



# Strategic Plan 2008



# Overview

Hartford Approach to Grantmaking

Aging and Health Program

Discussion



# Contents

## Hartford Approach to Grantmaking

- I. Mission and Goal
- II. Characteristics of Successful Foundations
- III. Principles
- IV. Values
- V. Grantmaking Process
- VI. Partnerships and Leverage

## Aging and Health Program

- VII. History
- VIII. Program Overview
- IX. Measuring Impact
- X. Strategies and Analysis
- XI. Key Issues

## Discussion



# I. MISSION AND GOAL

## Mission

The John A. Hartford Foundation is a private philanthropy established in 1929 by John A. Hartford, with the broad charge of “doing the greatest good for the greatest number.” The Foundation is committed to the preservation and growth of its assets in order to fulfill its mission and strengthen its impact.

## Goal

The Foundation’s overall goal is to improve the health of older adults by creating a more skilled workforce and a better designed health care system.



## II. SUCCESSFUL FOUNDATIONS SHARE SIX GENERAL CHARACTERISTICS

- A clear mission and goal
- A decision to focus
- Well-defined objectives, outcomes, and strategies
- A sustained commitment
- A solid intellectual and practical grounding in their field of interest
- An ability to learn from and build on past projects to develop future initiatives



### III. PRINCIPLES FOR PROGRAM DEVELOPMENT AND IMPLEMENTATION

#### The Foundation Seeks to Fund Projects That:

- Will have the greatest impact on improving the health care of older adults.
- Build on the knowledge gained from Hartford's past work, taking care to keep focused on our mission, goals, and objectives.
- Support people and places that are most likely to succeed.



### III. PRINCIPLES FOR PROGRAM DEVELOPMENT AND IMPLEMENTATION

(Continued)

- Take advantage of natural experiments, partnership opportunities, and the best ideas in the field to maximize Foundation and other resources to achieve these goals.
- Will continue to be relevant and effective in a dynamic and changing health care marketplace.
- Have national replication potential.



## IV. VALUES

### Guided by Four Core Values:

- Reliance on a strong, committed, and involved Board
- A narrow, well-defined, and long-term focus
- Employment of an expert staff team
- Continuous learning and improvement for trustees, staff, and grantees



## V. GRANTMAKING PROCESS

### Development of Program Initiatives and Grants

Based on the strategic plan and an analysis of:

- The problems faced by older people, and the health professionals, and the systems that provide their care
- Experience and knowledge gained from the Foundation's current and past projects
- The relevant grant activities of other foundations and government actions and policies
- Open door policy and active cultivation of a wide network
- Convening grantees
- Input and review by outside experts
- Findings in commissioned white papers and research



## V. GRANTMAKING PROCESS

(Continued)

### Serendipity and Hard Work

- Extensive reading, meetings, visits, and conversations between and among Trustees, staff, grantees, and others within or impacted by the health system
- Alert to and take advantage of good ideas and special opportunities from grantees, prospective grantees, and other individuals and organizations



## VI. PARTNERSHIPS and LEVERAGE

### Partnerships Are Essential

- Partnerships with other entities—foundations, governments, organizations and individuals—extend the Hartford Foundation’s ability to improve the health care of older people in the U.S.
- Acting together, partners can better achieve their objectives. “Better” is measured by greater knowledge, creativity, efficiency, scope and speed.
- Partnerships enable the Foundation to coordinate its efforts with other stakeholders to achieve better results, even in the absence of joint project funding arrangements.
- More broadly, partnerships draw more attention to the Foundation’s goal of improving health care for older adults.



## VI. PARTNERSHIPS and LEVERAGE (Continued)

### What Kind of Partnerships Has Hartford Formed?

- Co-funding—the partnership may begin at the conception, birth, or later stage of a project’s development or operation
- Sustaining Funds—occurs when another organization sustains existing Hartford projects or funds the adoption/adaptation of the model in other places
- Affinity Funding—another organization may build on Hartford work
- Coordinated Funding—where we and another partner divide objectives and funding, while communicating and sharing lessons



## VI. PARTNERSHIPS and LEVERAGE (Continued)

### Why and How Has Hartford Been Successful?

- Excellent reputation for funding outstanding projects
- Knowledge of and frequent contact with key counterparts in foundations, government and organizations
- Active searches for potential partners
- Advised in the development of new foundations
- Membership in and seats on the boards of foundation affinity groups in aging and in health
- Participation of local funders in Hartford evaluation site visits



## VI. PARTNERSHIPS and LEVERAGE (Continued)

<u>Year</u>	<u>Total</u>
2000	\$24,486,500
2001	\$39,986,550
2002	\$36,756,831
2003	\$56,391,037
2004	\$90,688,740
2005	\$58,484,729
2006	\$197,240,992
2007	\$198,206,894
<b>Grand Total</b>	<b>\$703,791,140</b>



# Aging and Health Program

- VII. History
- VIII. Program Overview
- IX. Measuring Impact
- X. Strategies and Analysis
- XI. Key Issues





## VII. AGING AND HEALTH HISTORY

### Distinguished History in Biomedical Research

- Aging and Health Began in 1982
  - First Grant: Hartford Geriatric Physician Faculty Development Awards (1982-1987)
- Internal Environment
  - Health Care Cost and Quality (1979-1995+) \$77M, 200 grants
  - John A. and George L. Hartford Fellowship Program (1979-1986) Research Award for Physician Scientists 85 Awards



## VII. AGING AND HEALTH HISTORY

(Continued)

### Program Grows and Diversifies 1982-1987

- Academic Geriatrics and Training
  - Hartford Geriatric Physician Faculty
- Long-Term Care Financing
  - On Lok – Technical Assistance for Replication
- Medications and the Elderly
  - Lou Harris and Associates – National Survey of Prescribing for Older Adults



## VII. AGING AND HEALTH HISTORY

(Continued)

