The Commonwealth Fund

2007 Annual Report

THE COMMONWEALTH FUND

2007 Annual Report

Working toward the goal of a high performance health care system for all Americans, the Fund builds on its long tradition of scientific inquiry, a commitment to social progress, partnership with others who share common concerns, and the innovative use of communications to disseminate its work. The 2007 Annual Report offers highlights of the Fund's activities in the past year.

Program Highlights, 2007 (continued)

Karen Davis

President's Message
2007 ANNUAL REPORT

A Prescription for Our Nation's Ailing Health Care System

The last time health care reform was on the national agenda, a fictional couple named Harry and Louise helped ensure its demise with the refrain, "There has to be a better way." The couple, who appeared in advertisements sponsored by the Health Insurance Association of America, decried what some viewed as the bureaucratic nature of the 1993 health care reform proposal and urged viewers to contact their congressional representatives to vote against it. The ads put a human face on the issue for millions of Americans.

Nearly 15 years later, the U.S. health care system—despite some incremental reforms—is, if anything, worse off.

Today, Harry and Louise might very well be among the 47 million uninsured Americans who are struggling to pay for needed medical care, possibly bankrupting themselves in the process. Or they might be one of millions of Americans unable to obtain the coordinated, quality care enjoyed by residents of so many other countries and instead experiencing lost medical records, redundant tests, and poor oversight of chronic health conditions. Or they might already be victims of one of the thousands of medical errors that occur in the United States every year—most of which would be preventable with better information systems and more reliable care processes.

One thing is for certain: On the eve of a presidential election in which health care promises to play a prominent role, Harry and Louise, as well as others like them, still do not have access to a high performance health system.

To understand what this means for Americans and how our system could be so much better, let us consider another fictional couple: Angela and Martin. Only this time, let's imagine the two of them not in today's health care system but in a world somewhere in the near future, one in which the United States has embraced and implemented a high performance health system. Yes, Harry and Louise—there *is* a better way. It is called a high performance health system, and this is what it looks like.

AUTOMATIC, AFFORDABLE HEALTH INSURANCE FOR ALL

Martin's Story

Martin took a deep breath and gazed across the vista before him. The two-mile hike up the mountain had been challenging, but he felt great. As well he should. Ever since the country implemented universal health coverage

GETTING TO A HIGH PERFORMANCE HEALTH SYSTEM

These five strategies are essential for achieving a high performance health system:

1. Extending affordable health insurance to all.
2. Aligning financial incentives to enhance value and achieve savings.
3. Organizing the health care system around the patient to ensure that care is accessible and coordinated.
4. Meeting and raising benchmarks for high-quality, efficient care.
5. Ensuring accountable national leadership and public/private collaboration.

three years ago, he'd been able to afford the medications and preventive care that kept his high blood pressure, cholesterol, and diabetes under control. He felt like a new person. He'd finally found the energy to begin exercising and the encouragement to lose weight. Last week, his doctor told him he was doing so well that he might even be able to cut the dosages of two of his medications.

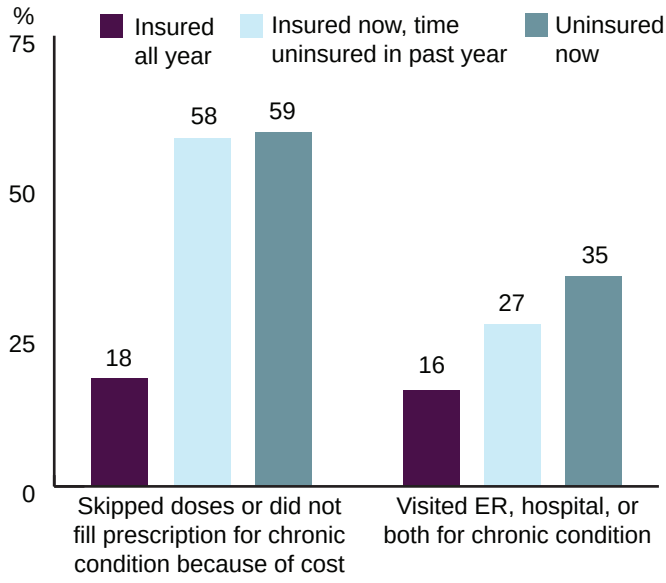
While the costs of extending health insurance coverage are significant, so are the economic and human costs of leaving millions of people without coverage and comprehensive benefits, including prescription drugs. The Institute of Medicine estimates that 18,000 avoidable deaths occur each year in the United States as a direct result of individuals being uninsured. The aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter life spans falls between $65 billion and $130 billion for each year without coverage.[1]

