COST CONTAINMENT

What Health Care Costs Americans

Cost Per Household

- Through taxes
- Out-of-pocket
- Through employer contributions

To help the nation address the problem of escalating health care costs.
The Robert Wood Johnson Foundation was established as a national philanthropy in 1972 and today is the largest U.S. foundation devoted to health care. The Foundation concentrates its grantmaking in four areas:

- assuring access to basic health services
- improving the way services are organized and provided to people with chronic health conditions
- promoting health and preventing disease by reducing harm from substance abuse
- seeking opportunities to help the nation address the problem of escalating health care costs.

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Annual Report
for 1994 of
The Robert Wood Johnson Foundation

Cost Containment

Route 1 and College Road East, Post Office Box 2316, Princeton, New Jersey 08543-2316
Robert Wood Johnson devoted his life to public service and to building the small but innovative family firm of Johnson & Johnson into the world's largest health and medical care products conglomerate.

The title by which most knew him — General — grew out of his service during World War II as a brigadier general in charge of the New York Ordnance District. He resigned his commission to accept President Roosevelt's appointment as vice chairman of the War Production Board and chairman of the Smaller War Plants Corporation.

General Johnson was an ardent egalitarian, an industrialist fiercely committed to free enterprise who championed — and paid — a minimum wage even the unions of his day considered beyond expectation, and a disciplined perfectionist who sometimes had to restrain himself from acts of reckless generosity. Over the course of his 74 years, General Johnson would also be a politician, writer, sailor, pilot, activist, and philanthropist.

His interest in hospitals led him to conclude that hospital administrators needed specialized training. So he joined with Dr. Malcolm Thomas MacEachern, then president of the American College of Surgeons, in a movement that led to the founding at Northwestern University of one of the first schools of hospital administration.

General Johnson also had an intense concern for the hospital patient whom he saw as being lost in the often bewildering world of medical care. He strongly advocated improved education for both doctors and nurses, and he admired a keen medical mind that also was linked to a caring heart.

His philosophy of corporate responsibility received its most enduring expression in his one-page management credo for Johnson & Johnson. It declares a company's first responsibility to be to its customers, followed by its workers, management, community and stockholders — in that order.

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

General Robert Wood Johnson's sense of personal responsibility toward society was expressed imperishably in the disposition of his own immense fortune. He left virtually all of it to the foundation that bears his name, creating one of the world's largest private philanthropies.
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Trends in National Health Expenditures
(special insert)  
Inside back cover
A
fter someone of real accomplishment
dies, people often speak of their
passing as marking "the end of
an era."

I hope however, that epitaph will never
apply to Dr. David E. Rogers insofar as The
Robert Wood Johnson Foundation is concerned.

David died December 5, 1994, and we
should always try to hold to the values that
were at the root of his presidency of the
Foundation — intellectual rigor, compassion,
and leadership. But even more importantly, it
was David's quest for fairness in society, his
powerful social conscience, that transcends.

In 1971, Gustav O. Lienhard, the
Foundation's chairman and a former president
of Johnson & Johnson, made a gutsy decision in
hiring David as the Foundation's
first president. The late Gus
Lienhard was a consummate
businessman, valuing efficiency
and effectiveness; David liked to
describe himself as "a
troublemaker." Together, they
set a complementary standard of
thorough methodology and
calculated risk-taking.

With their leadership and our
endowment of over $1 billion, we
were poised to place the Foundation
on the front lines of improving
health care for all Americans. In
selecting David, Gus Lienhard also insured that
the Foundation would have an independent
voice, one that wasn't afraid to challenge the
accepted ethos of the medical fraternity.

The first big decision was to focus the
Foundation's grant making on the needs of
Americans as the people themselves — not
the professionals — saw them. In 1971,
decrying medicine's increasing specialization,
we called for greater emphasis on primary
care. And we backed our words with actions.

We established programs to train
doctors, physician assistants, and nurse
practitioners to work in primary care settings,
we funded medical schools' efforts to focus on
primary care, and we created demonstration
projects to help these new professionals work
in underserved communities nationwide. We
supported research into how patients fared
from what medicine did — and did not do —
for them, spurring the adoption of health care
delivery studies in medical curricula. And it
was done with strong approval from Gus
Lienhard and the first Board of Trustees.

But beyond the big picture, Dr. Rogers
was mindful of those with special problems in
obtaining good health care. His compassion
drove us to focus on those most in need,
whether they lived in the inner-city or in rural
America, whether their problems were
physical or mental, acute or chronic.

We battled complacency by the
members of the medical profession —
perhaps best embodied by our leadership in
fighting AIDS. We promoted treatment
programs that became models for cities and
states and fought to protect the confidentiality
of people with AIDS. Thanks to our early
efforts, we were the first major source of
private funding for the AIDS pandemic.

After leaving the Foundation in 1986,
Dr. Rogers continued this commitment. He
most recently was co-chair of the National
Commission on AIDS.

Dr. Rogers also believed the Foundation
should help guide and nurture the next
generation of physicians and other health
professionals. Initiatives to that end included
the Clinical Scholars Program, the Clinical
Nurse Scholars Program, the Faculty
Fellowships in Health Care Finance Program
and the Washington Health Policy Fellowships
Program. In recognition of these efforts, the
Foundation and the Association of American
Medical Colleges this year created the David E. Rogers Award, to be given annually to a medical school faculty member who has made major contributions to improving the health and health care of the American people. The Rogers Award complements the Gustav O. Lienhard Award, created at his retirement as board chair in 1986. Administered by the Institute of Medicine of the National Academy of Sciences, the Lienhard Award honors people who have made outstanding contributions toward the improvement of health care in the United States.

It is no longer 1971, and as time has advanced, so have we. Where two decades ago, discussions of health care were conducted largely outside the public domain, today they have the highest visibility. The subject is of profound concern to individual Americans and to the politicians who represent them, which has made debate both passionate and divisive.

Driving that debate are the realities of health care today. When we once as a nation tried to determine where best to spend our dollars to do the most good, now we must first find those dollars to spend. Since 1970, health care expenditures have almost quadrupled, reaching nearly $1 trillion last year.

The magnitude of these dollars colors and seems to overwhelm thinking about every aspect of health care.

At the Foundation, assuring access to basic health care, especially among the underserved, remains a core mission. But with an eye on developing problems, we have invested in programming to address the increasing costs of care, the difficulties people with chronic conditions face when seeking care, and the harm wrought by substance abuse on our people, our communities and our society.

Gus Lienhard (left) and David Rogers circa 1974

The Foundation looks a lot different than it did back when Gus Lienhard chose David Rogers to be president. To be true to our mission, our programming has had to change to respond to the need. We will probably look a lot different 20 years hence. But then as now, we shall be working for a fair system that provides affordable and effective health care for all.

Sidney F. Wentz
Chairman, Board of Trustees
One of the best years of my life was spent studying European medical care. In the 1980s, I had the privilege of visiting hospitals and speaking with health professionals in six different countries; subsequently, I have visited institutions in several other nations. A major reason for these visits was to try to understand why the United States spends so much on medical care — now amounting to nearly 14 percent of Gross Domestic Product — far outstripping the proportion spent by any other country.

Everywhere there is tremendous admiration for the science and technology of American medicine, mixed with amazement that we have yet to provide basic health care coverage to all our citizens and with disappointment that our national health indices do not show sufficient value for our investment in health care.

Clearly, no single factor explains why we spend so much. Perhaps the best insights came from my visits to the intensive care units of European teaching hospitals, where the differences between our styles of medical care were most vividly illustrated. A typical intensive care unit in the United States is filled with desperately ill patients, some on their road to recovery following serious surgery and others in the final months of a terminal, chronic illness. By contrast, the European hospitals had fewer intensive care units, fewer intensive care patients, and — most dramatically — significantly fewer dying patients.

In each of these hospitals, I met clinicians who had some training at a U.S. teaching hospital. In every case, they found this experience professionally gratifying, and they complimented the quality of the teaching here as well as our advanced technology. When I pressed them to explain the relative tranquility of European intensive care units compared to ours, an embarrassed pause usually ensued. “We really admire the sophistication of American medicine,” one clinician responded, “but you don’t know when to stop.”

We don’t know when to stop! The more I reflected on that response, the more it helped to explain why our medical care system is so expensive. All along the line — from the attitudes of patients and their families about the kind of care they want to patients’ decisions about which doctors to consult, to the doctors’ choices about referrals, treatments, and when and where to hospitalize, to hospitals’ decisions to build and fill intensive care units — in the United States the pressure to intervene aggressively is enormous and it comes from multiple directions.

Often we hear claims, as we did in the recent political debate about health care reform, that amelioration of a single factor — administrative costs, or excessive patient demand, or malpractice claims, or outright fraud — is the key to controlling health care costs. The truth, of course, is much more complicated. Just as a complex set of supply and demand factors has caused U.S. intensive care units to flourish, these factors are also responsible for the expansion — and the high cost — of the nation’s health care generally.
Higher Spending Doesn't Guarantee Better Health for Americans

Per capita spending, 1992

Note: Per capita spending adjusted to 1994 U.S. dollars.

Americans Use More Health Services by Choice

Responses to question: "If your personal doctor told you that you had an incurable and fatal disease, would you accept that diagnosis or seek a second opinion?"

Responses from citizens aged 65 or older

Demand Factors That Stimulate Medical Expenditures

A distinguishing feature of American culture is our fascination with medicine, health, and vitality. Our avidity for medical information can be seen in the coverage of medical news in the print and visual media, coverage that is much more comprehensive than in other countries. Breakthroughs in medical science are routinely trumpeted in our morning newspapers and touted on the evening news. The cumulative impact of these stories is to leave the impression that a scientific advance that can remedy every ailment either exists or is just around the corner. Unfortunately, the scientific disappointments — the promising cancer drugs that prove ineffective — are less likely to make the news, certainly not the headlines.

A Harris Poll conducted in five English-speaking countries during my year abroad asked people 65 or older the following question: “If your personal doctor told you that you had an incurable and fatal disease, would you accept that diagnosis or seek a second opinion?” The results (shown opposite) reveal striking cross-cultural differences, with the stoical British 10 times as likely to accept their mortality as the more skeptical Americans.

If you asked U.S. physicians why we spend so much for health care, many would point to the costs associated with medical malpractice. It is true that our malpractice insurance premiums for physicians and hospitals are far higher than those in any other country — often by a huge factor. For example, in 1981 the annual malpractice premium for a major teaching hospital in Western Europe was less than $50,000, while in the United States it was close to $2,000,000. Individual physicians now face hefty annual premiums, and in high-risk specialties such as obstetrics, neurosurgery, and anesthesiology premiums easily surpass $100,000.

News reports of large malpractice awards appear frequently. No wonder many people believe malpractice insurance reform is the key to reducing health care costs. Yet, in reality, malpractice — including the insurance premiums and the defensive medicine they inspire — cost less than $35 billion, only 3.5 percent of the projected $1 trillion spent on health care in 1994.

Just as physicians are likely to identify malpractice insurance as the villain in the health care costs drama, economists tend to blame health insurance. Insurance distorts the market by insulating patients from the kinds of price comparisons they can make when purchasing other goods, such as food or transportation. Economists argue that if consumers assumed more of the financial burden directly, they would become more price-sensitive and demand less health care. Empirical data support this theory, and increasingly the United States is moving away from traditional indemnity insurance to arrangements that change the financial incentives for both patients and physicians. However, no evidence indicates that lack of cost-sharing propelled the United States to its current high level of spending. In fact, Americans already pay more out-of-pocket for their health care than do citizens of many other countries, including Germans and Canadians. Universal health insurance systems cover most medical care costs for both these populations.

Additional demand factors that add to our health care costs are our demographic and social features. The number of Americans surviving into old age is increasing, and it is they who are most at risk for the complications of chronic illnesses. They predominate in our hospitals, intensive care units, and nursing homes. In this regard the United States does not differ much from other Western nations.
A “demand factor” in the U.S. medical care system that does stand out, however, is caring for people with conditions traceable to behavior, conditions that are mostly preventable. A prime example is violence. The rate of homicide in the United States is over 11 times greater than in England, for example, and the chances of a young black American man dying of homicide are over 200 times greater than those of a Swedish man the same age. While substance abuse is the number one preventable killer of Americans — with about 520,000 lives lost annually from tobacco, alcohol, and illicit drugs — here we have made remarkable progress. Compared with many other nations, we have greatly reduced our consumption of cigarettes and our death rate from drunken driving. By contrast, rates of another primarily behavior-related disorder, AIDS, are 30 percent higher in the United States than in Europe. But even if a cure for AIDS were found tomorrow, the savings would barely dent the nation’s health care bill. While together these behavioral features of modern American life paint a unique national portrait, they do not explain fully our higher health care costs.

A final demand factor targeted by policymakers is greed, inefficiency, and outright fraud. In some instances fraud stems from consumers who file false medical disability claims. In other cases, it results from dishonest health care providers. No one knows how much money is spent fraudulently — here or in other countries. Although polls show 60 percent of Americans believe greed, waste, and high profits are a “very important” reason for rising health costs, most health economists doubt this factor is substantial.

In short, none of the demand factors commonly proposed, even in combination, explains more than a small fraction of the higher U.S. medical expenditure rates.

Supply Factors That Affect Medical Expenditures

In my opinion, the greatest factor stimulating high U.S. medical care utilization and expenditures lies in the supply side. We simply have overdeveloped our medical capacity. Compare the lavish lobbies of a typical U.S. hospital with its utilitarian European counterpart and you will appreciate how much we have invested in medical care. U.S. hospitals have achieved some efficiencies. They have the shortest lengths-of-stay in the world — rates that are still declining. Our hospitals also have pioneered in moving surgery and convalescence outside the hospital walls, and home health care is now the fastest-growing component of the health care economy. Meanwhile, we lead the world in performing expensive diagnostic and therapeutic procedures, such as magnetic resonance imaging, coronary artery bypass surgery, hemodialysis, and organ transplants. These supply factors contribute to both medical inflation and intensity of services.

Our high rates of use reflect the extent to which we have invested in the resources — people, facilities, and equipment — to perform these procedures. In the case of magnetic resonance imaging, Orange County, California, has more imaging machines for its 2.4 million people than all of Canada for its 27 million people. Similar comparisons can be made for the distribution of laboratories that perform coronary artery catheterization or operating suites that do coronary artery bypass surgery.
Demand for Intensive Care Is Rising Sharply

ICU beds as a percent of all hospital beds, 1980–1992

1992
Total ICU beds: 96,707
Total costs: $55 billion
Percent of inpatient days in ICUs: 11.3%

Cardiovascular Procedures
Much More Frequent in the U.S.
Rates per 100,000 population

Note: All rates are for 1990 except U.S. rates are for 1988 and U.K. bypass surgery rates are for 1989.

Source: Personal communication with Mark Hlatky, MD, Department of Health Research and Policy, Stanford University School of Medicine; and Collins-Nakai RL, Husseysne HA, and Scully HE. “Access to Cardiovascular Care: An International Comparison,” Journal of the American College of Cardiology 19(7): 1477–1485, 1992. Table 1, p. 1478.
The concept “Build it and they will come” has never been more true than in health care. Our surfeit of medical technology means that insured patients in the United States seldom have to wait for care, urgent or elective. Of course, easy access has a price, and for us it is the cumulative cost of many, many high-priced procedures. For example, Americans had some 708,000 coronary artery surgery and related coronary angioplasty procedures in 1992, 2.8 per 1,000 people, many times more than in other countries. The cost of each one of these procedures is high — approximately $41,000 for bypass surgery and $16,500 for angioplasty — putting the grand total for 1992 alone at some $19 billion. Similar high rates of utilization and expense exist across a wide spectrum of expensive treatments.

In my view, we need look no farther to discover why the U.S. medical bill is so high. If every one of those procedures were medically indicated, then our investment would translate into higher quality care and better health for Americans. But it doesn’t. We are not ahead of other Western nations on key health measures.

In fact, many experts believe a substantial minority of these high-cost procedures are not medically indicated or could be replaced by less invasive, less costly treatments that would do as much or more good. What’s more, every one of these unnecessary procedures exposes patients to unwarranted danger.

We have accumulated highly trained personnel to perform these procedures, and we pay them well. We train thousands of new physicians annually, and lure many foreign-educated physicians and nurses with our high wages and excellent working conditions. As a result, we find we have too many physicians, especially specialists. A recent estimate projects an excess of 139,000 specialty physicians by the year 2000 — nearly a third of the overall physician supply. This has tremendous cost implications. To the extent that specialists have professional and economic incentives to perform their special procedures unnecessarily, the oversupply contributes to high costs. To the extent that specialists instead perform tasks outside their expertise or function as part-time generalists, the way they practice is simply more expensive than that of people trained as generalists.

The combination of a disproportionate investment in specialty physicians, plus a fee-for-service payment system that offers major financial incentives to provide expensive, high-tech care, is a major explanation for the high cost of the U.S. medical care system. We currently witness a shift from fee-for-service payment for medical services to capitation, which neutralizes some of the pro-technology economic incentives. A major national challenge will be to restructure the medical work force accordingly.

Another supply-side factor that increases U.S. medical expenditures is administration. Compared with providers in other countries, hospitals and physicians in the United States confront a blizzard of forms and procedures from hundreds of health insurance carriers, each requiring a different administrative process. The costs of complying with these requirements are “empty calories.” They contribute to medical fat without adding any value to care. Many experts estimate that these administrative costs account for at least 10 percent of the nation’s total health bill. Based on the 1994 estimated expenditure of $1 trillion, administrative costs could amount to some $100 billion — enough to provide health insurance coverage for every one of the 40 million Americans who currently are uninsured.
Where Are We Now?

The year 1994 witnessed a tumultuous political debate about the future of health care financing in the United States, fueled to a great extent by concern about uncontrollable rising costs and strong initial public support for fundamental reform. Ultimately there was no consensus on what approach to adopt, and no reform emerged from Congress. Yet, while national attention was riveted on the debate in Washington, great changes in health care delivery were occurring throughout the country.