### Growth and Reconfiguration 1988-1992

- Academic Geriatrics and Training
  - Centers of Excellence in Geriatric Medicine
  - Beeson Award
- First Major Services Initiative 1989
  - Hospital Outcomes Project for Elders, 7 sites around the country reducing adverse effects of hospitalization
- Organization and Financing of Long-Term Care
- Medications and the Elderly



## VII. AGING AND HEALTH HISTORY

(Continued)

### Continued Growth and Reconfiguration 1992-1994

- Academic Geriatrics and Training
  - Centers of Excellence in Geriatric Medicine
  - Residency Training
  - Subspecialties
- Integrating Health Related Services for the Elderly
  - 1992 Generalist Physician Initiative – Multisite effort to test models of comprehensive primary care for older adults
- Interdisciplinary Team Exploration 1994



## VII. AGING AND HEALTH HISTORY

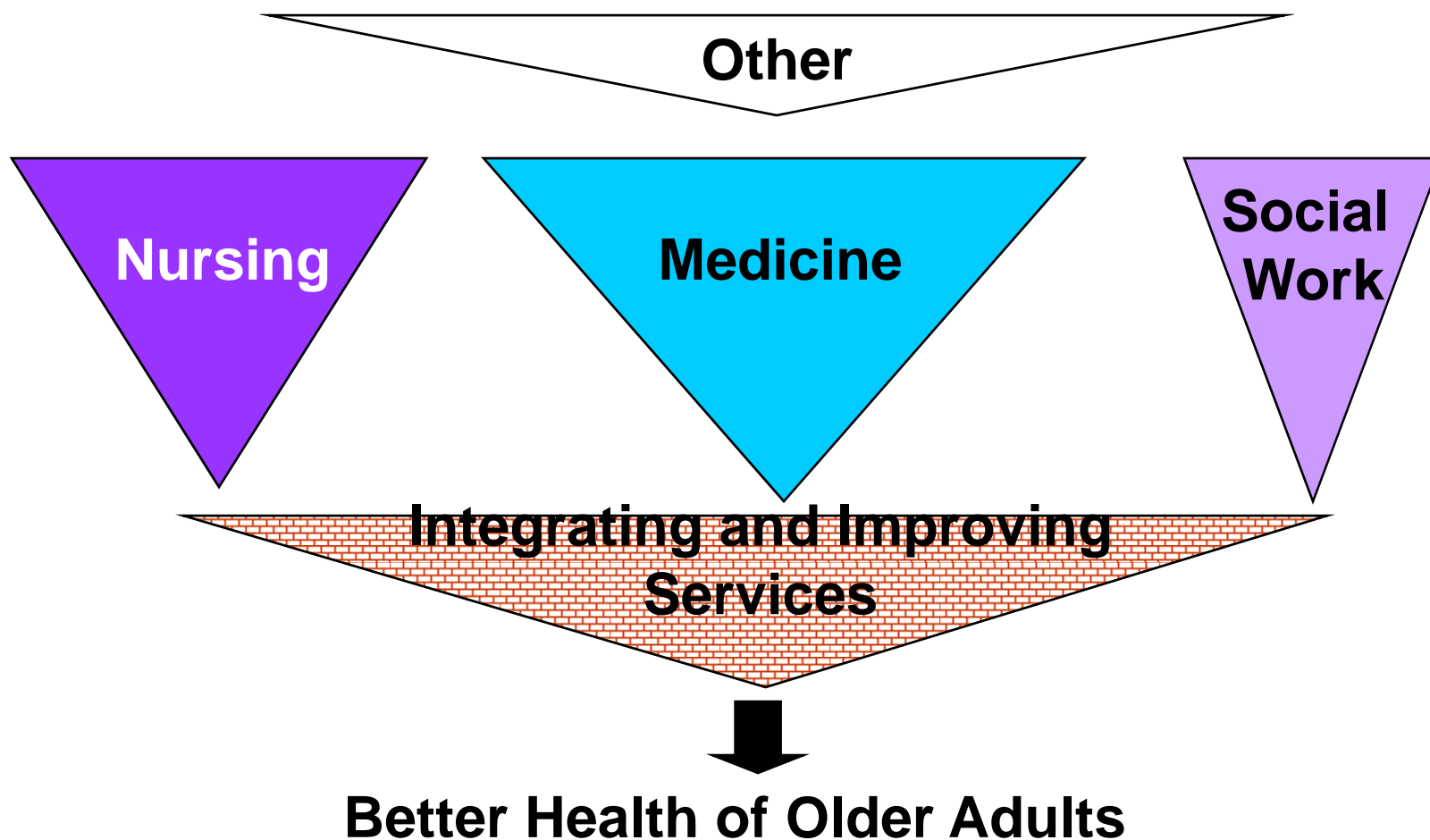
(Continued)

### Expansion and New Disciplines 1995-2002

- Geriatric Interdisciplinary Team Training 1996-2002
- Hartford Institute for Geriatric Nursing (NYU) 1995-2006
- Geriatric Social Work Initiative 1998 –
- Geriatric Nursing Initiative 1999 –



