriatricians to meet the needs of an aging population, the Foundation began to support two major initiatives to educate and train non-geriatrician physicians in the care of older adults. The first, entitled **Increasing Geriatrics Expertise in Surgical and Medical Specialties** (also known as the **Geriatrics for Specialists Initiative**), was launched in 1992 and is currently funded through 2019—a 27-year commitment totaling \$14.8 million.⁶¹ Housed at the American Geriatrics Society, it is a multifaceted initiative designed to embed geriatrics training into the surgical and medical specialties through: (1) partnerships with 11 surgical and medical specialty associations and development of a statement of shared principles; (2) development of a research agenda and a multispecialty network of researchers to carry out the research; (3) support and nurturing of specialty leaders and scholars through the Dennis W. Jahnigen Career Development Scholar Awards program; and (4) advocacy for the incorporation of geriatric concepts into national residency training guidelines and specialty board certification examinations.

As of 2017, the Jahnigen Awards have supported 79 young investigators.⁶² A recent article about the program by two of the program's directors and the CEO of the American Geriatrics Society describes the impact of the Jahnigen and GEMSTAR⁶³ awardees as "spectacular," noting that, as of 2013, they had produced more than three thousand peer-reviewed articles, generated \$87 million in additional grant support, and obtained five national leadership positions.⁶⁴

But the program's most significant impact may well be on the curriculum and certification front. In the late 1990's, the Association of Program Directors in Surgery integrated geriatric concepts into the national curriculum for general surgery, and in 2000 the American Board of Surgery added geriatrics to its national certification requirements.⁶⁵ Given that roughly 1,400 general surgeons take the certification exam each year,⁶⁶ that adds up to about 24,000 surgeons who, over the past 17 years have had to learn the geriatric concepts covered in the exams. In other words, an entire generation of general surgeons now in practice has had to learn how to provide appropriate

care for their older patients. By 2014, building on this breakthrough in general surgery, eight more surgical and related medical specialties—anesthesiology, emergency medicine, gynecology, ophthalmology, orthopedic surgery, physical medicine and rehabilitation, thoracic surgery, and urology—had also “included a focus on aging” in their certification exams, and all except thoracic surgery had developed the necessary geriatric curricular materials.⁶⁷

In 1994, two years after it had begun its work with surgeons and related medical specialists, the Foundation launched its second major initiative to train non-geriatric physicians in the care of older patients. This initiative, to which the Foundation would devote \$9.3 million over the next 26 years, was focused on internal medicine and its subspecialties and was named **Integrating Geriatrics Into the Subspecialties of Internal Medicine**. While the program bore some similarities to its companion program for surgeons and related specialties—including a scholarship program, named the T. Franklin Williams Scholars Awards—its approach was different. William Hazzard, MD, who ran the program under the auspices of the American Geriatrics Society for 12 years (1994-2006),⁶⁸ conducted annual five-day retreats that brought key academic leaders in internal medicine subspecialties such as cardiology, gastroenterology, and oncology together with leading geriatricians in an effort to “sensitize” them to the importance of integrating geriatrics content into their curricula.

Although it is difficult to summarize the impact of this approach, a recent article about the program by the geriatrician and oncologist Arti Hurria, MD, and colleagues indicates that most of the subspecialties have made at least some—and several cases substantial—progress in incorporating geriatrics content into their journals, their continuing medical education curricula, their fellowship training, and—perhaps most significantly—their training examinations. On a four-point scale indicating the degree of progress made on each of these items, Hurria and her colleagues scored cardiology and nephrology each 4 points on their inclusion of geriatric content in their training exams, while general internal medicine, oncology, hematology, and diabetes each received 3 points.⁶⁹ Beyond such actions, many of the subspecialty societies have taken additional steps to prepare their members for the care of older patients. For example, the American College of Cardiology has established a geriatric cardiology section that already has approximately 2,000 members and 400 fellows.⁷⁰ (To put this figure

in perspective, there are just over 30,000 practicing cardiologists in the United States today.)⁷¹

In addition, with co-funding from the Atlantic Philanthropies, the program has devoted \$10 million to the support of 101 T. Franklin Williams scholars, who in turn have generated over \$150 million in grant support from the NIH alone. But the amount of money leveraged is only part of the story. Among the many serious geriatric health issues addressed, the Williams scholars have already “identified potential therapeutic targets in hypertension-associated left ventricular hypertrophy, explored new research directions in high-impact areas such as venous thromboembolism in older adults after joint replacement, shown efficacy of high-dose influenza vaccine in older adults, . . . and conducted randomized controlled trials of interventions against pneumonia.”⁷² It is entirely possible that in the long run the greatest payoff from the program, in terms of improvements in the care of older adults, may come from scientific studies such as these.

Incorporating geriatrics into medical student and resident training

The third component of the Foundation’s strategy to increase the number of physicians who were prepared to care for older patients was focused on those in the early stages of the medical education process: medical students and residents. The program for medical students, entitled **Medical Student Training in Aging Research (MSTAR)** and coordinated by the American Federation for Aging Research, began in 1993 and over the next 24 years (until 2017) received \$9.3 million from The John A. Hartford Foundation. The National Institute on Aging became a funding partner in 2004 with a commitment of about \$6.5 million, greatly expanding the program,⁷³ and plans to continue funding the program in 2018.⁷⁴

The American Federation for Aging Research website describes the program as follows: “The MSTAR Program provides medical students with an enriching experience in aging-related research and geriatrics, with the mentorship of top experts in the field. . . . Students participate in an eight- to twelve-week structured research, clinical, and didactic program in geriatrics, appropriate to their level of training and interests. Research projects are offered in basic, translational, clinical, or health services research relevant to older people.”⁷⁵

Given that it is a short-term training program and that there is no evaluation of the program that compares MSTAR students with matched comparisons who did

not participate in MSTAR, it is difficult to fully assess the program's impact. But we do know that as of 2017, the program has trained 2,301 medical students—an average of about 96 students per year over the past 24 years. Given that, since 2002, an average of about 16,500 medical students have graduated from American medical schools each year,⁷⁶ this represents less than one percent (0.6) of all graduating medical students. And in a 2012 press release, the American Federation for Aging Research reported that of those former MSTAR participants who were at that time in medical practice, 20 percent were in geriatric medicine or an aging-related specialty.⁷⁷ If this figure is correct, it would mean that about 0.1 percent—one in a thousand—of all United States medical school graduates went into geriatrics or an aging-related specialty as a result of the MSTAR program.⁷⁸

The other Foundation program aimed at medical students—the **Geriatrics Curriculum Grants Initiative**—got underway in January 2000. Managed by the Association of American Medical Colleges and funded at \$5.2 million over a four-year period (followed by a three-year dissemination grant of \$270,000), the program provided support to 40 medical schools across the country “to improve attitudes toward older patients and equip medical students with the knowledge to effectively treat older patients.”⁷⁹ Given that there are 146 medical schools in the United States,⁸⁰ the 40 medical schools included in the program represented a significant share of the total (27 percent)—which meant that this program did in fact have the potential to reach a significant share of the nation's medical students.

What we don't know, however, is how much of an impact the program had on those students who were reached. The Foundation's 2012 Annual Report cites a survey of all graduating medical students by the Association of American Medical Colleges that “demonstrated a rapid rise in perceived competence in the care of older patients and satisfaction with geriatrics education at medical schools that received curriculum grants,”⁸¹ but whether this rise in perceived competence reflected actual improvements in competence is not clear.

That said, in addition to whatever direct impact it may have had, the program apparently had a substantial *indirect* impact through an \$80 million program launched in 2001 by the Donald W. Reynolds Foundation—which “built on the Hartford Foundation's investments.”⁸² Like the Geriatrics Curriculum Grants Initiative, the Reynolds Foundation's program provided support to 40 medical

schools over time, but at a substantially higher level (\$2 million per school). An independent evaluation of the first 10 schools funded through the Reynolds Foundation initiative found that: “By 2005, students at Reynolds-supported schools reported higher levels of geriatrics/gerontology education and more exposure to expert geriatric care by the attending faculty compared to students at non-Reynolds schools. Innovations and products were disseminated via journal publications, conference presentations, and POGOE (Portal of Geriatric Online Education).”⁸³ While these outcomes are certainly encouraging, the evaluators cautioned that “the full impact of these programs on care of older persons will not be known until these trainees enter practice and educational careers.”⁸⁴

In addition to its two programs for medical students, The John A. Hartford Foundation funded two sister programs directed at medical residents. The first was a four-year \$5.4 million initiative coordinated by the Geriatrics Educational Resource and Dissemination Center at Stanford University and entitled the **Geriatrics in Primary Care Training Initiative**. In addition to Stanford, the program supported seven medical schools to develop geriatrics curricula for their primary care residents.⁸⁵ The curricula were to “emphasize clinical skills and topics in geriatrics not usually covered in traditional internal medicine and family training programs.”⁸⁶

The seven schools also produced a wealth of educational materials, including computer-based learning modules, pocket cards for easy reference, new instructional materials, exams, rotations, and training exercises for use in residency training programs.⁸⁷ Many of those materials were subsequently made widely available (for sale) by the Stanford resource center through its website,⁸⁸ which was still active as of December 2017. According to Georgette Stratos, PhD, co-director of the Stanford Faculty Development Center for Medical Teachers, “The total items distributed during the years 1998-2004 and 2011-2017 (with a gap of five years) is 144,225. The approximate number of institutions that ordered geriatric educational materials during these time frames is 735. ...By the end of 2004, 440 medical teachers (faculty or residents) had received the complete 14-hour curriculum. At least another 2,500 healthcare professionals had received modified versions of the full curriculum.”⁸⁹

The other initiative focused on medical residents involved the replication in 13 medical schools of a model program at Boston Medical Center entitled CRIT, or

Chief Resident Immersion Training in the Care of Older Adults. Between 2007 and 2012, the Foundation provided \$1.9 million to the Association of Directors of Geriatric Academic Programs to implement the program. As explained on the organization’s website, CRIT brings together chief residents and faculty responsible for residency training in surgical and medical specialties for an intensive two-day program. The main focus of the two days is on helping the chief residents acquire the necessary teaching and leadership skills to train their residents in the care of older patients with complex conditions.⁹⁰

As for CRIT’s impact, to date the two-day programs have been held over 30 times at 16 medical schools across the country, and follow-up surveys of the participating chief residents indicated that they “were more confident in their application of clinical skills related to the care of older adults, were more likely to teach geriatric principles to residents and medical students, had an increased recognition of the importance of interdisciplinary approaches to the care of older adults, and had more confidence to coordinate care across disciplines and specialties.”⁹¹ The fact that the program has been held at 16 medical schools means that it has reached chief residents at 11 percent of the nation’s 146 medical schools.

NURSE TRAINING PROGRAMS

In 1996, 13 years after embarking on its work in geriatric medicine, The John A. Hartford Foundation began a systematic effort to build the field of geriatric nursing. Although it had made some earlier forays into geriatric nursing territory—most notably through its support of the NICHE program—the Foundation was now ready to address the challenge of geriatric nursing head-on. As with physicians, its approach involved three mutually reinforcing strategies:

1. Jump-start the field and give it prominence.
2. Train and educate a core group of geriatric nursing scholars to attract and mentor new faculty members and to conduct cutting-edge research.
3. Incorporate geriatrics into nursing school curricula and accreditation guidelines so that all nurses and nursing students are trained in the care of elderly patients.

Perhaps because among all of the health care professions, nurses provide most of the hands-on care for older adults, the Foundation’s efforts to build a field of geriatric nursing is considered among its most important contributions

by many of the experts we interviewed. Its interlocking strategies created a cadre of geriatric nursing scholars and educators, fostered strong and enduring geriatric nursing institutions and programs, and embedded geriatrics content in nursing education and credentialing. Each of these strategies is discussed in turn in the following sections.

Jump-starting the field

The Foundation recognized that a time-honored way to jump-start a field was giving a big, highly visible grant to a widely respected leader in the field. And indeed, its \$5 million grant to New York University to establish **The Hartford Institute for Geriatric Nursing**, under the leadership of Mathy Mezey and co-directed by Terry Fulmer, did just that. (As Fulmer later commented, “This kind of extraordinary support for geriatric nursing was unimaginable when I was graduating from college.”⁹²) Charged with creating “a national repository of information about gerontological nursing care relevant to both policy and practice,” the Institute’s overarching mandate was in fact much broader: “To do great things to advance geriatric nursing.”⁹³

Toward that end, the Institute held conferences, convened leaders in the field, produced and widely disseminated print and online publications, developed new assessment tools, and granted prestigious awards to promote both the value and values of geriatric nursing. It also incubated and promoted the NICHE program, which as of 2017 was operational in 764 sites—including 587 community hospitals⁹⁴ (this represents one in eight, or 12 percent, of the nation’s 4,862 community hospitals).⁹⁵

In addition, the Institute actively sought to embed geriatric content in the training of all nurses. Mezey recalls that when the Institute first got underway, the Foundation favored the creation of geriatric nursing as a specialty. But as Mezey and her colleagues spoke with others in the field, it became clear that the best way to advance geriatric nursing practice would be to embed geriatric concepts and principles in nursing education and training across the board—much as the Foundation was doing in its work with non-geriatrician physicians. As a result, the Institute worked with 54 national specialty nursing associations to develop new standards for the care of older patients, and as of 2005, all new or revised specialty nursing standards submitted to the American Nurses Association’s Congress of Nursing Practice had to address the care of older adults.⁹⁶

Along similar lines, the Institute collaborated with the American Association of Colleges of Nursing to increase the exposure of nursing students to geriatrics. According to a 2011 article co-authored by Mezey, Geraldine Bednash, PhD, RN, FAAN, at that time executive director of the American Association of Colleges of Nursing, and M. Elaine Tagliareni, EdD, RN, FAAN, former president of the National League of Nursing, this collaboration “resulted in a major shift by baccalaureate programs to include content and learning experiences about care of older adults as a core component in the basic course of studies.” Indeed, by 2003, most of the nation’s BSN nursing programs (92 percent) had integrated geriatrics into at least one course, up from just 63 percent in 1997.⁹⁷

Developing a core group of geriatric nursing research scholars

The centerpiece of the Foundation’s effort to develop a field of geriatric nursing was an ambitious 17-year, \$53.2 million national initiative entitled **Building Academic Geriatric Nursing Capacity**.⁹⁸ The idea behind the initiative was to create a whole new cadre of nurse scholars who would “prepare future generations of nursing students and build the knowledge needed to foster new evidence-based models of care.”⁹⁹

The initiative had two parts: (1) the Patricia G. Archbold pre-doctoral scholarships and Claire M. Fagin post-doctoral fellowships to strengthen the scholarly and leadership underpinnings of geriatrics in academic nursing; and (2) grants to establish Centers of Geriatric Nursing Excellence, initially at five nursing schools across the country and eventually at four more.¹⁰⁰

As of 2015, a total of 280 pre-doctoral scholars and post-doctoral fellows had been funded through the initiative, and as of 2013, these scholars and fellows “had published 2,521 peer-reviewed articles, made over 4,900 presentations, received prestigious honors, and obtained over \$200 million in grants. As faculty, this group has mentored and taught geriatrics and gerontological nursing to more than 184,000 nursing students.”¹⁰¹

To put these figures in context, while 184,000 students is certainly an impressive total, over the 13-year period during which these totals were achieved (2000-2013) it translates into an average of just over 14,000 students per year. The total number of undergraduate, graduate and doctoral nursing degrees awarded in one year alone (2015) was over 270,000¹⁰²—and of course that does not include the many nursing students who didn’t graduate that year.

In other words, on average the scholars and fellows were mentoring and teaching fewer than 5 percent of all nursing students. From a financial standpoint, the more than \$200 million in grant support obtained by the scholars and fellows represents a return of almost 7 to 1 on the \$29.5 million cost of the scholarships and fellowships.¹⁰³

As for the Centers of Geriatric Nursing Excellence funded through the initiative, the impact on their institutions appears to have been significant. As one of the respondents to our e-mail survey reported, “We increased the enrollment of our doctoral students in Geriatric Nursing from 2 students in 2000 to 36 in 2005 (1800% increase)... [and] increased our masters students in Gerontological Nursing from 2 in 2000 to 43 in 2004 and 30 in 2005... We leveraged the initial \$1.3 million John A. Hartford [Foundation] grant to \$16,600,959 by obtaining research and training grants.”

Claire Fagin, RN, PhD, FAAN, the first director of the national initiative, told us that of the first five centers, four were successful. She said that in general the initiative was successful in creating the field of geriatric nursing because it had all the pieces (pre-doctoral, doctoral, post-doctoral, and a center) in one place, which she believes allowed for greater synergy than occurred in the medical or social work areas.

Incorporating geriatrics into nursing school curricula and accreditation guidelines

As noted earlier, among its many activities, The Hartford Institute for Geriatric Nursing actively collaborated with the American Association of Colleges of Nursing in an effort to incorporate geriatrics into nursing school curricula. Beginning in 2001, the Foundation provided almost \$11 million to the Association for this purpose, and to recruit students into advanced practice geriatric nursing programs. The Association, in turn, added geriatrics to its list of required core competencies for all BSN graduates and assembled the Geriatric Nursing Education Consortium, which brought together over 800 nursing faculty representing almost 70 percent (418) of the nation’s nursing programs to receive training in geriatric curricula. In other words, the Association created a new set of academic requirements and then helped to prepare nursing school faculty to meet those requirements. According to the Foundation’s 2012 Annual Report, just two years later “82 percent of participating institutions revised and enhanced senior-level nursing courses with evidence-based curricular material on caring for older adults and new courses in geriatric nursing were created.

At least 70 percent of the revised and enhanced courses are required by their institutional programs, as are 43 percent of the stand-alone courses.¹⁰⁴ The upshot, the Annual Report goes on to say, was that “thousands of nursing students, in nearly half the nursing schools in the country, will be exposed to best practices in geriatric care across a wide range of course offerings.”¹⁰⁵ Unfortunately, we don’t know how much of an impact this exposure to best practices in geriatric care has had on the actual care that these students went on to provide to older patients once they entered practice, but there is no question that the program’s reach—in terms of the proportion of the nation’s undergraduate nursing students who were exposed to this geriatric content—was impressive.