More than half of working-age adults who were uninsured sometime during 2005 reported problems paying medical bills during that time or were paying off accrued medical debt, compared with one-quarter of those who were insured all year.[2] Medical debt forces families to make stark tradeoffs. For example, 40 percent of uninsured adults with medical bill problems were unable to pay for basic necessities like food, heat, or rent, and nearly 50 percent had used all their savings to pay their bills.

Gaps in coverage for uninsured people with chronic health conditions may have long-run cost implications for the health system. Among individuals with chronic health conditions, the uninsured are three times as likely as the insured to not fill medication prescriptions written by their physicians or to skip doses to make the medications

The uninsured are less likely to be able to manage their chronic condition.

Percent of adults ages 19–64 with at least one chronic condition*



* Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, ***Gaps in Health Insurance: An All-American Problem—Findings from the Commonwealth Fund Biennial Health Insurance Survey*** (New York: The Commonwealth Fund, Apr. 2006).

Thirty-seven percent of U.S. adults fail to get needed care because of the cost.

Percent in past year due to cost:	Australia	Canada	Germany	Netherlands	New Zealand	United Kingdom	United States
Did not fill prescription or skipped doses	13	8	11	2	10	5	23
Had a medical problem but did not visit doctor	13	4	12	1	19	2	25
Skipped test, treatment or follow-up	17	5	8	2	13	3	23
Percent who said yes to at least one of the above	26	12	21	5	25	8	37

Source: Based on C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," ***Health Affairs*** Web Exclusive (Oct. 31, 2007):w717–w734.

last longer. The uninsured are also twice as likely to seek care from an emergency room or to be hospitalized for a chronic condition. Meanwhile, older adults who are uninsured enter Medicare with more serious health problems and experience higher hospitalization rates once their Medicare coverage begins at age 65.[3]

Largely because so many lack insurance coverage and so many have high out-of-pocket costs for medical care, adults in the United States are much more likely than their counterparts in other countries to report not getting the care they need. One-fourth of U.S. adults report not filling prescriptions or skipping doses, and 37 percent report failing to get some kind of needed care. By contrast, only 5 percent of adults in the Netherlands report problems accessing care because of the cost.

Angela's Story

As she sat in the room waiting for her dose of radiation, Angela closed her eyes and leaned back with a sigh. Yes, having breast cancer was terrible. Yes, having to go through radiation therapy was fatiguing. But she couldn't help feeling how lucky she was. As an independent consultant, she had flexibility in her job. And thanks to the new universal health care coverage implemented three years ago, she had gotten regular mammograms—which caught her cancer early—and she could afford the lumpectomy and all the rest of the care she needed without breaking into her retirement account.

Plus, signing up for the health plan had been so simple. She'd completed all the paperwork online. And when she moved two years ago and needed a new plan, the change was seamless—there were no gaps in coverage, despite her preexisting asthma. Since she didn't work for someone else, she was able to access a group plan her state had created, and her contribution was pegged to her income to ensure affordability.