## VIII. AGING AND HEALTH PROGRAM: OVERVIEW





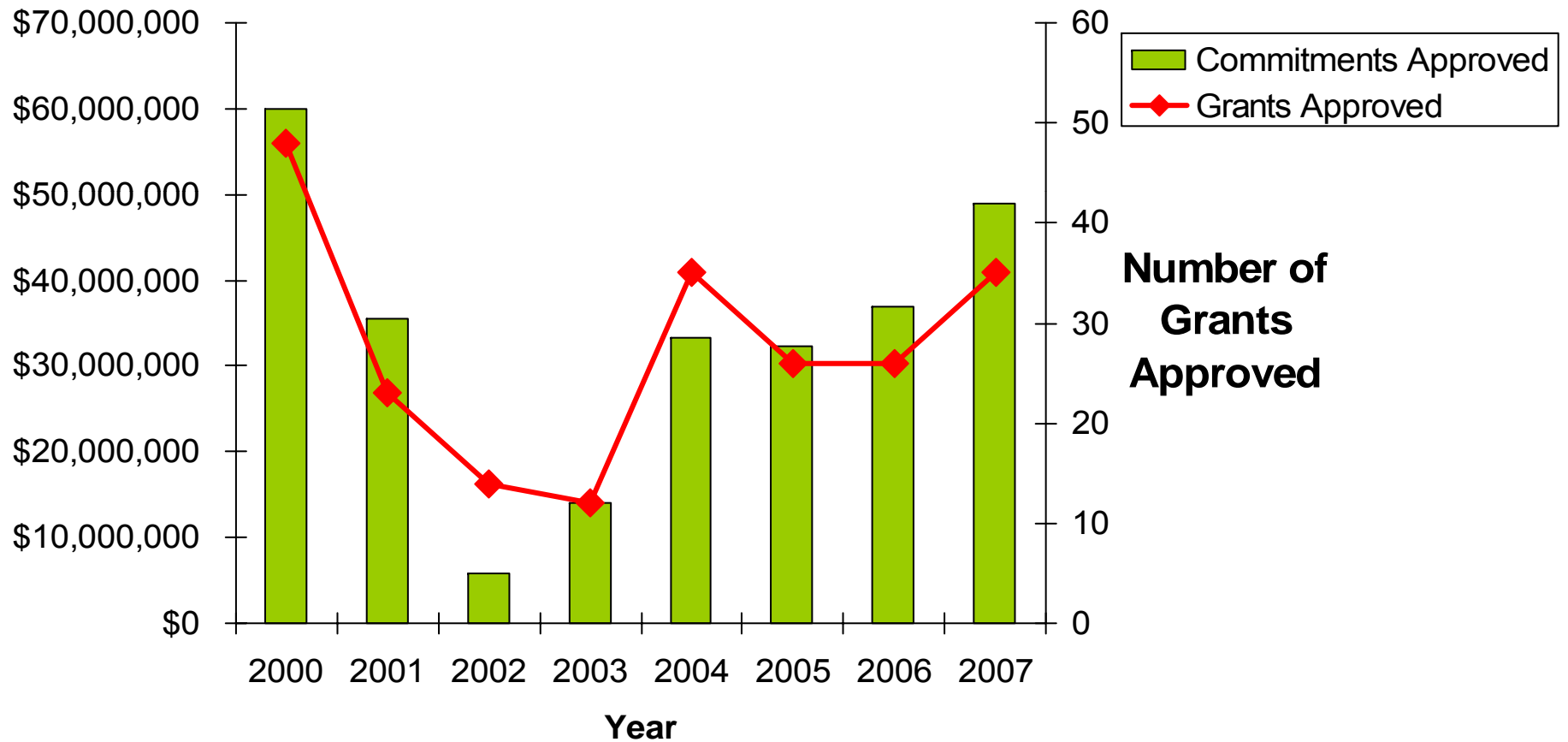
## VIII. AGING AND HEALTH PROGRAM: OVERVIEW (Continued)

### Four Areas and Allocation of Funds (commitments 2003-2007)

<u>Area</u>	<u>Plan</u>	<u>Actual</u>
Medicine	40%	38%
Nursing	24%	22%
Social Work	16%	26%
Services	20%	12%