These changes are market-driven, propelled by the main purchasers of medical care — businesses and state governments — who are desperate to curtail runaway expenditures. By far the most popular market reform has been managed care. Managed care means different things to different people. Large employers often call their efforts to encourage traditional, fee-for-service providers to reduce utilization and prices “managed care.” But in its most precise definition, as used in the accompanying charts, the term refers to health maintenance organizations. These may be either the tightly run group practice type, such as Kaiser Permanente, or looser affiliations of physicians and hospitals linked by marketing and payment formulas and typically coordinated by a large, well-capitalized for-profit insurance company. For-profit HMOs are the fastest growing type of managed care.

No matter how it is defined, managed care embraces certain common elements, including controls on utilization and the use of business techniques to improve efficiency. The more tightly administered managed care organizations typically use two important fiscal controls: they pay physicians according to capitation rather than fee-for-service, and they rely on generalist health professionals to provide basic services and restrict the use of specialists and their technologies.

The move toward managed care has become a stampede. HMO enrollment increased from 12.5 million people in 1983 to an estimated 50 million in 1994. Estimates of further growth are as bullish as 100 million by the year 2000. Using a broader definition of managed care, perhaps 51 percent of all full-time workers are enrolled in some type of managed care arrangement.

States see managed care as a solution to rising Medicaid expenditures and are rapidly converting their fee-for-service Medicaid plans into managed care, the majority of which are administered as for-profit plans. Currently 45 states and the District of Columbia have Medicaid managed care plans, involving 23 percent of the Medicaid population nationally. That proportion is accelerating by the month. Somewhat surprisingly, given many providers’ past reluctance to accept Medicaid reimbursement rates, competition to run the new Medicaid managed care contracts is fierce.

The new aggressive cost-consciousness of employers and states has spotlighted the underlying structure of medical care in this country, exposing the excess capacity that exists in most metropolitan areas. As a result, doctors and hospitals are engaged in a frenzy of planning, network construction, mergers, and consolidations. Physicians are faced with tough choices, such as whether to sell their practices to corporate networks, to accept greatly discounted fees for their usual services, or to join closed-panel HMOs. Increasingly they must choose between two unhappy alternatives — accepting greatly reduced business (and income) or relocating to less desirable communities. Hospitals are downsizing units — or even closing them — and the closure of a whole hospital is no longer extraordinary.
Growth in the Number Of Americans Receiving Their Care in HMOs, 1980-1994

In millions

Note: "Health Maintenance Organizations (HMOs)" include Individual Practice Arrangements (IPAs), networks, group, staff, and mixed-model HMOs.

Medical Graduates Choice
of Primary Care Specialties,
1984–1994

COGME Goal for 2000

- General
- Pediatrics
- General internal
- medicine
- Family practice

Note: Survey question regarding specialty choice changed in 1991; 1990 data not available. The Council on Graduate Medical Education (COGME) and many other organizations recommend that, by 2000, at least half of residency graduates should enter practice as generalist physicians.

Sources: 1984–1994 Association of American Medical Colleges Medical School Graduation Questionnaire.
Some physicians are counterattacking. In a few areas of the country, notably southern California, physician groups are creating their own managed care networks, in order to gain control of the organization and financing of medical care. This isn’t easy. The need for massive amounts of capital to market, acquire, and manage health services favors the capital-laden insurance companies. Many other obstacles also come into play, including antitrust laws, which limit physicians’ ability to organize collectively.

In short, the market conditions for physicians are in flux. What will happen to unemployed and underemployed specialists is not clear, nor do we yet know whether graduate medical education will respond to the new market signals by reducing the number of specialty trainees as well as the 6,000 international medical graduates imported annually to fill hospital residency slots.

Clearly many Americans prefer to let market forces — not regulation — control health care costs. In fact, unleashing market forces may be the fastest way to clear some of our excess acute-care capacity.

But even if market forces dominate the health sector, a number of significant challenges will remain. Market forces favor the strong over the weak, the well-capitalized over the underfunded. Particularly vulnerable are the less financially competitive hospitals in the inner cities and in rural areas and our high-cost academic medical centers.

A second challenge concerns the fate of those vital ancillary products, medical education and research. Price competition is unmasking the true costs of these activities. Inevitably they will depend on explicit public subsidies and thus will be exposed to the vagaries of government budgetary processes.

Another characteristic of the market is the unforgiving way it treats people who cannot afford its products. Currently about 40 million Americans do not have health insurance. An additional 33.4 million who cannot afford private coverage are enrolled in Medicaid. In many states, conventional Medicaid plans pay doctors and hospitals so poorly that they do not participate, severely limiting the number of providers an enrollee can choose from. The increasingly popular view that we are overinvested in entitlements may further diminish Medicaid. Finally, some four million illegal entrants to the United States, many of whom perform vital agricultural, manufacturing, service, and domestic functions, are uninsured. In the new competitive world of managed care, no one is stepping forward to pay for the care for all these groups.

A last, very personal concern of mine has to do with the fate of medicine itself. I worry about the relationship between doctors and patients when health care is treated as a market product — an investment commodity — just like any other. I worry when practitioners’ success is defined by how well they conform to the profit requirements of their employers and shareholders.

These are some of the challenges that confront my profession and our country, even without health care reform, as market forces are transforming the face of health care in the United States.
The RWJF Response

What will be The Robert Wood Johnson Foundation's response to these fundamental changes? First, we will monitor and assess what is happening in the market and try to understand how those changes will affect the health and health care of the American people. We plan to disseminate this information widely so that the nation as a whole can stay informed about the direction and magnitude of market-driven changes in health care delivery.

A changing health system will have an impact on each of The Robert Wood Johnson Foundation's four major program areas. For our access goal, we have several programs in the field attempting to reform health services — improve access and reduce costs — at the state level. Projects in these programs are testing a wide variety of approaches. Meanwhile, we also will be watching the effects of growth in managed care: for example, the extent to which Medicaid patients now using public institutions are able to switch to mainstream medical care and whether those who do switch enjoy better access, greater convenience, and better quality care. However, previous experience with enrolling low-income patients in HMOs provides a caution: prepaid plans have incentives to underserve people who are less able to understand and maneuver the health care delivery system. Lower payments to hospitals under managed care eliminate the source of revenue that has allowed private facilities to serve uninsured people and may force more of the uninsured to seek care at public institutions. At the same time, public hospitals and clinics themselves face budgetary constraints; in the current political environment, states can't raise taxes to support them, state and local government budgets are shrinking, and they now are losing paying Medicaid clients to managed care systems. As a result, they may be forced to institute longer waits for services and offer stripped-down services.

The changing market also is altering employment opportunities for all health professionals. In general, the trend will be to shift care out of expensive hospitals into less costly ambulatory settings, reducing job opportunities for hospital nurses and medical specialists, to cite two examples. In many communities nursing graduates are no longer able to secure hospital nursing jobs, and new physician graduates of residency programs in anesthesiology and pathology face similar difficulties. Again, these are trends worth watching.

Reform's impact on health care costs raises significant questions. Market forces — abetted by the system's excess capacity — undoubtedly will diminish the use of costly hospital services. How much will we save? If, as some analysts believe, providers held back on price increases during the health care reform debate, expect a round of increases that will offset savings. What becomes of the savings? Ideally, perhaps, savings from unnecessary services would stay in the health care sector; while the nation's total health care bill would not decline, we could use these funds to expand services for the uninsured, for example. More likely, at least in for-profit organizations, the savings will be siphoned from health services into shareholder dividends, executive salaries, and other accoutrements of multi-billion-dollar businesses. Certainly the profit potential of managed care has attracted Wall Street's eye. One of the fastest-growing East Coast HMOs recently boasted that its "medical-loss" ratio — the amount of premium dollars paid out for medical care — was only 70 percent. Data on private insurers' fiscal operations are proprietary, so the picture is sketchy. Still, the image that is appearing is deeply concerning to those of us who still believe the business of health care is health.
Drop in Health Insurance Through Employers and Increases in Medicaid, Non-group Insurance, and Number of Uninsured Mark 1988-1994

People under age 65

![Bar chart showing changes in health insurance coverage from 1988 to 1994.](chart)

**Note:** Other includes Medicare coverage for people under 65 and insurance associated with current or past military service. Data for 1994 are estimated based on 1988 and 1992 data.

**Source:** Holahan J, Winterbottom C, and Rajan S. *The Changing Composition of Health Insurance Coverage in the United States.* Washington, DC: The Urban Institute, January 1996. Table 7. This work was sponsored in part by The Robert Wood Johnson Foundation.
U.S. Health Costs Expected To Rise Faster than Income

Actual and projected annual growth rate, per capita


With respect to the Foundation's chronic care goal, systems of managed care could improve services for people with chronic illnesses. Such plans typically attempt to prevent and postpone complications and costly hospitalizations and to take advantage of their fiscal flexibility to integrate the diversity of services needed. The risk is that subtle rationing could limit access to costly treatment, such as hip replacement surgery, that could improve people's ability to be up and about. The tendency of managed care contracts to handle differently — or “carve out” — care for chronic conditions like mental illness, AIDS, and drug addiction highlights the need for accountability. Of course, the most lucrative way for managed care organizations to control costs among people with chronic illnesses is to avoid enrolling them in the first place. Hence, the technical issues of adverse selection, risk adjustment, and outcomes measurement have increasing importance, and the Foundation is supporting a number of projects to improve our understanding of these issues.

The connection between our substance abuse goal area and health care reform is more subtle, but at least two real links exist. First, to the degree that cost-effective prevention strategies can be identified, they could become a part of a basic benefits package of managed care clinical services. Lack of reimbursement has made these services not feasible in traditional fee-for-service medicine. Second, the extent to which managed care systems integrate, separate, or exempt substance abuse treatment services will dramatically change the shape of the clinical approach to addiction.

Conclusion

There is, of course, no absolutely right amount for any nation to spend on health care. Indeed, many Americans, while not wanting to spend more themselves, paradoxically believe the United States spends not too much but too little. The problem is that the country's current rising expenditures, combined with our aversion to raising taxes or increasing the federal budget deficit, leave no room to solve two major problems: the lack of coverage for a large number of Americans and the fragility of coverage among the majority whose health insurance is linked to employment. Slowing medical inflation could generate new resources to expand and secure health insurance. Alternatively, if funds saved do not stay in the health care sector, the gap between the more and less fortunate could widen, exposing the implicit rationing of medical care that already exists. Because the demand for medical care surely will exceed the national willingness to pay for it, the challenge of health care cost containment is likely to endure for as long as there are patients needing care, institutions in place to offer services, and the trained professionals to provide them.

Steven A. Schroeder, MD
President
To Assure That Americans of All Ages Have Access to Basic Health Care

In 1994, we saw a historic national debate over health care reform. The debate was stimulated in large part by the poignant fact that millions of Americans lack access to basic health care. No legislation passed Congress, and millions of people remained without timely, affordable access to care.

Many people think the lack of access to basic health care has only one cause: no health insurance. Indeed, in 1994, the U.S. Census Bureau announced that nearly 40 million Americans — one out of every seven of us — are without health coverage and the financial protection it affords. But there are other, equally formidable barriers to care. The Foundation's work also addresses sociocultural barriers, organizational barriers, and barriers related to the supply and distribution of health services and providers.

Sociocultural barriers are some of the most subtle and difficult. Such barriers are essentially misunderstandings, but they go beyond language differences to the fundamental differences between patients and providers with respect to their values, knowledge, expectations, and intentions. Given the growing diversity of our population, the likelihood of deep misunderstandings only increases.

In 1994, 11 implementation grants started under Opening Doors: A Program to Reduce Sociocultural Barriers to Health Care, a program co-funded with the Henry J. Kaiser Family Foundation. These grantees focus on problems in obtaining maternal, child, and reproductive services. Their programs include projects that are developing interpreter services, providing training for health professionals on cultural issues, and helping consumers understand how the health care system works. They were chosen from more than 800 applicants; 700 applications were submitted for a second round of funding.

An activity that addresses both sociocultural barriers and supply and distribution barriers — the Minority Medical Education Program — was reauthorized for four years. Designed to interest talented minority college students in medicine as a career, the program has had measurable success, nearly doubling the odds of medical school acceptance for participants.

However, if we want to increase the pool of promising minority students, we need to start earlier in the educational pipeline. One such effort to be supported by the Foundation is Project 3000 by 2000: Health Professions Partnership Initiative, an activity of the Association of American Medical Colleges. Under this program, health professions schools develop partnerships with local schools and colleges to enhance students' academic preparation for careers in the health sciences.

Numerous Foundation efforts aim to strengthen the primary care workforce. One such program provides support to generalist physicians who devote time to research and special teaching/role modeling opportunities. This program, the Generalist Physician Faculty Scholars Program, was reauthorized for four more years in 1994.

Focusing further on supply and distribution barriers, the Foundation continued its efforts to increase the supply and enhance training for health professionals by launching two new programs. Research has shown that people who live in underserved areas are more likely to establish practices in those same communities.

Partnerships for Training: Regional Education...
Systems for Nurse Practitioners, Certified Nurse-Midwives, and Physician Assistants is designed to support the development of innovative distance-learning technologies that allow people from underserved communities to remain in them while receiving the education and clinical skills training needed to practice. Enhancing the Capacity of the Nursing Workforce to Adapt to Changes in the Health Care System will be a three-year program for nursing education programs in a defined region to design a continuum of education opportunities (from associate through graduate degrees) that will prepare nurses to work in a full range of patient care settings and serve in a wider variety of clinical and administrative roles. Both of these programs are expected to help nurses adapt to the rapidly changing health care marketplace and its need for more primary and chronic care workers.

The Foundation also funded a new initiative to aid rural communities whose health care delivery systems are challenged by the aggressive, market-driven changes under way in health care. The effort is a partnership with the federal Health Care Financing Administration (HCFA), which is encouraging the formation of rural health networks in six states. The networks will involve area organizations in offering a continuum of health care to a defined rural population.

The Foundation is also working with practicing physicians. Reach Out: Physicians’ Initiative to Expand Care to Underserved Americans awarded 22 implementation grants to physician-led projects across the country. The grantees include a group of physicians in Oakland, California, who volunteer their time to do ambulatory surgery and The Jefferson County Medical Society Outreach Program in Kentucky, which will create "Access for All," a project to increase private physician participation in caring for the homeless, hungry, and addicted. A second round of Reach Out grants will be made in Summer 1995.

Access to basic health care will remain a problem for many Americans in 1995. As the Foundation continues to use its resources to improve access to care for all Americans, new efforts may address issues of urban health and access in the rapidly changing health care marketplace.

To Improve the Way Services are Organized and Provided to People with Chronic Health Conditions

Over 90 million Americans live with chronic illnesses. In 1990, the direct costs of their medical care ran upwards of $425 billion — 61 percent of the nation’s health care expenditures for the year. The total cost of chronic illness — which must include the lost productivity resulting from illness, premature death, and disability — reached perhaps $655 billion. The true extent of these costs and questions of who should pay them, are critical issues that will only increase in importance as the average age of the population increases and chronic illness rates expand.

One in four Americans takes care of someone with a chronic illness, and almost everyone knows someone who is living with diabetes, arthritis, emphysema, cancer, heart disease, chronic mental illness, AIDS, or a physical disability. People with chronic illnesses — and the friends and family who care for them — face tremendous challenges. Piecing together and coordinating the various needed services is a daunting task. Though their chronic conditions are diverse, people encounter similar experiences when they try to obtain health services.

The changing health care system offers both tremendous potential and possible risk for people living with chronic conditions. As more integrated systems of care are formed, the infrastructure for delivery of services to the chronically ill may improve, services may be more appropriate, and service delivery may become more coordinated. Or, managed care systems may underserve or even avoid enrolling people with chronic conditions, in order to keep costs down.
and remain competitive. These issues led the Foundation, in 1994, to pursue a five-part strategy within its chronic care grantmaking, focusing on research, policy analysis, communications, model development, and training of health professionals.

In the research arena, the Foundation sponsored the collection and analysis of data. Specifically,
  - a national survey is under way examining the characteristics and experiences of Americans with disabilities
  - results are coming in from an intensive study of a medium-sized U.S. city that maps the existing chronic care service system, assesses the demand for various services, and describes the actual experience of a group of chronically ill people within the system
  - work began on a chartbook on chronic illness (to be published in 1995) that will contain the latest statistics and trends.

A key hurdle facing chronic care reform is the existence of service systems that have been developed one disease, one population group, or one funding stream at a time. As various health care reform proposals were being debated, the Foundation sponsored both policy analysis and convening of interest groups concerned with different chronic illnesses, in order to discuss ways of melding their concerns and incorporating them into reform discussions.

Within the area of communications, the Foundation used data from its research and policy discussions to increase public awareness of challenges faced by chronically ill people and the problems they encounter within the chronic care service system.

The Foundation also sought to replicate successful models for the organization, financing, and delivery of services. Specifically, in 1994, we continued our replication of the Mental Health Services Program for Youth, which attempts to integrate services involving a broad spectrum of social agencies — health, mental health, welfare, education, juvenile justice, and others. The Foundation continued to implement and evaluate its State Initiatives in Long-Term Care programs.

**What Do Serious Chronic Conditions Cost?**

- People in nursing homes or personal care homes
- People with one or more functional limitations (ADL/ADL)
- Remainder of U.S. population

**Note:** Estimates of people's level of functioning are based on two sets of activities: activities of daily living (ADLs) are those essential for self-care; instrumental activities of daily living (IADLs) assess the ability to perform household and social tasks. People with ADLs and/or IADLs are a small part of the population with chronic illnesses. Data for 1987.

The Foundation anticipates making grants to six new sites in its second round of funding within the Building Health Systems for People with Chronic Illnesses program, designed to find better ways to organize, finance, and integrate services for people with chronic conditions. Within the Chronic Care Initiatives in HMOs program, the Foundation funded seven projects attempting more comprehensive managed care systems for the full range of patients with chronic illnesses. We also continued efforts to foster systems for chronically ill elderly people living in rural areas, through the Coming Home program.