Fast-forwarding to the present, the Foundation’s 2016 Annual Report indicates that “[t]oday, more than 90 percent of baccalaureate nursing programs have gerontologic content integrated into their curriculum and all graduates are expected to have geriatrics as one of their core competencies.”¹⁰⁶ Add to this the fact that the proportion of BSN nurses in practice has been steadily climbing—from 41 percent in 2001 to 47 percent in 2015 (while the actual number of BSN nurses has almost doubled, from 859,911 in 2001 to 1,503,815 in 2015)¹⁰⁷—and it becomes clear that a growing share of the new generation of nurses now practicing has received at least some level of preparation and training in the care of older patients. This could turn out to be the Foundation’s most lasting achievement in its development of geriatric nursing.

SOCIAL WORKER TRAINING PROGRAMS

As we discussed in Section 1 (pp.20-21), in 1998 the Foundation launched the Geriatric Social Work Initiative to “enhance the geriatric capacity of social work education, including faculty, curriculum, students, and training.”¹⁰⁸ As in medicine and nursing, the initiative addressed three interrelated components of social work education. Specifically, its goals were to:

1. Incorporate geriatrics into the social work curriculum and accreditation standards.
2. Increase the number and capabilities of social work faculty committed to geriatrics.
3. Strengthen geriatrics content and experience in the field placements (practicums) of master’s-level social work students.

The John A. Hartford Foundation’s embrace of geriatric social work had an electrifying effect on the field. Academics and practitioners alike used words like “transformative” and “seismic shift” to describe its impact. Not only did the attention of a major national foundation give the field credibility, academic respectability, and funding, it also sparked the development of a core group of educators and researchers who served as leaders, role models, and mentors. And by working with the Council on Social Work Education, the Foundation ensured that the care of older adults would remain a part of the social work curriculum beyond the life of its grants.

Incorporating geriatrics into the curriculum and accreditation standards

The first step towards incorporating geriatrics into the nation’s social work curricula and accreditation standards was to identify a set of core competencies that baccalaureate and masters-level social work students needed to master in order to effectively serve older clients.¹⁰⁹ In 1998, with funding from the Foundation, the Council on Social Work Education—which accredits the nation’s 600-plus social work programs—undertook this task, using a consensus-based process to winnow an initial list of 128 potential competencies down to 65 core competencies.¹¹⁰ On its face, this may not seem like a particularly noteworthy accomplishment, but in fact the identification of a list of widely agreed-upon competencies set the stage for the incorporation of gerontological content into social work curricula and into the accreditation standards for all social work programs.

In 2001, the Foundation followed its initial grant to the Council on Social Work Education with support for its **Geriatric Enrichment in Social Work Education Project (GeroRich)**, which provided \$30,000 awards to 67 social work programs across the country to “infuse” gerontological competencies into their baccalaureate and master’s-level curricula and to prepare their faculty to teach this new material.

An independent evaluation of the program published in 2008 reported positive results for the participating programs: “Based on common outcome measures, the GeroRich program was found to be effective in (1) increasing the amount of gerontological content in the curriculum, (2) engaging faculty in the change process, and (3) exposing students to gerontological content.”¹¹¹ The 67 social work programs that were funded through GeroRich represent roughly 10 percent of the more than 600 accredited social work programs in the country,

and thus can be assumed to have had an impact on no more than 10 percent of the nation's social work students (fewer if not all students in the participating programs were exposed to the GeroRich materials). Four years later, however, the Foundation's Annual Report indicated that 250 social work programs—about 40 percent of the national total—had infused gerontological competencies into their curricula “or developed a minor, certificate, specialization, or area of emphasis in geriatrics.”¹¹² This suggests that the GeroRich model may have been replicated in other schools, greatly amplifying its impact.¹¹³

In the meantime, in 2004 the Foundation had made another major grant to the Council on Social Work Education, this time to establish the **National Center for Gerontological Social Work Education (Gero-Ed Center)**. The purpose of the Gero-Ed Center was to institutionalize and expand the impact of the Foundation's earlier efforts in this area, and toward this end it worked on multiple fronts, including faculty training, curriculum development, dissemination of materials, student recruitment (especially students from disadvantaged backgrounds), and persuading editors and publishers to incorporate gerontological content into social work textbooks.

It is difficult to quantify the impact of such a wide range of activities, but it is likely that, among other things, the Gero-Ed Center—through its work in faculty training, curriculum development, and materials dissemination—contributed directly to the rapid spread of the GeroRich model beyond the original 67 programs. Another partial measure of Gero-Ed's impact is the change in content on aging and older adults in social work textbooks. An extensive content analysis of social work textbooks in 2003 found that only 3 percent of 10,000 pages of text even mentioned aging or older adults. Several years later, the content analysis was repeated, looking specifically at books of authors who had met with GeroEd staff. The share of pages that mentioned aging or older adults had almost doubled, from 3-5.5 percent¹¹⁴—a substantial increase but still a relatively small percentage given that people age 65 and older comprise almost 15 percent of the United States population.¹¹⁵

Increasing the number and geriatric capabilities of faculty

Following on the heels of its first grant to the Council on Social Work Education, in 1999 the Foundation launched what over the next 16 years was to become an investment of almost \$35 million to increase the number and capabilities of social work faculty committed to geriatrics by attracting and supporting junior faculty and doctoral

students who would pursue careers in academic geriatric social work. This second component of the Geriatric Social Work Initiative supported two training programs, both administered by the Gerontological Society of America: the **Hartford Geriatric Social Work Faculty Scholars Program**, which over the years provided two-year stipends of \$50,000 a year to 125 junior faculty, and the **Hartford Doctoral Fellows in Geriatric Social Work Program**, which provided the same level of support to 104 doctoral (and later pre-doctoral) students.

With regard to the impact of these programs, the final report of the Faculty Scholars program indicates that, as of 2014, 94 percent of the 125 Faculty Scholars were still teaching about geriatric social work and 99 percent were conducting research in the field.¹¹⁶ While this is praiseworthy, the 125 Faculty Scholars represent less than 1 percent of the nation's social work faculty. The roughly 5,000 students that they were projected to teach each year comprise about 4 percent of the 123,090 full-time and part-time masters and baccalaureate social work students reported by the Council.¹¹⁷

As for the 104 Doctoral Fellows, 96 percent of them had completed their dissertations (compared with 71 percent of their peers), and as of 2010, almost half the Fellows (47 percent) were in a tenure-track position (compared with 27 percent of their peers).¹¹⁸ The Council on Social Work Education reports that there were 2,033 social work PhD students in 2015, so on an annualized basis the 104 Doctoral Fellows would represent less than 1 percent (0.8 percent) of the national total.¹¹⁹

But these “hard” data tell only part of the story. As in medicine and nursing, some of the greatest downstream benefits from the Foundation's investments in the social work scholars and fellows may emerge from the research that they conducted—or that they will conduct years from now as their careers in geriatric social work continue to evolve. Similarly, the value of the leadership that these scholars and fellows may provide (or inspire in others) is impossible to quantify. We may, however, catch a glimpse of some of these “soft”—but no less important—outcomes in some of the responses to our email survey.

One respondent, for example, told us: “It is impressive to see the growth in social work scholars in aging and the ripple effect to our students in undergraduate and graduate levels. Every year I graduate around 10 or so geriatric social workers who go directly into the workforce and help fill gaps in services in my local community.” Another respondent declared, “For me, personally and

professionally—and [for] my institution—the JAHF fellowship has had a tremendous impact and is likely the single most important thing to happen to me during the formative stages of my career development. I can directly attribute much of my success to this program.”

Strengthening geriatrics content and experience in field placements

The third component of the Foundation’s Geriatric Social Work Initiative focused on the field placement (practicum) experience that is required for all MSW students. The hope was that by having these students rotate through multiple field placements rather than just one agency, they would become aware of the range of settings in which they could potentially work with older adults, and that this would persuade them to specialize in geriatric social work.¹²⁰ There was also a concern that, by being limited to one field placement, MSW students were often inadequately prepared to deal with the range of issues facing elderly clients.¹²¹ Accordingly, in 1999 the Foundation made a grant to the New York Academy of Medicine to establish and manage what became known as the **Hartford Partnership Program for Aging Education**, an \$11 million national initiative designed to give MSW students the chance to rotate through multiple field placements during their practicum experience. Beginning with 11 planning grants in 1999, followed by six implementation grants in 2000, the Partnership Program grew steadily over time, so that by 2012 the rotational practicum model had been adopted by 97 schools of social work across the country¹²²—40 percent of the nation’s 242 MSW programs.¹²³

As impressive as the 40 percent figure is, again, the numbers alone do not tell the whole story. For example, a respondent to our e-mail survey who participated in one of the rotational practicums wrote: “My field placement consisted of two days in a non-profit organization focused on senior empowerment and advocacy, and a one-day placement at a foundation providing micro-grants to older adults to allow them to remain in the community with dignity and autonomy... [I was] then was hired by the non-profit organization to take a program director position in the department where I did the internship. Fast forward to 2017, I am still at the non-profit. I am Director of Legislative Affairs, and I have the added responsibility of overseeing the field placement program for all MSW and BSW students at our agency. I regularly talk to them about what it means to work with older adults, and hopefully inspire them to keep an open mind to a future in the field

of gerontology.” This kind of “passing of the torch” to the next generation does not show up in the usual program statistics but may be one of the more important by-products of the initiative.

MODELS OF CARE

We turn now to the second major component of the Foundation’s strategy to improve the care of older Americans: its efforts to develop and promulgate effective new models of care. Since 1983, the Foundation has supported many of the field’s innovators—an accomplishment which, in itself, should not be minimized. Although the Foundation is well known for its support of geriatric training, its support for better and more cost-effective ways of providing care to older patients is equally impressive. Over the years, the Foundation has supported models in the following areas:

1. Team care
2. Transition from hospital to home
3. Medication management
4. Improving hospital care for the elderly
5. Depression and palliative care

First, however, dating back to 1983, the Foundation was an early supporter of PACE, a pioneering model of community-based care for older individuals who might otherwise be in a nursing home.

Community-based Care

PACE

The Program of All-inclusive Care for the Elderly (PACE), which is based on the On Lok model developed in San Francisco’s Chinatown community in the early 1970’s, provides coordinated health and social support services that make it possible for nursing home-eligible individuals age 55 and over—many of whom who are covered by both Medicare and Medicaid—to stay in the community rather than entering a nursing home.¹²⁴ Along with the Robert Wood Johnson Foundation and the Retirement Research Foundation, The John A. Hartford Foundation was an early and consistent source of support for PACE, providing a total \$4.7 million for the refinement and replication of the model between 1983 and 2008.

As of December 2017, there are 123 active PACE programs in 31 states (up from 11 programs in 9 states in 1994) that together serve over 40,000 older Americans.¹²⁵ While this represents an impressive achievement, it should

be considered in the context of the potential overall need. Although we do not know precisely how many individuals meet the PACE admission criteria, we do know that about 1.4 million older adults are nursing home residents.¹²⁶ If even half of these individuals would have been able to live in the community with the kinds of support services that PACE provides, it would mean that PACE is currently serving about 6 percent of the total population eligible for the program.

Team Care

The Generalist Physician Initiative

The **Generalist Physician Initiative** (1992-2002) was the Foundation's first program to use a multi-disciplinary team to meet the often-complex health and social needs of older patients. The \$4.5 million initiative funded six primary care practices across the country "to develop and test team care models, involving nurses, social workers and other health professionals, that integrate health care services with community-based social and supportive services to improve patient care in their doctors' offices."¹²⁷ One of the program's most promising sites—the Carle Clinic Association, in Champaign, Illinois—was selected to participate in the national Medicare Coordinated Care Demonstration project authorized by the Balanced Budget Act of 1997, helping to inform national efforts in health care delivery reform.¹²⁸ But for the Foundation itself, probably the most important outcome of the Generalist Physician Initiative was the realization that many health care professionals "lacked the skills needed for effective teamwork."¹²⁹ Because the complex health and social needs of older patients often required a team approach, this was no small matter, and it paved the way for a number of subsequent Foundation initiatives—including the Geriatric Interdisciplinary Team Training initiative.¹³⁰

Geriatric Interdisciplinary Team Training (GITT)

The \$12.3 million **Geriatric Interdisciplinary Team Training** program, launched in 1995, was designed to address head-on the lack of skills needed for effective teamwork. Building on earlier initiatives by the Veterans Administration and the Bureau of Health Professions—as well as the lessons learned from the Generalist Physicians Initiative—the GITT program supported the development and testing of teaching models in which advanced practice nursing students, masters-level social work students, medical residents in internal medicine and family practice, and students in other health professions were trained to work together in interdisciplinary teams in the care of older patients with complex health and social needs. Goals

included teaching trainees respect for other disciplines and imparting the skills to work effectively with other professionals. Under the program, the Foundation awarded one-year planning grants to 12 institutions, eight of which received three-year implementation grants. The initiative also funded a resource center at the New York University School of Nursing.

Over the four years of the program, the GITT sites trained 1,341 health professions students. A 2004 evaluation by David Reuben and colleagues concluded that in general the participating medical residents did not make good team members, creating an important obstacle to interdisciplinary team training.¹³¹ As the evaluators put it, "The study's findings raise fundamental questions about the attainability and desirability of the goal of equality among disciplines."¹³²

A 2005 evaluation by Terry Fulmer, the initiative's director, and colleagues concluded that the GITT initiative "has demonstrated that attitudes towards teams change when trainees are exposed to interdisciplinary care and that self-perceived skills can be significantly improved for all disciplines."¹³³ But like Reuben and his colleagues, Fulmer and her colleagues found that in general medical residents were not as responsive to interdisciplinary team training as their fellow students in nursing and social work, noting that "although the improvement in self-reported skills is an important outcome of GITT, there are clear signs that despite the interdisciplinary team training, medical trainees value teams less."¹³⁴

Yet despite the apparent reluctance of the medical residents to be team players, in his recent interview for this report David Reuben told us that, in hindsight, "GITT was far ahead of its time. A lot of its principles are now recognized, and it was cutting edge. It was on the right track, and its contributions are now being recognized... GITT was bold in recognizing that you've got to do business differently. Now everybody is talking about team care."¹³⁵

Geriatric Interdisciplinary Teams in Practice

In 2001, the Foundation expanded its efforts to promote interdisciplinary team care by moving beyond training directly into practice. The primary vehicle for this was a \$12.5 million initiative, entitled **Geriatric Interdisciplinary Teams in Practice**, that over the next 14 years funded "the creation and testing of five new models of team care in diverse practice settings."¹³⁶ After the first few years of the initiative, four of these models were considered so successful that the Foundation funded

the University of Colorado to actively promote their replication, and two of the four—Care Management Plus and the Care Transition Intervention—proved to be so popular that the Foundation later provided still more funding for their dissemination. Both are discussed below.

Developed by David Dorr, MD, at Intermountain Healthcare, the **Care Management Plus** model assigns a care manager (a nurse or social worker) to coordinate the care of high-risk patients with multiple chronic illnesses. The care manager works as a member of a team with other health care providers at the organization's primary care clinics and a sophisticated health information system developed at Intermountain helps to guide the care manager. In an evaluation of the model, patients served by the Care Management Plus teams—especially those with diabetes—were found to have fewer hospitalizations and lower mortality rates than matched controls. Initially, the Geriatric Interdisciplinary Teams in Practice initiative funded the further development and replication of the model in seven Intermountain clinics. By 2016, with additional funding from the Agency for Healthcare Research and Quality, the Gordon and Betty Moore Foundation, and others, Care Management Plus had been implemented in 420 primary care clinics across the country. These clinics serve a total of about 3 million patients, about 5 to 10 percent of whom “are invited to participate in the [Care Management Plus] program”—which means that in any given year roughly 150,000 to 300,000 patients have been “invited to participate” in Care Management Plus (although not all of them are age 65 or older, and presumably not all of them accept the invitation).¹³⁷ The Foundation devoted \$2.7 million Care Management Plus between 2001 and 2012.

The **Care Transition Intervention** model was developed by Eric Coleman, MD, to ease the move from hospital to home by having an advanced practice nurse serve as a “transition coach” for patients with complex conditions. The coach begins working with the patients in the hospital and continues at home for a month after discharge. Patients assume more responsibility for their own care by keeping a personal health record, with particular attention to medication management. A randomized controlled trial found that the intervention reduced readmission rates and hospital costs.¹³⁸ According to Coleman, as of 2017 the Care Transition Intervention has been adopted by more than 1,000 hospitals and long-term care facilities in over 40 states. Three major health plans and several states have adopted the model, as has the federal Center for Medicare & Medicaid Innovations (calling it the Community-

based Care Transition Program). The fact that Medicare is now penalizing hospitals for short-term readmissions may well have contributed to the widespread uptake of the model. Indeed, a leading geriatrician who regards the Care Transition Intervention as the most influential of the models supported by the Foundation told us, “Coleman went to Congress and told them about the readmissions problem. He talked to CMS and they rallied around the importance of reducing readmissions. Ultimately, Eric was instrumental in CMS’s decision to penalize readmission. This is a real accomplishment.” The Foundation devoted \$2.9 million to the Care Transition Intervention model between 2000 and 2015.

Guided Care

Guided Care is a nurse-directed model of coordinated care, developed by Chad Boulton, MD, of the Johns Hopkins School of Medicine to improve the care of high-need, high-cost older patients. As Boulton has pointed out, “For older adults with several chronic conditions, the old approach of taking one disease at a time and seeing different specialists in different settings for each one doesn’t work. Quality of care is low when care is not coordinated.”¹³⁹ Accordingly, the model is designed to help primary care practices “meet the complex needs of patients with multiple chronic conditions” by using “a trained Guided Care nurse [who] works closely with patients, physicians and others to provide coordinated, patient-centered care.”¹⁴⁰

A randomized controlled trial showed that the model did in fact improve the quality of care, although its impact on the use of high-cost services was mixed.¹⁴¹ As of 2016, 18 health systems of varying sizes had adopted Guided Care.¹⁴² Johns Hopkins University licenses the Guided Care model and according to Boulton, thousands of nurses have been trained and certified. But like other models of this kind, uptake of Guided Care has been hampered by the lack of payment and incentives under the fee-for-service reimbursement system. Boulton believes, however, that there could be renewed interest as value-based care becomes more common. The Foundation devoted \$3.6 million to the Guided Care model between 2004 and 2012.

Transition from Hospital to Home

Care Transition Intervention

The Care Transition Intervention—one of the models supported through the Geriatric Interdisciplinary Teams in Practice initiative—was discussed above (p.27).