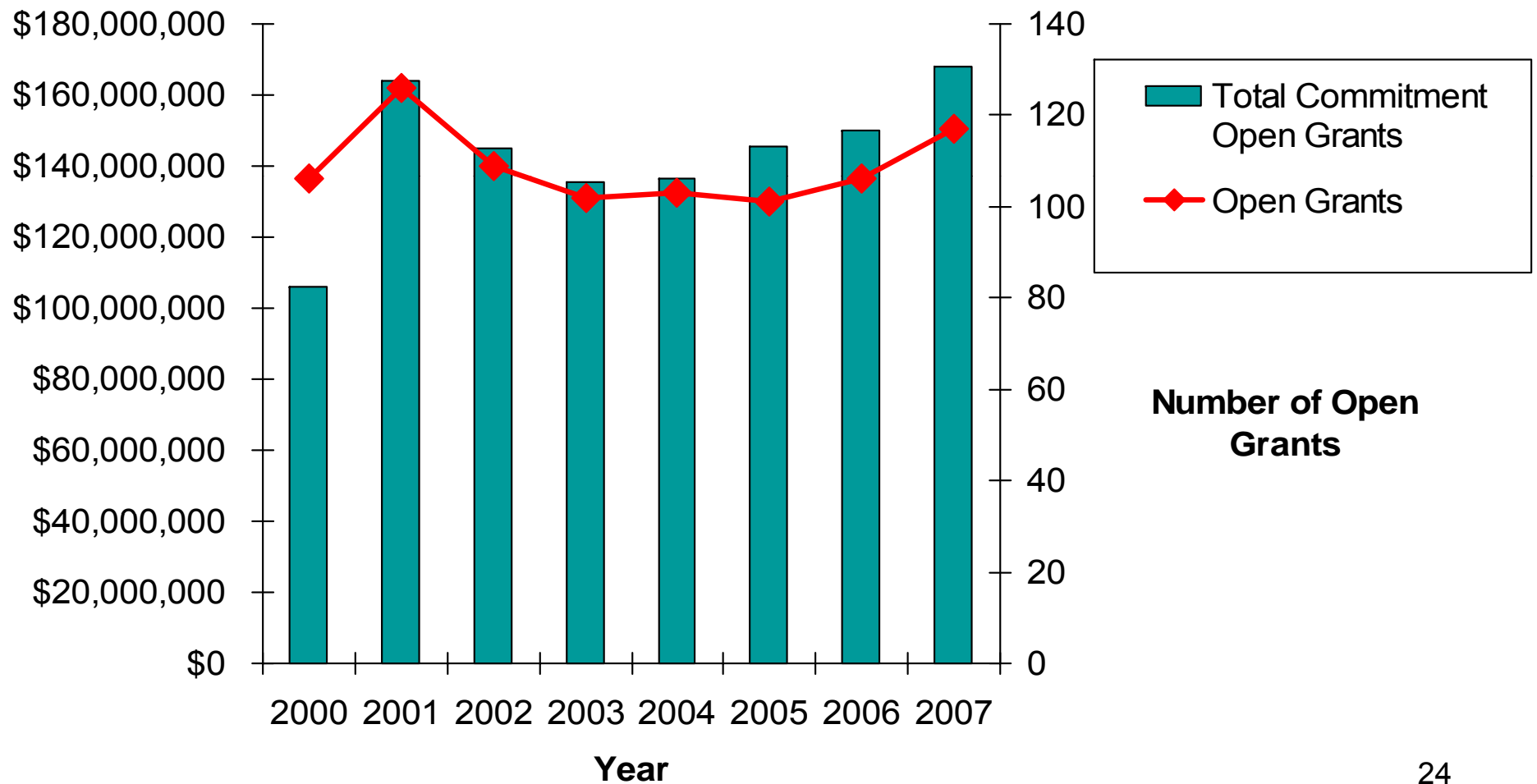


## VIII. AGING AND HEALTH PROGRAM: OVERVIEW (Continued)





## VIII. AGING AND HEALTH PROGRAM: OVERVIEW (Continued)





## VIII. AGING AND HEALTH PROGRAM: OVERVIEW (Continued)

Aging and Health Commitments: 2003 - 2008 (in thousands)

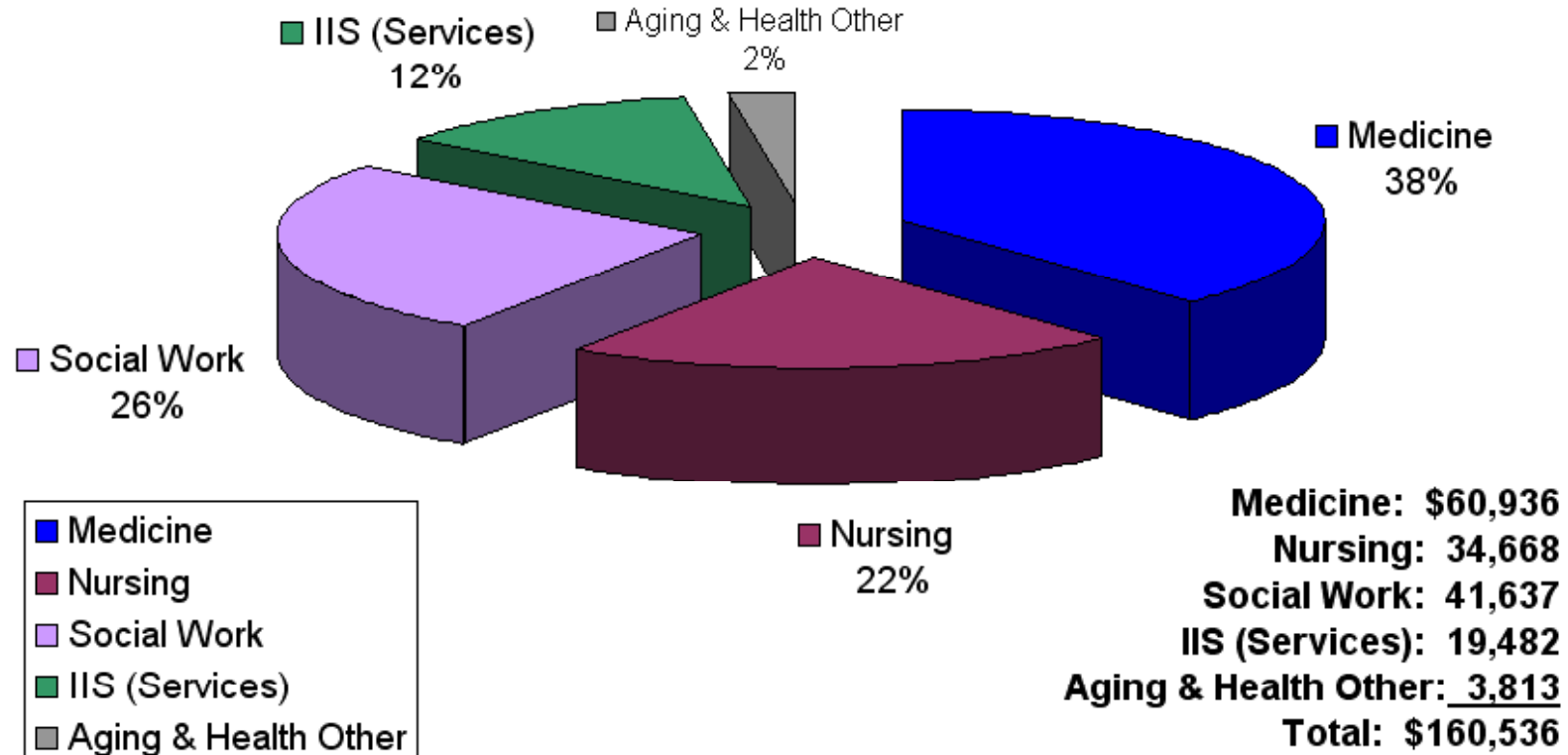
Program Areas (in dollars)	2003	2004	2005	2006	2007	2008	Grand Totals ('03 - '07)
Medicine	7,221	12,986	1,518	19,787	19,424	5,450	60,936
Nursing	3,050	4,267	18,587	591	8,173	12,132	34,668
Social Work	3,449	9,185	5,383	9,195	14,425	0	41,637
IIS (Services)	328	6,606	2,376	4,800	5,372	6,369	19,482
Aging & Health Other	0	135	2,340	1,264	74	1,904	3,813
<b>Totals By Year (in current \$s):</b>	<b>14,048</b>	<b>33,179</b>	<b>30,204</b>	<b>35,637</b>	<b>47,468</b>	<b>25,855</b>	<b>160,536</b>
<i>Cumulative Total (Current \$s):</i>		33,179	63,383	99,020	146,488	172,343	
<b>Totals By Year (in constant \$s):</b>	<b>8,215</b>	<b>18,899</b>	<b>16,641</b>	<b>19,021</b>	<b>24,633</b>	<b>2,519</b>	<b>87,409</b>
<i>Cumulative Total (Constant \$s):</i>		18,899	35,540	54,561	79,194	81,713	
Program Areas (percentages)	2003	2004	2005	2006	2007	2008	Grand Totals ('03 - '07)
Medicine	51.4%	39.1%	5.0%	55.5%	40.9%	21.1%	38.0%
Nursing	21.7%	12.9%	61.5%	1.7%	17.2%	46.9%	21.6%
Social Work	24.6%	27.7%	17.8%	25.8%	30.4%	0.0%	25.9%
IIS (Services)	2.3%	19.9%	7.9%	13.5%	11.3%	24.6%	12.1%
Aging & Health Other	0.0%	0.4%	7.7%	3.5%	0.2%	7.4%	2.4%
<b>Totals:</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