In the area of training health professionals serving chronically ill people, we are developing plans for a new program to improve clinical practice and have supported pilot work for a new clinical case series to be published in a major clinical journal.

In summary, the Foundation has sought in the past year to expand the successes of previous initiatives and to introduce chronic care issues into the marketplace of reform ideas in both the public and private sectors.

**To Promote Health and Prevent Disease by Reducing Harm Caused by Substance Abuse**

Substance abuse is responsible for more than half a million deaths each year in the United States. This tremendous loss of life is particularly tragic because it is unnecessary. Deaths caused by tobacco, alcohol, and illicit drugs are preventable. And the harm caused by substance abuse extends beyond lost lives. Substance abuse destroys families, hurts businesses, cripples neighborhoods, and has nearly incapacitated our social service and criminal justice systems.

The Foundation continued its attempts to reduce the harm caused by substance abuse during 1994. As in previous years, our efforts were concentrated in five priority areas:

- Communicating substance abuse as the nation's number one health problem
- Reducing the harm caused by tobacco
- Understanding the causes (etiology) of substance abuse
- Prevention and early intervention
- Reducing demand through community initiatives

The importance of communicating substance abuse as the nation's number one health problem was brought home during 1994. Government data showed that the remarkable decline in illicit drug use by Americans — under way since the mid-1980s — came to a halt in 1993. Worse, illicit drug use has increased among secondary school students. This increase corresponded with a decrease in students' negative attitudes about illicit drugs.

The Foundation renewed its support of the Partnership for a Drug-Free America's media campaign to reduce demand for illegal drugs. The campaign continues to reinforce messages aimed at denormalizing drug use, particularly among adolescents.

In the tobacco area, we made grants under two previously authorized programs. Eight new projects received funding under the Tobacco Policy Research and Evaluation Program, bringing the current number of grantees to 19. The projects identify, analyze, and evaluate...
public- and private-sector policies aimed at reducing tobacco use. Nineteen states received awards under SmokeLess States: Statewide Tobacco Prevention and Control Initiatives, a program designed to help statewide coalitions develop comprehensive tobacco reduction strategies, especially to stop use by children and youth. To help each of the SmokeLess States grantees develop and implement their strategies, household telephone surveys on a variety of tobacco policy issues will be conducted by Mathematica Policy Research, Inc.

A new program was authorized in the prevention and early intervention area. The Substance Abuse Policy Research Program will enable investigators to conduct policy research in four areas: tobacco, alcohol, illegal drugs, and multiple substances. It is intended to increase understanding of the range, impact, and consequences of public and private policies for reducing the harm caused by substance abuse.

Through a grant to the Family Resource Coalition, a technical assistance center will be established to help up to 10 states form statewide networks of local family support service programs. These programs will help families help their children through training in childrearing, home visiting, infant and toddler day care centers, and other means. Research has shown that family support services result in significant reductions in high-risk behavior in late childhood and early adolescence. Projects under the Foundation’s Free to Grow: Head Start Partnerships to Promote Substance-Free Communities program also embody the family support concept. To date, six local Head Start sites have been funded to develop models to strengthen the family and neighborhood environments for high-risk preschool children.

A project also was funded to disseminate findings from a Foundation-supported Harvard University School of Public Health national study of college students’ drinking practices. The study documented how widespread college binge drinking is among undergraduates and the variety of problems it causes, not only for binge drinkers but for others as well. The findings are being released through professional journals, visits to colleges and universities, special publications, and other avenues.

The Foundation’s work in the community initiatives area continued to focus on implementation of major programs. Second-phase implementation grants were awarded under the Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol program. This effort seeks to demonstrate that, by consolidating resources and creating a single community-wide system of prevention, early identification, treatment, and aftercare, communities can reduce the demand for and use of illegal drugs and alcohol. Fifteen grants began for another community-focused program, Healthy Nations: Reducing Substance Abuse Among Native Americans. This program supports efforts to integrate public awareness campaigns, prevention programs, and services for treatment, aftercare, and support. Projects are encouraged to incorporate traditional cultural values. New community initiatives also began in 1994. The One Church-One Addict program expands the traditional role of the church in providing assistance to people in need by creating volunteer congregation support teams for individuals recovering from substance abuse. The National Drugs Don’t Work Partnership will provide technical assistance and seed money for comprehensive substance abuse workplace programs in 10 sites.

Plans for 1995 include continued public education efforts in the tobacco area, a program to reduce college binge drinking, and program development in two areas: environmental approaches to reducing alcohol abuse and substance abuse in the criminal justice system.
Public Education and Health Care Reform

As the 1993–94 health care reform debate began to escalate, the Foundation saw a need to help the public policy community, the media, and the American public better understand the issues surrounding rising health care costs and access to care. During this period, the Foundation built on its long-standing tradition of educational and informational activities by supporting seminars, symposia, informational briefings, and various other educational activities with the single objective: to increase public understanding of the issues and the proposed solutions, in order to lay the basis for sound judgment and responsible action.

Activities for the public policy community included support and contracts to:
- the Columbia Institute for 12 bipartisan town hall meetings for members of Congress and the public on health care reform issues
- the Congressional Research Service for educational seminars for members of Congress on health care reform
- Princeton University for a conference on the social, fiscal, and political implications of using employer mandates to achieve managed care and for a critique of the Clinton Administration’s health plan. Papers from both meetings were published as special editions of Health Affairs
- the Alpha Center, under the Health Care Financing and Organization Initiative for a meeting discussing the incentives for risk selection by insurance companies under reform and for a meeting discussing integrated service networks in managed care systems.

Activities for the media included support to:
- University of Pennsylvania, The Annenberg School for Communication to monitor the role of media in the national health care reform debate
- the Radio and Television News Directors Foundation for a series of satellite-delivered workshops on how to improve local coverage of health care reform
- the Society for Professional Journalists for a series of workshops to enhance the reporting of health care reform issues
- the American Political Network to conduct a press briefing for Capitol Hill journalists on how health care reform would be handled by Congress.

Public education activities included grants and contracts for:
- “What’s Ailing Medicine”—an hour-long television documentary hosted by Walter Cronkite and aired over the Public Broadcasting System that analyzed strengths and weaknesses of the current health care system
- an hour-long PBS television special, “The Great Health Care Debate,” hosted by Bill Moyers that analyzed the role of media in the health care reform debate
- “To Your Health,” a two-hour NBC News television special that examined then-current issues of health care reform
- a campaign by Rock the Vote Education Fund that discussed health care reform in terms of the concerns of young people ages 17 to 24, such as substance abuse, pregnancy, and mental illness
- the Committee for a Responsible Federal Budget for citizen-education seminars on the economic and budgetary aspects of health care reform
- “Critical Choice,” an augmented reporting and outreach program by National Public Radio to enable local public radio affiliates to conduct special events—town forums, community call-in programs, and so on—around health care reform.
During 1994, the Foundation made 481 grants totaling $180.51 million in support of programs and projects to improve health care in the United States. These grant funds, viewed in terms of the Foundation’s principal objectives, were distributed as follows:

- $71.02 million for programs that assure that Americans of all ages have access to basic health care
- $56.96 million for programs that promote health and prevent disease by reducing harm caused by substance abuse
- $26.86 million for programs that improve the way services are organized and provided to people with chronic health conditions
- $18.94 million for programs that help the nation address the problem of escalating medical care expenditures, and
- $6.73 million for a variety of other purposes, principally in the New Brunswick, New Jersey area where the Foundation originated.

The distribution of funds for 1994 by areas of interest is charted below. The geographic distribution of 1994 funds is diagrammed on the opposite page. Since becoming a national philanthropy in 1972, our appropriations have totaled $1.74 billion.
1994 appropriations by geographical region
($180.51 million)

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<tr>
<th>U.S. population</th>
<th>Region</th>
<th>RW/JF funds</th>
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<td>16%</td>
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<tr>
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<td>South Atlantic</td>
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1994 Grants

This section is a listing of the 481 grants made in 1994. They are grouped according to the Foundation's goal that they address — access grants, chronic health conditions grants, cost containment grants, and substance abuse grants. Those addressing more than one goal are included under cross-cutting grants (with the goal areas specified within each entry). Projects addressing purposes outside the Foundation's goal areas are included under other grants.

In addition to the 481 grants made in 1994, the Foundation continued to make payments on and monitor 1,099 grants awarded in prior years. Together these two groups comprise the Foundation's active grants. A complete list of these grants is available on a 3.5 inch, high-density, IBM-compatible computer diskette. Address requests to:

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

Electronic mail requests can be sent via the Internet to:

publications@rwjf.org
Access

University of Alaska, Fairbanks
Fairbanks, AK
$399,905
Program to strengthen training of Alaska’s rural village health aides (for 3 years). ID#022979

All Kids Count: Establishing Immunization Monitoring and Follow-up Systems
Support for projects to develop and implement systems that improve and sustain access to immunizations for preschool children (for the periods indicated).

The Task Force for Child Survival and Development
Atlanta, GA
$395,117
Technical assistance and direction for All Kids Count: Establishing Immunization Monitoring and Follow-up Systems (for 1 year). ID#022194

University of North Carolina at Chapel Hill
Chapel Hill, NC
$11,770
Dissemination of the All Kids Count Program Interim Evaluation Findings (for 1 year). ID#024521

Alpha Center for Health Planning, Inc.
Washington, DC
$196,033
Technical assistance center for rural hospital models (for 1 year). ID#022539

American Association of Colleges of Nursing
Washington, DC
$44,830
Task force on differentiated competencies for nursing practice (for 9 months). ID#023629

American Medical Association
Chicago, IL
$100,000
National survey of resident physician career opportunities (for 6 months). ID#024470

The Aspen Institute, Inc.
Queenstown, MD
$140,000
Roundable on initiatives for children, families, and communities (for 2 years). ID#023674

Capital Area United Way, Inc.
Lansing, MI
$48,521
Planning a community-wide service program for multi-problem families (for 1 year). ID#023669

The Center for Health Policy Development
Portland, ME
$20,000
Second National Primary Care Conference (for 7 months). ID#023725

Community Care Funding Partners Program
Primary care projects for underserved groups, jointly funded with local foundations and other private sources (for the periods indicated).

Dunn Memorial Hospital
Bedford, IN
$100,000
(3 years)

Esperanza Health Center Inc.
Philadelphia, PA
$100,000
(3 years)

Community Information Exchange
Washington, DC
$44,977
Analysis of community development organization efforts to expand health services (for 1 year). ID#024443

Contra Costa County Department of Health Services
Martinez, CA
$218,501
Development of a family health maintenance organization (for 1 year). ID#023705

The Council of State Governments
Washington, DC
$152,589
Education of Southern policymakers about the use of nurse practitioners, certified nurse-midwives, and physician assistants (for 2 years). ID#024365

Emory University, School of Medicine
Atlanta, GA
$129,226
Effects of illiteracy on patient-provider interactions (for 4 months). ID#021118

Freedom From Hunger
Davis, CA
$460,628
Development of a community health advisor program in two Southern states (for 2 years). ID#023760
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University of Nevada, School of Medicine
Reno, NV
$749,931
(3 years)

The University of New Mexico, School of Medicine
Albuquerque, NM
$600,000
(3 years)

New York Medical College
Valhalla, NY
$1,553,245
(3 years)

The Pennsylvania State University, College of Medicine
Hershey, PA
$750,000
(3 years)

The University of Texas Medical Branch at Galveston
Galveston, TX
$1,494,850
(3 years)

UB Foundation Services, Inc.
Buffalo, NY
$598,334
(3 years)

University of Virginia, School of Medicine
Charlottesville, VA
$2,304,003
(3 years)

University of Missouri — Columbia, School of Medicine
Columbia, MO
$309,479
Technical assistance and direction for The Generalist Physician Initiative (for 1 year). ID#023437

George Mason University, College of Nursing and Health Science
Fairfax, VA
$49,763
Support for initial programming at the Center for Child and Family Welfare (for 16 months).
ID#024190

Group Health Foundation
Washington, DC
$12,561
Proceedings of a symposium on medical school – HMO educational collaboration (for 3 months). ID#024603

Harvard Medical School
Boston, MA
$199,986
Research on U.S. culture, ethnicity, and health care (for 2 years). ID#022031

Healthy Futures
Four-year initiative to support new efforts in southern states to coordinate and improve maternal, perinatal, and infant care services (for the periods indicated).

University of North Carolina at Chapel Hill, School of Public Health
Chapel Hill, NC
$24,658
Dissemination of findings from the evaluation of the Healthy Futures program (for 6 months). ID#024617

Helping Hands Simian Aides for the Disabled, Inc.
Boston, MA
$163,883
Medical interpreting services using video conferencing (for 2 years). ID#024070

Interfaith Conference of Metropolitan Washington, Inc.
Washington, DC
$50,000
Study of community placement of services for people with chronic health conditions (for 1 year). ID#024734

Jersey Battered Women’s Service
Morris Plains, NJ
$43,800
Medical care in a battered women’s service program (for 1 year). ID#024855

Ladders In Nursing Careers (LINC) Program
Expands a career advancement program for health care employees to pursue careers in nursing (for the periods indicated).

Hospital Research and Educational Trust
Chicago, IL
$286,566
Technical assistance and direction for the Ladders in Nursing Careers (LINC) Program (for 1 year). ID#020709

Making the Grade: State and Local Partnerships to Establish School-Based Health Centers
Promotes the increased availability of school-based health services for children and youth with unmet health care needs (for the periods indicated).

The George Washington University Medical Center
Washington, DC
$495,278
Technical assistance and direction for Making the Grade: State and Local Partnerships to Establish School-Based Health Centers (for 1 year). ID#023540

Massachusetts Health Research Institute, Inc.
Boston, MA
$64,965
Planning for two-way information channels on access to health care (for 6 months). ID#024297
McHarron Medical College  
Nashville, TN  
$1,000,000  
Enhancement of clinical training sites and strategic planning (for 1.5 years). ID#022734

Minority Medical Education Program
Summer enrichment program to help minority students successfully compete for medical school acceptance (for the periods indicated).

Baylor College of Medicine  
Houston, TX  
$998,712  
(4 years)

Case Western Reserve University, School of Medicine  
Cleveland, OH  
$999,968  
(4 years)

University of Virginia, School of Medicine  
Charlottesville, VA  
$1,000,000  
(4 years)

University of Washington, School of Medicine  
Seattle, WA  
$1,000,000  
(4 years)

Association of American Medical Colleges  
Washington, DC  
$444,638  
Technical assistance and direction for the Minority Medical Education Program (for 1 year). ID#022941

Minority Medical Faculty Development Program
Program to provide four-year postdoctoral fellowships for minority physicians interested in academic careers in biomedical research, clinical investigation, and health services research (for the periods indicated).

University of Alabama at Birmingham, School of Medicine  
Birmingham, AL  
$305,000  
(2 years)

Baylor College of Medicine  
Houston, TX  
$163,006  
(2 years)

Beth Israel Hospital Association  
Boston, MA  
$163,006  
(2 years)

BWH Anesthesia Foundation, Inc.  
Boston, MA  
$163,006  
(2 years)

University of California, Los Angeles, School of Medicine  
Los Angeles, CA  
$1,099,018  
(2.5 years)

University of California, San Diego, School of Medicine  
La Jolla, CA  
$152,500  
(2 years)

University of California, San Francisco, School of Medicine  
San Francisco, CA  
$467,954  
(2.5 years)

Children’s Hospital Corporation  
Boston, MA  
$163,006  
(2 years)

Children’s Hospital Medical Center  
Cincinnati, OH  
$46,233  
(6 months)

Children’s Hospital of Philadelphia  
Philadelphia, PA  
$163,006  
(2 years)

Emory University, School of Medicine  
Atlanta, GA  
$152,500  
(2 years)

The General Hospital Corporation — Massachusetts General Hospital  
Boston, MA  
$163,006  
(2 years)

Harvard Medical School  
Boston, MA  
$163,006  
(23 months)

Indiana University, School of Medicine  
Indianapolis, IN  
$163,006  
(2 years)

The Johns Hopkins University, School of Medicine  
Baltimore, MD  
$315,506  
(2.5 years)

Louisiana State University Medical Center  
New Orleans, LA  
$163,006  
(2 years)

University of Michigan Medical Center  
Ann Arbor, MI  
$152,500  
(2 years)

Oregon Health Sciences University, School of Medicine  
Portland, OR  
$152,500  
(2 years)
University of Pennsylvania, School of Medicine
Philadelphia, PA
$163,006
(2 years)

Stanford University, School of Medicine
Stanford, CA
$305,000
(2.5 years)

Vanderbilt University, School of Medicine
Nashville, TN
$152,246
(2 years)

University of Virginia, School of Medicine
Charlottesville, VA
$152,500
(2 years)

University of Oklahoma, College of Public Health
Oklahoma City, OK
$442,360
Technical assistance and direction for the Minority Medical Faculty Development Program (for 1 year). ID#022652

National Academy of Sciences — Institute of Medicine
Washington, DC
$350,000
Developing a public health performance monitoring system (for 2 years). ID#024336 AND
$300,000
Planning for an effective primary care system (for 2 years). ID#022795
$39,980
Study of health services research training and workforce issues (for 5 months). ID#024791

National Public Health and Hospital Institute
Washington, DC
$249,246
Analyses of health and sociodemographic factors in urban areas (for 1 year). ID#022724

Nursing Services Manpower Development Program
Initiative to stimulate and test new approaches in attracting individuals into the field of nursing services and fostering growth for those already in the field (for the periods indicated).

University of Illinois, College of Nursing at Chicago
Chicago, IL
$394,598
(4 years)

Opening Doors: A Program to Reduce Sociocultural Barriers to Health Care
Supports demonstration and research projects to improve access to maternal, child, and reproductive health services (for the periods indicated).