Better Outcomes by Optimizing Safe Transitions (BOOST)

In 2005, the Foundation funded the Society of Hospital Medicine to initiate **Project BOOST**. A comprehensive intervention developed by a panel of national experts, BOOST provides hospitals with a year of expert mentoring and peer support to help them improve the transition from hospital to home for older patients. An online BOOST community reinforces the in-person and telephone mentoring. An evaluation published in the *Journal of Hospital Medicine* found that BOOST hospitals had reduced their readmission rates by nearly 14 percent, from 14.7 percent to 12.7 percent.¹⁴³ As of 2017, there were 234 BOOST sites around the country (about 5 percent of the nation's 4,862 hospitals), up from about 100 hospitals in 2012. Between 2005 and 2010, the Foundation devoted \$1.9 million to Project BOOST. After the Foundation's funding ended, the Society for Hospital Medicine continued the program.¹⁴⁴

Transitional Care Model

Developed by Mary Naylor, PhD, RN, FAAN, and her colleagues at the University of Pennsylvania, the **Transitional Care Model (TCM)** employs advance practice nurses to coordinate older patients' care while in the hospital, design plans for follow-up care, and make post-discharge home visits. A series of three randomized controlled trials funded by the National Institute of Nursing Research "consistently demonstrated the capacity of the TCM to improve acutely ill older patients' experiences with care, and health and quality of life outcomes. Outcomes have demonstrated reduced re-hospitalizations and total healthcare costs, after accounting for the additional costs of the intervention."¹⁴⁵

Despite these positive outcomes, Naylor told us that there was not much interest in the model in "real world" health care systems, primarily because of the absence of financial incentives. In response, The John A. Hartford Foundation, together with the Gordon and Betty Moore Foundation, supported Naylor's efforts to implement the TCM in the Kaiser Health System in California, where the incentives were in better alignment with the model. According to Naylor, 59 percent of the respondents to a recent survey of hospitals and other organizations (funded by the Robert Wood Johnson Foundation) said that they had either adopted or adapted the TCM, but she is not sure how representative these respondents are of the field as a whole (she believes that those organizations that have implemented the model may have been more likely to respond to the survey). Nevertheless, Naylor said, "The

John A. Hartford Foundation and others got us through a major hurdle by showing that it worked in the real world. They also helped position us to inform policy. We spent a lot of time on the Hill. The Affordable Care Act provisions on Accountable Care Organizations and bundled payments had transitional care called out. Hartford and Moore partnered with us and never gave up on us." The John A. Hartford Foundation devoted about \$473,000 to the TCM between 2006 and 2009.

Medication Management

The Beers Criteria

In 1989, the Foundation made a \$251,000 grant to Mark Beers, MD, at UCLA, one of a number of grants that it awarded over the years in the area of geriatric pharmacology. Entitled "Improving the Appropriateness of Prescribing in Nursing Homes," the grant led to the development of the **Beers Criteria for Potentially Inappropriate Medication Use in Older Adults**, first published in 1991. According to the American Geriatrics Society, which in 2011 assumed responsibility for maintaining and updating them, the Beers Criteria are today "one of the most frequently consulted sources about the safety of prescribing medications for older adults."¹⁴⁶

Because the medications included on the Beers list "have been found to be associated with poor health outcomes, including confusion, falls, and mortality,"¹⁴⁷ use of the Beers Criteria has presumably saved lives and prevented poor health outcomes among older patients, although we were unable to find any hard quantitative estimates of just how many patients may have benefitted in this way. Recently, concerns have been raised by some providers that health insurance companies are refusing to approve the use of medications on the Beers list for patients age 65 and over. This may be problematic, since not all medications on the Beers list are inappropriate in all cases.¹⁴⁸

HomeMeds

Beginning in 1994, the Foundation funded Vanderbilt University, in collaboration with visiting nurse services in New York and Los Angeles, to develop and test a model that would enable home health and social service providers to help older adults living at home to manage their medications. Building on this work, in 2001 the Foundation made a grant to the Partners in Care Foundation in San Fernando, California, to promote the widespread adoption of this medication management model by home health and social service agencies, and in 2006, it provided additional funding to the Partners

in Care Foundation to test a technology-enabled version of the model, named **HomeMeds**.

According to the program's website, HomeMeds has now been implemented in over 45 sites in 18 states.¹⁴⁹ Since 2011, more than 11,000 older adults have had their medications screened for potential risks via the HomeMeds program, and between 40 and 50 percent of those screened had potential problems.¹⁵⁰ To put these figures in context, each year there are nearly 100,000 emergency hospitalizations for adverse drug events in U.S. adults aged 65 years or older.¹⁵¹ Given that 11,000 older adults have been screened in the six years since 2011, and that roughly half of them had potential problems, HomeMeds is picking up on average about 1,000 problems per year, or 1 percent of the total number of adults hospitalized for adverse drug events each year (and presumably a smaller percentage of *all* those age 65 and over who experience potential problems, since not all potential problems result in emergency hospitalization). Between 1994 and 2010, the Foundation devoted almost \$3.3 million to the development, testing and dissemination of this model, including almost \$1.3 million to Vanderbilt University and \$2 million to the Partners in Care Foundation.

Improving Hospital Care for the Elderly

Hospital Outcomes Program for Elders (HOPE)

Hospitalization can be a life-saver for the elderly, but it can also spawn health problems of its own, including infections, adverse drug reactions, falls, and delirium. In 1989, the Foundation awarded six grants, totaling \$3 million to develop and test a variety of approaches to reducing the risks encountered by older hospital patients. Two of the resulting model programs lived on after the grants ended, and both continue to flourish today.

One is the **NICHE (Nurses Improving Care for Healthsystem Elders)** program, developed by Terry Fulmer and mentioned earlier in this report. In an article published in 2012 in the *Journal of Clinical Nursing*, Elizabeth Capuzeti, PhD, RN, FAAN, and her colleagues describe the program as follows: "NICHE is an evidence-based programme that has been evolving through research conducted over the last 20 years. The core components of a system-wide, acute care programme designed to meet the needs of older adults are grouped into eight categories (guiding principles, leadership, organisational structures, the physical environment, patient- and family-centred approaches, ageing-sensitive practices, geriatric staff competence, and interdisciplinary resources and processes). Each category is viewed as an important element and,

when combined, represents a unified system-wide approach to improving geriatric acute care."¹⁵²

NICHE is considered a stepping stone for hospitals wishing to attain magnet status, and as we noted earlier, as of 2017, NICHE programs were active in 764 sites, including 587 community hospitals—about one in eight (12 percent) of the nation's 4,862 community hospitals. Between 1989 and 1995, the Foundation made three consecutive grants totaling \$1.5 million to the Yale, Columbia, and New York University schools of nursing to support the development and dissemination of the model. After that, NICHE was housed at The Hartford Institute for Geriatric Nursing at New York University, and it remains a program of the Rory Meyers College of Nursing at New York University today.

The second HOPE model that has continued to flourish is the **ACE unit (Acute Care for the Elderly)**, developed by Charles Seth Landefeld, MD, a general internist who is now chairman of medicine at the University of Alabama at Birmingham. As Landefeld recalls, one of the Foundation's trustees had a bad experience at a hospital, and asked the staff to explore what could be done to improve hospital care for older patients. Senior program officer Donna Regenstreif asked Landefeld and others in the field for their ideas, and Landefeld, who at that time was at Case Western Reserve, wrote a proposal that focused on changing the patient's environment and the mindset of the doctors and nurses who cared for the patient. Drawing on the work of sociologist Irving Goffman and the noted physician and educator Maria Montessori, Landefeld sought to make the hospital environment friendlier to patients. This involved simple things like wall coverings to identify their rooms, carpets on the floor, lower beds, raised toilet seats, and handrails in hallways. The ACE model also changed the "social dimensions" of care so that nurses, for example, could take more initiative, allowing snacks without an order and avoiding sedatives where appropriate. And it changed the way that care was delivered so that instead of making individual visits, doctors, nurses, and social workers visited the patient together. The model also devoted greater and earlier attention to discharge planning, engaging the patient's family from day one.

In 1995, Landefeld and his colleagues reported in the *New England Journal of Medicine* on the findings of a study which found that ACE units reduced patients' length of stay, readmissions, and costs while improving their functional abilities.¹⁵³ According to Landefeld,

approximately 250 of the nation's 4,862 hospitals—roughly 5 percent—now have ACE units. His work on the ACE concept began in 1989 with a \$485,000 grant from The John A. Hartford Foundation.

Hospital at Home

One way to reduce the risks of hospitalization for older patients is to improve the care that they receive in the hospital—which is what the six projects funded through the Hospital Outcomes Program for Elders, including NICHE and ACE, sought to do. Another approach is to keep the patient out of the hospital in the first place and provide the hospital services that he or she needs at home. This was the strategy that John Burton, MD, and Bruce Leff, MD, at Johns Hopkins University developed and tested in a model program they called **Hospital at Home**. The Foundation's 2012 Annual Report describes the model succinctly: "Instead of admitting a patient to the hospital, physicians, nurses and other support staff bring their services, along with equipment and other technologies, to the patient's home."¹⁵⁴

A randomized clinical trial involving 455 older patients found that the Hospital at Home model "met quality standards at rates similar to those of acute hospital care" and produced cost savings of almost 20 percent.¹⁵⁵ Despite these impressive results, uptake of the Hospital at Home model has so far been spotty, largely because its costs are not reimbursed under Medicare's existing fee-for-service payment policies.¹⁵⁶ However, in our interview with him, Leff told us that a new payment policy is under consideration by the federal government that would permit reimbursement for Hospital at Home services under traditional fee-for-service Medicare. If the new policy is approved, adoption of the Hospital at Home model could accelerate. Meanwhile, Leff said, venture capital money has been "pouring in." Between 1994 and 2012, the Foundation devoted \$6.4 million to Hospital at Home.

Depression and Palliative Care

Project IMPACT

The history and impact to date of **Project IMPACT (Improving Mood-Promoting Access to Collaborative Treatment for Late-Life Depression)**—a model program developed by Jürgen Unützer, MD, for the treatment of depression in older primary care patients—was discussed in Section 1 (pp.21-22).

Center to Advance Palliative Care

Palliative care offers a team-based approach to providing relief from the pain and distress suffered by people with

life-threatening illnesses. Unlike hospice care, which is provided only toward the end of life, palliative care can be delivered at the same time as curative treatment.¹⁵⁷

The Foundation has supported the **Center to Advance Palliative Care** at Mt. Sinai Medical Center, directed by Diane Meier, MD, since 2006, when the Robert Wood Johnson Foundation ended its funding. Its support was critical since the Center had no other major source of support at the time. Today the Center has 1,200 institutional (hospital and community) members, 34,000 registered individual users and over 130,000 completed online courses. Funding from the Foundation has given the Center the opportunity "to ensure a supportive infrastructure and environment for palliative care research, education and clinical care."¹⁵⁸

Since the Center's inception, palliative care has taken off. According to Center staff, "In 2000, just 24.5 percent of hospitals with more than 50 beds reported palliative care programs. In 2015, 75 percent (1,744) of such hospitals reported a program."¹⁵⁹ This represents a tripling in the provision of palliative care in medium- and large-size hospitals in just 15 years, and as of 2015, almost 90 percent of hospitals with 300 beds or more offered palliative care.¹⁶⁰ The American Board of Medical Specialties now recognizes palliative care as a specialty, and there are currently more than 7,000 physicians and osteopaths with a subspecialty certification in hospice and palliative medicine¹⁶¹—roughly on a par with the number of board-certified geriatricians. The widespread adoption of palliative care represents a clear, tangible, and significant improvement in care for older adults. What's more, as of January 1, 2016, Medicare began covering "advance care planning" as a separate billable service.¹⁶²

Since its initial support in 2006, the Foundation has devoted \$3.3 million to the Center to Advance Palliative Care, including a 5-year, \$2 million grant awarded in 2014 for the development of a transformation business plan. In 2015, as part of that plan, the Center transitioned to a membership organization "in order to achieve the scale needed to increase demand and to support expanding palliative care across the spectrum of care delivery."¹⁶³ The transition to a membership organization was inspired by the NICHE program's success as a membership organization. According to Meier, as of 2017 half of the Center's operating budget comes from its membership.

While the bulk of the Foundation's funding in aging and health between April 1983 and April 2015 went into training programs and new models of care, the

Foundation also made some significant investments in leadership development, public policy, and other areas of importance in preparing the health care system for an aging population, such as the paraprofessional workforce and family caregiving. Not surprisingly, many of the programs in these areas fall into more than one category. In fact many of the major training programs discussed earlier included a good deal of leadership development, just as a number of the Foundation's grantees in model development became quite involved in public policy as they sought ways to expand the adoption of their models.

That said, there were certain programs that were focused primarily on leadership, public policy, and specific topics such as paraprofessional providers and family caregiving, and these are discussed in the following sections.

LEADERSHIP

As the Foundation continued in its efforts to prepare the nation's physicians for an aging population, it became apparent that the clinicians running the academic geriatrics training programs didn't always have the necessary leadership and management skills to meet the challenge. In response, the Foundation launched the **Hartford Geriatrics Leadership Development Program** to train newly appointed directors to be effective leaders, followed several years later by the **Senior Leadership Development Scholars Program** to "propel many participants to the next level of leadership."¹⁶⁴ Between 2001 and 2013, the two programs—which were administered by the Association of Directors of Geriatric Academic Programs and to which the Foundation devoted approximately \$2.7 million—trained 27 Leadership Development Scholars and 14 Senior Leadership Development Scholars.¹⁶⁵

Beyond these basic numbers, it is difficult to quantify the impact of the two programs. David Reuben, one of the programs' co-directors, has stated that "as a result of the [programs'] leadership work, program directors find that they are more effective as leaders and are able to bring more resources not only to their own institutions, but to the field of geriatrics as well."¹⁶⁶ In addition, some of the Senior Leadership Development Scholars have assumed influential positions, including Marie Bernard, MD, Deputy Director of the National Institute on Aging; Linda Fried, MD, MPH, Dean of the Mailman/Columbia University School of Public Health; and Mary Tinetti, MD, Director of the Yale University Program on Aging.¹⁶⁷ While these and other leaders supported by the two programs have unquestionably had an impact on the

field, it is always difficult in assessing leadership programs of this kind to determine how much of that impact is attributable to the programs and how much is attributable to the inherent strengths and talents that qualified the participants for the programs in the first place.

As important as it was to strengthen geriatrics leadership in academia, the Foundation soon realized that it was equally important to strengthen geriatrics leadership in the "real world" of practice so that new evidence-based approaches to geriatrics care could be implemented in real-world practice settings. Accordingly, in 2007 the Foundation teamed up with the Atlantic Philanthropies and began funding the **Practice Change Fellows Program**. The program provided a two-year training opportunity for nurses, physicians, and social workers in leadership positions to develop the necessary skills, content expertise, and relationships to enable them "to positively influence care for older adults."¹⁶⁸

In 2012, the program—administered by Eric Coleman at the University of Colorado-Denver¹⁶⁹—evolved into the **Practice Change Leadership Program**, which reduced the length of support from 24 to 15 months, thus enabling it to support a larger number of leaders (both foundations also increased their levels of support). As Coleman pointed out in a *Health Affairs* blog about the program, "Wide gaps remain between evidence-based approaches, nationally recognized best practices, and how care is currently delivered for many conditions that disproportionately affect [older adults]. Strong leadership is needed to ensure that innovations are implemented to improve health and functional outcomes in [this population]."¹⁷⁰ Taking a page from the *Shark Tank* TV show playbook, program participants would go before "a panel of real-world health care financial experts to deliver the business case for their project, make an 'ask,' and receive real-time feedback."¹⁷¹

Since 2007, the Foundation has devoted \$4.3 million to the two programs (including a 3-year, \$2.25 million commitment that began in January 2016) and, together with the Atlantic Philanthropies, has supported 38 Practice Change Fellows and 49 Practice Change Leaders. A 2011 evaluation of the Fellows program by the Altarum Institute found that the program had allowed participants to hone their leadership skills and put into action innovative approaches to organizational change. "In some cases, the effect has been dramatic and large scale, directly affecting hundreds of patients annually and extending to many more through policy change and program diffusion,"¹⁷² the report stated, adding, "The [Practice

Change Fellows] projects represent some of the most innovative ideas and research translations in the field.”¹⁷³

As with other training and leadership development programs, gauging the quantitative impact of these programs is a challenge. The Altarum report notes that “one fellow led the development of a geriatric patient-centered medical home that serves more than 2,500 older adults.”¹⁷⁴ While this is indeed an impressive accomplishment, even if every participant in the two programs were to match it, the total number of older adults who would benefit directly would be about 220,000 over the past decade—a fraction of the 49.2 million Americans age 65 and over,¹⁷⁵ or of the 6.3 million older adults estimated to need of long-term care services.¹⁷⁶ Of course, the programs’ impact could be greatly magnified if other health systems—or policy makers—were to learn from or adopt the innovations implemented by the Practice Change fellows and leaders, but we have no way to determine the extent to which such a ripple effect may have occurred.