Includes Projected Commitments through December 2008



# VIII. AGING AND HEALTH PROGRAM: OVERVIEW (Continued)

## Aging & Health Grants Committed: 2003-2007



NOTE: ALL DOLLAR FIGURES EXPRESSED IN THOUSANDS



## VIII. AGING AND HEALTH PROGRAM: OVERVIEW (Continued)

Aging and Health Grant Payouts: 2003 - 2008 (in thousands)

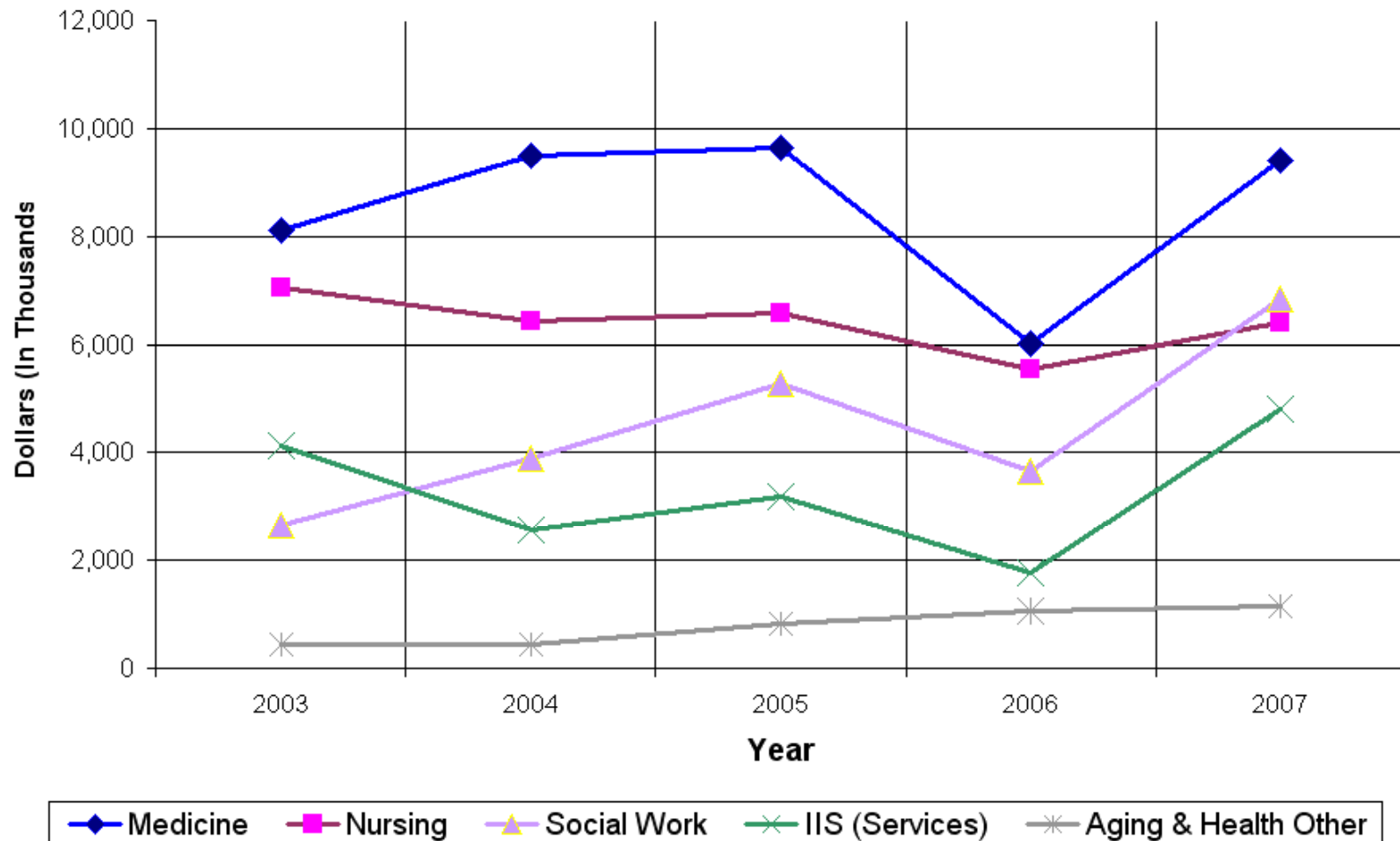
Program Areas (in dollars)	2003	2004	2005	2006	2007	2008	Grand Totals ( '03 - '07)
Medicine	8,118	9,492	9,630	6,029	9,392	3,802	42,661
Nursing	7,044	6,424	6,567	5,550	6,407	3,924	31,992
Social Work	2,655	3,906	5,265	3,650	6,830	4,862	22,306
IIS (Services)	4,132	2,577	3,191	1,777	4,815	2,854	16,492
Aging & Health Other	451	429	813	1,070	1,142	579	3,905
<b>Totals By Year (in current \$s):</b>	<b>22,400</b>	<b>22,828</b>	<b>25,466</b>	<b>18,076</b>	<b>28,586</b>	<b>16,021</b>	<b>117,356</b>
<i>Cumulative Total (Current \$s):</i>		22,828	48,294	66,370	94,956	110,977	
<b>Totals By Year (in constant \$s):</b>	<b>13,099</b>	<b>13,003</b>	<b>14,030</b>	<b>9,648</b>	<b>14,835</b>	<b>1,561</b>	<b>64,615</b>
<i>Cumulative Total (Constant \$s):</i>		13,003	27,034	36,681	51,516	53,077	
Program Areas (percentages)	2003	2004	2005	2006	2007	2008	Grand Totals ( '03 - '07)
Medicine	36.2%	41.6%	37.8%	33.4%	32.9%	23.7%	36.4%
Nursing	31.4%	28.1%	25.8%	30.7%	22.4%	24.5%	27.3%
Social Work	11.9%	17.1%	20.7%	20.2%	23.9%	30.3%	19.0%
IIS (Services)	18.4%	11.3%	12.5%	9.8%	16.8%	17.8%	14.1%
Aging & Health Other	2.0%	1.9%	3.2%	5.9%	4.0%	3.6%	3.3%
<b>Totals:</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