Greater Southeast Community Hospital Foundation, Inc.
Washington, DC
$656,288
Expanded technical assistance and direction for Opening Doors: A Program to Reduce Sociocultural Barriers to Health Care (for 1 year). ID#022193

University of Maryland at College Park, College of Health and Human Resources
College Park, MD
$276,544
Evaluation of Opening Doors: A Program to Reduce Sociocultural Barriers to Health Care (for 25 months). ID#024111

Partnerships for Training: Regional Education Systems for Nurse Practitioners, Certified Nurse-Midwives, and Physician Assistants
Supports innovative regional education models designed to address shortages of primary care practitioners in medically underserved areas (for the periods indicated).

Association of Academic Health Centers, Inc.
Washington, DC
$361,172
Technical assistance and direction for Partnerships for Training: Regional Education Systems for Nurse Practitioners, Certified Nurse-Midwives, and Physician Assistants (for 1 year). ID#023646

Practice Sights: State Primary Care Development Strategies
Challenges states to improve the distribution of primary care providers in medically underserved areas (for the periods indicated).

Health Research, Inc.
Albany, NY
$1,097,153
(3 years)

University of Kentucky, Research Foundation
Lexington, KY
$760,000
(3 years)

Minnesota Department of Health
Minneapolis, MN
$777,245
(3 years)

Mountain States Group, Inc.
Boise, ID
$894,977
(3 years)
State of Nebraska, Department of Health  
Lincoln, NE  
$801,055  
(3 years)

State of New Hampshire, Department of Health and Human Services  
Concord, NH  
$650,000  
(3 years)

State of New Mexico, Department of Health  
Santa Fe, NM  
$810,152  
(3 years)

Commonwealth of Pennsylvania, Department of Health  
Harrisburg, PA  
$874,505  
(3 years)

South Dakota Department of Health  
Pierre, SD  
$484,625  
(3 years)

Commonwealth of Virginia, Joint Commission on Health Care  
Richmond, VA  
$798,000  
(3 years)

North Carolina Foundation for Alternative Health Programs, Inc.  
Raleigh, NC  
$495,752  
Technical assistance and direction for Practice Sights: State Primary Care Development Strategies  
(1 year). ID#022412

Puerto Rico Community Foundation, Inc.  
Hato Rey, PR  
$50,000  
Comprehensive service model for high-risk adolescents in Puerto Rico (for 3 months). ID#019321

Reach Out: Physicians’ Initiative to Expand Care to Underserved Americans  
Supports development and implementation by private physicians of innovative models to expand their role in caring for the medically underserved (for the periods indicated).

The Academy of Medicine of Toledo and Lucas County  
Toledo, OH  
$99,930  
(1 year)

Ambulatory Surgery Access Coalition  
Oakland, CA  
$81,885  
(1 year)

Blue Hill Memorial Hospital, Inc.  
Blue Hill, ME  
$100,000  
(1 year)

Buncombe County Medical Society  
Asheville, NC  
$99,989  
(1 year)

Capital Medical Society Foundation, Inc.  
Tallahassee, FL  
$74,620  
(1 year)

Charles R. Drew University of Medicine and Science  
Los Angeles, CA  
$98,236  
(1 year)

Colorado Chapter of the Academy of Pediatrics  
Englewood, CO  
$100,000  
(1 year)

Gift of Life Foundation  
Montgomery, AL  
$94,085  
(1 year)

Howard University Hospital  
Washington, DC  
$99,811  
(1 year)

Jefferson County Medical Society Outreach Program, Inc.  
Louisville, KY  
$97,930  
(1 year)

Kalamazoo Academy of Medicine  
Portage, MI  
$61,473  
(1 year)

Klamath Comprehensive Care, Inc.  
Klamath Falls, OR  
$100,000  
(1 year)

Lancaster County Medical Society  
Lincoln, NE  
$99,782  
(1 year)

Lane County Medical Society  
Eugene, OR  
$71,903  
(1 year)

Montgomery County Medical Society  
Daytona, OH  
$100,000  
(1 year)

MultiCultural Primary Care Medical Group  
San Diego, CA  
$100,000  
(1 year)

Palmetto Project, Inc.  
Charleston, SC  
$100,000  
(1 year)

C.V. Roman Medical Society  
Dallas, TX  
$87,798  
(1 year)
Sacramento — El Dorado Medical Society
Sacramento, CA
$100,000
(1 year)

St. Vincent de Paul Village, Inc.
San Diego, CA
$99,265
(1 year)

Seacoast HealthNet, Inc.
Portsmouth, NH
$94,481
(1 year)

South Carolina Institute for Medical Education and Research
Columbia, SC
$95,985
(1 year)

American College of Physicians
Philadelphia, PA
$313,159
Technical assistance and direction for Reach Out: Physicians’ Initiative to Expand Care to Underserved Americans (for 5 months). ID#022198

Brown University
Providence, RI
$493,567
Technical assistance and direction for Reach Out: Physicians’ Initiative to Expand Care to Underserved Americans (for 1 year). ID#024002

Western Consortium for Public Health
Berkeley, CA
$212,118
Evaluation of Reach Out: Physicians’ Initiative to Expand Care to Underserved Americans (for 2 years). ID#023910

Rutgers, The State University, Institute for Health, Health Care Policy, and Aging Research
New Brunswick, NJ
$49,907
Expansion of an internship in health policy for minority students (for 1 year). ID#023728

School-Based Adolescent Health Care Program
Establishment of comprehensive health services clinics in public secondary schools (for the periods indicated).

Alpha Center for Health Planning, Inc.
Washington, DC
$119,144
(7 months)

Strengthening Hospital Nursing: A Program to Improve Patient Care
Support of efforts to improve patient care by institution-wide restructuring of hospital nursing services (for the periods indicated).

St. Anthony’s Health Care Foundation, Inc.
Saint Petersburg, Fl
$326,862
Technical assistance and direction for Strengthening Hospital Nursing: A Program to Improve Patient Care (for 1 year). ID#022195

Western Consortium for Public Health
Berkeley, CA
$225,769
Evaluation of the Strengthening Hospital Nursing program (for 3 years). ID#024329

UMDNJ — Robert Wood Johnson Medical School
Piscataway, NJ
$24,987
Improving cultural competence of health care providers via video (for 1 year). ID#023886

Volusia County Cooperative Health Group, Inc.
Daytona Beach, FL
$160,153
Public–private partnership to expand care to the underserved (for 3 years). ID#021391

University of Wisconsin — Madison Medical School
Madison, WI
$120,954
Analysis of Canadian approaches to physician supply (for 15 months). ID#022768
AND
$373,584
Policy studies on health workforce issues (for 2 years). ID#024109

Women Aware
New Brunswick, NJ
$9,000
On-site nursing service in battered women’s shelter (for 1 year). ID#022639
AIDS National Interfaith Network, Inc.
Washington, DC
$29,000
Support for AIDS workers to attend a national skills-building conference (for 3 months).
ID#024071

The American Association of Physicians for Human Rights, Inc.
San Francisco, CA
$15,000
Strategy meeting on preventing HIV infection among gay and bisexual men (for 6 months).
ID#023481

Beth Israel Hospital Association
Boston, MA
$99,223
Case studies on clinical practice: A new JAMA series (for 9 months).
ID#024032

Building Health Systems for People with Chronic Illnesses
Supports models of caring for people with chronic illnesses aimed at improving the organization, delivery, and financing of services (for the periods indicated).

Children’s Hospital Corporation
Boston, MA
$153,550
(1 year)

Fairview Foundation
Minneapolis, MN
$644,212
(3 years)

Metropolitan Jewish Geriatric Center
Brooklyn, NY
$474,038
(3 years)

State of Wisconsin, Department of Health and Social Services
Madison, WI
$1,109,951
(3 years)

The Genesee Hospital
Rochester, NY
$416,841
Technical assistance and direction for Building Health Systems for People with Chronic Illnesses (for 1 year).
ID#022832

University of Minnesota, School of Public Health
Minneapolis, MN
$21,504
Evaluation of Oregon’s assisted living program (for 2.5 years).
ID#024981

CAHSAH (California Association for Health Services at Home) Foundation
Sacramento, CA
$140,650
Uniform home health database and patient classification (for 1 year).
ID#021997

Program on the Care of Critically Ill Hospitalized Adults
National collaborative effort to enable physicians and their critically ill adult patients to determine appropriate clinical management strategies (for the periods indicated).

The George Washington University Medical Center
Washington, DC
$872,709
Technical assistance and direction for the Program on the Care of Critically Ill Hospitalized Adults (for 1.5 years).
ID#023715

Center for Health and Long Term Care Research, Inc.
Waltham, MA
$49,326
Understanding geographic variation in use of Medicaid and Medicare home care services (for 7 months).
ID#023682

The Center for Mental Health, Inc.
Washington, DC
$495,206
A managed care model for high-risk families (for 2 years).
ID#023757

The Center School
Highland Park, NJ
$13,000
Summer therapy program for children with learning disabilities (for 2 months).
ID#022424

Chronic Care Initiatives in HMOs
Supports projects to identify, nurture, and evaluate innovations in the delivery of services to chronically ill patients in prepaid managed care organizations (for the periods indicated).

University of California, Los Angeles, School of Medicine
Los Angeles, CA
$515,470
(20 months)

Group Health Cooperative of Puget Sound
Seattle, WA
$609,131
(3 years)

Henry Ford Health System
Detroit, MI
$513,508
(3 years)
<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Amount</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Foundation Health Plan of Colorado</td>
<td>Denver, CO</td>
<td>$471,940</td>
<td>2.5 years</td>
</tr>
<tr>
<td>National Committee for Quality Assurance</td>
<td>Washington, DC</td>
<td>$86,099</td>
<td>9 months</td>
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<tr>
<td>St. Mary Medical Center</td>
<td>Long Beach, CA</td>
<td>$64,988</td>
<td>6 months</td>
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<tr>
<td>Sierra Health Services, Inc.</td>
<td>Las Vegas, NV</td>
<td>$68,920</td>
<td>1 year</td>
</tr>
<tr>
<td>Group Health Foundation</td>
<td>Washington, DC</td>
<td>$312,251</td>
<td>312,251</td>
</tr>
<tr>
<td>Technical assistance and direction for Chronic Care Initiatives in HMOs</td>
<td></td>
<td></td>
<td>(for 1 year)</td>
</tr>
<tr>
<td>Program on Chronic Mental Illness</td>
<td></td>
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<tr>
<td>Support for community-wide projects aimed at consolidating and expanding</td>
<td></td>
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<tr>
<td>services for people with chronic mental illness (for the periods indicated).</td>
<td></td>
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</tr>
<tr>
<td>University of Massachusetts, Social and Demographic Research Institute</td>
<td>Amherst, MA</td>
<td>$30,000</td>
<td>1 year</td>
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<tr>
<td>COMCARE, Inc.</td>
<td>Phoenix, AZ</td>
<td>$13,069</td>
<td>1 year</td>
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<tr>
<td>AIDS Family Services, Inc.</td>
<td>Buffalo, NY</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Allegheny Valley Association of Churches</td>
<td>Natrona Heights, PA</td>
<td>$25,000</td>
<td>1.5 years</td>
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<tr>
<td>Allied Silver Spring Interfaith Services for Seniors Today</td>
<td>Silver Spring, MD</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>The Ark of Refuge, Inc.</td>
<td>San Francisco, CA</td>
<td>$25,000</td>
<td>1.5 years</td>
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<tr>
<td>Catholic Social Services</td>
<td>Owosso, MI</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>East Hill Foursquare Church</td>
<td>Gresham, OR</td>
<td>$25,000</td>
<td>1.5 years</td>
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<tr>
<td>Ecumenical Outreach Project, Inc.</td>
<td>Clarksville, PA</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>First Baptist Church</td>
<td>Hornell, NY</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>First Congregational Church</td>
<td>Memphis, TN</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>First Presbyterian Church of Miami</td>
<td>Miami, FL</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Friedens Evangelical Church</td>
<td>Port Washington, WI</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Grace Episcopal Church</td>
<td>Middletown, NY</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Guilford Regional AIDS Interfaith Network</td>
<td>Greensboro, NC</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Highlands Community Services Board</td>
<td>Bristol, VA</td>
<td>$25,000</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Organization</td>
<td>Location</td>
<td>Amount</td>
<td>Duration</td>
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<td>----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Church of the Holy Comforter</td>
<td>Burlington, NC</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Hope House of St. Croix Valley</td>
<td>Stillwater, MN</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Inter-Faith Ministries — Wichita, Inc.</td>
<td>Wichita, KS</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Interfaith Caregiving Network, Inc.</td>
<td>Waukesha, WI</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Lakeland Hospice, Inc.</td>
<td>Fergus Falls, MN</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Lamoille Elders Networking Services</td>
<td>Johnson, VT</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Macomb Baptist Association</td>
<td>Mt. Clemens, MI</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Mid-Valley Alliance for the Mentally Ill</td>
<td>Albany, OR</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Middletown Interfaith Housing, Inc.</td>
<td>Middletown, PA</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Monadnock Family Services</td>
<td>Keene, NH</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Outreach House Inc.</td>
<td>Hanover, NH</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Pacific Home and Community Care</td>
<td>Honolulu, HI</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Project WORD, Inc.</td>
<td>Fairfax, VA</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>RAIN (The Regional AIDS Interfaith Network) of the Southern Piedmont</td>
<td>Charlotte, NC</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Round Rock Caregivers</td>
<td>Round Rock, TX</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>S.C. Christian Action Council, Inc.</td>
<td>Columbia, SC</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>St. Mary’s Family Respite Center</td>
<td>Philadelphia, PA</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>San Carlos — Estero Interfaith Caregivers, Inc.</td>
<td>Estero, FL</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>The Shepherd Center</td>
<td>Alexandria, LA</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Sierra Vista Community United Church of Christ</td>
<td>Sierra Vista, AZ</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Trenton Ecumenical Area Ministry</td>
<td>Trenton, NJ</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Trinity United Presbyterian Church</td>
<td>Uniontown, PA</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>The United Protestant Appeal, Inc.</td>
<td>Miami, FL</td>
<td>$25,000</td>
<td>(1.5 years)</td>
</tr>
<tr>
<td>Upper Pinellas Interfaith Volunteer Caregivers, Inc.</td>
<td>Dunedin, FL</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<td>Volunteer Interfaith Caregivers — Southwest</td>
<td>Houston, TX</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Wake Interfaith Volunteer Caregivers</td>
<td>Raleigh, NC</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Wicomico County Interfaith Volunteer Caregivers Coalition, Inc.</td>
<td>Salisbury, MD</td>
<td>$25,000</td>
<td>(1.5 years)</td>
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<tr>
<td>Kingston Hospital</td>
<td>Kingston, NY</td>
<td>$1,048,996</td>
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<tr>
<td>Technical assistance and direction for Faith in Action:</td>
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<tr>
<td>Replication of the Interfaith Volunteer Caregivers Program (for 1 year)</td>
<td></td>
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<tr>
<td>(ID#021987)</td>
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</tbody>
</table>
Funding Partnership for People with Disabilities
Program involving many grantmakers to foster the integration of people with disabilities into all aspects of American life (for the periods indicated).

Vermont Center for Independent Living
Montpelier, VT
$48,092 (1 year)

Harvard Medical School
Boston, MA
$25,797
AIDS curriculum for people with chronic mental illness (for 8 months). ID#022886

Harvard University, School of Public Health
Boston, MA
$248,344
Evaluation of the New Hampshire Partners in Health project (for 3 years). ID#023569

Homeless Families Program
Initiative to help homeless families obtain needed health and supportive services, including permanent housing (for the periods indicated).

City of Baltimore, Office of the Mayor
Baltimore, MD
$200,000 (1.5 years)

The General Hospital Corporation — Massachusetts General Hospital
Boston, MA
$474,728
Technical assistance and direction for the Homeless Families Program (for 1 year). ID#022453

University of Illinois at Chicago
Chicago, IL
$30,007
Assessment of the impact of media coverage on survey response rates (for 3 months). ID#023803

Improving Child Health Services: Removing Categorical Barriers to Care
Support for communities to resstructure child health and social service systems (for the periods indicated).

United Way, Inc. — Portland, Maine
Portland, ME
$351,637 (2 years)

University of Washington, Graduate School of Public Affairs
Seattle, WA
$381,789
Technical assistance and direction for Improving Child Health Services: Removing Categorical Barriers to Care (for 1 year). ID#023455

Improving Service Systems for People with Disabilities
Initiative to improve service delivery systems through community-based agencies run by and for people with physical disabilities (for the periods indicated).

SUMMIT Independent Living Center
Missoula, MT
$50,000 (10 months)

The Institute for Rehabilitation and Research
Houston, TX
$453,942
Technical assistance and direction for Improving Service Systems for People with Disabilities (for 1 year). ID#022630

Long Distance Love
New Brunswick, NJ
$15,000
Telephone support service for New Jersey hospital patients (for 1 year). ID#024686

Medical College of Virginia Foundation
Richmond, VA
$100,271
Evaluation of the Medicaid working group initiative (for 3 years). ID#023389

Mental Health Services Program for Youth
Development of model financing and service delivery systems for children and youth with serious mental disorders (for the periods indicated).

Washington Business Group on Health
Washington, DC
$482,481
Technical assistance and direction for the Mental Health Services Program for Youth (for 1 year). ID#021988

Mental Health Services Program for Youth Dissemination
Offers technical assistance, training, and small start-up grants to help states and communities improve services for children with serious mental disorders (for the periods indicated).

State of Michigan, Department of Mental Health
Lansing, MI
$75,000 (1.5 months)

State of Minnesota, Department of Human Services
St. Paul, MN
$75,000 (1 year)
State of Mississippi, Office of the Governor
Jackson, MS
$100,000
(1 year)

State of Ohio, Office of the Governor
Columbus, OH
$74,000
(1 year)

Old Disease, New Challenge: Tuberculosis in the 1990s
Focusing on public health systems, supports projects that develop and test new approaches to the problem of tuberculosis among people at risk (for the periods indicated).