In 2013, the same year that the Practice Change Fellows Program was transformed into the Practice Change Leaders Program, the Foundation committed \$5 million to another major leadership program, discussed earlier, that was aimed at the real world of health care delivery: the **Hartford Change AGENTS Initiative**. As we noted, in contrast to the two Practice Change programs—which together supported fewer than a hundred participants over a 10-year period—the Change AGENTS Initiative sought to leverage the Foundation’s many past investments in training and leadership development by mobilizing “more than 3,000 scholars and health systems leaders the Foundation has supported during the last three decades and [encouraging] them to work directly on changes in practice and service delivery that improve the health of older patients.”¹⁷⁷

Administered by the Gerontological Society of America, the initiative gave \$10,000 Action Awards to 34 interdisciplinary teams and established policy and communications institutes and dementia care and medical home networks. Examples of the kinds of activities funded through the Action Awards included a project “to reduce disability, lower cost-of-care, and improve quality-of-life for people receiving services through Michigan’s home and community based services Medicaid waiver program” and a project “to build the capacity of nursing home social workers and nurses to work together to enhance how their facility identifies, documents, and addresses

medical care preferences of residents in an emergency situation.”¹⁷⁸ At the same time, the program’s policy and communications institutes trained former grantees on how to navigate the ins and outs of the policy-making process and how to get their messages across effectively to policy makers and health systems leaders. An example of a project done through the communications institute was an effort by two Utah-based participants “to move the Utah State Legislature away from one-time funding for the Utah Caregiver Support Program into ongoing financial support. We are using the research-based play, ‘Portrait of a Caregiver,’ as a tool in these efforts.”¹⁷⁹

How much of an impact the Change AGENTS Initiative, which ended in early 2017, has had is not clear, and would in any case be difficult to determine, given its broad scope and the wealth of activities carried out by its many participants. Moreover, the fact that many of the program’s activities appear to have been focused on policy change makes their impact all the more difficult to discern. For example, assuming that the Utah Legislature did decide to provide ongoing funding for the Caregiver Support Program, it is unlikely that the Change AGENTS’ activities were the only factor that influenced their decision. In most cases, public policy is shaped by the confluence of multiple actors and forces, and it is near impossible to disentangle the impact of any one of those factors. The initiative’s website does, however, include several glowing testimonials from key players in the public policy arena, including the following from U.S. Senator Susan Collins (R-Maine): “Congratulations to the Hartford Change AGENTS! What a fitting name to describe your leadership and the important work you have undertaken in the last three years to improve the lives of older Americans and their families. Your efforts have truly made a difference. I am so fortunate to have a Change AGENT as a member of my staff on the Senate Aging Committee. Sarah Khasawinah epitomizes the academic diligence, innovative thinking, and tenacious advocacy on behalf of older adults that are the hallmark of this initiative. The movement you have each worked so hard to advance will most certainly continue.”¹⁸⁰ It is worth noting that the RAISE Family Caregivers Act promoted by the Eldercare Workforce Alliance (discussed below) was sponsored by Senator Collins.¹⁸¹

PUBLIC POLICY

Arguably, the Change AGENTS Initiative is as much a policy program as it is a program focused on leadership development. And indeed, like many of the Foundation’s training and model development programs, it can probably

best be understood as a hybrid that covers multiple bases. The Foundation did, however, make a number of grants that were purely about public policy.

These include a series of six grants between 1997 and 2015 totaling \$5.8 million to the **National Health Policy Forum** at George Washington University in Washington, DC.¹⁸² Established in 1972 and run until 2016 by Judith Miller Jones, a former Hill staffer, the Forum “provided a learning environment for federal health policy staff in which they could explore the issues, challenges, and trade-offs of health policy decisions, without the glare of the media or the pressure of special interest groups.”¹⁸³ For the Foundation, which had funded the Forum in earlier years in connection with its work on health care costs, the Forum represented a respected channel for educating and informing federal policy makers, their staff, and federal health officials about the challenges facing older patients and their providers—as well as about promising new models and approaches to meeting their needs. Among the Foundation grantees who made presentations or whose work was presented at the Forum were David Reuben, Eric Coleman, Jürgen Unützer, and Sharon Foerster, LCSW, a Practice Change Fellow.¹⁸⁴

Given its nature as a nonpartisan forum for learning and discussion, it is hard to point to specific federal policies or other outcomes that can be directly attributed to the Foundation’s support for the Forum—nor was that the Foundation’s intent.¹⁸⁵ However, there is little doubt that by continually providing policy makers and their staffs with sound, unbiased information about health and aging, the Foundation helped to elevate their understanding of the issues facing the field, and perhaps helped to insulate them from some of the misleading claims made by special interests with a vested financial stake in the policies under consideration.

In addition to its support for the National Health Policy Forum, the Foundation made several public policy grants to the **Institute of Medicine**, including a grant in 2007 that we alluded to earlier which, together with support from nine other funders, resulted in the report *Retooling for an Aging America: Building the Healthcare Workforce*, published in 2008.¹⁸⁶ The committee that produced the report was chaired by John Rowe, MD, a long-time Foundation grantee, and included Terry Fulmer, David Reuben, and other leaders in the field. After carefully examining the workforce needs of the nation’s aging population, the committee concluded that “the definition of the health care workforce must be expanded to

include everyone involved in a patient’s care: health care professionals, direct-care workers, informal caregivers (usually family and friends), and patients themselves. All of these individuals must have the essential data, knowledge, and tools to provide high-quality health care.”¹⁸⁷ The committee proposed a three-part strategy to bring this about that included: (1) enhancing the geriatric competence of the entire workforce; (2) increasing the recruitment and retention of geriatric specialists and caregivers; and (3) improving the way care was delivered.¹⁸⁸

These were, of course, issues that The John A. Hartford Foundation had been working on for years, but the Foundation understood that bringing about the necessary changes on a nationwide scale would ultimately require the involvement of the federal government and other major players. The Foundation also understood that, by itself, simply producing a report was not enough. The shelves of the National Academy of Sciences were filled with weighty reports that had been quietly gathering dust in the years since their release. It was to preclude this fate and to ensure that the recommendations of the *Retooling* report received the attention they deserved that the Foundation, together with the Atlantic Philanthropies, funded the creation of the **Eldercare Workforce Alliance**, a group that has now grown to 31 organizations “joined together to address the immediate and future workforce crisis in caring for an aging America.”¹⁸⁹ Since its creation in 2008, the Foundation has devoted almost \$1.4 million to the Alliance, with matching support from the Atlantic Philanthropies.

In 2016, the Alliance’s co-convenor and its policy and communications manager reported that the Alliance “has been successful in advancing several of the recommendations of the IOM report across various settings and priorities.”¹⁹⁰ Among its accomplishments, they said, “the Alliance has successfully advocated for the inclusion of provisions on geriatric education and training, as well as training of the direct care workforce, in the Affordable Care Act. This included expansion of the Geriatric Academic Career Awards to additional disciplines, the inclusion of the direct care workforce in Title VII definitions of health care providers, as well as authorization of several geriatric training opportunities and a Medicaid demonstration for direct care workers.”¹⁹¹ In addition, they noted that the Alliance had successfully advocated for the extension of the Fair Labor Standards Act minimum wage and overtime protections to home- and community-based services workers.¹⁹² More recently, the Alliance’s website featured a statement of support for

the Senate's passage in September 2017 of the RAISE Family Caregivers Act,¹⁹³ which was subsequently passed by the House of Representatives in late December, 2017.¹⁹⁴ It is not clear, however, how much of a role the Alliance played in bringing this outcome about.

PARAPROFESSIONALS

As noted, the Institute of Medicine's *Retooling* report called for an expanded definition of the health care workforce that included, among others, direct care workers (also known as paraprofessional health care workers) and family caregivers. Over the years, the Foundation has focused on both groups, and in fact family caregiving has become one of its three new priorities.

The Foundation's support for direct care workers began in 2006 with a grant to the **Paraprofessional Healthcare Institute** (now known as PHI), a national organization that describes itself as "the nation's leading authority on the direct care workforce."¹⁹⁵ With joint funding from the Atlantic Philanthropies, PHI launched the Center for Coaching Supervision and Leadership, which helped nursing homes and home health agencies across the country train their direct care workers. According to PHI's website, the Center for Coaching Supervision and Leadership worked with 31 organizations in 14 states, including nursing homes, continuing care retirement communities, and home- and community-based service providers.¹⁹⁶

A follow-up evaluation of the program found that 77 percent of trained supervisors reported that they often or always practiced the PHI Coaching Supervision approach at work, while 18 percent reported that they sometimes employed the PHI approach. The estimated cost savings from the resulting organizational efficiencies averaged \$6,000 per supervisor. In all, 98 PHI Coaching Supervision and Leadership trainers across the participating sites trained more than 2,000 supervisors and 3,000 direct care workers between 2006 and 2010.¹⁹⁷ Given PHI's estimates that in 2012 there were over 4 million direct care workers in the United States,¹⁹⁸ this represents a small fraction (about 0.1 percent) of the total need.

In 2013, The John A. Hartford Foundation partnered with the F.B. Heron Foundation in a "philanthropic equity" campaign to strengthen PHI so that it could "secure better training, working conditions, and wages for millions of direct care workers."¹⁹⁹ A recent PHI report indicates that inflation-adjusted median hourly wages for home care

workers have increased slightly between 2006 and 2016 (from \$10.33 to 10.49).²⁰⁰ It is not clear whether PHI's philanthropic equity campaign ever reached its \$9 million goal, although PHI does currently list 20 foundations among its supporters, including The John A. Hartford Foundation, the F. B. Heron Foundation, the Ford Foundation, the Gordon and Betty Moore Foundation, and others.²⁰¹ In all, The John A. Hartford Foundation devoted \$4.4 million to PHI between 2006 and 2017.

FAMILY CAREGIVERS

The Foundation's first grant in support of family caregivers was made in 2007 in support of a project by AARP entitled **Professional Partners Supporting Family Caregiving**. Renewed in 2009, the following year the project produced—in collaboration with the National Association of Social Workers, the U.S. Administration on Aging, and the Family Caregiver Alliance—a set of standards for social work practice for family caregivers of older adults.²⁰² Two years later, in 2012, the project issued a major report entitled *Home Alone: Family Caregivers Providing Complex Chronic Care*. Co-authored by the project director, Susan Reinhard, RN, PhD, and Carol Levine and Sarah Samis of the United Hospital Fund, the report included the results of a new survey that found that "almost half (46 percent) of family caregivers performed medical/nursing tasks for care recipients with multiple chronic physical and cognitive conditions."²⁰³ The report, which received widespread attention, highlighted the lack of preparation and training for family caregivers caring for older family members with complex conditions. Building on the report's findings and input from caregiver organizations, AARP drafted the CARE Act, model legislation that, as of July 2017, has since been enacted in 39 states and territories.²⁰⁴ Although the exact language of the law varies from state to state, among its key provisions is a requirement that "the hospital must offer the family caregiver instructions on how to perform the medical/nursing tasks that are included in the discharge plan and answer questions about those tasks."²⁰⁵

In 2014, the Foundation joined 14 other funders in supporting an Institute of Medicine report on family caregiving which recommended that the federal government "develop and execute a National Family Caregiver Strategy that, administratively or through new federal legislation, explicitly and systematically addresses and supports the essential role of family caregivers to older adults. This strategy should include specific measures to adapt the nation's health care and long-term services and

supports (LTSS) systems and workplaces to effectively and respectfully engage family caregivers and to support their health, values, and social and economic well-being, and to address the needs of our increasingly culturally and ethnically diverse caregiver population.”²⁰⁶ And indeed, the RAISE Family Caregivers Act, passed by both houses of Congress in 2017, “directs the Department of Health and Human Services (HHS) to develop, maintain, and periodically update a National Family Caregiving Strategy.”²⁰⁷

GEOGRAPHIC IMPACT

Given the wide range and diversity of Foundation-sponsored programs and activities in health and aging since 1983, it is impossible to determine the full weight of the Foundation’s impact by state or by geographic region, although it may be possible for some individual programs (for example, the adoption of AARP’s model CARE Act in 39 states). However, it occurred to us that one way to get a rough idea of the Foundation’s impact by state would be to review the addresses of the participants in the Change AGENTS program, which sought to engage and mobilize some 3,000 individuals funded by the Foundation’s health and aging programs since 1983. Although many of these participants may have been geographically grouped together at the time that they were funded by the Foundation—for example, at a Center of Excellence—

presumably many of them have since dispersed to other locations where their impact is now being felt.

The results are presented in Table 2. A comparison of the last two columns reveals whether the Change AGENTS participants are “over-represented” or “under-represented” relative to the share of the nation’s population residing in their state of residence. Thus, for example, Change AGENTS are under-represented in Florida, which has 1.38 percent of the total number of Change AGENTS living in the United States but 6.38 percent of the nation’s population. Conversely, Change AGENTS are over-represented in Maryland, which has 4.09 percent of the nation’s Change AGENTS but only 1.86 percent of its population. (In some cases, such as Iowa—which has 0.95 percent of the nation’s Change AGENTS and 0.97 percent of the nation’s population—the number of Change AGENTS is roughly proportional to the state’s population.)

As indicated in Table 2, every state except Wyoming has at least one Change AGENT—and Wyoming has the smallest population of the 50 states. And while the number of Change AGENTS is only occasionally directly proportional to the states’ population (for example, Iowa and Nebraska), in general, the more populous states—states such as California, Texas, and New York—have relatively more Change AGENTS, while the least populous states—like the Dakotas, Idaho, and Alaska—have only a few.

Table 2. Geographic Distribution (by State) of 3,274 Change AGENTS Participants Funded by The John A. Hartford Foundation²⁰⁸

STATE	NUMBER OF CHANGE AGENTS PARTICIPANTS	% OF TOTAL US CHANGE AGENTS PARTICIPANTS	% OF TOTAL US POPULATION (2016 ESTIMATES)
Alabama	37	1.13%	1.51%
Alaska	2	0.06%	0.23%
Arizona	50	1.53%	2.15%
Arkansas	22	0.68%	0.93%
California	347	10.66%	12.15%
Colorado	46	1.41%	1.72%
Connecticut	73	2.24%	1.11%
Delaware	5	0.15%	0.30%
Florida	45	1.38%	6.38%
Georgia	46	1.41%	3.19%
Hawaii	70	2.15%	0.44%
Idaho	3	0.09%	0.52%
Illinois	104	3.20%	3.96%
Indiana	39	1.20%	2.05%
Iowa	31	0.95%	0.97%
Kansas	13	0.40%	0.90%

Table 2. Geographic Distribution (by State) of 3,274 Change AGENTS Participants Funded by The John A. Hartford Foundation²⁰⁸ (continued)

STATE	NUMBER OF CHANGE AGENTS PARTICIPANTS	% OF TOTAL US CHANGE AGENTS PARTICIPANTS	% OF TOTAL US POPULATION (2016 ESTIMATES)
Kentucky	10	0.31%	1.37%
Louisiana	4	0.12%	1.45%
Maine	24	0.74%	0.41%
Maryland	133	4.09%	1.86%
Massachusetts	158	4.86%	2.11%
Michigan	137	4.21%	3.07%
Minnesota	27	0.83%	1.71%
Mississippi	9	0.28%	0.93%
Missouri	61	1.87%	1.89%
Montana	3	0.09%	0.32%
Nebraska	20	0.61%	0.59%
Nevada	10	0.31%	0.91%
New Hampshire	5	0.15%	0.41%
New Jersey	30	0.92%	2.77%
New Mexico	5	0.15%	0.64%
New York	396	12.17%	6.11%
North Carolina	140	4.30%	3.14%
North Dakota	1	0.03%	0.24%
Ohio	217	6.69%	3.59%
Oklahoma	12	0.37%	1.21%
Oregon	46	1.41%	1.27%
Pennsylvania	154	4.73%	3.96%
Rhode Island	25	0.77%	0.33%
South Carolina	22	0.68%	1.54%
South Dakota	3	0.09%	0.27%
Tennessee	20	0.68%	2.06%
Texas	192	5.90%	8.62%
Utah	41	1.26%	0.94%
Vermont	3	0.09%	0.19%
Virginia	57	1.75%	2.60%
Washington	207	6.36%	2.26%
West Virginia	3	0.09%	0.57%
Wisconsin	61	1.87%	1.79%
Wyoming	0	0.00%	0.18%
DC	62	1.91%	0.21%
Puerto Rico	25	0.77%	1.06%
Non-US ²⁰⁹	20		

SO WHAT DO ALL THE NUMBERS TELL US?

We have covered a lot of ground in this section of our report, trying to provide a sense, wherever possible, of the quantitative output and impact of each of The John A. Hartford Foundation's major programs in health and aging between April 1983 and April 2015, including its many training initiatives for physicians, nurses and social workers; the many models it has supported; and its leadership and policy programs. But what do all of those numbers add up to and what do they tell us about the Foundation's overall impact?

Impact on the number of practicing geriatricians

Although between April 1983 and April 2015 The John A. Hartford Foundation devoted almost \$172 million to physician training in geriatrics, none of its major programs in this area were focused directly on the training of practicing geriatricians. Instead, the Foundation's physician training programs were focused primarily on the training of academic geriatricians and non-geriatrician physicians. Nevertheless, there was clearly the hope and expectation—particularly in the early years—that an increase in the number of geriatrics faculty would result in an increase in the ranks of practicing geriatricians. Did such an increase actually occur?

It appears that it did, at least initially. As we noted earlier, the plan for health and aging that was presented to the Foundation's Board of Trustees in April 1983 referenced the fact that there were “relatively few physicians (less than 750 nationally in 1977) with special interest and training in the care of older people.” This figure seems to have come from a 1977 survey by the American Medical Association in which only 0.2 percent of respondents listed geriatrics as one of the areas of emphasis in their practice. As the Institute of Medicine later reported, “this was equivalent to 715 of the then 363,619 physicians in the United States.”²¹⁰ Unfortunately, this is probably the best measure available for the late 1970's because it wasn't until 1978 that geriatrics was recognized as a medical specialty, and actual board certification in geriatrics (by the American Board of Family Medicine and the American Board of Internal Medicine) didn't begin until 10 years later, in 1988.²¹¹

The earliest trend data on the number of board-certified geriatricians that we were able to find begins in 1992 and extends until 2010.²¹² These data, which include the number of geriatricians with active certification by the American Board of Family Medicine, the American Board of Internal Medicine, and the American Board of

Psychiatry and Neurology, indicate that in 1992 there were 6,789 board-certified geriatricians in the United States—almost 10 times the estimated 715 physicians who identified geriatrics as an area of emphasis in their practice in the 1977 survey by the American Medical Association. Regrettably, the 1977 and 1992 numbers are not measuring the same thing, so that, strictly speaking, they not represent a trend. Nevertheless, the numbers do suggest that a remarkable increase had occurred during those 15 years in the number of physicians providing geriatric care. Moreover, this apparent increase in the number of geriatricians continued for another four years until it peaked in 1996 at 11,184, after which it gradually declined to 8,734 in 2010.²¹³

Just how much, if any, of this apparent increase in the number of geriatricians can be attributed to the Foundation's programs is hard to say. Its initial program in this area—the Geriatric Faculty Development Awards—sponsored a total of 29 faculty members between 1983 and 1986, 26 of whom stayed in geriatrics, probably not enough to account for the apparent surge in the number of geriatricians between 1977 and 1992.²¹⁴ But its next program, the Academic Geriatrics Recruitment Initiative, is another story. Launched in 1988, it established 10 Centers of Excellence, and between 1990 and 1998, these centers supported 163 fellows and 222 faculty²¹⁵—an average of 48 faculty and fellows per year. If these figures are applied to their first four years of operation (1988-1992), the Centers of Excellence would have supported almost 200 (192) faculty and fellows during that time, enough (based on the estimates calculated by Reuben, et.al.)²¹⁶ to train or mentor more than 22,000 trainees by 1992—which, at least in theory, might have been enough to add thousands of new geriatricians to the national total.