Payments Made Through June 2008



# VIII. AGING AND HEALTH PROGRAM: OVERVIEW (Continued)

## Aging and Health Grant Payouts: 2003 - 2007





## IX. MEASURING IMPACT

- How does a foundation best measure its impact?





## X. STRATEGIES AND ANALYSIS

### Medicine - All MDs Prepared to Care for Older Adults

#### Indicators of Impact

- Geriatrics Divisions Increase Faculty Size by 20%
- 50% of Medical Schools Adopt New Geriatric Competencies
- 50% of Residencies, Specialties, & Subspecialties Adopt Specific Geriatric Training Standards (Currently ~ 30%)

#### Strategies

- Faculty Development
- Curricular Change
- Centers of Excellence



## X. STRATEGIES AND ANALYSIS (Continued)

### Medicine - All MDs Prepared to Care for Older Adults

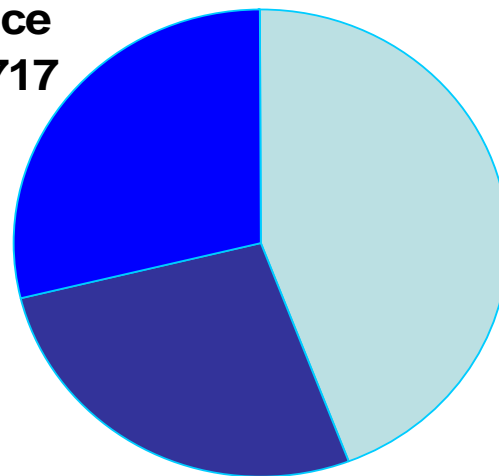
#### Current Commitments in Medicine by Strategy