American Lung Association
New York, NY
$35,653
(6 months)

University of California, San Francisco, School of Medicine
San Francisco, CA
$467,964
Technical assistance and direction for Old Disease, New Challenge: Tuberculosis in the 1990s (for 1 year). ID#022372

Parents Reaching Out to Help, Inc.
Algodones, NM
$149,921
Advocacy network for families with children having chronic conditions (for 2 years). ID#023615

Partners in Caregiving: The Dementia Services Program
Promotes the development and growth of adult day centers to address the needs of people with chronic cognitive disorders (for the periods indicated).

Wake Forest University, The Bowman Gray School of Medicine
Winston-Salem, NC
$2,163,743
Technical assistance and direction for Partners in Caregiving: The Dementia Services Program (for 2 years). ID#018556

Replication of the Foundation’s Programs on Mental Illness
Offers technical assistance about the lessons learned from several Foundation initiatives designed to improve mental health care (for the periods indicated).

State of Maine, Department of Mental Health and Mental Retardation
Augusta, ME
$119,680
(17 months)

Stanford University, School of Medicine
Stanford, CA
$135,000
Development of a case management system for people with serious disorders (for 11 months). ID#024204

United Seniors Health Cooperative
Washington, DC
$189,831
Analysis of cash disability allowances for long-term care (for 1.5 years). ID#023584

Washington Business Group on Health
Washington, DC
$99,591
Project to improve chronic care service delivery under health reform (for 4 months). ID#023639
<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Amount</th>
<th>Summary</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abt Associates Inc.</td>
<td>Cambridge, MA</td>
<td>$49,984</td>
<td>Planning for evaluation of health link (for 7 months).</td>
<td>024852</td>
</tr>
<tr>
<td>Albuquerque Public Schools</td>
<td>Albuquerque, NM</td>
<td>$100,000</td>
<td>Alternative high school for chemically dependent students in recovery (for 6 months).</td>
<td>023843</td>
</tr>
<tr>
<td>American Alliance for Rights and Responsibilities</td>
<td>Washington, DC</td>
<td>$290,483</td>
<td>One Church – One Addict (for 2 years).</td>
<td>023965</td>
</tr>
<tr>
<td>American Bar Association Fund for Justice and Education</td>
<td>Chicago, IL</td>
<td>$500,000</td>
<td>Recruitment of ABA members for community anti-drug coalitions (for 2 years).</td>
<td>023195</td>
</tr>
<tr>
<td>City of Baltimore, Department of Health</td>
<td>Baltimore, MD</td>
<td>$50,000</td>
<td>Implementation of a pilot needle-exchange program (for 1 year).</td>
<td>023978</td>
</tr>
<tr>
<td>Best Friends Foundation</td>
<td>Washington, DC</td>
<td>$296,812</td>
<td>Replicating a health program for young teen girls stressing abstinence (for 2 years).</td>
<td>022002</td>
</tr>
<tr>
<td>Black Clergy, Inc.</td>
<td>Philadelphia, PA</td>
<td>$15,000</td>
<td>Anti-smoking radio campaign aimed at African-American smokers (for 3 months).</td>
<td>023947</td>
</tr>
<tr>
<td>Boston University, School of Public Health</td>
<td>Boston, MA</td>
<td>$39,246</td>
<td>Review and analysis of programs to reduce college drinking (for 4 months).</td>
<td>026365</td>
</tr>
<tr>
<td>Brown University</td>
<td>Providence, RI</td>
<td>$23,976</td>
<td>Analysis of how racial biases affect drug policies (for 1 year).</td>
<td>024698</td>
</tr>
<tr>
<td>University of California, San Diego</td>
<td>La Jolla, CA</td>
<td>$40,000</td>
<td>37th International Congress on Alcoholism and Drug Dependence (for 15 months).</td>
<td>023890</td>
</tr>
<tr>
<td>The Carter Center, Inc.</td>
<td>Atlanta, GA</td>
<td>$91,000</td>
<td>Consensus conference on policy options to prevent tobacco use among children and youth (for 4 months).</td>
<td>026464</td>
</tr>
<tr>
<td>The Center on Addiction and Substance Abuse at Columbia</td>
<td>New York, NY</td>
<td>$3,044,067</td>
<td>Demonstration of an aftercare program for substance abusing ex-offenders (for 3 years).</td>
<td>019859</td>
</tr>
<tr>
<td>Center for Science in the Public Interest</td>
<td>Washington, DC</td>
<td>$50,312</td>
<td>Produce and disseminate citizens' action guide to alcohol taxes and health (for 1 year).</td>
<td>024758</td>
</tr>
<tr>
<td>Center for Sustainable Systems, Inc.</td>
<td>Berea, KY</td>
<td>$98,422</td>
<td>Survey of tobacco farmers’ attitudes toward policy and economic trends affecting the tobacco industry (for 1 year).</td>
<td>026374</td>
</tr>
<tr>
<td>Clean &amp; Sober Streets, Inc.</td>
<td>Washington, DC</td>
<td>$50,000</td>
<td>Counselor training for homeless people with substance abuse histories (for 1 year).</td>
<td>024675</td>
</tr>
<tr>
<td>University of Connecticut Health Center</td>
<td>Farmington, CT</td>
<td>$174,509</td>
<td>Encouraging early screening and brief interventions for alcohol abuse (for 1 year).</td>
<td>023464</td>
</tr>
<tr>
<td>Daytop International, Inc.</td>
<td>New York, NY</td>
<td>$7,500</td>
<td>Conference report on community responses to the drug problem (for 2 months).</td>
<td>024154</td>
</tr>
<tr>
<td>Drug Strategies</td>
<td>Washington, DC</td>
<td>$200,238</td>
<td>Pilot development of state statistical profiles on substance abuse (for 1.5 years).</td>
<td>024010</td>
</tr>
</tbody>
</table>
Family Support Services Program
Technical assistance and training initiative to establish statewide networks of community-based family support service centers (for the periods indicated).

Family Resource Coalition
Chicago, IL
$2,700,098
(3 years)

Fighting Back: Community initiatives to Reduce Demand for Illegal Drugs and Alcohol
Support of community-wide efforts to reduce alcohol and drug abuse through public awareness strategies, prevention, early identification, and treatment interventions (for the periods indicated).

Council on Alcoholism and Drug Abuse
Santa Barbara, CA
$1,285,238
(2.5 years)

The Greater Kansas City Community Foundation
Kansas City, MO
$1,564,355
(2.5 years)

Lexington/Richland Alcohol and Drug Abuse Council, Inc.
Columbia, SC
$1,438,511
(2.5 years)

City of Little Rock
Little Rock, AR
$1,194,725
(2.5 years)

Marshall Heights Community Development Organization
Washington, DC
$1,429,749
(2.5 years)

Mecklenburg County Area Mental Health/Mental Retardation Authority
Charlotte, NC
$1,144,767
(1 year)

Milwaukee County
Milwaukee, WI
$1,323,094
(2.5 years)

City of New Haven, Office of the Mayor
New Haven, CT
$1,590,013
(2.5 years)

Northwest New Mexico Fighting Back, Inc.
Gallup, NM
$1,493,322
(2.5 years)

United Way of San Antonio and Bexar County
San Antonio, TX
$1,722,058
(2.5 years)

City of Vallejo
Vallejo, CA
$1,380,711
(2.5 years)

Worcester Fights Back, Inc.
Worcester, MA
$1,181,698
(2.5 years)

Vanderbilt University, School of Medicine
Nashville, TN
$778,892
Technical assistance and direction for Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol (for 1 year). ID#022919

Research Foundation of the City University of New York
New York, NY
$916,643
Evaluation of the Fighting Back program - Phase IV (for 1 year). ID#024727

Free to Grow: Head Start Partnerships to Promote Substance-Free Communities
Model development and implementation for the Head Start Program to work with families of preschool children and neighborhoods to prevent substance abuse (for the periods indicated).

Aspira Inc. of Puerto Rico
Rio Piedras, PR
$300,000
(2 years)

Audubon Area Community Services, Inc.
Owensboro, KY
$311,535
(2 years)

Charles R. Drew University of Medicine and Science
Los Angeles, CA
$316,526
(2 years)

Community Partnership for Child Development
Colorado Springs, CO
$303,689
(2 years)

Concerned Parents for Head Start
Paterson, NJ
$305,396
(2 years)

Fort George Community Enrichment Center, Inc.
New York, NY
$200,000
(1 year)

Columbia University School of Public Health:
New York, NY
$439,116
Technical assistance and direction for Free to Grow: Head Start Partnerships to Promote Substance-Free Communities (for 1 year). ID#021986
The George Washington University, Center for Health Policy Research
Washington, DC
$13,351
Preparation of a textbook on needs and resources for drug-exposed infants (for 11 months). ID#023901

Harvard Medical School
Boston, MA
$49,998
Statewide dissemination of an anti-alcohol abuse theatre project (for 6 months). ID#022541

Harvard University, School of Public Health
Boston, MA
$195,888
Dissemination of findings on drinking patterns of college-age youth (for 8 months). ID#024464

University of Hawaii at Manoa, Social Science Research Institute
Honolulu, HI
$129,924
Integrated approach to drug policies in Hawaii (for 1.5 years). ID#024720

University of Illinois at Chicago
Chicago, IL
$288,962
Study of whether plain cigarette packaging affects purchases by youth (for 1 year). ID#023352

University of Miami, School of Medicine
Miami, FL
$50,000
Early intervention project for cocaine-exposed infants (for 1 year). ID#023423

Michigan Public Health Institute
Okemos, MI
$140,349
Support of tobacco policy research dissemination (for 3 years). ID#024647

National Drugs Don’t Work Partnership
New York, NY
$800,000
National Drugs Don’t Work Partnership (for 2 years). ID#023616

University of New Mexico
Albuquerque, NM
$18,957
Study of effectiveness of victim impact panels (for 1 year). ID#023927

North Bay Health Resources Center, Inc.
Petaluma, CA
$98,921
Community mobilization to combat substance abuse and tobacco use (for 1 year). ID#021635

Partnership for a Drug-Free America, Inc.
New York, NY
$7,300,000
Continuation of a media campaign to reduce demand for illegal drugs (for 3 years). ID#022753

University of Rhode Island
Kingston, RI
$49,786
Feasibility of a computer-delivered smoking cessation program (for 14 months). ID#020713

Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy
Challenges researchers to develop innovative smoking cessation interventions to increase the number of childbearing women who quit smoking and stay smoke-free (for the periods indicated).

University of Alabama at Birmingham, School of Medicine
Birmingham, AL
$429,873
Technical assistance and direction for Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy (for 1 year). ID#022250

SmokeLess States: Statewide Tobacco Prevention and Control Initiatives
Supports development and implementation of comprehensive statewide strategies to reduce tobacco use through education, treatment, and policy initiatives (for the periods indicated).

Alaska Native Health Board
Anchorage, AK
$968,895
(4 years)

American Cancer Society, Inc., Alabama Division, Inc.
Birmingham, AL
$200,000
(2 years)

American Cancer Society, Inc., Arizona Division, Inc.
Phoenix, AZ
$1,029,898
(3 years)
American Cancer Society, Inc., Florida Division, Inc.
Tampa, FL
$300,000
(4 years)

American Cancer Society, Inc., Nevada Division, Inc.
Las Vegas, NV
$199,220
(2 years)

American Heart Association Inc. of Metropolitan Chicago, Inc.
Chicago, IL
$1,000,000
(4 years)

American Heart Association Inc., Oregon Affiliate, Inc.
Portland, OR
$200,000
(2 years)

American Lung Association of Kansas
Topeka, KS
$873,265
(4 years)

American Lung Association of Kentucky, Inc.
Louisville, KY
$200,000
(2 years)

The Coalition for a Tobacco-Free Colorado
Denver, CO
$1,000,000
(2 years)

State of Georgia, Department of Human Resources
Atlanta, GA
$199,613
(2 years)

Health Education, Inc.
Lincoln, NE
$199,200
(2 years)

Institute for Public Policy Advocacy
Washington, DC
$175,000
(1 year)

Medical and Chirurgical Faculty of Maryland
Baltimore, MD
$199,981
(2 years)

Medical Society of New Jersey
Lawrenceville, NJ
$899,600
(4 years)

Minnesota Coalition for a Smoke-Free Society 2000
Minneapolis, MN
$199,971
(2 years)

State of Vermont, Department of Health
Burlington, VT
$400,000
(4 years)

University of Virginia, School of Medicine
Charlottesville, VA
$149,063
(2 years)

Washington D.O.C.
Seattle, WA
$199,910
(2 years)

West Virginia Hospital Research and Education Foundation, Inc.
South Charleston, WV
$981,384
(4 years)

American Medical Association
Chicago, IL
$462,277
Technical assistance and direction for SmokeLess States: Statewide Tobacco Prevention and Control Initiatives (for 1 year). ID#022830

Substance Abuse Policy Research Program
Supports projects that will produce policy-relevant information regarding abuse of tobacco, alcohol, illegal drugs, and multiple substances (for the periods indicated).

Wake Forest University, The Bowman Gray School of Medicine
 Winston-Salem, NC
$189,424
Technical assistance and direction for the Substance Abuse Policy Research Program (for 1 year). ID#026488

University of Texas Health Science Center at Houston School of Public Health
Houston, TX
$325,137
Test of markers for smoking cessation efforts (for 2 years). ID#024584

Tobacco Policy Research and Evaluation Program
Supports projects that will produce policy-relevant information about ways to reduce tobacco use in the United States (for the periods indicated).

University of California, Berkeley, School of Social Welfare
Berkeley, CA
$83,122
(11 months)

University of California, San Diego
La Jolla, CA
$94,144
(1 year)

Health Research, Inc.
Buffalo, NY
$126,593
(2 years)
RAND Corporation
Santa Monica, CA
$199,020
(1.5 years)

Tobacco Control Resource Center, Inc.
Boston, MA
$113,804
(1.5 years)

University of Wisconsin — Madison Law School
Madison, WI
$288,967
(2 years)

Stanford University, School of Law
Stanford, CA
$62,974
Technical assistance and direction for the Tobacco Policy Research and Evaluation Program (for 1 year).
ID#023517

University of California, San Francisco, School of Medicine
San Francisco, CA
$280,517
Quality of research on environmental tobacco smoke by different sponsors (for 2.5 years).
ID#024783

North Bay Health Resources Center, Inc.
Petaluma, CA
$255,940
Study of ways to reduce tobacco sales to minors (for 2 years).
ID#024784

The Van Ost Institute for Family Living, Inc.
Englewood, NJ
$46,775
Research on alcoholism among seniors (for 1 year).
ID#024201

Video Action, Inc.
Washington, DC
$90,000
Distribution and outreach for a video on substance abuse and pregnancy (for 6 months).
ID#024059

Western Public Radio, Inc.
San Francisco, CA
$50,000
Further dissemination of audio program, Drug-Proofing Your Children (for 3 months).
ID#024194

University of Wisconsin — Madison
Madison, WI
$182,941
Development and pilot test of computer-based intervention system for families of alcoholics (for 21 months).
ID#024466
University of California, Los Angeles, School of Medicine
Los Angeles, CA
$197,137
Utilization management effects on physician/patient satisfaction (for 1 year). ID#023332

Center for Research in Ambulatory Health Care Administration, Inc.
Englewood, CO
$1,302,746
National physician profiling system (for 3.5 years). ID#020268

Changes in Health Care Financing and Organization
Support for projects to examine and test how changes in the financing and organization of health services affect health care costs, quality, and access (for the periods indicated).

State of California Managed Risk Medical Insurance Board
Sacramento, CA
$487,582
(19 months)

The General Hospital Corporation — Massachusetts General Hospital
Boston, MA
$490,559
(2 years)

Georgetown University, School of Medicine
Washington, DC
$354,006
(2.5 years)

Harvard University, School of Public Health
Boston, MA
$29,818
(9 months)

Health Research, Inc.
Albany, NY
$1,243,824
(27 months)

Massachusetts Health Research Institute, Inc.
Boston, MA
$176,280
(1.5 years)

State of Minnesota, Department of Human Services
St. Paul, MN
$70,100
(5 months)

University of Pennsylvania, School of Medicine
Philadelphia, PA
$368,381
(1.5 years)

Western Consortium for Public Health
Berkeley, CA
$34,944
(1 year)

Alpha Center for Health Planning, Inc.
Washington, DC
$495,857
Technical assistance and direction for Changes in Health Care Financing and Organization (for 13 months). ID#023909

IHC Hospitals, Inc.
Salt Lake City, UT
$131,659
Assessment of medical practice guidelines and improving their development (for 1 year). ID#022913

IMPACS: Improving Malpractice Prevention and Compensation Systems
Supports development, demonstration, and evaluation of innovative mechanisms for compensating people injured by medical care (for the periods indicated).

Copic Medical Foundation
Englewood, CO
$823,169
(1.5 years)

Utah Alliance for Healthcare, Inc.
Salt Lake City, UT
$729,520
(2 years)

Georgetown University, School of Medicine
Washington, DC
$236,306
Technical assistance and direction for IMPACS: Improving Malpractice Prevention and Compensation Systems (for 1 year). ID#023810

The Long-Term Care Data Institute, Inc.
Cambridge, MA
$65,295
Development of prevalence-based long-term care financing models (for 1 year). ID#023795
National Perinatal Information Center, Inc.
Providence, RI
$45,195
Study of outcomes of very short post-partum hospital stays (for 6 months). ID#023834

New York University, Robert F. Wagner Graduate School of Public Service
New York, NY
$32,378
Assessing the impact of Medicaid managed care in New York City (for 1 year). ID#024742

Rutgers, The State University, Graduate School of Management
Newark, NJ
$49,994
Workshops on health care policy and regulation (for 2 years). ID#024590

Scholars in Health Policy Research Program
Offers two-year postdoctoral training to recent graduates in economics, political science, and sociology to advance their involvement in health policy research (for the periods indicated).