Today, according to the American Geriatrics Society, there are fewer than 7,300 board-certified geriatricians in practice in the United States.²¹⁷ While this represents roughly a 10-fold net increase over the number of physicians with an emphasis on geriatric care in their practices 40 years ago, it also represents a decline of almost 4,000 (about 36 percent) from the peak of 11,184 reached in 1996,²¹⁸ at the same time that the proportion of older Americans has continued to climb. The decline in the number of practicing geriatricians since the mid-1990's probably reflects the reality that, with rising burdens of student debt, few medical students choose to enter a specialty in which they are paid less than colleagues who have received less extensive training; in which they must be prepared to work longer hours than many of their

colleagues; and in which they are granted relatively little prestige for working with a population that many would rather avoid. The upshot is that despite the promising early gains, the present number of board-certified geriatricians falls far short of the 20,000 geriatricians that the American Geriatrics Society says are now needed²¹⁹—which, as we noted earlier, is precisely why The John A. Hartford Foundation broadened its approach to include the training of non-geriatrician physicians.

Impact on academic geriatricians

From the beginning of its work in health and aging, the Foundation placed special emphasis on increasing the number of academic geriatricians, based on the seemingly reasonable premise that if it hoped to increase the number of practicing geriatricians to meet the growing need for geriatric care, there would need to be enough academic geriatricians to train them in their specialty. As we noted earlier, the Foundation's 1983 Annual Report cited a projected need for 2,000 academic geriatricians by 1990. The \$2.5 million Geriatrics Faculty Development Awards program, launched that same year, did not make much of a dent in this need, ultimately producing only 26 academic geriatricians, although the reputation of the participating schools gave credibility to the idea of academic geriatrics. But its successor, the Academic Geriatricians Recruitment program, began the establishment of Centers of Excellence, and from 1988 to 2015, the Foundation expended \$71.5 million in support of Centers of Excellence across the country—40 percent of its total expenditures for physician training. By 2015, these Centers had supported 1,164 fellows and junior faculty, almost all of whom have remained in aging. Assuming that the need for academic geriatricians grew somewhat beyond 2,000 as the population continued to age after 1990, it still seems fair to say that by 2015 the Centers of Excellence by themselves may have met as much as half the national need for academic geriatricians. This represents a remarkable achievement for a single private foundation.

The Foundation's other major program in support of academic geriatrics—the Beeson Scholars, to which the Foundation devoted \$39 million—supported 219 scholars, only about one-fifth the number of fellows and junior faculty supported through the Centers of Excellence. But its purpose was different, and the scholars made an important contribution in establishing the credibility of geriatrics within academic medicine. In addition, some of the research conducted by Beeson Scholars may have led

to significant advances in the care of older Americans—but these, unfortunately, are impossible to quantify. (However, an evaluation of the Beeson Scholars program did conclude that “it is unlikely that most top medical schools would have created strong geriatrics research programs as rapidly [as they did] without the focused investment of the Beeson Program.”)²²⁰

Impact on non-geriatric physicians

As a result of the Foundation's Geriatrics for Specialists initiative, geriatrics content was integrated into the general surgery curriculum by the late 1990's, and beginning in 2000, geriatrics was incorporated into the board certification examinations for general surgery. This means that all of the 24,000 general surgeons who have been board-certified since 2000—an entire generation—have had to master geriatrics content in preparation for their boards. Eight more surgical and related medical specialties have since followed suit and added geriatrics questions to their certification exams. This clearly represents a major step towards “getting the health care system to take better care of the elderly.”

It is a little more difficult to assess the impact of the companion \$9.3-million initiative to integrate geriatrics into the subspecialties of internal medicine. This initiative employed a series of annual retreats to try to coax academic leaders into integrating geriatric content into their curricula, and while most of the internal medicine subspecialties have indeed made progress in incorporating geriatrics content into their journals, their continuing medical education curricula, and their training exams, so far there does not appear to be a “stick” in the form of board examination questions to match these relatively benign “carrots.”

Impact on medical students and residents

The various programs aimed at medical students and medical residents were fairly limited in their scope and impact. For example, the MSTAR program trained 2,301 medical students—an average of 96 students per year—which represents less than 1 percent of all graduating medical students, and only 20 percent of these MSTAR students went into geriatric medicine or an aging-related specialty. Similarly, by the end of 2004, only 440 primary care faculty and residents had received the 14-hour curriculum developed in the Geriatrics in Primary Care Training initiative—a small fraction of the national total (in 2007, there were almost 24,000 internal medicine residents in the United States).²²¹

Overall impact on physicians

Thus, in terms of the kinds of quantitative measures that we have available to us, it appears that The John A. Hartford Foundation:

- Helped to bring about a substantial increase in the number of practicing geriatricians during the 1980's and 1990's.
- Made a real dent in the need for academic geriatricians, primarily through its investment in Centers of Excellence.
- Played an important role in advancing geriatrics knowledge and skills among the nation's non-geriatrician physicians, especially in the surgical and related medical specialties.

Impact on nursing

In the mid-1990s, when the Foundation began investing in geriatrics nursing, fewer than 1 percent of the nation's 2.2 million practicing nurses were certified in geriatrics, fewer than 0.002 percent were geriatric nurse practitioners or clinical specialists, and only 23 percent of the nation's nursing schools had even a single required course in geriatrics.²²² Less than a decade later, 92 percent of the nation's baccalaureate nursing programs had integrated geriatrics into at least one course, and all new or revised specialty nursing standards submitted to the American Nursing Association's Congress of Nursing Practice had to address the care of older adults. Claire Fagin, the renowned nursing leader who initially directed the Building Academic Geriatric Nursing Capacity initiative, credits The John A. Hartford Foundation with creating the field of geriatric nursing. We agree with this assessment.

The establishment of The Hartford Institute for Geriatric Nursing, with two of the nation's leading academic nurses—Mathy Mezey and Terry Fulmer—to head it, sent a powerful signal to the field that geriatric nursing was important and that a major foundation was prepared to support it. Its teaching materials, such as the “Try This” series, provide practical guidance to many thousands of nurses caring for older patients, and the Institute actively promoted the adoption of new models of geriatric nursing care, such as NICHE, by health systems and organizations across the country. And through the Institute, the Foundation began to focus on embedding geriatric content in the education and training of all nurses.

Meanwhile, the Foundation was also supporting the American Association of Colleges of Nursing, which added geriatrics to its list of required core competencies for all graduates of BSN programs. To enable their students to meet this requirement, more than 90 percent of the nation's BSN programs have incorporated gerontological content into their curricula. Given that BSN nurses now comprise roughly half of the nursing workforce, the new geriatrics competency requirements and the corresponding changes in the BSN curricula represent a major step forward in the preparation of the nursing workforce for the care of an aging population—and a signal contribution by The John A. Hartford Foundation.

The Foundation made another valuable contribution to the field of geriatrics nursing through the establishment of Centers of Geriatric Nursing Excellence and its support for 280 pre-doctoral Archbold scholars and postdoctoral Fagin fellows. As in the case of the Beeson, Jahnigen, and Williams awards in medicine, these prestigious awards helped to elevate the profile and stature of geriatrics in academic nursing. And undoubtedly, some of the research conducted by the scholars and fellows has resulted in improvements in nursing care for older patients—although again, there is no way to quantify this aspect of the Centers' impact. What can be quantified are the 184,000 nursing students who were taught by the scholars and fellows over a 13-year period. As we indicated, while this is certainly an impressive total, it represents less than 5 percent of all nursing school graduates in the United States during this time.

Impact on social work

There is widespread agreement among academic social workers that the Foundation's interventions transformed the field of geriatric social work, which barely existed before the Foundation entered. “There is a climate change, a seismic shift,” said Frank Baskind, the former dean of the Virginia Commonwealth University School of Social Work. In particular, our review of the data suggests that the Foundation had a major impact on social work education through its GeroRich and GeroEd programs. As in nursing and medicine, one of the goals was to “infuse” gerontological content into social work curricula, and by 2012, some 250 social work programs—40 percent of the total—had done so. The Foundation's earlier support for efforts to include aging as one of the core competencies

for social work students may well have contributed to this rapid uptake of gerontological content by so many schools of social work. As one of our interviewees told us, “The key to the social work strategy was credentialing.” All schools of social work now require master’s-level students to be familiar with the special needs of older clients and how to address them.

The impact of the Faculty Scholars and Doctoral Fellows programs, to which the Foundation devoted \$35 million, is less clear. The two programs supported 125 scholars and 104 fellows, respectively. The 125 scholars represent fewer than 1 percent of all social work faculty over the 15 years of the program, just as the 104 fellows comprise fewer than 1 percent of all social work doctoral students during that time. The 81,000 students taught by the faculty scholars over the 15 years of the program represent about 4 percent of all bachelors- and masters-level social work students. Yet while the numbers are relatively small, the impact may have been greater than the numbers alone suggest. As one interviewee observed, “When Hartford entered the field, it was a blank slate. Very few faculty members—five or six—were trained in aging. Now there are geriatric social work faculty around the country.” Meanwhile, the rotational model for master’s-level field placements promoted by the Hartford Partnership Program for Aging Education was adopted by 40 percent of the nation’s MSW programs—an impressive achievement.

Although several of the individuals whom we interviewed or who responded to our email survey talked enthusiastically about the Foundation’s transformative impact on social work education and cited the surprising number of leaders in the field who have been connected with or otherwise influenced by the Foundation’s social work initiatives, some questioned whether the current focus on aging in social work education will be sustained without the Foundation’s continuing support. In addition, the question remains whether, as in the case of geriatric medicine and nursing, specializing in geriatric social work represents an attractive career option. “There’s no market for geriatric social workers,” one respondent told us. “No money in it.” Again, this appears to confirm the Foundation’s decision to focus on ensuring that all social work students have at least some exposure to aging.

Impact of models of care

The Foundation has funded quite a number of innovative models of care that have been shown to improve outcomes for older patients. But just as the current health care financing system discourages the spread of geriatric medicine, nursing, and social work, it acts as a drag on adoption of the models of care developed by the Foundation. Even though the potential market for these models could be enormous if value-based care becomes the norm, so far most of them have not been widely adopted. For example, the PACE model of home- and community-based services for nursing home-eligible individuals who would prefer to remain in their communities, which began receiving Foundation support more than three decades ago, currently serves only about 40,000 people—probably less than 6 percent of the potential market. BOOST, a care transition model, and ACE, a hospital care model for older patients, have both been adopted by 5 percent of the nation’s hospitals, and the Care Transition Intervention, according to Eric Coleman, is currently in about 1,000 hospitals and long-term care facilities, or about 5 percent of the roughly 20,000 hospitals and nursing homes in the United States.²²³ Project IMPACT, the depression care model for primary care practices, has trained between 5,000 and 6,000 primary care providers, about 3 percent of the almost 200,000 non-pediatric primary care physicians in the United States.²²⁴ And HomeMeds, the medication screening model, is now in 45 sites and picking up about 1 percent of the total number of adults hospitalized for adverse drug events each year.

Some of the Foundation-sponsored models have gained greater traction. The NICHE model of nursing care, for example, has been adopted by 12 percent of the nation’s hospitals, and the Transitional Care Model also appears to have picked up steam. Yet so far only one—the palliative care model promoted by the Center to Advance Palliative Care—can truly be said to have become an integral part of mainstream health care.²²⁵ As of 2015, almost 90 percent of hospitals with 300 or more beds had a palliative care program, as did 75 percent of hospitals with 50 or more beds—triple the percentage 15 years earlier. The Foundation should consider this a major accomplishment.

And so with the exception of palliative care, the bottom line is that the Foundation has funded the development of a whole fleet of exciting new models of care that are poised to go mainstream in a financing system that is driven by value rather than volume. For the moment, however, the impact of most of the innovative models of care sponsored by the Foundation remains limited to a relatively small fraction of the total number of older Americans who could potentially benefit from them.

Impact on leadership and public policy

The impact of the Foundation's investments in leadership and public policy is especially challenging to quantify, apart from obvious measures like the number of leaders trained or the number of reports issued. The question remains: what impact did these leaders and reports have? The issue is further complicated by the fact that leadership development and public policy are intertwined with many of the Foundation's training and model development programs, making their impact even more difficult to discern. In those cases where we can measure specific outcomes—like the Practice Change Fellow who led the development of a geriatric patient-centered medical home

that serves more than 2,500 older adults—the immediate impact is impressive, but it is not clear how much of an impact such accomplishments ultimately have on the big picture. In rare cases, a direct large-scale impact can in fact be detected—for example, the adoption of AARP's model CARE Act for family caregivers by 39 states.

But the fact that it is often difficult to detect and quantify the impact of leadership and policy grants does not mean that they are not having a significant impact. For example, while there is no way to measure or quantify it, the fact that a Foundation-sponsored Change AGent was on Senator Collins' staff may well have played a critical role in persuading her to sponsor the RAISE legislation—legislation that, according to the Caregiver Action Network, has the potential to benefit millions of family caregivers across the country.²²⁶ Indeed, a strong case can be made that without the necessary changes in public policy—especially as it relates to reimbursement—and the leadership to bring those changes about, it will ultimately prove impossible to fully realize the Foundation's vision of a health care system that is truly responsive to the health care needs of older Americans.

SECTION 3. VIEWS FROM THE FIELD (AND FROM WITHIN): QUALITATIVE ASSESSMENTS OF THE FOUNDATION'S IMPACT

As we have just discussed, quantitative measures by themselves tell only part of the story when it comes to determining a foundation's impact. In order to obtain a more complete picture of the impact of The John A. Hartford Foundation in the area of health and aging, we interviewed three groups of knowledgeable observers: grantees, Board and staff members, and funding partners. We also conducted an email survey of grantees. We begin with the grantee perspective.

GRANTEE INTERVIEWS

We conducted in-depth telephone interviews with 23 of the Foundation's past (and in some cases current) grantees, many of whom are widely recognized as leaders in the field.²²⁷ Among their comments regarding the Foundation's overall impact on aging and health:

- The John A. Hartford Foundation *is* aging. They have a very positive and consistent brand in aging, which they've earned by investing in the core foundational stuff. The investments in medicine, nursing and social work have really paid off. Many of the people emerging from their Centers of Excellence are now the leaders in the field.
- It's really remarkable if you look at the models that CMS is now pushing. Five or six of the 10 models they're pushing got their start with Hartford funding.
- Hartford has made a big difference. To judge their impact, look at the roster of influential people in the field and the number of research articles and books. It's quite impressive. It would not have happened without Hartford.
- I can't imagine that we'd be anywhere near where we are without Hartford. Hartford has been really good both in terms of the infrastructure and the spirit of geriatrics. No one else has stepped up the way they have.
- As an organization, they have been the major driving force in making health care focus on what matters for older adults. Most innovations in the care of older people would not exist without them, and almost every geriatrician has benefitted from Hartford's support and encouragement. Another area in which Hartford has been influential is teamwork—the use of multi-disciplinary teams.
- Their contribution is hard to overstate. When you're trying to reform care in a system that is resistant to change—as my colleagues and I were trying to do—having the support of the Hartford Foundation was invaluable.
- Hartford put academic geriatrics—in medicine, nursing, and social work—on the map. Before Hartford's investments, geriatrics was haphazard. Its support and leadership gave the academic institutions resources, a seat at table, and respect; that helped to level the playing field. Academics is about who can bring in the money, and Hartford's money made a difference. They are up there in the Hall of Fame. Hartford's strongest contributions were its investments in people early on, just as they were getting started in geriatrics as teachers and researchers. Those are critical times. Nurturing them was incredibly important.

Beyond their positive assessments of the Foundation's overall impact, these grantees—many of whom have been funded by the Foundation over long periods of time—shared a number of additional observations. Several remarked on the evolution of the Foundation's approach to training, from initially simply trying to train enough geriatricians to meet the growing need for geriatric care to a more comprehensive strategy of ensuring that all physicians, nurses and social workers received sufficient exposure to geriatrics training to be able to provide appropriate care to their older patients and clients. “What they did in internal medicine is noteworthy,” a physician told us. “They were able to influence the test for credentialing internal medicine doctors so that you could not pass test unless you knew geriatrics. This was a real accomplishment.” Another physician observed that the two approaches—training more geriatricians and training non-geriatrician providers—“are not mutually exclusive. You need specialists to train others. And, as Hartford realized, all physicians should know enough to be able to care for older patients.”

A number of the interviewees emphasized the importance of the economic side of the equation in advancing the Foundation's vision. One told us, “Even with all the success in education, the field of geriatrics has continued to struggle. Not many people go into it. Reimbursement and culture of practice issues have never allowed geriatricians to practice the way they are taught in the

medical schools. For example, in the fee-for-service system, geriatricians are money losers for medical systems, in part because they want to keep people out of hospitals. Geriatricians are time- and person- intensive; they need to have a team, but there is no reimbursement for teams. The only way it works is in a prepaid system like Kaiser, where you are rewarded for keeping people as well as they can be. But our health care doesn't go there." Another said it would have been good for the Foundation to spend more time on policy. "Ultimately, it means that all the resources you pour in are not going to stick if you don't change reimbursement policy."

One former grantee, citing the Hospital at Home program as an example, noted the irony that some of the innovative models of care that have not taken off in this country because the government won't pay for them have meanwhile been adopted in other countries. But another whose model program has gained traction in recent years said that the increased uptake had occurred "largely because the payment systems are now more aligned with the model—things like bundled payments, ACOs, and Medicare non-payment for early readmissions."

Finally, one interviewee urged that the Foundation rethink leaving its past commitment to faculty development, telling us, "That's the way you keep the field vibrant. It's shining the spotlight, giving it credibility." Another expressed optimism about the future and said that so far there had not been a falling-off in geriatrics—quickly adding, "Of course, you can never train enough."

GRANTEE SURVEY RESPONSES

In addition to the telephone interviews with grantees, we also conducted a confidential email survey of former Foundation grantees and awardees, using an email address list from the Foundation's Change AGENTS program. The Change AGENTS program, which was administered by the Gerontological Society of America, sought to recruit and engage the large numbers of scholars and leaders in the field who had received funding from the Foundation over the previous 30 years. The six-question survey was sent to 1,731 valid email addresses and we received 163 responses, a response rate of 9.4 percent. We do not know whether these respondents were representative of the entire group of Change AGENTS participants, but it is possible that those with a more positive experience were more likely to respond.