43 Grants (5 Faculty, 9 Curricular Change, 29 Center Program)

**Centers of Excellence**  
**\$17,374,717**

**Faculty Development**  
**\$26,578,396**

**Curricular Change**  
**\$16,304,448**

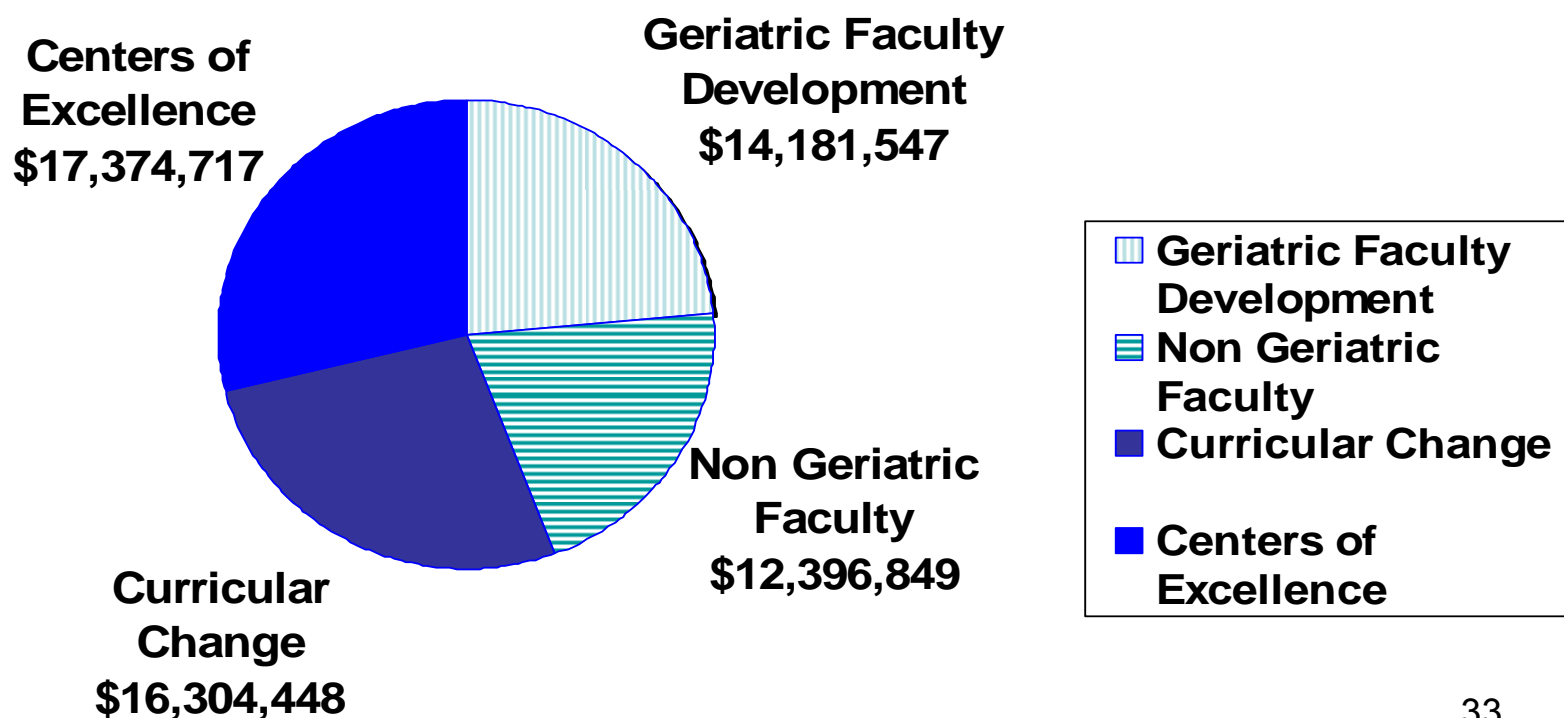




## X. STRATEGIES AND ANALYSIS (Continued)

### Medicine - All MDs Prepared to Care for Older Adults

#### Current Commitments in Medicine by Strategy and Geriatrician/Non-Geriatrician Faculty





## X. STRATEGIES AND ANALYSIS (Continued)

### B. Nursing - All Nurses Prepared to Care for Older Adults

#### Indicators of Impact

- 50% of Nursing Schools Adopt AACN Geriatric Competencies (BSN, APRN)
- 50% of Nursing Schools Have  $\geq 1$  Geriatrics Specialized Faculty Member (currently  $\sim 30\%$ )

#### Strategies

- Faculty Development
- Curricular Change
- Centers of Excellence

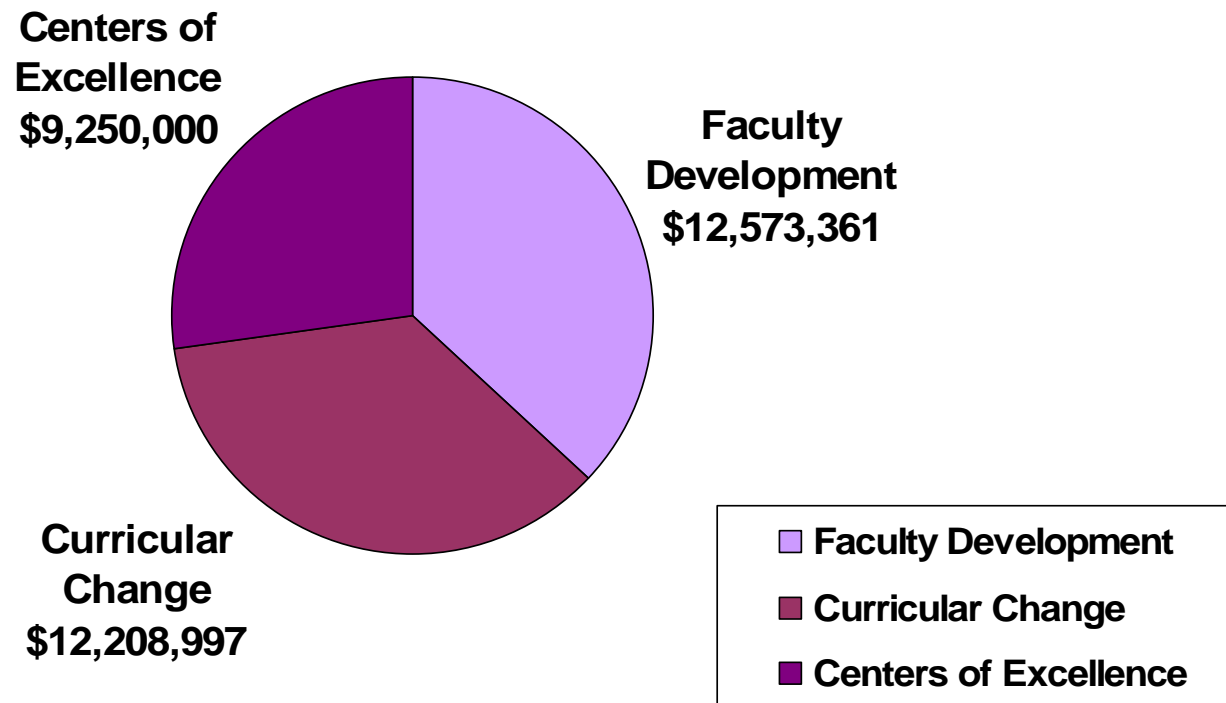


## X. STRATEGIES AND ANALYSIS (Continued)

### B. Nursing - All Nurses Prepared to Care for Older Adults

Current Commitments in Nursing by Strategy

17 Grants (2 Faculty, 6 Curricular Change, 9 Centers)





## X. STRATEGIES AND ANALYSIS (Continued)

### C. Social Work - All SWs Prepared to Care for Older Adults

#### Indicators of Impact

- 50% of MSW Programs Require Coursework in Aging (currently ~ 25%)
- 60% of Programs have  $\geq 2$  Faculty Members Specializing in Geriatrics
- 75% of MSW Programs Adopt Hartford Practicum Model for Training (currently ~ 30%)