Boston University, School of Management
Boston, MA
$400,805
Technical assistance and direction for the Scholars in Health Policy Research Program (for 11 months). ID#021242

United Mine Workers of America Combined Benefit Fund
Washington, DC
$200,000
Impact of curtailing payment for imaging in referring doctor’s facility (for 1 year). ID#022799

Western Consortium for Public Health
Berkeley, CA
$130,675
Impact of potential Medicare and Medicaid cuts on the uninsured (for 8 months). ID#023433
Cross-Cutting Grants

Alpha Center for Health Planning, Inc.
Washington, DC
$50,000
Conference on issues not addressed under health care reform (for 3 months). ID#024290
Access, Chronic Health Conditions

American Cancer Society, New Jersey Division, Inc.
Fords, NJ
$17,795
Vehicle to transport children to outpatient oncology therapy (for 3 months). ID#023876
Access, Chronic Health Conditions

American Library Association
Chicago, IL
$50,000
Planning for a public library health care information project (for 1 year). ID#024102
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Association of State and Territorial Health Officials
Washington, DC
$50,000
Public education campaign on the role of public health in health reform (for 6 months). ID#024108
Access, Cost Containment

Boston University, School of Medicine
Boston, MA
$47,775
Health services research in national health care delivery systems (for 9 months). ID#024666
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Charles R. Drew University of Medicine and Science
Los Angeles, CA
$47,749
Faculty retreat on implementing the university's strategic plan (for 9 months). ID#024715
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Church Women United, Inc.
Washington, DC
$192,108
Values-based discussions of health care reform (for 1 year). ID#022649
Access, Cost Containment

Clinical Scholars Program
Postdoctoral fellowships for young physicians to develop research skills in non-biological disciplines relevant to medical care (for the periods indicated).
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

University of California, Los Angeles, School of Medicine
Los Angeles, CA
$361,157
(2 years)

University of California, San Francisco, School of Medicine
San Francisco, CA
$231,600
(2 years)

University of North Carolina at Chapel Hill, School of Medicine
Chapel Hill, NC
$351,327
(2 years)

University of Pennsylvania, School of Medicine
Philadelphia, PA
$392,031
(2 years)

Stanford University, School of Medicine
Stanford, CA
$228,734
(2 years)

University of Washington, School of Medicine
Seattle, WA
$635,496
(2 years)

Yale University, School of Medicine
New Haven, CT
$233,175
(2 years)

Committee for Responsible Federal Budget
Washington, DC
$260,650
Public education on the budgetary aspects of health reform (for 1 year). ID#023361
Access, Cost Containment

Community Health Leadership Program
Recognizes individuals for contributions to the RWJF mission and seeks to enhance their capacity for more permanent and widespread impact on our nation's health care problems (for the periods indicated).
Access, Chronic Health Conditions, Substance Abuse, Other
Massachusetts Health Research Institute, Inc.  
Boston, MA  
$366,051  
Technical assistance and direction for the Community Health Leadership Program (for 1 year). ID#021683

Dartmouth-Hitchcock Medical Center  
Hanover, NH  
$2,296,187  
Using small area analysis techniques to assess health reforms (for 35 months). ID#022477  
Access, Cost Containment

Educational Broadcasting Corporation/WNET/Thirteen  
New York, NY  
$400,000  
Partial support for a television program on the health care reform debate (for 1 year). ID#024213  
Access, Cost Containment

The George Washington University, Center for Health Policy Research  
Washington, DC  
$9,591  
Report on mainstreaming the homeless under health care reform (for 2 months). ID#023846  
Access, Cost Containment

The George Washington University Medical Center  
Washington, DC  
$296,182  
Program of short-term policy analysis of health care reform issues (for 1 year). ID#023619  
Access, Cost Containment

Georgetown University, School of Medicine  
Washington, DC  
$17,974  
Conference on health care reform's effects on the workforce (for 4 months). ID#023456  
Access, Cost Containment

Group Health Foundation  
Washington, DC  
$7,000  
Conference on the collaboration between managed care and public health organizations (for 3 months). ID#026453  
Access, Chronic Health, Conditions, Substance Abuse, Cost Containment, Other

Harvard University, School of Public Health  
Boston, MA  
$299,996  
Consumers' views on health plans in three nations (for 10 months). ID#021474  
Access, Chronic Health, Conditions, Substance Abuse, Cost Containment, Other

Health Policy Fellowships Program  
One-year fellowships with the federal government in Washington, D.C., for faculty from academic health science centers (for the periods indicated). Access, Chronic Health, Conditions, Substance Abuse, Cost Containment, Other

University of Alabama at Birmingham, School of Health Related Professions  
Birmingham, AL  
$63,000  
(1 year)

Baylor College of Medicine  
Houston, TX  
$63,279  
(1 year)

University of California, Los Angeles, School of Medicine  
Los Angeles, CA  
$59,250  
(1 year)

Research Foundation of the City University of New York  
New York, NY  
$10,920  
(2 months)

Columbia University, College of Physicians and Surgeons  
New York, NY  
$11,214  
(2 months)

IHC Hospitals, Inc.  
Salt Lake City, UT  
$60,000  
(1 year)

University of Maryland, School of Medicine  
Baltimore, MD  
$59,000  
(1 year)

Montefiore Medical Center  
Bronx, NY  
$5,284  
(2 months)

National Rehabilitation Hospital, Inc.  
Washington, DC  
$62,500  
(1 year)

Thomas Jefferson University, Jefferson Medical College  
Philadelphia, PA  
$10,039  
(2 months)

Yale University, School of Medicine  
New Haven, CT  
$10,200  
(2 months)

National Academy of Sciences — Institute of Medicine  
Washington, DC  
$400,000  
Technical assistance to the Health Policy Fellowships Program (for 1 year). ID#023799
Health Systems Research, Inc.
Washington, DC
$117,175
Identifying consumer priorities for information about health plan performance (for 9 months).
ID#024337
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Information for State Health Policy
Support to help states strengthen their health statistics systems needed for policymaking (for the periods indicated).
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

State of Wisconsin, Department of Health and Social Services
Madison, WI
$749,996
(44 months)

Foundation of the University of Medicine and Dentistry of New Jersey
Newark, NJ
$341,319
Technical assistance and direction for the Information for State Health Policy program (for 1 year).
ID#023724

Injury Prevention Program
Dissemination of a pilot project at Columbia University, Harlem Hospital Center, that significantly reduced children's hospital admissions for trauma (for the periods indicated).
Access, Cost Containment

Columbia University, Harlem Hospital Center
New York, NY
$1,143,657
(3 years)

International Women's Media Foundation
Arlington, VA
$50,000
Journalists' conference on health issues affecting women (for 8 months).
ID#024195
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Investigator Awards in Health Policy Research
Supports individuals working in the field of health policy research to address problems affecting the health and care of Americans (for the periods indicated).

Brown University
Providence, RI
$249,916
(3 years)
Other

Indiana University, School of Public and Environmental Affairs
Bloomington, IN
$249,972
(3 years)
Other

University of Michigan, School of Public Health
Ann Arbor, MI
$242,587
(2 years)
Access

Northwestern University
Evanston, IL
$81,528
(8 months)
Other

Foundation for Health Services Research, Inc.
Washington, DC
$324,480
Technical assistance and direction for the Investigator Awards in Health Policy Research program (for 1 year).
ID#022569
Access, Other

Local Initiative Funding Partners Program — Phase II
Matching grants program to enable local philanthropies to sponsor innovative health services projects, focusing on the Foundation's goal areas (for the periods indicated).

Beatitudes Center
D.O.A.R., Inc.
Phoenix, AZ
$202,784
(3 years)
Chronic Health Conditions

Brownsville Community Health Clinic Corporation
Brownsville, TX
$329,241
(4 years)
Access

Clinica Adelante, Inc.
Surprise, AZ
$112,285
(2 years)
Access

Collier AIDS Resources and Education Service, Inc.
Naples, FL
$400,000
(3 years)
Chronic Health Conditions

Council on Aging in the Midlands, Inc.
Columbia, SC
$199,762
(4 years)
Chronic Health Conditions

El Dorado County Public Health Department
South Lake Tahoe, CA
$129,130
(3 years)
Access

City of Estelline, Estelline Medical Rural Health Clinic
Estelline, SD
$18,733
(1 year)
Chronic Health Conditions
The George Washington University Medical Center  
Washington, DC  
$75,711  
(3 months)  
Access, Chronic Health Conditions, Substance Abuse

Health Care Center for the Homeless Inc.  
Orlando, FL  
$425,000  
(4 years)  
Access

Interfaith Council for the Homeless  
Chicago, IL  
$450,000  
(3 years)  
Access

Judge Baker Children's Center  
Boston, MA  
$399,999  
(3 years)  
Substance Abuse

Justice Resource Institute, Inc.  
Boston, MA  
$400,000  
(3 years)  
Access

Latino Center for Prevention and Action in Health and Welfare  
Santa Ana, CA  
$156,000  
(3 years)  
Chronic Health Conditions

MOMS Health Consortium  
Rockford, IL  
$350,000  
(3 years)  
Access

The University of Texas Medical Branch at Galveston  
Galveston, TX  
$394,972  
(3 years)  
Access

United Way of Central Indiana, Inc.  
Indianapolis, IN  
$439,293  
(3 years)  
Access

Women's Street Support Center of Phoenix  
Phoenix, AZ  
$165,063  
(3 years)  
Access

Zacchaeus Medical Clinic, Inc.  
Washington, DC  
$232,803  
(4 years)  
Access

The George Washington University Medical Center  
Washington, DC  
$513,949  
Technical assistance and direction for the Local Initiative Funding Partners Program — Phase II (for 1 year).  
ID#022940  
Access, Chronic Health Conditions, Substance Abuse

Massachusetts Health Research Institute, Inc.  
Boston, MA  
$130,029  
Advisor to the Foundation on program development (for 1 year).  
ID#023405  
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Middlesex County Recreation Council (John E. Toolan Kiddie Keep Well Camp)  
Edison, NJ  
$227,150  
Camping program for children with health problems (for 1 year).  
ID#0225098  
Access, Chronic Health Conditions

The National Leadership Coalition for Health Care Reform  
Washington, DC  
$195,330  
Educating business leaders about their stake in health care reform (for 1 year).  
ID#024398  
Access, Cost Containment

National Public Health and Hospital Institute  
Washington, DC  
$34,542  
Plan to monitor health reform by using emergency rooms (for 4 months).  
ID#024396  
Access, Chronic Health Conditions, Substance Abuse, Cost Containment

National Public Radio, Inc.  
Washington, DC  
$236,396  
Public education on health care reform (for 7 months).  
ID#024065  
Access, Cost Containment

State of New Jersey, Department of Health  
Trenton, NJ  
$49,800  
Coordination of New Jersey’s response to health care reform (for 6 months).  
ID#024741  
Access, Cost Containment

New Jersey Health Services Development Program — Phase II  
Innovative projects to address the state’s health care needs, focusing on the Foundation’s goal areas (for the periods indicated).

Hispanic Family Center of Southern New Jersey, Inc.  
Camden, NJ  
$238,939  
(3 years)  
Access, Chronic Health Conditions

Jersey City Medical Center  
Jersey City, NJ  
$250,000  
(2 years)  
Other
Kresfield Adult Social Daycare Center, Inc.
Washington, NJ
$188,355
(2 years)
Chronic Health Conditions

Metropolitan Ecumenical Ministry
Newark, NJ
$249,940
(2 years)
Substance Abuse

State of New Jersey, Department of Health
Trenton, NJ
$238,251
(3 years)
Access, Chronic Health Conditions

Northern New Jersey Maternal Child Health Consortium, Inc.
Paramus, NJ
$238,939
(1.5 years)
Substance Abuse

Princeton Center for Leadership Training, Inc.
Lawrenceville, NJ
$248,919
(2 years)
Other

UMDNJ Community Mental Health Center at Piscataway
Piscataway, NJ
$232,619
(2 years)
Access, Chronic Health Conditions

Health Research and Educational Trust of New Jersey
Princeton, NJ
$206,015
Technical assistance and direction for the New Jersey Health Services Development Program (for 1 year). ID#019098
Access, Chronic Health Conditions, Substance Abuse, Other

The New York Academy of Medicine
New York, NY
$230,000
Establishment of the Center for Urban Epidemiologic Studies (for 1 year). ID#024169
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

New York University, Robert F. Wagner Graduate School of Public Service
New York, NY
$45,409
Planning meetings on key evaluation issues for RWJF (for 9 months). ID#026154
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

University of North Carolina at Chapel Hill, School of Nursing
Chapel Hill, NC
$13,999
Conference on nursing education and practice strategies for North Carolina (for 1 year). ID#024471
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

University of Oklahoma, College of Public Health
Oklahoma City, OK
$83,236
Washington policy and program information activities (for 1 year). ID#024138
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

University of Pennsylvania, The Annenberg School for Communication
Philadelphia, PA
$42,365
Evaluation of NRC Special (for 4 months). ID#024437
Access, Cost Containment

$624,743
Media monitoring to improve public understanding of health care reform (for 19 months). ID#023678
Access, Cost Containment

The People-to-People Health Foundation, Inc.
Millwood, VA
$169,238
Health Affairs issue analyzing the Clinton Administration health reform plan (for 9 months). ID#023771
Access, Cost Containment

Replication and Program Services, Inc.
Philadelphia, PA
$200,000
Knowledge diffusion via a generic replication organization (for 33 months). ID#022656
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Research and Demonstrations to Improve Long-Term and Ambulatory Care Quality
Initiative to stimulate the development and testing of new methods for measuring and improving the quality of patient care in long-term and ambulatory care settings (for the periods indicated).

Indiana University, School of Law
Indianapolis, IN
$47,492
(2 years)
Access, Chronic Health Conditions, Substance Abuse, Cost Containment

Rock the Vote Education Fund
Los Angeles, CA
$2,893,600
Health care reform project (for 1 year). ID#023792
Access, Cost Containment
Rutgers, The State University, Institute for Health, Health Care Policy, and Aging Research
New Brunswick, NJ
$50,000
Television series on health care issues in New Jersey (for 1 year).
ID#019974
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

State Initiatives in Health Care Reform
Initiative to help states plan and develop reforms that improve the delivery and financing of health care (for the periods indicated).

State of Alaska, Department of Health and Social Services
Juneau, AK
$110,250
(1.5 years)
Access, Cost Containment

State of Florida, Agency for Health Care Administration
Tallahassee, FL
$1,491,850
(2 years)
Access

Health Research, Inc.
Albany, NY
$852,736
(1.5 years)
Access

Commonwealth of Kentucky, Office of the Governor
Frankfort, KY
$299,500
(1.5 years)
Access, Cost Containment

State of Maine, Department of Human Services
Augusta, ME
$100,029
(1.5 years)
Access, Cost Containment

State of Maryland, Health Care Access and Cost Commission
Baltimore, MD
$292,575
(15 months)
Cost Containment

Missouri Department of Health
Jefferson City, MO
$296,715
(1.5 years)
Access, Cost Containment

National Governors’ Association, Center for Policy Research
Washington, DC
$309,026
(2 years)
Access

State of Nebraska, Department of Health
Lincoln, NE
$100,001
(1.5 years)
Access, Cost Containment

State of North Carolina, North Carolina Health Planning Commission
Raleigh, NC
$95,045
(17 months)
Access, Cost Containment

Commonwealth of Puerto Rico, Puerto Rico Health Insurance Administration
San Juan, PR
$287,642
(1.5 years)
Access, Cost Containment

State of Vermont, Health Care Authority
Montpelier, VT
$342,993
(1 year)
Access

State of Washington, Office of Financial Management
Olympia, WA
$1,459,632
(2 years)
Access

Columbia University, School of Public Health
New York, NY
$359,404
Evaluation of the State initiatives in Health Care Reform program (for 2.5 years).
ID#024466
Access, Cost Containment

State Initiatives in Long-Term Care
Supports state reform of long-term care financing and service delivery systems and development of comprehensive strategies to broaden access to long-term care coverage (for the periods indicated).
Chronic Health Conditions, Cost Containment

State of Colorado, Department of Health Care Policy and Financing
Denver, CO
$199,376
(1.5 years)

State of Florida, Department of Elderly Affairs
Tallahassee, FL
$217,249
(1.5 years)

State of New Hampshire, Department of Health and Human Services
Concord, NH
$198,808
(1.5 years)
State of Oklahoma, Department of Human Services
Oklahoma City, OK
$183,509
(1.5 years)

State of Vermont, Health Care Authority
Montpelier, VT
$65,219
(1 year)

University of Maryland, Center on Aging
College Park, MD
$399,172
Technical assistance and direction for the State Initiatives in Long-Term Care program (for 1 year). ID#022831

Tides Foundation
San Francisco, CA
$15,000
Seminar on health issues for Sustainable Cities Conference (for 6 months). ID#024214
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

University of Medicine and Dentistry of New Jersey
Newark, NJ
$49,860
Statistical analysis of graduate medical education trends in New Jersey (for 1 year). ID#023369
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Foundation of the University of Medicine and Dentistry of New Jersey
Newark, NJ
$14,000,000
Endowment to strengthen the University's academic and service capacities (for 5 years). ID#023301
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Vanderbilt University, School of Law
Nashville, TN
$184,916
Study of laws affecting the organization and management of health services (for 21 months). ID#021719
Access, Chronic Health Conditions, Substance Abuse, Cost Containment, Other

Yale University, School of Organization and Management
New Haven, CT
$32,468
Documentation of the policy process for health care reform (for 10 months). ID#023786
Access, Cost Containment
American National Red Cross  
Washington, DC  
$50,000  
Disaster relief for Southern California earthquake (for 1 month). ID#023865

University of Arkansas for Medical Sciences  
Little Rock, AR  
$15,028  
Development of a training program for infant/toddler caregivers (for 1 year). ID#024681

Benton Foundation  
Washington, DC  
$20,000  
Meeting on new information technology and the public interest (for 2 months). ID#023949