The survey included a question that asked respondents to provide a quantitative rating of the Foundation's impact:

"On a 10-point scale (where 10 is the highest score), how would you rate [The John A. Hartford Foundation's] overall impact on the field of aging?" The mean rating on this item was 9.21, with only 15 of the 163 respondents rating the Foundation's impact at 7 or below. This is an impressive score—especially since the responses were confidential, so that presumably most respondents felt that it was "safe" to be candid in their responses.

In addition to the quantitative rating, we invited the survey respondents to provide a written assessment of the Foundation's impact. Specifically, we asked: "Based on your overall knowledge of The John A. Hartford Foundation, what in your judgment has been its impact on the field of aging?" Here is a sampling of their responses:

- The John A. Hartford Foundation has had a tremendous impact on the field of geriatrics and on improving care for older adults. Its early commitment to supporting the development of geriatrics academic leaders helped the field to grow at a much faster pace than would have been possible without external funding... These investments are paying dividends now as the Foundation pivots to efforts to create systems change.
- Without a doubt, the grants, training programs, leadership, and guidance provided by The John A. Hartford Foundation and its staff have been the predominant forces in moving American health care toward effective health care for older Americans.
- Tremendous impact in putting aging and needs of older adults and their families in the forefront of nursing.
- I would give a rating of 7 in terms of the overall impact of the Hartford Foundation on the field of aging. The overall social and financial issues are so strongly biased against aging in the U.S. that the impact of Hartford must be considered absolutely phenomenal.
- Over the past few decades, The JAHF has had a tremendous impact in developing a workforce and the research needed to address the needs of an aging population. It has helped to raise the visibility of the field of geriatrics within academic institutions across the country, and many of the grantees are now in leadership positions. ...They have helped to "geriatricize" physicians from other specialties and other health professionals.
- The Hartford Foundation is a rock star for all it has done for our field (medicine). Many Hartford-funded

initiatives have become core practices and processes and [its] dedication to both the clinical work and the education of those providing it has been exemplary.

- The JAHF is well known as a leader in the field of educating the workforce for an aging America. [Its] work has deep roots and great breadth in that area. In addition, [its] communications work has been critical. The JAHF is a leader in disseminating timely information... The most recent work with the Framework Institute is a good example of leading the field in developing a narrative on aging and messaging that we can and should be using.
- JAHF programming and funding revolutionized the field of health care for aging. In the profession of nursing it raised aging to be a desired specialty [and] prepared a cadre of bright young clinicians and scientists who are beginning to assume leadership... To be a JAHF scholar or fellow was universally recognized in the field as a mark of excellence and high potential.
- The Foundation has had a significant effect on educational enterprises in all health/medical professions. [Its] impact on policy issues has been less visible [and its] impact on strengthening interprofessional education and practice has been disappointing.
- I'm unable to comment on its impact on medicine and nursing, but The JAHF has been the single most transformative ingredient in gerontological social work, period. When I first began my social work education decades ago, aging was a topic you "had to" study (albeit superficially), but that was widely regarded as depressing and dreary. Ageism was rampant in schools of social work and went largely unchallenged... Fast forward to today, and some of the brightest, most talented, most energized social work professors in the country study aging and prepare future gerontological social workers.
- I don't get to see the big picture of the Hartford Foundation; mostly I work in nursing homes, my office, and classrooms. When people discover my training opportunities with the Hartford Foundation, they are always extremely respectful of the Hartford name, and say very glowing things about me because I have been affiliated with the Hartford Foundation.
- The John A. Hartford Foundation has fundamentally changed the face of geriatrics in America. When the history of this recent era in medicine is written, the

chapter on the health care of older adults will be rich with the influence of The John A. Hartford Foundation.

Perhaps not surprisingly, given that most of these respondents received their funding from the Foundation prior to the establishment of its current priorities, a number of them expressed disappointment or concern that the Foundation is no longer funding the kinds of training and research programs that it did in the past. For example, one respondent commented, "Geriatric nursing is not a profession that attracts large numbers of students. The Hartford Foundation through its Center grants and fellowships was instrumental in increasing the number of students we were able to attract to the field. I worry that this may not continue without funding."

Another respondent declared that the Foundation has had "the single largest impact in applied geriatrics of any foundation in the country, second only to NIH in research funding but playing a far outsized role compared to the funds provided. A whole generation of scientists would not exist if JAHF did not fund workforce development programs, which sadly does have me worried for the future given the shift away from workforce over the past seven years." And another wrote: "Previously, tremendous impact due to their support of clinical training programs in geriatrics and huge undertakings like GITT. Currently, I don't know how the new Foundation directions will have impact or whether the new leadership will be able to foster the collaborations that were promoted in the past."

But despite such expressions of concern, most of the survey respondents' written assessments of the Foundation's impact were highly favorable—as one would expect, given the 9.21 average score on the 10-point scale.

BOARD AND STAFF PERSPECTIVES

As part of our assessment, we spoke with 12 current and former Foundation staff members, including two former executive directors and the current president, and with the current and immediate past Board chairs and another current Board member.²²⁸ Most expressed great pride in the Foundation's accomplishments in health and aging:

- There would be no field of geriatrics without The John A. Hartford Foundation. Even though there is an NIA, they have no way to disseminate and to scale programs, which the Foundation does. They built the entire field of geriatrics and sub-fields within it. For example, at the GSA meeting, where the academic geriatric world comes together, there was a nursing interest group,

started by Terry Fulmer, among others. Today it is the largest special interest group in the GSA—from 5 people at beginning to 800 currently.

- It's been like pushing a big boulder up a steep hill. But the Foundation made a difference. It's hard to quantify their impact, but basically they put geriatrics on the map... One of the Foundation's other accomplishments was that it got the NIH into geriatrics. This was a landmark achievement.
- The people tapped by the Foundation as leaders in the field for the fellows programs are now all over the place. You can't pick up a copy of *Health Affairs* without finding someone in it who was funded by the Foundation, even on topics outside aging. Go into a hospital anywhere—even in rural communities—and you'll see ACE units, NICHE units, etc.—all models once funded by the Foundation. Models like Project IMPACT, Transition Care, and evidence-based assessment tools are in wide-spread use, and palliative care is now in 90 percent of large hospitals.
- It's hard to quantify the Foundation's impact in aging, but I think it was immeasurable. We took aging out of the closet so it became respectable. People could hold their heads up.
- When the Foundation began its work, geriatrics was not at the table—at medical schools or foundations. Hartford's example brought in other foundations, and their interest validated the concept. Hartford's leadership resulted in embedding geriatrics in medical schools and medicine.
- Hartford has been hugely influential in professional education. They put geriatrics on the map. One of the geniuses of what they did is that they stayed the course for 30 years.
- The Foundation was way ahead of its time. The field would not be where it is without The John A. Hartford Foundation. It made great contributions, especially early on in the 1980s. At that time, there were hardly any geriatricians and aging was not taught in med schools. The Foundation created leaders and gave the field credibility with its fellowship programs and centers of excellence. Geriatrics is now a legitimate field that attracts more people than before. The Foundation can take a lot of credit for establishing the credibility of the health and aging.

- The Foundation's mission was to improve the nation's capacity to deliver effective and affordable care for the growing elderly population, and the primary strategy to advance this mission was to increase academic capacity in medicine, nursing and social work to prepare providers to care for elderly patients. To a large extent, this was achieved.

Several of the interviewees in this group singled out certain Foundation “home runs” that they considered particularly noteworthy. For example, one former staff member pointed to the Centers of Excellence and the Beeson Scholars program because they made aging “a respectable area of focus,” as well as Geriatric Interdisciplinary Team Training—commenting that even though it wasn't sustained at the time, “now it goes without saying that you need a team approach.”

Another interviewee considered the many partnerships with other funders—especially those with the Atlantic Philanthropies and the Donald W. Reynolds Foundation—a home run, as well as the widespread adoption of several of the models supported by the Foundation, including palliative care, the Care Transition Intervention, and Project IMPACT. Another cited PACE, Hospital at Home, and the Paraprofessional Healthcare Institute as home runs. Yet another referenced the Foundation's impact on social work education, singling out the Hartford Geriatric Social Work Faculty Scholars Program as “an outstanding success.” No doubt this diversity of responses is in part a reflection of the diversity of backgrounds and perspectives represented among the Board and staff members we interviewed. But it also reflects the fact that the Foundation has been successful on multiple fronts, so there is a wealth of “home runs” to choose from.

As for why the Foundation has had as many successful programs as it has, several of the interviewees noted the importance of patience—the Foundation's willingness to stay the course and stick with initiatives and key individuals for many years, if necessary. In addition, one of them said, the Foundation was willing to take risks and accept failures: “To get one success like a Care Transition or a Project IMPACT, we had to support many other models that didn't work out as well.”

The interviewees also mentioned some of the obstacles that they believe had impeded the Foundation's impact, especially in the area of health care financing. To illustrate

the problem, one cited a particularly egregious example in which half of the elderly patients who had shown signs of dementia in cognitive tests didn't know it because their physicians didn't want to tell them: "They wrote it in the chart but they didn't have time to deal with someone crying in their office." Another told us that the Foundation had not done much in the area of financing, but said that one of its great strengths was that it recognized its limitations and that it did not have the capacity to have a significant impact on the health care financing system. But another, who agreed that the Foundation had not done much in the area of financing, declared, "This was a big mistake. Hartford spent its money building the supply, but you need to create demand, too." Others maintained that the Foundation had in fact made some successful inroads in financing policy, especially in connection with some of the model programs that it has supported.

Other obstacles that were mentioned included the fact that "no one wanted to give up anything in their curriculum to make room for aging;" the difficulties of determining leadership and apportioning credit within funding partnerships; and "the tyranny of the CPT codes—and the professional societies." It was also suggested that the Foundation had not paid enough attention to diversity and that it had not sought sufficient consumer input in the design of its strategies and initiatives.

OTHER FOUNDATIONS' PERSPECTIVES

In addition the Foundation's grantees, staff and board members, we also spoke with staff from other foundations that have been funding partners with The John A. Hartford Foundation²²⁹ (including two staff members who have also worked for many years at The John A. Hartford Foundation).²³⁰ Those who had worked directly with the Foundation's staff spoke highly of the relationship. One, for example, said he held the Foundation in "very high regard" and that it "always had good people." He commended it for working in genuine collaboration with other funders—"something that other foundations talk about but don't always do." Others talked about the influence that the Foundation had had on their foundations' grantmaking.

Their perceptions of The John A. Hartford Foundation's impact on health and aging were generally positive. One, for example, discussed its impact on social work and said

that social workers today are definitely better at caring for the elderly than was the case 30 years ago. There still aren't enough of them, she said, but this was not the Foundation's fault. The problem was the continuing stigma attached to geriatrics, as well as inadequate pay: "A social worker can make more at a hospital than in a nursing home." She credited the Foundation with engaging and preparing more young people in geriatric social work through curriculum change, which she attributed to the Foundation's support of the Council on Social Work Education.

Another also praised the Foundation's focus on the education of providers, but added, "I think that going forward, they need to broaden their definition of providers. My sense is that the workforce of tomorrow is not going to be built from the hospital on out; it's going to be built from the patient and the community on out. And if that's going to be the case, then what does that team look like? What does the training for that team look like? And what do the supports for that team look like? It takes on a whole different view."

Another interviewee was especially positive about the Foundation's contributions, giving it great credit for its staying power. "This is rare in philanthropy," he observed. "It's not hyperbole to say that Hartford built the field of geriatrics. Of course, others were there, too, but Hartford's commitment to centers of excellence, to training physicians and medical students and residents in geriatrics, and to forcing academics to recognize the importance of an aging population—all these things created a field that wasn't there before." He also commended the Foundation's willingness to test new models of care such as Care Transitions and Hospital at Home, which he called the Foundation's "greatest hits." And, importantly, he credited the Foundation with bringing others along—other foundations, professional associations, and even the National Institute on Aging.

That said, he believes that geriatrics is now at a crossroads, resulting in part from the ongoing changes in the health care system and in part from the profession's continuing ambivalence about its identity and its role within the health care system. "The field is wrestling with this," he said. "It's not about Hartford's money, or lack of it. With or without Hartford's money, you'd still have vacancies in a third of the geriatric residency slots."

SECTION 4. THE BOTTOM LINE: SUMMARIZING THE FOUNDATION'S IMPACT ON AGING AND HEALTH

Because they have their own resources and are essentially accountable only to their own governing boards, private foundations are almost uniquely positioned to take risks on behalf of the greater social good and to stay with a topic or an issue for the long haul. In contrast to government, which is often under pressure to deliver results before the next election, or the corporate sector, which seeks to deliver good news in the next quarterly report to shareholders, foundations can keep working on a problem for as long as it takes to have an impact—decades or longer, if necessary. Moreover, they can take on those problems or issues that don't necessarily make the headlines but that in the long run have a far greater impact on the public well-being.²³¹

It is precisely these advantages that make private philanthropy such an invaluable social resource. Even though the aggregate resources of foundations are dwarfed by those of the public sector and the corporate sector, the reality is that most of society's greatest problems and challenges don't lend themselves to a quick fix—and therefore they are unlikely to receive the kind of sustained attention that they require from either the public sector or the corporate sector (which, after all, is focused on profitability and returns to shareholders, not on solving society's problems). Only foundations (or in some cases, very wealthy individuals) are truly well positioned to address fundamental social issues and challenges of this kind.

Yet in our experience, few foundations take full advantage of this unique structural advantage. The reasons vary: turnover in the board or in the Foundation's leadership, with every new leader eager to make their own mark; the desire for the foundation to be “a player” on the front-burner issues of the moment; or simply boredom or impatience and a desire to “do something new.”

One of the outstanding achievements of The John A. Hartford Foundation over the past 35 years has been its steadfast determination to avoid these pitfalls and to stay the course in addressing one of the most critical challenges facing modern society: the aging of its population. Many of the leaders in the field with whom we spoke in preparing this report commented on—and marveled at—the Foundation's sustained focus on aging and health over so many years.

But commendable as it is, its sustained attention to aging is not the only thing that the Foundation got right. In addition:

- It chose a fundamentally important issue to which very few others were paying attention at the time: the aging of the population.
- It zeroed in on a critical but potentially manageable aspect of the problem: the capacity of the nation's health care system to respond to the needs of an aging population.
- It developed and faithfully implemented a carefully reasoned strategy of mutually reinforcing programs and activities to address the problem, rather than—as foundations all too often do—simply declaring a set of priorities and then making grants that fall within those priorities, regardless of whether those grants have the potential to add up to a meaningful impact on the problem.
- It generally took the scale of the problem or the unmet need into account in the design of its strategies, even if ultimately the actual impact of its programs didn't always correspond to the scale of the need. This is a key step that foundations often overlook.
- It actively monitored its programs and strategies, learned from its experiences, and modified its strategies accordingly. For example, as it became clear that there would never be enough geriatricians to meet the growing need for geriatric care, the Foundation expanded its focus to the training of non-geriatrics physicians. And as it became clear that physicians alone could not improve the care of older patients, the Foundation expanded its focus to include nurses and social workers.
- It took calculated risks, tolerated failure, and had the patience to stick with an idea or a model from its inception and initial testing all the way to its widespread adoption.
- It actively sought out funding partners as a means of leveraging its impact and openly shared the credit for whatever gains those partnerships achieved.

In addition, the Foundation hired a talented and committed staff and gave it the support and the running room that it needed to develop and execute its strategies

and initiatives. To top it off, the Foundation successfully weathered and rebounded from two traumatic plunges in the market value of its assets, giving it the necessary resources to stay the course in the implementation of its strategies.

HAS CARE FOR THE ELDERLY IMPROVED?

Having done so many things right, we come back to the central question of what impact the Foundation has actually had on the capacity of the health care system to care for an aging population. In the preceding sections of this report, we have approached this question in two ways. In Section 2, we provided an assessment of the quantitative impact of the Foundation's major programs and initiatives, looking both at the number of "outputs" produced (for example, the number of academic geriatricians trained) and, wherever possible, how that number corresponds to the potential need or "market" for that output (for example, how many academic geriatricians are required to meet the national need). In Section 3, we provided a qualitative assessment of the Foundation's overall impact from the perspective of key stakeholders, including grantees and awardees, members of the Foundation's board and staff, and some of the Foundation's funding partners.

A third way to approach the question of the Foundation's impact, which we mentioned at the beginning of Section 2, is to go back to the Foundation's overarching goal and try to determine whether the health care system is in fact doing in a better job of caring for the elderly today than it did in 1983, and if so, what role—if any—the Foundation played in bringing that improvement about. Unfortunately, as we noted, this is not as easy as it sounds, both because there is no consensus on what measures to use to determine whether or not care for the elderly has improved, and because, even if there were agreement on a set of measures and we observed improvement in those measures, there would be the problem of attribution.

Looking at some of the available indirect measures that may reflect improvements in care, we did find that some seemed to be moving in the right direction. Life expectancy at age 65, for example, increased from 16.4 years in 1980 to 19.3 years in 2014, a gain of almost 18 percent.²³² What's more—and this is particularly relevant for our purposes—as life expectancy at age 65 increased, there was a corresponding increase in the number and proportion of years that individuals age 65 and over remained disability-free.²³³ In other words, not only

are older Americans living longer than they were in the early 1980's, but they are also staying healthy longer.