#### Strategies

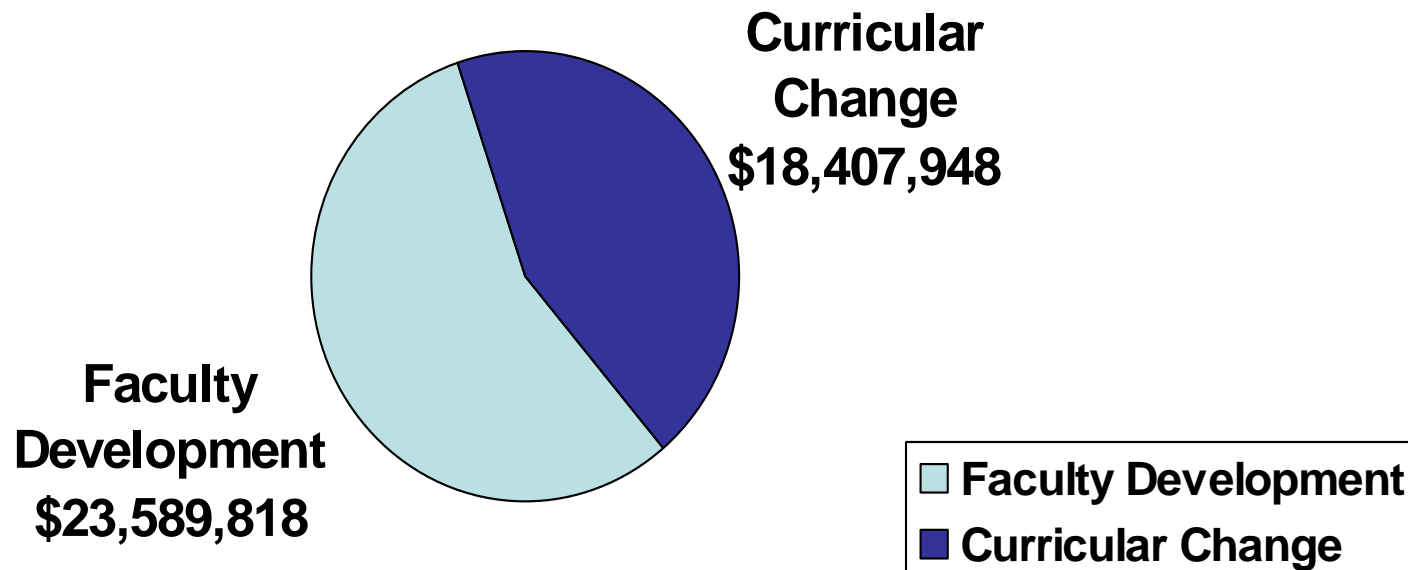
- Faculty Development
- Curricular Change



## X. STRATEGIES AND ANALYSIS (Continued)

### C. Social Work - All SWs Prepared to Care for Older Adults

Current Commitments in Social Work by Strategy  
8 Grants (4 Faculty, 4 Curricular Change)





## X. STRATEGIES AND ANALYSIS (Continued)

### D. Integrating and Improving Services - Care Delivery is Redesigned to Promote Quality Geriatrics

#### Indicators of Impact

- Two new models of care successfully demonstrate clinical benefit and feasibility
- Four models in dissemination become self sustaining in their spread

#### Strategies

- Model Development and Testing in Applied Settings
- Dissemination of Innovations
- Developing Agents of Change

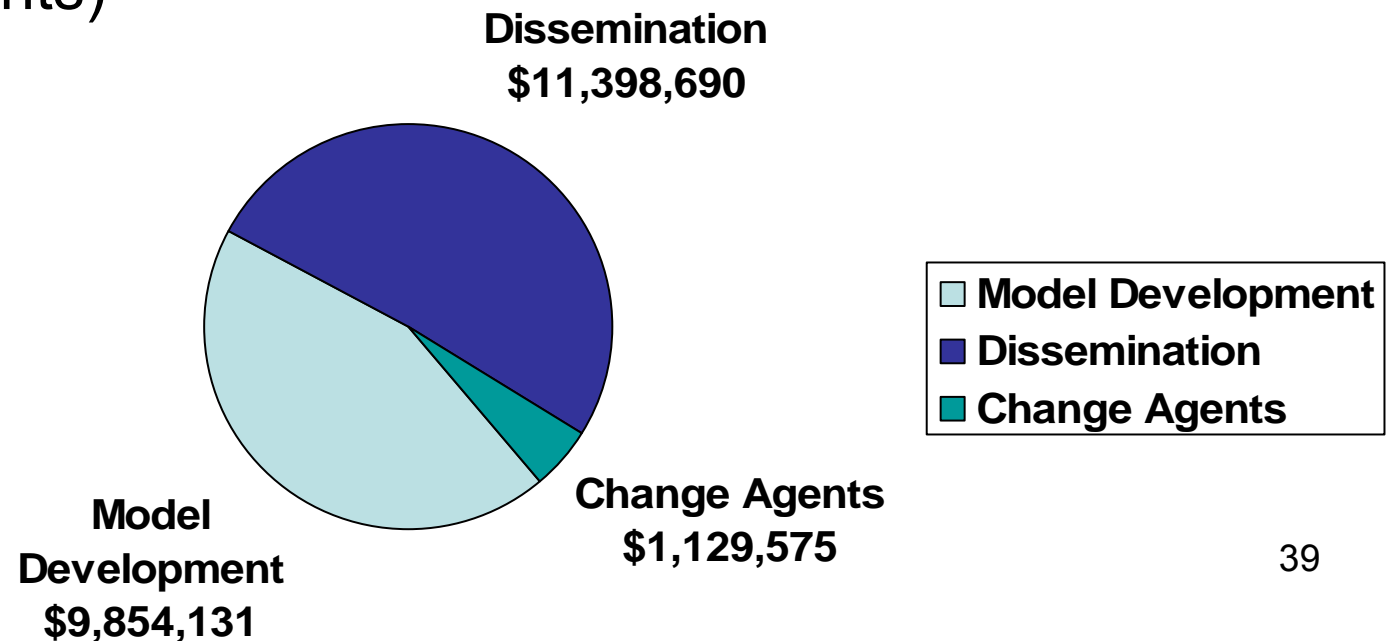


## X. STRATEGIES AND ANALYSIS (Continued)

### D. Integrating and Improving Services - Care Delivery is Redesigned to Promote Quality Geriatrics

Current Commitments in Services by Strategy

16 Grants (6 Model Development, 8 Dissemination, 2 Change Agents)





## XI. KEY ISSUES

### Allocation

We believe that the allocation of money to program areas is a good reflection of the costs and opportunities they provide, however, are there changing factors we need to consider?

### Communications

We are probably in the bottom quartile in the investment we make in communicating about our work, should we do more?

### Evaluation

We make little use of outside systematic program evaluation, should we do more?

### Policy

Most of the societal changes we want require changes in state and federal policy, should we be more active in these arenas?

### Timing

We have 10-20 years to resolve the problems of geriatric care before they become intractable. What should change about our work as we get closer to the period of most rapid demographic change?



# DISCUSSION