Cenacle Retreat House  
Highland Park, NJ  
$20,000  
Facility repairs and renovations (for 1 year). ID#022923

Cold Spring Harbor Laboratory  
Cold Spring Harbor, NY  
$145,616  
Meetings on the health care implications of the human genome project (for 1 year). ID#022602

Elijah’s Promise, Inc.  
New Brunswick, NJ  
$100,000  
Renovation of a facility to provide meals for the poor (for 1 year). ID#023934

The Foundation Center  
New York, NY  
$250,000  
Development of a computerized information network on foundations (for 1 year). ID#024693

Harvard University  
Cambridge, MA  
$188,990  
Analysis of domestic policy gridlock (for 1 year). ID#022847

The Middlesex-Somerset-Mercer Regional Study Council  
Princeton, NJ  
$50,000  
Support for regional planning (for 1 year). ID#026458

New Brunswick Development Corporation  
New Brunswick, NJ  
$295,586  
Redevelopment program for New Brunswick, New Jersey (for 1 year). ID#023279

University of Rhode Island  
Kingston, RI  
$44,767  
Development of survey on effects of domestic violence (for 1 year). ID#023802

Saint Louis University School of Public Health  
St. Louis, MO  
$49,188  
Improving training for Missouri officials who set natural disaster policy (for 1 year). ID#023975

St. Vincent de Paul Societies  
Metuchen, NJ  
$66,000  
Program to assist the indigent (for 1 year). ID#023467

The Salvation Army  
New Brunswick, NJ  
$110,000  
Support services for the indigent and distressed (for 1 year). ID#023078

Social Science Research Council  
New York, NY  
$15,000  
Dissemination of report on sexuality research opportunities (for 4 months). ID#024373

The United Way of Central Jersey, Inc.  
Milltown, NJ  
$300,000  
Support for the 1994 campaign (for 1 year). ID#023438

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<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 1994 Grants</td>
<td>180,510,763</td>
</tr>
<tr>
<td>Refunds of Prior Years’ Grants, Net of Transfers</td>
<td>(2,175,829)</td>
</tr>
<tr>
<td>Cancellations of Prior Years’ Grants, Net of Transfers</td>
<td>(7,945,920)</td>
</tr>
<tr>
<td>Transfer Grants: Balance Unspent By Original Grantees and Cancelled or Refunded in 1994</td>
<td>(410,780)</td>
</tr>
<tr>
<td>Transferred to New Grantees</td>
<td>506,831</td>
</tr>
<tr>
<td>Grants Net for 1994</td>
<td>170,483,065</td>
</tr>
</tbody>
</table>
Selected Bibliography

Each year the Foundation's grantees report to us the publications and other information materials that have been produced as a direct or indirect result of their grants. This bibliography presents a sampling of citations from the books, book chapters, journal articles, reports, and audiovisual materials that have been produced and reported to us by Foundation grantees. The publications are available through medical libraries and/or the publishers. We regret that copies are not available from the Foundation.

Books


Book Chapters


Journal Articles


**Reports**


Audiovisual Materials


Teachers’ Classroom Practice (series of videotapes showing changes in teachers’ classroom practice during the Child Development Project). Oakland, California: Developmental Studies Center, 1994.

Net grants and program contracts and related activities totaled $183,985,000. The Robert Wood Johnson Foundation funds a number of national programs involving multiyear grants to groups of grantees. Thus, the amounts awarded from year to year may differ significantly.

Program development and evaluation, administrative and investment expenses for the year came to $17,775,000; and federal excise tax on investment income amounted to $1,247,000, making a grand total of grant authorizations and expenditures of $203,007,000. This total was $73,225,000 more than gross investment income of $129,781,000. In 1993, total grant authorizations and expenditures were $36,664,000 more than gross revenue.

The Internal Revenue Code requires private foundations to make qualifying distributions of five percent of the fair market value of assets not used in carrying out the charitable purpose of the Foundation. The amounts required to be paid out for 1994 and 1993 were approximately $170,500,000 and $161,100,000, respectively.

A list of investment securities held at December 31, 1994, is available upon request to the Treasurer, The Robert Wood Johnson Foundation, Post Office Box 2316, Princeton, New Jersey 08543-2316.

Andrew Greene
Vice President and Treasurer

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Report of Independent Accountants

To the Trustees of
The Robert Wood Johnson Foundation:

We have audited the accompanying statements of assets, liabilities and foundation principal of The Robert Wood Johnson Foundation (the “Foundation”) as of December 31, 1994 and 1993 and the related statements of investment income, expenses, grants, and changes in foundation principal for the years then ended. These financial statements are the responsibility of the Foundation’s management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Foundation at December 31, 1994 and 1993 and the investment income, expenses, grants, and changes in foundation principal for the years then ended in conformity with generally accepted accounting principles.

Princeton, New Jersey
January 27, 1995

Coopers & Lybrand L.L.P.
**Statement of Assets, Liabilities and Foundation Principal**

at December 31, 1994 and 1993  
(Dollars in thousands)

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>1994</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$3,037</td>
<td>$3,037</td>
</tr>
<tr>
<td>Interest and dividends receivable</td>
<td>14,037</td>
<td>11,919</td>
</tr>
<tr>
<td>Investments at market value:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson &amp; Johnson common stock</td>
<td>2,287,011</td>
<td>2,041,427</td>
</tr>
<tr>
<td>Other equity investments</td>
<td>58,801</td>
<td>186,289</td>
</tr>
<tr>
<td>Fixed income investments</td>
<td>1,352,791</td>
<td>1,182,826</td>
</tr>
<tr>
<td>Program related investments</td>
<td>19,444</td>
<td>20,688</td>
</tr>
<tr>
<td>Cash surrender value, net</td>
<td>2,321</td>
<td>1,407</td>
</tr>
<tr>
<td>Land, building, furniture and equipment at cost, net of depreciation</td>
<td>14,611</td>
<td>12,285</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td><strong>$3,749,019</strong></td>
<td><strong>$3,456,844</strong></td>
</tr>
</tbody>
</table>

| LIABILITIES AND FOUNDATION PRINCIPAL |             |             |
| Liabilities:                        |             |             |
| Accounts payable                    | $ 514      | $ 299      |
| Payable on pending security transactions | 90,427   | 84,566     |
| Unpaid grants                       | 184,448    | 169,090    |
| Federal excise tax payable          | 1,967      | 58         |
| Deferred federal excise tax         | 40,884     | 36,992     |
| **Total liabilities**               | 318,240    | 291,003    |
| Foundation principal                | 3,430,779  | 3,165,839  |
| **Total liabilities**               | **$3,749,019** | **$3,456,844** |

See notes to financial statements.
### Statement of Investment Income, Expenses, Grants and Changes in Foundation Principal
for the years ended December 31, 1994 and 1993
(Dollars in thousands)

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Investment income:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends</td>
<td>$54,551</td>
<td>$49,256</td>
</tr>
<tr>
<td>Interest</td>
<td>75,230</td>
<td>73,404</td>
</tr>
<tr>
<td><strong>Less:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal excise tax</td>
<td>1,247</td>
<td>1,244</td>
</tr>
<tr>
<td>Investment expense</td>
<td>2,495</td>
<td>2,197</td>
</tr>
<tr>
<td><strong>Total Investment Income:</strong></td>
<td>126,039</td>
<td>119,219</td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program development and evaluation</td>
<td>9,813</td>
<td>8,857</td>
</tr>
<tr>
<td>General administration</td>
<td>5,467</td>
<td>5,456</td>
</tr>
<tr>
<td><strong>Total Expenses:</strong></td>
<td>15,280</td>
<td>14,313</td>
</tr>
<tr>
<td><strong>Income available for grants:</strong></td>
<td>110,759</td>
<td>104,906</td>
</tr>
<tr>
<td>Less: Grants, net of refunds and cancellations</td>
<td>170,485</td>
<td>130,969</td>
</tr>
<tr>
<td>Program contracts and related activities</td>
<td>13,500</td>
<td>10,601</td>
</tr>
<tr>
<td><strong>Excess of grants and expenses over income:</strong></td>
<td>(73,226)</td>
<td>(36,664)</td>
</tr>
<tr>
<td><strong>Adjustments to Foundation principal net of related federal excise tax:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Realized gains on sale of securities</td>
<td>157,136</td>
<td>59,725</td>
</tr>
<tr>
<td>Unrealized appreciation (depreciation) on investments</td>
<td>181,030</td>
<td>(255,653)</td>
</tr>
<tr>
<td><strong>Total Adjustments:</strong></td>
<td>338,166</td>
<td>(195,928)</td>
</tr>
<tr>
<td><strong>Net increase (decrease) in Foundation principal:</strong></td>
<td>264,940</td>
<td>(232,592)</td>
</tr>
<tr>
<td>Foundation principal, beginning of year</td>
<td>3,165,839</td>
<td>3,398,431</td>
</tr>
<tr>
<td>Foundation principal, end of year</td>
<td>$3,430,779</td>
<td>$3,165,839</td>
</tr>
</tbody>
</table>

See notes to financial statements.
NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies:

The Foundation is a private foundation as described in Section 501(c)(3) of the Internal Revenue Code.

Investments represent securities traded on a national securities exchange which by their nature are subject to market fluctuations. Investments are valued at the last reported sales price on the last business day of the year.

Grants are recorded as a liability in the year they are awarded and are usually paid within a five-year period.

Depreciation of $1,332,511 in 1994 and $920,837 in 1993 is calculated using the straight-line method over the estimated useful lives of the depreciable assets.

Deferred federal excise taxes are the result of unrealized appreciation on investments being reported for financial statement purposes in different periods than for tax purposes.

2. Investments:

The cost and market values of the investments are summarized as follows (dollars in thousands):

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th></th>
<th>1993</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost</td>
<td>Market Value</td>
<td>Cost</td>
<td>Market Value</td>
</tr>
<tr>
<td>Johnson &amp; Johnson Common Stock</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41,771,897 and 45,491,400 shares</td>
<td>$99,788</td>
<td>$2,287,011</td>
<td>$108,674</td>
<td>$2,041,427</td>
</tr>
<tr>
<td>in 1994 and 1993, respectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other equity investments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internally managed including temporary cash of $19,598</td>
<td>–</td>
<td>–</td>
<td>110,394</td>
<td>126,527</td>
</tr>
<tr>
<td>Externally managed</td>
<td>56,013</td>
<td>58,801</td>
<td>52,156</td>
<td>59,762</td>
</tr>
<tr>
<td>Fixed income investments</td>
<td>1,389,955</td>
<td>1,352,791</td>
<td>1,171,393</td>
<td>1,182,826</td>
</tr>
<tr>
<td></td>
<td>$1,545,756</td>
<td>$3,698,603</td>
<td>$1,442,617</td>
<td>$3,410,542</td>
</tr>
</tbody>
</table>

The net realized gains (losses) on sales of securities for the years ended December 31, 1994 and 1993 were as follows (dollars in thousands):

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson &amp; Johnson common stock</td>
<td>$189,141</td>
<td>$ –</td>
</tr>
<tr>
<td>Other securities, net</td>
<td>(32,005)</td>
<td>59,725</td>
</tr>
<tr>
<td></td>
<td>$157,136</td>
<td>$59,725</td>
</tr>
</tbody>
</table>

3. Retirement Plan:

Substantially all employees of the Foundation are covered by a retirement plan which provides for retirement benefits through the purchase of individually-owned annuities. The Foundation’s policy is to fund costs incurred. Pension expense was $1,035,906 and $974,800 in 1994 and 1993, respectively.
At the January 1995 meeting of the Board, Linda Griego was elected trustee of the Foundation. Ms. Griego is chief executive officer of Rebuild LA, a nonprofit public benefit corporation that focuses on economic revitalization of communities of greater Los Angeles.

Also at the January 1995 meeting, Leonard F. Hill and Frank J. Hoenemeyer, trustees of the Foundation, were each elected to the office of trustee emeritus. Mr. Hill’s quarter century of service as trustee began in 1971 when the Foundation became a major philanthropy and included participation in all facets of the Foundation’s growth and development. Mr. Hoenemeyer served as a trustee and as a member and then the chairman of the Finance Committee of the Board over the past nine years. At their election as trustees emeriti, Mr. Hill and Mr. Hoenemeyer were cited by the Board for their faithful, distinguished, and valuable service to the Foundation.

David E. Rogers, MD, died on December 5, 1994. He served as president of the Foundation from January 1972 through November 1986 and was trustee emeritus. The Foundation is indebted to Dr. Rogers for his vision and leadership during its formative years. Dr. Rogers was the Walsh McDermott University Professor of Medicine at the Cornell University Medical College in New York City and had served as the co-chair of the National Commission on AIDS. The Foundation has established the David E. Rogers Award to recognize a member of a medical school faculty who during his/her career made major contributions to improving the health and health care of the American people. This award will be made annually at the fall meeting of the Association of American Medical Colleges.

Staff changes

In July 1994, Marilyn Aguirre-Molina, EdD, joined the Foundation as senior program officer. Prior to joining the Foundation, Dr. Aguirre-Molina was an assistant professor in the Department of Environmental and Community Medicine and co-director of the Health Education and Behavioral Science Track at the University of Medicine and Dentistry of New Jersey. Dr. Aguirre-Molina received her EdD in health education from Columbia University.

In July 1994, Paul Tarini joined the Foundation as communications officer. Prior to joining the Foundation, Mr. Tarini worked as senior public information officer in the American Medical Association’s Department of Science News. Mr. Tarini received his MA in public affairs journalism from Columbia College Chicago, Chicago, Illinois. Also in July 1994, Joan Hollendonner, associate communications officer, was promoted to communications officer.

In October 1994, F. Marc LaForce, MD, joined the staff as special advisor to the Foundation for a six-month period during a sabbatical leave from The Genesee Hospital in Rochester, New York, where he is the physician-in-chief. He also directs the Foundation’s Building Health Systems for People with Chronic Illnesses program.

In January 1995, Rona K. Smyth Henry joined the Foundation as financial officer, from The Bowman Gray School of Medicine of Wake Forest University. Ms. Henry received her MBA and MPH in health services management from the University of California, Berkeley.

This report covers the period through February 10, 1995.
In December 1994, Pauline M. Seitz, senior program officer, left the Foundation to become program director of the Foundation’s New Jersey Health Initiatives Program at the Health Research Educational Trust of the New Jersey Hospital Association. Ms. Seitz joined the Foundation in October 1987.

In December 1994, Vivian E. Fransen, communications officer, left the Foundation to become director of development for the Bonnie Brae School for troubled boys in Millington, New Jersey. Ms. Fransen joined the Foundation in September 1989.

In January 1995, Philip J. Gallagher, librarian, retired from the Foundation after more than 21 years of service.

In February 1995, Floyd K. Morris, senior financial officer, left the Foundation to assume the position of assistant administrator at the Kenmore Health Center, Harvard Community Health Plan, Boston. Mr. Morris joined the Foundation in June 1989.

Program directors

Maxine Hayes, MD, MPH, was appointed program director to the program, Improving Child Health Services: Removing Categorical Barriers to Care. Dr. Hayes is assistant secretary, Washington State Department of Health, Child Health Services.

Jean Johnson-Pawlson, PhD, was appointed program director to the program, Partnerships for Training: Regional Education Systems for Nurse Practitioners, Certified Nurse-Midwives, and Physician Assistants. Dr. Johnson-Pawlson is associate dean of health sciences at George Washington University School of Medicine.

Sol Levine, PhD, was appointed program director to the program, Investigator Awards in Health Policy Research. Dr. Levine is professor and acting chair at the Harvard School of Public Health Department of Health and Social Behavior; and senior scientist, and director of the Joint Program in Society and Health, The Health Institute, New England Medical Center.

Susan D. Horn, PhD, completed her assignment directing the Program for Faculty Fellowships in Health Care Finance. Dr. Horn was appointed to this position in 1987.

Sandra L. Meicher, PhD, completed her assignment directing the program, Improving Child Health Services: Removing Categorical Barriers to Care. Dr. Meicher was appointed to this position in 1993.

Linda J. Rosen, PhD, completed her assignment as acting director of the New Jersey Health Services Development Program. Dr. Rosen was appointed to this position in 1993.

Board activities

The Board of Trustees met five times in 1994 to conduct business, review proposals, and appropriate funds. In addition, the Nominating, Human Resources, Finance, and Audit Committees met as required to consider and prepare recommendations to the Board.

J. Warren Wood III
Vice President, General Counsel and Secretary
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*Special Advisor to the Foundation*

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Spencer L. Lester
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Lynee Long-Higham
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Janice A. Opalski
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Sheila Weeks-Brown
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Technical Support Services Operator

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Denise M. Inverso
Fixed Income Portfolio Manager

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Personnel Assistant

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Benefits Specialist

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Heidi N. Tucci
Office Services Coordinator

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Receptionist/Operator

M. M. Thorpes
Receptionist/Operator

Amy K. Brand
Mail Services Coordinator

Sandra A. Georgeanni
Records Supervisor

Vicky J. Coveskeli
Records Assistant

Barbara J. Tretola
Manager, Travel/Conference Services

James Rohmann
Chauffeur

Bernadine Rein
Travel Assistant

Staff as of February 10, 1995.
The Robert Wood Johnson Foundation funds a number of multyear, multisite national programs whose grantees are located throughout the country. Most of these programs are managed by institutions outside the Foundation.