Other positive trends, reported by the Agency for Healthcare Research and Quality in 2009, include the following short-term improvements between 2003 and 2007:

- Rates of potentially preventable hospitalizations declined faster among older adults (age 65 and over) than among younger adults (ages 18–64).
- Among older adults, the rate of hospital stays for angina without procedure fell by almost half (from 13.4 to 7.6 discharges per 10,000 population) and the rate of stay for congestive heart failure fell by about one quarter (from 222.4 to 190.5 discharges per 10,000 population).
- The rate of hospital stays for diabetes decreased by 8 percent among older adults (from 54.5 to 49.9 discharges per 10,000 population). In contrast, the rate of these stays among younger adults increased from 18.2 discharges to 19.4 discharges per 10,000 population.²³⁴

On the other hand, the Centers for Disease Control and Prevention reported a substantial increase between 2005 and 2014 in the death rate from unintentional falls among older Americans,²³⁵ and an analysis of data from the National Hospital Ambulatory Medical Care Survey revealed that the rate of emergency department visits by nursing home residents for ambulatory care-sensitive conditions—medical conditions that can be effectively managed with appropriate care outside the hospital—actually increased between 2001 and 2010, although the increase was not statistically significant.²³⁶

In other words, while there have been a number of positive trends in measures that may reflect in improvements in care for the elderly, not all the trends have been in the right direction. And whether those positive trends that did occur can be attributed, at least in part, to the work of The John A. Hartford Foundation is not clear. For example, life expectancy at age 65 increased by the same amount (18 percent) between 1950 and 1980—before the Foundation became involved in aging and health—as it did between 1980 and 2014.²³⁷

In addition to reviewing the available data, we also asked a number of the grantees and other health care leaders we interviewed for this report whether they believed that health care for older Americans had improved since the

early 1980's. Some believed that it had, as reflected in the following comments:

- Care has definitely improved. For example, the protocols for depression care issued by the National Institute on Aging, which were influenced by Unützer's work, and the protocols for dementia have improved care. The importance of physical activity is now recognized, such as Tai Chi for balance, and palliative care has certainly improved.
- Senior care has greatly improved over the past 30 years because of attention to older people, and so has palliative care, so that their wishes are now respected and acted upon.
- I believe care for the elderly has improved over the past 30 years, but my evidence is strictly anecdotal. I get the sense that clinicians take the needs of the elderly more seriously than in the past. In the past, a lot of them wrote off the elderly. Now people care.
- I believe that care for the elderly has improved. Hartford can't take full credit for that, but it can take some. Hospital care has certainly improved. Some examples are the attention given to delirium, falls, and catheters not being in too long. And Hartford has made a contribution to end-of-life care. Technology and medication have also improved care, and so has life-style change, but Hartford has been in the mix.
- Yes, it has improved. Just look at the increase in disability-free life expectancy. Cardiac care has improved, as has care for other conditions affecting older people. You cannot tease out Hartford's contribution, but Hartford stepped up and did aging only. It was an important message.

But others were less certain:

- Has care improved? That's the billion dollar question. Probably yes, but there is still a tremendously long way to go. Most older adults still get fragmented, disease-oriented care. The real need is to completely reorganize the way care for older adults is delivered. Hartford has planted the seed for how to get there.
- Care for most of the elderly has not improved much over the past 30-plus years, although there has been some improvement in the care of high utilizers in

certain managed care settings. But there's a lot less in the way of scalable solutions for most of the elderly, including efforts to address individual behaviors and social determinants.

- It's a mixed picture. There are things we can do better, but the cost has sky-rocketed. Patient-centered care has improved some, but not as much as it needs to. The medical-industrial complex is part of the problem. We have to do a better job of promoting people's dignity and quality of life.
- The biggest positive change in care for the elderly came with the enactment of Medicare, which greatly improved access to care for the elderly. The other positive development has been on the technology front, with new and more effective diagnostic and treatment options. But there's been a downside: the technology has made it more difficult to deliver care in a sensitive manner. There are multiple doctors involved and there's no one to orchestrate the care. At the same time, there are the continual economic pressures that make it increasingly difficult for doctors to devote the necessary time to their older patients. These are some of the powerful currents that Hartford's efforts to improve care for older patients are swimming against.

As these comments suggest, different observers have come to different conclusions about how much improvement there has been in the care of the elderly and about the Foundation's role in those improvements. In part, this reflects differences in personal experience. But it also stems from the absence of an agreed-upon set of metrics or indicators with which to measure how good a job the health care system is doing in taking care of the elderly. This is something that the Foundation may wish to pursue in the future—not only so that, going forward, there would be an agreed-upon way to monitor the nation's progress towards improving care for the elderly, but also as a way to forge a consensus in the field about what would actually constitute improved care for the elderly.²³⁸ In addition, the development of such measures could provide a way to highlight improved care for the elderly as a national priority, much as quantitative indicators of other health issues such as childhood obesity, teen pregnancy, and the uninsured have helped to place those concerns on the front burner.

THE FOUNDATION'S IMPACT: A COMPOSITE PICTURE

We have now considered the question of The John A. Hartford Foundation's impact on the care of older Americans from three different perspectives:

1. A quantitative assessment of the impact of each of the Foundation's major programs in health and aging between 1983 and 2015.
2. A qualitative assessment of the cumulative impact of the Foundation's programs in health and aging during that time, based on the views of its grantees and awardees, its staff and board members, and other foundations.
3. A combined quantitative and qualitative assessment of the extent of improvement in health care for older Americans since the early 1980's and various views of the Foundation's contribution that improvement.

Each of these approaches has its limitations, but given the extent to which the findings appear to converge, we believe that they provide a consistent composite picture of the Foundation's impact. Perhaps not surprisingly for an effort of this magnitude and duration, its impact has played out on multiple fronts.

First, the Foundation has clearly led the way in creating a whole new field in American health care, essentially from scratch. Its sustained investments in geriatrics training for faculty in medicine, nursing, and social work produced a corps of top-notch geriatrics academics who: (1) taught and mentored large numbers of students within their respective professions, thereby greatly amplifying the impact of their training; (2) conducted innovative research that advanced the care of older patients and clients; and (3) elevated the prestige and credibility of geriatrics within their professions, their home institutions, and the field at large. With regard to the scale of the impact, the Centers of Excellence alone met roughly half the national need for academic geriatricians that was projected for 1990.

Second, as it became clear that it would not be possible to produce enough practicing geriatricians, geriatric nurses, or geriatric social workers to meet the health care and social service needs of the growing number of older Americans, the Foundation pushed hard to ensure that all of the nation's practicing physicians, nurses and social workers who provided care to older patients and clients received geriatrics training in the course of their professional education. The impact of these efforts on the

nation's nurses has been particularly striking, with more than 90 percent of baccalaureate nursing programs now having geriatric content integrated into their curriculum and with all baccalaureate nursing graduates expected to have geriatrics as one of their core competencies. Similarly, the widespread integration of gerontological content into social work curricula will have a lasting impact on the profession, and the incorporation of geriatrics content into many of the medical and surgical certification exams represents another major achievement that has already had a widespread impact on American medicine.

Third, a number of the models of care that the Foundation has supported have been widely adopted, including the Beers Criteria, NICHE, the Transitional Care Model, and especially palliative care, which is now in almost 90 percent of the nation's large hospitals.²³⁹ Others, such as Project IMPACT, the Care Transition Intervention, GITT, PACE, Hospital at Home, Care Management Plus, BOOST, Guided Care, ACE, and HomeMeds, have had more limited uptake so far (in the range of 5 percent or less) but could pick up steam if recent trends toward value-based care continue. (In the meantime, some of the Foundation's grantees—like Jürgen Unützer, who developed Project IMPACT—have taken the bull by the horns and worked directly with CMS to develop the necessary Medicare billing codes so that medical practices can be reimbursed for implementing the model.)

Beyond their varying degrees of uptake by the mainstream health care system, the many models of care supported by the Foundation, when considered as a whole, send a fundamentally important message to policy makers and health care leaders. For these carefully researched models provide hard evidence: (a) that the health care system could be doing a much better job of caring for the nation's elderly than it is currently doing, and (b) that its failure to do so is due not to a lack of knowledge but to the biases and inadequacies of the existing reimbursement system. This is a message that The John A. Hartford Foundation, with its decades of experience in testing and supporting these models of improved care for the elderly, is uniquely positioned to deliver.

Finally, hardest to quantify but every bit as important as its other achievements, the Foundation appears to have had a real impact on the stigma that has long bedeviled the field of geriatrics and aging. We caught glimpses of this in many of the interviews and email responses: "We took aging out of the closet, so it became respectable." "In the profession of nursing [the Foundation] raised aging to be

a desired specialty... To be a JAHF scholar or fellow was universally recognized in the field as a mark of excellence and high potential.” “Ageism was rampant in schools of social work and went largely unchallenged... Fast forward to today, and some of the brightest, most talented, most energized social work professors in the country study aging and prepare future gerontological social workers.” “There is less stigma. Med schools with geriatrics have done a good job in exposing students to older people, not just sick ones. Aging is less of a problem.”

This is not say that the stigma surrounding aging has disappeared, but by lending its prestige as a pre-eminent national foundation—and backing it up with major funding for more than three decades—the Foundation has without question made a meaningful dent in one of the biggest barriers that for so long has kept geriatrics on the margins of health care.

YOU GET WHAT YOU PAY FOR

Of course the other major barrier that has kept geriatrics on the periphery—to which we have alluded repeatedly and which was raised by so many of the leaders in the field with whom we spoke—is the existing financing system, and in particular the traditional fee-for-service Medicare program, which not only covers almost 70 percent of Americans age 65 and over²⁴⁰ but also influences the reimbursement policies of much of the private insurance industry. One of the main reasons there aren't enough geriatricians: under existing Medicare policy, they are among the lowest paid of all the medical specialties.²⁴¹ One of the main reasons that non-geriatric physicians don't always apply their geriatric skills and know-how: it takes too much time for physicians paid on a per-visit basis. (To repeat Christopher Langston's observation, “If you can't squeeze it into an 11-minute visit, it's not happening.”) And, as we just discussed, one of the main reasons that many of the innovative models developed with the Foundation's support are still at the starting gate: they're either not reimbursed or not seen as cost-effective under fee-for-service Medicare.²⁴²

Since the enactment of the Affordable Care Act in 2010, Medicare has begun gradually shifting towards a value-based approach to reimbursement in the hopes of containing rising costs. And despite earlier signs to the contrary, it now appears that CMS will continue to move the program in that direction (although on a voluntary basis, which will probably limit its spread and its impact).²⁴³ This may help to accelerate the adoption

of some of the Foundation-sponsored models of care, and could potentially even help to bring geriatricians' salaries more in line with other specialties. As one of the health care leaders we spoke with explained, “For many years, there was little interest in what happened to patients when they left the hospital. But when government started penalizing hospitals for readmissions, hospitals started paying attention. In the future, value-based care should reduce the discrepancies between the reimbursement of primary care physicians and geriatricians and the specialties. The former can do it better and for less cost. Whether health care systems can make the changes to value is up in the air. It's a big, big change.”

But the trend towards value-based care—assuming that it continues—is not necessarily a panacea for those seeking better care for older Americans. As David Blumenthal, MD, and David Squires pointed out in an article about bundled payments (which are a key element of value-based care), bundled payments do have some drawbacks, especially when applied to patients with multiple chronic conditions. For instance, they may not include the costs of treating related conditions; they may inhibit certain forms of care coordination; and they “could encourage destructive competition for patients with profitable bundles”—meaning patients who are less expensive to treat because they don't have any accompanying chronic conditions.²⁴⁴ This suggests that while the trend towards value-based care may be encouraging, it will bear close watching—and perhaps occasional intervention—to ensure that it really does support the kinds of improvements in the care of the nation's elderly that The John A. Hartford Foundation has worked so hard, and for so long, to bring about.

For many years—apart from its support for the National Health Policy Forum, for occasional Institute of Medicine reports, and for special issues of *Health Affairs*—the Foundation largely steered clear of any policy-related programs or initiatives. In the final years of the period covered in this report, however, the Foundation took a number of steps to engage more directly in the policy process—for example, through its support of the Change AGents initiative, the Eldercare Workforce Alliance, and AARP's development of the model CARE Act, and especially through the staff's work with some of the Foundation's grantees to help them secure the necessary reimbursement for their models of care.

This is hard, often deeply frustrating work, all the more so in today's polarized political climate. Yet as one of the

Foundation's former staff members succinctly stated, "Hartford spent its money building the supply, but you need to create demand, too." Without the necessary financing and the right financial incentives, not only will it be hard for many of the programs in which the Foundation has invested to get to scale, but it may be hard even to sustain much of what the Foundation has accomplished.

Fortunately, there is one positive development that could work in favor of the necessary policy changes that was

not yet a factor back in the 1980's: the fact that the baby boomers are now entering the retirement years in record numbers and are beginning to experience for themselves—in their own care and in the care of their parents—the very real limitations of existing health care for older Americans. Together, the baby boomers and their parents represent one of the biggest voting blocs in American politics. If their experiences could be translated and channeled into a widespread demand for more sensitive, less fragmented, and more effective care, real and lasting change might indeed be possible.

APPENDIX A. PERSONS INTERVIEWED FOR THIS REPORT

GRANTEES

Barbara Berkman
Chad Boulton
Elizabeth Bragg
Christine Cassel
Eric Coleman
Claire Fagin
James Firman
Linda Fried
William Hazzard
James Hinterlong
Nancy Hooyman
Seth Landefeld
Bruce Leff
Diane Meier
Mathy Mezey
Mary Naylor
David Reuben
John Rowe
June Simmons
Mary Tinetti
Jürgen Unützer
Patricia Volland
Gregg Warsaw

TRUSTEES AND STAFF

Amy Berman
John Billings
Francisco Doll
Terry Fulmer
Mary Jane Koren
Christopher Langston
John Mach
Nora O'Brien-Suric
Donna Regenstreif
Corrine Rieder
Laura Robbins
Rani Snyder
Norman Volk
Rachael Watman
Margaret Wolff

OTHER FOUNDATIONS

Steven Anderson (Donald W. Reynolds Foundation)
Bruce Chernof (The SCAN Foundation)
Christopher Langston (Atlantic Philanthropies)*
Jane Isaacs Lowe (Robert Wood Johnson Foundation)
Joseph Prevratil (Archstone Foundation)
Richard Reynolds (Robert Wood Johnson Foundation)
Steven Schroeder (Robert Wood Johnson Foundation)
Rani Snyder (Donald W. Reynolds Foundation)*
Nancy Zions (Jewish Healthcare Foundation)

*Also served on Foundation staff

APPENDIX B. SUMMARY OF THE PRINCIPAL OUTPUTS AND QUANTITATIVE IMPACTS OF THE JOHN A. HARTFORD FOUNDATION'S MAJOR TRAINING AND MODEL PROGRAMS FUNDED BETWEEN APRIL 1983 AND APRIL 2015

PROGRAM TITLE	JAHF FUNDING	YEARS FUNDED	MAIN OUTPUT	QUANTITATIVE IMPACT
Physician training programs				
Geriatric Faculty Development Awards	\$2.5 mil	1983-1987	29 faculty trained	N/A
Academic Geriatric Recruitment/ Centers of Excellence	\$71.5 mil	1988-2015	28 Centers of Excellence created; 1,164 junior faculty and fellows supported	Met roughly 50% of the estimated need for academic geriatricians; 55,000 trainees taught or mentored each year; raised \$15+ for every \$1 in fellowship funding
Beeson Career Development Awards	\$39 mil	1994-	219 Beeson scholars funded	Met roughly 10% of the estimated need for academic geriatricians
Increasing Geriatrics Expertise in Surgical and Medical Specialties (aka Geriatrics for Specialists)	\$14.8 mil	1992-2019	Geriatrics questions added to boards in 9 surgical & related specialties; 79 Jahnigen scholars funded	All 24,000 general surgeons boarded since 2000 required to answer board exam questions re: care of older adults
Integrating Geriatrics into the Subspecialties of Internal Medicine	\$9.3 mil	1994-2020	Geriatric content added to journals, CME curricula, and training exams; 101 Williams scholars funded	6 of 12 subspecialties scored 3 or 4 points on 4-point scale re: integration of geriatric content
Medical Student Training in Aging Research (MSTAR)	\$9.3 mil	1993-2017	2,013 medical students trained	0.1% of all med school grads chose geriatrics as result of MSTAR
Geriatrics Curriculum Grants Initiative	\$5.5 mil	2000-2008	Supported 40 medical schools to improve student attitudes and knowledge re: care of older adults	Program impacted 27% of US medical schools, students reported increased competence and satisfaction re: care of older adults
Geriatrics in Primary Care Training Initiative	\$5.4 mil	1994-1998	8 med schools developed geriatrics curricula, materials for primary care residents	At least 440 residents & faculty had received full curriculum; almost 150,000 educational materials distributed
Chief Resident Immersion Training in Care of Older Adults (CRIT)	\$1.9 mil	2007-2012	At least 30 2-day training sessions held at 16 med schools	Program has trained chief residents at 11% of nation's 146 med schools
Nurse Training Programs				
The Hartford Institute for Geriatric Nursing	\$12.3 mil	1996-2009	New standards of care for older adults developed with 54 nursing specialty associations; NICHE disseminated to 764 sites (as of 2017); "Try This" series widely used through ConsultGeri website	As of 2005, all new or revised specialty nursing standards have to address care of older adults; NICHE in 12% of US hospitals
Building Academic Geriatric Nursing Capacity	\$53.2 mil	2000-2017	9 Centers of Geriatric Nursing Excellence created; 280 Archbold scholars and Fagin fellows funded	As of 2013, more than 184,000 nursing students taught and mentored re: geriatric nursing (about 5% of all nursing students during this 13-year period); more than 2,500 peer-reviewed articles published; raised more than \$7 for every \$1 in scholarship/fellowship
Curriculum grants in nursing	\$11 mil	2001-2013	AACN added geriatrics to list of core nursing competencies; 800 faculty representing almost 70% of nursing schools trained in geriatric curricula	82% of participating schools added geriatric content to senior-level nursing courses; today, 90% of all BSN programs have geriatric course content and all BSN graduates must have geriatrics as a core competency

PROGRAM TITLE	JAHF FUNDING	YEARS FUNDED	MAIN OUTPUT	QUANTITATIVE IMPACT
Social Worker Training Programs				
Geriatric Enrichment in Social Work Education Project (GeroRich)	\$6.7 mil	2001-2004	Gerontological content added to curricula and faculty trained at 67 schools of social work	Gerontological content taught in about 10% of nation's social work programs
National Center for Gerontological Social Work Education (GeroEd Center)	\$6.9 mil	2004-2016	Faculty trained, gerontological materials and curricula developed and distributed	250 social work schools included gerontological content in their curricula—about 40% of nation's social work programs
Hartford Geriatric Social Work Faculty Scholars Program	\$24.3 mil	1999-2015	125 faculty trained; teach about 5,000 students/year	Big increase, but is only about 1% of nation's social work faculty; they teach about 4% of all bachelor's and master's level social work students
Hartford Doctoral Fellows in Geriatric Social Work Program	\$9.9 mil	2000-2014	94 doctoral fellows supported; 47% in tenure track positions in 2010	On an annualized basis, the 94 fellows represent about 1% of all social work PhD students
Hartford Partnership Program for Aging Education	\$11 mil	1999-2012	Rotational practicum model adopted by 97 MSW programs	Adopted by 40% of nation's MSW programs; unclear how widely sustained
Models of Care				
Program of All-Inclusive Care for the Elderly (PACE)	\$4.7 mil	1983-2008	Makes it possible for older adults with multiple conditions to stay out of nursing home	Currently serves about 40,000 older adults (about 6% of eligible population)
Geriatric Interdisciplinary Team Training (GITT)	\$12.3 mil	1995-2004	Trained 1,341 health professions students in team care for older adults with complex conditions	A cutting-edge model that was ahead of its time; now gaining traction with shift toward value-based care
Care Management Plus	\$2.7 mil	2001-2012	Cut complications and mortality rates in complex older patients	In 420 primary care clinics; 150,000-300,000 patients/year “invited to participate”
Care Transition Intervention	\$2.9 mil	2000-2015	Reduced readmission rates and hospital costs	Adopted by 1,000 hospitals and long-term care facilities (about 5% of the nation's 20,000 hospitals and nursing homes); may have influenced CMS rule to penalize readmissions
Guided Care	\$3.6 mil	2004-2012	Improved quality of care for older patients, impact on costs mixed	Adopted by 18 health systems, thousands of nurses trained
Better Outcomes by Optimizing Safe Transitions (BOOST)	\$1.9 mil	2005-2010	Reduced readmission rate by 14%	In 234 hospitals across the country (about 5% of nation's hospitals)
Transitional Care Model	\$0.47 mil	2006-2009	Improved outcomes for older patients, reduced readmits and costs	Survey found 59% of health care organizations had adopted TCM (but may be biased)
Beers List	\$0.25 mil	1989-1991	Used to prevent prescription errors with older patients	“One of the most frequently consulted sources”
HomeMeds	\$3.3 mil	1994-2010	Used for medication management for homebound elderly	11,000 older adults screened (picking up about 1% of all patients who were hospitalized for medication-related problems)
Nurses Improving Care for Health-system Elders (NICHE)	\$1.5 mil	1989-1995	Improved nursing care for older adults	Now in 764 sites, including 587 US hospitals (about 12% of all US hospitals)
Acute Care for the Elderly (ACE)	\$0.49 mil	1989	Reduced length of stay, readmits, and costs; improved functional status	In 250 hospitals (about 5% of all US hospitals)
Hospital at Home	\$6.4 mil	1994-2012	Cost 20% less than hospital stay, with similar outcomes	Uptake limited so far but being considered for Medicare payment
Improving Mood-Promoting Access to Collaborative Treatment for Late-Life Depression (Project IMPACT)	\$8 mil	1998-2017	Reduced costs and more than doubled effectiveness of depression care in older patients in primary care practices	5,000-6,000 physicians trained in 1,000 practices so far; new Medicare billing code recently implemented
Center to Advance Palliative Care	\$3.3 mil	2006-2019	Reduced pain and reduced costs	In 75% of US hospitals with 50+ beds; in 90% of hospital with 300+ beds

ENDNOTES

- 1 Prior to joining The John A. Hartford Foundation as Assistant Director in December 1981, Billings had served as executive director of the Utah Health Cost Management Foundation, a Foundation grantee.
- 2 Between 1952 and 1979, the Foundation had devoted most of its grantmaking to biomedical research, totalling more than \$220 million during that period.
- 3 James Farley later served as Chairman of the Foundation's Board of Trustees, from 1989 until 2002. He passed away in 2015.
- 4 Billings was succeeded by Stephen Eyre, who served as the Foundation's executive director from 1985 to 1997; Eyre was succeeded by Corinne Rieder, EdD, who served as executive director from 1998 to 2015.
- 5 Norman Volk, who was on the Board at that time, confirmed in our interview with him that "the idea came from the staff."
- 6 Norman Volk served on the Board of Trustees for 31 years, from 1979 to 2015, including 13 years (2002-2015) as Chairman of the Board.
- 7 Thirty-one years later, in 2014, those age 65 and over constituted 15.1 percent of the U.S. population and accounted for 33.6 percent of health care costs (<https://www.ncbi.nlm.nih.gov/books/NBK425792/>). But while the share of total health care costs attributable to those age 65 and over has increased since the early 1980's, this actually represents a 22.5 percent reduction in the *per capita* share of health care costs attributable to that age group.
- 8 Already in 1983, the Foundation had recognized the need for a dramatic increase in the number of academic geriatricians: "It is estimated that 2,000 academic geriatricians must be trained by the year 1990; this number is at least ten times the number who are currently members of medical faculties in the United States" (1983 Annual Report, p.38).
- 9 Now known as the National Academy of Medicine.
- 10 2012 Annual Report, p.17.
- 11 It appears that biomedical research—one of the three recommended priorities in the original April 1983 plan—was to some extent incorporated into later geriatrics training programs such as the Centers of Excellence and the Beeson Scholars program, in which at least some of the awardees conducted biomedical research. The Foundation also continued to make occasional individual biomedical research grants, such as a 1996 grant to Cold Spring Harbor Laboratory on the biology of long-term memory.
- 12 By the time the Foundation awarded its final grants in Health Care Cost and Quality, it had made 195 grants in the area, totaling \$77 million—a substantial amount, but a fraction of what it was to spend in Health and Aging.
- 13 1994 Annual Report, p.4. Most of the remaining 20 percent was reserved for the Foundation's continuing support of community health reform and community health management information systems.
- 14 1994 Annual Report, p.12.
- 15 Ibid.
- 16 T. Fulmer, et al., "Geriatric Interdisciplinary Team Training Program Evaluation Results," *Journal of Aging and Health*, 17(4):443-470, August 2005.
- 17 Now renamed Nurses Improving Care for Healthsystem Elders.
- 18 1996 Annual Report, p.4.
- 19 1997 Annual Report, p.22.
- 20 1998 Annual Report, p.40.
- 21 Levinson, Marc, *The Great A & P and the Struggle for Small Business in America*, Hill and Wang, New York, 2011, p.259.
- 22 1981, 2000 Annual Reports. According to the CPI calculator, \$616 million in December 2000 had the same buying power as \$308 million in January 1981. Thus, while in nominal terms the increase from \$129 million to \$616 million represented almost a five-fold increase, in real (inflation-adjusted) terms, the increase was about half that.
- 23 In 1996, the Foundation awarded \$19 million in health and aging grants; by 2000, the total was \$63 million.
- 24 2002 Annual Report, p.5.
- 25 2003 Annual Report, p.5.
- 26 In 2002, the Foundation awarded \$6 million in grants in health and aging, down from \$40.4 million in 2001; in 2003, \$14 million. The following two years, it awarded \$33 million (2004) and \$32 million (2005).
- 27 2003 Annual Report, p.21.
- 28 Later renamed the Hartford Partnership Program for Aging Education.
- 29 J. Unützer, et al., "Collaborative Care of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial," *Journal of the American Medical Association*, 288(22): 2836-2845, December 11, 2002.
- 30 As of 2014, associate degree nurses still comprised 45 percent of the nursing workforce. <http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/workforce/Fast-Facts-2014-Nursing-Workforce.pdf> (accessed 9/9/17).
- 31 The nine other funders were AARP, the Archstone Foundation, the Atlantic Philanthropies, the California Endowment, the Commonwealth Fund, the Robert Wood Johnson Foundation, the Josiah Macy Jr. Foundation, the Retirement Research Foundation, and the Fan Fox and Leslie R. Samuels Foundation.
- 32 2002, 2007, 2008 Annual Reports.
- 33 2008 Annual Report, 2008, p.5.
- 34 Member organizations currently include, among others, AARP, the Alzheimers Association, the American Academy of Nursing, the American Geriatrics Society, the National Council on Aging, the Service Employees International Union, and the U.S. Department of Veterans Affairs.
- 35 Levinson, Marc, op.cit., p.177-181.
- 36 2008 Annual Report, p.69.
- 37 2009 Annual Report, p.58.
- 38 \$4 million in 2010; \$1.4 million in 2011. See 2010, 2011 Annual Reports.
- 39 2012 Annual Report, p.78.
- 40 Ibid.
- 41 2012 Annual Report, p.79.
- 42 2013 Annual Report, p.4.
- 43 2014 Annual Report, p.4.
- 44 Ibid.
- 45 Community Catalyst website: <https://www.communitycatalyst.org/about/mission-values> (accessed 9/28/17).
- 46 As an aside, it is interesting to note that the \$473,721,681 that the Foundation devoted to health and aging grants during these 32 years is more than triple the value of the Foundation's total assets in December 1983 (\$151,229,261). In other words, had the Foundation decided to spend down its assets over the past 32 years rather than maintaining and growing its endowment (as other foundations, such as Atlantic Philanthropies, have opted to do), it would have had considerably less to spend over the past 32 years and it would have had nothing left today for the future..
- 47 The dollar amounts come from a 2017 spreadsheet listing all approved health and aging grants awarded by The John A. Hartford Foundation since 1983. In determining the category of each grant, we used the listings in the Foundation's annual reports wherever possible. Otherwise—for example in the case of policy grants and research/evaluation grants—we used our best judgment based on the available grant descriptions.

- 48 The first grant we were able to identify that did seem to address this measurement issue, at least in part, was a 2013 grant of \$415,422 to the National Committee for Quality Assurance, co-funded by the SCAN Foundation, entitled “Quality Measurement to Assess the Performance of Goal Setting and Achievement in the Delivery of Medical and Long-Term Care.” The grant was renewed for another two years in the third quarter of 2015.
- 49 See footnote 8 on p.13 of this report.
- 50 D. Reuben, et al, “John A. Hartford Foundation Centers of Excellence Program: History, Impact, and Legacy,” *Journal of the American Geriatrics Society*, 65(7) 1396-1400, July 2017.
- 51 Ibid.
- 52 A. Young, et al., “A Census of Actively Licensed Physicians in the United States, 2016,” *Journal of Medical Regulation*, vol. 103, no. 2, 2017.
- 53 To put this number in perspective, in 2014 about 30 percent (29.9) of physician office visits in the United States were by patients age 65 and over (National Ambulatory Medical Care Survey: 2014 State and National Summary Tables, Table 4).
- 54 Interestingly, while the per capita cost (unadjusted for inflation) for those supported by the Center of Excellence program (\$61,426) was lower than the per capita cost for those supported with Geriatric Faculty Development Awards (\$86,206), the difference is not dramatic. The difference in impact appears to be largely attributable to the vast difference in the size and cost of the two programs.
- 55 D. Reuben, et al., op.cit.
- 56 If those who could not be reached or did not respond to the survey were equally successful in obtaining research funding, the total amount raised would be roughly \$3.8 billion and the total return on investment would be in the neighborhood of 50 to 1.
- 57 Today the Beeson award provides up to five years of support of up to \$225,000 per year.
- 58 American Federation for Aging Research, *Paul B. Beeson Emerging Leaders Career Development Awards in Aging, 2017 Report*. https://www.afar.org/docs/2017_BeesonReport_Final.pdf (accessed 10/10/17).
- 59 There is potential for synergies between the Beeson Scholars program and the Centers of Excellence, but the geographic overlap between the two programs has only been partial. While 135 of the 219 Beeson Scholars have been based in locations that also had a Center of Excellence, the remaining 84 were not. Moreover, even among the 28 schools that had a Center of Excellence, the distribution of Beeson Scholars was uneven. A few Centers of Excellence schools have had ten or more Beeson Scholars (Duke, Harvard, UCSF, Yale), but others have had only one (Emory, Chicago, Chapel Hill, Rochester) or none (Baylor, Brown, Alabama, Hawaii).
- 60 EJ Bragg, et al., “Paul B. Beeson career development awards in aging research and U.S. medical schools aging and geriatric medicine programs,” *Journal of the American Geriatrics Society*, 2011, Sept; 59(9):1730-8.
- 61 The program has received additional funding from the Atlantic Philanthropies and the National Institute on Aging.
- 62 S. Deiner, “Expanding the Field of Surgical Researchers: The Jahnigen Career Development Award,” *Journal of the American Geriatrics Society*, 17 May 2017.
- 63 Grants for Early Medical/Surgical Specialists’ Transition to Aging Research, a companion scholarship program funded by the National Institute on Aging since 2011. GEMSSSTAR has funded 26 surgical and related specialties scholars since 2011.
- 64 A.G. Lee, J.A. Burton, and N.E. Lundebjerg, “Geriatrics-for-Specialists Initiative: An Eleven Specialty Collaboration to Improve Care for Older Adults,” *Journal of the American Geriatric Society*, 65:2140-2145, 2017.
- 65 Ibid.
- 66 American Board of Surgery, “Statistics and Pass Rates,” <http://www.absurgery.org/default.jsp?statgeneral> (accessed 10/12/17).
- 67 A.G. Lee, op.cit.
- 68 The program has been continued through 2020 under the auspices of the Alliance for Academic Internal Medicine (2006-2016) and Wake Forest University (2016-2020).
- 69 A. Hurria, et al., “Aging, the Medical Subspecialties, and Career Development: Where We Were, Where We Are Going,” *Journal of the American Geriatrics Society*, 65:680-687, 2017.
- 70 Ibid.
- 71 Statista, “Number of active physicians in the U.S. in 2017, by specialty area,” <https://www.statista.com/statistics/209424/us-number-of-active-physicians-by-specialty-area/> (accessed 10/14/17).
- 72 A. Hurria, et al., op.cit.
- 73 2012 Annual Report, p.40.
- 74 American Federation for Aging Research, <https://www.afar.org/research/funding/mstar/> (accessed 10/15/17).
- 75 American Federation for Aging Research, <https://www.afar.org/research/funding/mstar>.
- 76 Henry J. Kaiser Family Foundation, “Total number of medical school graduates,” <https://www.kff.org/other/state-indicator/total-medical-school-graduates/?currentTimeframe=13&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed 10/15/17).
- 77 American Federation for Aging Research, “AFAR’s MSTAR program addresses shortage of geriatric medicine physicians,” press release, June 29, 2012.
- 78 Even that may be an overstatement of the program’s impact, because it is possible that the program attracted students who were already predisposed to geriatrics. If so, some of them might have gone into geriatrics or an aging-related specialty even without their MSTAR experience.
- 79 2012 Annual Report, p.61.
- 80 Association of American Medical Colleges, <https://www.aamc.org/download/321442/data/factstable1.pdf> (accessed 10/15/17).
- 81 2012 Annual Report, p.61.
- 82 Ibid. Rani Snyder, who served as director of the Reynolds Foundation’s Health Care Programs and is now Program Director at The John A. Hartford Foundation, told us that the Reynolds Foundation program was also in part modelled on The John A. Hartford Foundation’s Centers of Excellence, although the Reynolds Foundation limited its focus to education.
- 83 D. Reuben, et al., “Changing the Course of Geriatrics Education: An Evaluation of the First Cohort of Reynolds Geriatrics Education Programs,” *Academic Medicine*, May 2009; 84(5): 619-626.
- 84 Ibid.
- 85 University of Rochester School of Medicine, Baylor College of Medicine, Harvard Medical School, University of California Los Angeles School of Medicine, Johns Hopkins University School of Medicine, University of Chicago Pritzker School of Medicine, and University of Connecticut School of Medicine.
- 86 L. Chiang, “The Geriatrics Imperative: Meeting the Need for Physicians Trained in Geriatric Medicine,” *Journal of the American Medical Association*, 1998;279(13):1036-1037.
- 87 2012 Annual Report, p.41.
- 88 sugerc.stanford.edu.
- 89 Email communication received from Georgette Stratos, December 20,2017. She did not have information on product distribution between 2005 and 2010.
- 90 ADGAR, “Chief Resident Immersion Training in the Care of Older Adults,” <http://adgap.americangeriatrics.org/adgap-programs/crit/> (accessed 10/27/17).
- 91 ADGAR, op.cit.
- 92 T. Fulmer, “Geriatric Nursing 2.0!” *Journal of the American Geriatrics Society*, 63:1453-1458, 2015.
- 93 R. Watman et al., “The Hartford Geriatric Nursing Initiative: Developing a Focused Strategy and Strong Partnerships to Improve Nursing Care for Older Adults,” *Nursing Outlook* 59:182-188 (2011).
- 94 NICHE, Nurses Improving Care for Healthsystem Elders, <http://www.nicheprogram.org>.
- 95 American Hospital Association, “Fast Facts on US Hospitals,” <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml> (accessed 10/25/17).
- 96 J. Esterson et al., “Ensuring Specialty Nurse Competence to Care for Older Adults,” *JONA* 43:517-523 (2013).

- 97 G. Bednash, M. Mezey, and E. Tagliareni, "The Hartford Geriatric Nursing Initiative Experience in Geriatric Nursing Education: Looking Back, Looking Forward," *Nursing Outlook*, 2011 Jul-Aug; 59(4):228-35.
- 98 Over its 17 years, the initiative was coordinated by three different organizations: the American Academy of Nursing (2000-2012), the Gerontological Society of America (2016-2017), and New York University (2016-2017).
- 99 A.B. McBride, et al., "Clustering Excellence to Exert Transformative Change: The Hartford Geriatric Nursing Initiative," *Nursing Outlook*, 2011 Jul-Aug; 59(4):189-197.
- 100 The Donald W. Reynolds Foundation funded one additional center in 2008.
- 101 JT Harden and R. Watman, "The National Hartford Center of Gerontological Nursing Excellence: An Evaluation of a Nursing Initiative to Improve Care of Older Adults," *The Gerontologist*, Volume 55, Issue Suppl_1, 1 June 2015, Pages S1–S12.
- 102 P. Buerhaus, et al., "State of the Registered Nurse Workforce as a New Era of Health Reform Emerges," *Nursing Economics* 35:229-237 (2017).
- 103 The initiative funded 172 predoctoral scholars for 2 years at \$50,000 per year and 108 postdoctoral fellows for two years at \$60,000 per year—a total of \$29.5 million.
- 104 2012 Annual Report, p.60.
- 105 Ibid.
- 106 2016 Annual Report, p.24.
- 107 P. Beurhaus, et al., 2017, op.cit.
- 108 2003 Annual Report, p.21.
- 109 Ibid., p.25.
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