Below is a listing of all current national programs, including the names and addresses of the directors or co-directors:

**ALL KIDS COUNT: ESTABLISHING IMMUNIZATION MONITORING AND FOLLOW-UP SYSTEMS**
William H. Foege, MD
Executive Director
The Task Force for Child Survival and Development
The Carter Center, Emory University
One Copenhill
Atlanta, GA 30307-1406

**BUILDING HEALTH SYSTEMS FOR PEOPLE WITH CHRONIC ILLNESSES**
F. Marc LaForce, MD
Physician-in-Chief
Department of Medicine
The Genesee Hospital
224 Alexander Street
Rochester, NY 14607-4055

**CHANGES IN HEALTH CARE FINANCING AND ORGANIZATION**
Anne K. Gauthier
Associate Director
The Alpha Center
Suite 1100
1350 Connecticut Avenue, NW
Washington, DC 20036-1701

**CHRONIC CARE INITIATIVES IN HMOs**
Peter D. Fox, PhD
Director
Chronic Care Initiatives in HMOs
Group Health Foundation
1129 20th Street, NW, Suite 600
Washington, DC 20036-3403

**COMING HOME**
David C. Nolan
Director
Coming Home
Suite 610
44 Montgomery Street
San Francisco, CA 94104

**COMMUNITY HEALTH LEADERSHIP PROGRAM**
Catherine M. Dunham, EdD
Director
Community Health Leadership Program
Massachusetts Health Research Institute, Inc.
30 Winter Street, Suite 1005
Boston, MA 02108

**DEVELOPING LOCAL INFANT MORTALITY REVIEW COMMITTEES**
Kathleen A. Buckley, MSN, CNM
Director
National Fetal-Infant Mortality Review Program
American College of Obstetricians and Gynecologists
400 12th Street, SW
Washington, DC 20024-2188

**FAITH IN ACTION: REPLICATION OF THE INTERFAITH VOLUNTEER CAREGIVERS PROGRAM**
Kenneth G. Johnson, MD
Director
Health Services Research Center
Kingston Hospital
360 Broadway, Suite 105
PO Box 2290
Kingston, NY 12401-0227

**FAMILY SUPPORT SERVICES PROGRAM**
Judy L. Carter
Executive Director
Family Resource Coalition
200 South Michigan Avenue,
#1520
Chicago, IL 60604-2904

**FIGHTING BACK: COMMUNITY INITIATIVES TO REDUCE DEMAND FOR ILLEGAL DRUGS AND ALCOHOL**
W. Anderson Spickard, Jr., MD
Professor of Medicine
Vanderbilt University School of Medicine
2533 The Vanderbilt Clinic
23rd Avenue and Pierce Street
Nashville, TN 37232-5305

**FREE TO GROW: HEAD START PARTNERSHIPS TO PROMOTE SUBSTANCE-FREE COMMUNITIES**
Judith E. Jones
Director and Associate Clinical Professor of Public Health
National Center for Children in Poverty
Columbia University
154 Haven Avenue, 3rd Floor
New York, NY 10032

**GENERALIST PHYSICIAN FACULTY SCHOLARS PROGRAM**
John M. Eisenberg, MD
Chairman and Physician-in-Chief
Department of Medicine
5005 PHC
Georgetown University Medical Center
3800 Reservoir Road, NW
Washington, DC 20007-2197

**THE GENERALIST PHYSICIAN INITIATIVE**
Jack M. Colwill, MD
Professor and Chairman
Department of Family Medicine
University of Missouri-Columbia
M228 Medical Science Building
1 Hospital Drive
Columbia, MO 65212

**HEALTH POLICY FELLOWSHIPS PROGRAM**
Marion Ein Lewin
Director
Robert Wood Johnson Health Policy Fellows Program
Institute of Medicine
National Academy of Sciences
2101 Constitution Avenue, NW
Washington, DC 20418
HEALTH OF THE PUBLIC: AN ACADEMIC CHALLENGE
Thomas S. Inui, MD, ScM
Director
Health of the Public
Harvard Community Health Plan, Inc.
126 Brookline Avenue, Suite 200
Boston, MA 02215
Jonathan Showstack
Professor of Medicine and Health Policy
University of California, San Francisco
735 Parinasus Avenue
San Francisco, CA 94143-0994

HEALTHY NATIONS: REDUCING SUBSTANCE ABUSE AMONG NATIVE AMERICANS
Candace M. Fleming, PhD
Co-director
Healthy Nations: Reducing Substance Abuse Among Native Americans
Department of Psychiatry
University of Colorado Health Sciences Center
University North Pavilion A011-13
4455 East 12th Avenue
Denver, CO 80220
Spero M. Manson, PhD
Co-director
Healthy Nations: Reducing Substance Abuse Among Native Americans
Department of Psychiatry
University of Colorado Health Sciences Center
University North Pavilion A011-13
4455 East 12th Avenue
Denver, CO 80220

HOMELESS FAMILIES PROGRAM
James J. O'Connell III, MD
Director
Homeless Families Program
Massachusetts General Hospital
67 1/2 Chestnut Street
Boston, MA 02108

IMPACTS: IMPROVING MALPRACTICE PREVENTION AND COMPENSATION SYSTEMS
Robert A. Berenson, MD
Assistant Clinical Professor
Family and Community Medicine
Georgetown University, School of Medicine
Suite 525
2233 Wisconsin Avenue, NW
Washington, DC 20007

IMPROVING CHILD HEALTH SERVICES: REMOVING CATEGORICAL BARRIERS TO CARE
Maxine Hayes, MD, MPH
Assistant Secretary
Community Health Division
Washington State Department of Health
PO Box 47880
Olympia, WA 98504-7880

IMPROVING THE QUALITY OF HOSPITAL CARE
Andrea L. Kabcerell, RN, MPH
Senior Research Associate
College of Human Ecology
Cornell University
Martha van Renselal Hall, Room N132
Ithaca, NY 14853-4401

IMPROVING SERVICE SYSTEMS FOR PEOPLE WITH DISABILITIES
Lex Frieden
Senior Vice President
The Institute for Rehabilitation and Research
Texas Medical Center
1333 Moursund Avenue
Houston, TX 77030

INFANT HEALTH AND DEVELOPMENT PROGRAM REPLICATION
Godfrey P. Oakley, Jr., MD
Director
Division of Birth Defects and Developmental Disabilities Centers for Disease Control and Prevention
1600 Clifton Road, NE, F-34
Atlanta, GA 30333

INFORMATION FOR STATE HEALTH POLICY
Ira Kaufman
Clinical Associate Professor
Department of Environmental and Community Medicine
University of Medicine and Dentistry of New Jersey
675 Hoosier Lane, Room N118
Piscataway, NJ 08854-3635

INJURY PREVENTION PROGRAM
Barbara Barlow, MD
Chief of Pediatric Surgery
Columbia University
Harlem Hospital Center, MLK 17103
506 Lenox Avenue
New York, NY 10037

INVESTIGATOR AWARDS IN HEALTH POLICY RESEARCH
Sol Levine, PhD
Senior Scientist and Director
Joint Program in Society and Health
New England Medical Center Hospitals, Inc.
750 Washington Street
NEMC 343
Boston, MA 02111

LADDERS IN NURSING CAREERS PROGRAM
Margaret T. McNally
Vice President for Health Professions
New York Health Careers Center, Inc.
Greater New York Hospital Foundation
555 West 57th Street, 15th Floor
New York, NY 10019-2974

LOCAL INITIATIVE FUNDING PARTNERS PROGRAM
Ruth S. Hanft, PhD
Professor
Department of Health Services Management and Policy
George Washington University
Suite 700
1001 22nd Street, NW
Washington, DC 20037

MAKING THE GRADE: STATE AND LOCAL PARTNERSHIPS TO ESTABLISH SCHOOL-BASED HEALTH CENTERS
Julia Graham Lear, PhD
Director
Making the Grade
George Washington University
Suite 505
1330 Connecticut Avenue, NW
Washington, DC 20036

National Program Offices and Directors
MENTAL HEALTH SERVICES PROGRAM FOR YOUTH
Mary Jane England, MD
President
Washington Business Group
on Health
Suite 800
777 North Capitol Street, NE
Washington, DC 20002

MINORITY MEDICAL EDUCATION PROGRAM
Herbert W. Nickens, MD
Vice President
Division of Minority Health, Education, and Prevention
Association of American Medical Colleges
2450 N Street, NW
Washington, DC 20037-1126

MINORITY MEDICAL FACULTY DEVELOPMENT PROGRAM
James R. Gavin III, MD, PhD
Director
Minority Medical Faculty Development Program
4733 Bethesda Avenue, Suite 350
Bethesda, MD 20814

NEW JERSEY HEALTH INITIATIVES
(NEW JERSEY HEALTH SERVICES PROGRAM)
Pauline M. Seitz
Director
New Jersey Health Initiatives
Health Research and Educational Trust of New Jersey
760 Alexander Road, CN1
Princeton, NJ 08543-0001

NO PLACE LIKE HOME: PROVIDING SUPPORTIVE SERVICES IN SENIOR HOUSING
James J. Callahan, Jr., PhD
Director
Policy Center on Aging
Florence Heller Graduate School
Brandeis University
PO Box 9110
Waltham, MA 02254-9110

OLD DISEASE, NEW CHALLENGE: TUBERCULOSIS IN THE 1990S
Philip C. Hopewell, MD
Director
Old Disease, New Challenge: Tuberculosis in the 1990s
Division of Pulmonary and Critical Care Medicine
University of California, San Francisco
Campus Box 0841
San Francisco, CA 94143-0841

OPENING DOORS: A PROGRAM TO REDUCE SOCIOCULTURAL BARRIERS TO HEALTH CARE
Thomas W. Chapman
Director
The George Washington University Medical Center
Suite 810
1001 22nd Street, NW
Washington, DC 20037

PARTNERS IN CAREGIVING: THE DEMENTIA SERVICES PROGRAM
Barton V. Reifler, MD
Chairman
Department of Psychiatry and Behavioral Medicine
Wake Forest University
The Bowman Gray School of Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1087

PARTNERS FOR TRAINING: REGIONAL EDUCATION SYSTEMS FOR NURSE PRACTITIONERS, CERTIFIED NURSE-MIDWIVES, AND PHYSICIAN ASSISTANTS
Jean Johnson-Paulson
Association for Academic Health Centers
1616 P Street, NW, Suite 400
Washington, DC 20036

PRACTICE SIGHTS: STATE PRIMARY CARE DEVELOPMENT STRATEGIES
James D. Bernstein
President
North Carolina Foundation for Alternative Health Programs, Inc.
PO Box 10245
Raleigh, NC 27605-0245

PROGRAM TO ADDRESS SOCIOCULTURAL BARRIERS TO HEALTH CARE IN HISPANIC COMMUNITIES
Concepcion Orozco
Director
Program to Address Sociocultural Barriers to Health Care in Hispanic Communities
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)
1501 16th Street, NW
Washington, DC 20036-1401

PROGRAM ON THE CARE OF CRITICALLY ILL HOSPITALIZED ADULTS
William A. Knaus, MD
Director, ICU Research Unit
George Washington University Medical Center
2300 K Street, NW, Room 313
Washington, DC 20037

PROGRAM TO PROMOTE LONG-TERM CARE INSURANCE FOR THE ELDERLY
Mark R. Meiners, PhD
Associate Director
Center on Aging
University of Maryland
1240 HH Building
College Park, MD 20742-2611

PROJECT 3000 BY 2000 – HEALTH PROFESSIONS PARTNERSHIPS INITIATIVE
Herbert W. Nickens, MD
Vice President
Division of Minority Health, Education, and Prevention
Association of American Medical Colleges
2450 N Street, NW
Washington, DC 20037-1126

REACH OUT PHYSICIANS’ INITIATIVE TO EXPAND CARE TO UNDERSERVED AMERICANS
H. Denman Scott, MD, MPH
Reach Out National Program Office
Brown University Division of Biology and Medicine
167 Angell Street
Providence, RI 02912
Replication of the Foundation's Programs on Mental Illness

Martin D. Cohen
Executive Director
The Technical Assistance Collaborative, Inc.
1 Center Plaza, 3rd Floor
Government Center
Boston, MA 02108

Scholars in Health Policy Research Program

Alan B. Cohen, ScD
Director
Health Care Management Program
Boston University School of Management
685 Commonwealth Avenue,
Room 334
Boston, MA 02215

Service Credit Banking Program Replication

Mark R. Meiners, PhD
Associate Director
Center on Aging
University of Maryland
1240 HHP Building
College Park, MD 20742-2611

Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy

Robert L. Goldenberg, MD
Professor of Obstetrics and Gynecology
Director
Center for Obstetric Research
University of Alabama at Birmingham
Old Hillman Building, Room 452
UAB Station
Birmingham, AL 35233-7333

Smokeless States: Statewide Tobacco Prevention and Control Initiatives

Thomas P. Houston, MD
Director
Department of Preventive Medicine and Public Health
American Medical Association
515 North State Street
Chicago, IL 60610

State Initiatives in Health Care Reform

W. David Helms, PhD
President
The Alpha Center
Suite 1100
1350 Connecticut Avenue, NW
Washington, DC 20036-1701

State Initiatives in Long-Term Care

Mark R. Meiners, PhD
Associate Director
Center on Aging
University of Maryland
1240 HHP Building
College Park, MD 20742-2611

Statewide System of Care for Chronically Ill Elderly in Massachusetts

James Heoley
Director
Statewide System of Care for Chronically Ill Elderly in Massachusetts
East Boston Neighborhood Health Center
10 Gove Street
East Boston, MA 02128-1990

Strengthening Hospital Nursing: A Program to Improve Patient Care

Barbara A. Donahoo, RN, MA
President and CEO
All Children's Hospital, Inc.
33 Eighth Street South, 6th Floor
St. Petersburg, FL 33701

Substance Abuse Policy Research Program

David G. Altman, PhD
Associate Professor
Department of Public Health Sciences
Wake Forest University
The Bowman Gray School of Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1063

Supportive Services Program in Senior Housing

James J. Callahan, Jr., PhD
Director
Policy Center on Aging
Florence Heller Graduate School
Brandeis University
PO Box 9110
Walsham, MA 02254-9110

Tobacco Policy Research and Evaluation Program

Robert L. Rabin, JD, PhD
A. Calder Mackay Professor of Law
Stanford Law School
Crown Quadrangle
Stanford, CA 94305

The programs listed below are administered internally by Foundation staff (responsible officer in parentheses).

Clinical Scholars Program
(Annie Lea Shuster)

Community Care Funding Partners Program
(Terrance Keenan)

Generalist Provider Research Initiative
(Beth A. Stevens, PhD)

Nursing Services Manpower Development Program
(Rosemary Gibson)

Preparing Physicians for the Future: A Program in Medical Education
(Annie Lea Shuster)
Grant Application Guidelines

The Robert Wood Johnson Foundation is a private, independent philanthropy not connected with any corporation. Seeking to improve the health and health care of all Americans, it concentrates its grantmaking in four areas:
- assuring access to basic health services
- improving the way services are organized and provided to people with chronic health conditions
- promoting health and preventing disease by reducing harm from substance abuse
- seeking opportunities to help the nation address the problem of escalating health care costs.

The Foundation funds several kinds of projects:
- those initiated by applicants in response to Foundation calls for proposals or other invitational announcements. The call for proposals describes the program area, sets forth eligibility criteria, and details the specific application procedures and deadlines.
- those initiated by applicants and reflecting their own interests. Grants for such projects are made throughout the year. There are no specific application forms or deadlines.

The Foundation publishes and widely distributes its calls for proposals and national program announcements that provide eligibility criteria and application guidelines for these programs.

To apply for funding for a project reflecting your own interests, please submit a preliminary letter of inquiry, not a fully developed proposal. Ideally, this letter of inquiry will spare your time yet provide our staff with enough information to determine whether to request a full proposal from you. The letter of inquiry should be written on your institution’s letterhead, should not exceed four typewritten pages, and should contain the following information:
- a brief description of the problem to be addressed
- a statement of the project’s principal objectives
- a description of the proposed intervention, or, for research projects, the methodology
- a brief statement about the rationale for the project and how it fits with what others are doing
- the expected outcome
- the qualifications of the institution and the project’s principal personnel
- a timetable for the project
- the total estimated project budget, including the amount requested from the Foundation and any other anticipated sources of support
- any plans for evaluating the project’s results and disseminating its findings
- a plan for sustaining the project after grant funding expires
- a statement concerning the extent to which the project’s success will depend upon reaching appropriate audiences through the news media or promotional materials (newsletters, brochures, advertising, or opinion research)
- the name of the primary contact person for follow-up.

You may attach to the letter the curricula vitae of key staff, more detailed budget breakdowns, and background information concerning your institution, though this is not required.

The Review Process

Based on a review of your letter of inquiry by our program staff, a full proposal may be requested. If so, we will provide specific instructions about what information to include and how best to present it.

Each proposal is first examined to determine whether it involves one of the activities we are precluded from funding (see “Limitations”) and, if not, whether it clearly addresses one of our program goals. You
will be notified promptly if the proposal does not meet either of these initial criteria. If it does, it is assigned to a program officer for further review.

First-stage review

The program officer conducts a thorough study of the proposal, often in conjunction with other members of the program staff, sometimes with the assistance of outside consultants. This process generally lasts from two to three months, but requests for additional information sometimes prolong this stage of the review.

For any proposal that has a substantial health services or health policy research component, the program officer usually will have an outside reviewer assess the project's technical aspects.

If, during this process, it appears that the Foundation will be unable to provide support for the project, you will be notified promptly.

Second-stage review

Once the program officer believes he or she understands the project thoroughly, it will be reviewed and commented on by various Foundation work groups of program staff and administrative committees whose questions must be addressed. This phase of the approval process may take several weeks. Large or controversial projects must be reviewed by the Foundation's board of trustees at their quarterly meetings. If your grant is approved at any point, you will receive formal written communication from the Foundation's president.

Limitations

In general, the Foundation gives preference to applicants that are public agencies or are tax-exempt under Section 501(c)(3) of the Internal Revenue Code, and are not private foundations as defined under Section 509(a). The policies of the Foundation generally preclude support for:

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- basic biomedical research
- conferences, symposia, publications, or media projects unless they are clearly related to the Foundation's goals or an outgrowth of one of our grant programs
- research on unapproved drug therapies or devices
- international programs and institutions
- direct support of individuals.

Preliminary letters of inquiry should be addressed to:

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The Robert Wood Johnson Foundation
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