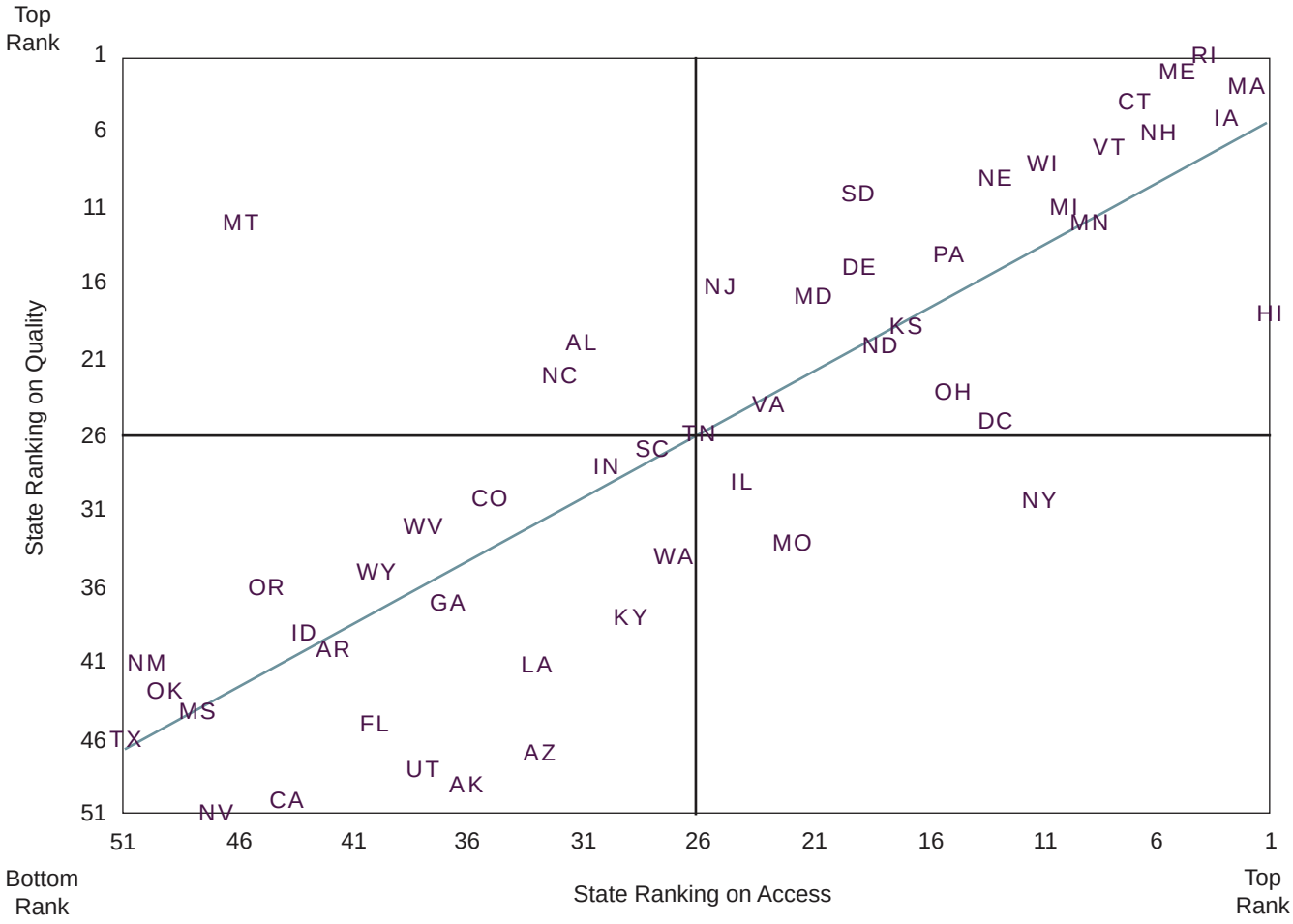
The new program had not significantly increased her taxes either. Financing was shared among the federal and state governments, employers, and, of course, individuals. And here's the best part: It had built-in incentives designed to drive health care providers and patients toward the highest-quality and most efficient health care possible.

Yes, she thought as she drifted off to sleep, things could be much worse.

Comprehensive health insurance coverage and quality go hand-in-hand. The Commonwealth Fund's State Scorecard on Health System Performance, released in June 2007, rated states on 32 indicators of performance, covering access, quality, avoidable hospital use and costs, equity, and "healthy lives."[4] States with the best access to care also had the highest rankings in quality. Most of those in the top quartile of performance rankings were states that have taken the lead in reforming and improving their health systems, and most have among the lowest uninsured rates in the nation.

Hawaii ranks first in the State Scorecard, an achievement that may be due, in part, to the state's early efforts to cover its residents. Hawaii's 1974 Prepaid Health Care Act mandated that employers—except for seasonal employers and a few others—provide insurance to all employees working more than 20 hours a week. Employers must pay 50 percent of premiums, but they can require employees to contribute up to 1.5 percent of their wages. Other residents, including employees working less than 20 hours a week, the self-employed, and Medicaid beneficiaries, receive

State Ranking on Access and Quality Dimensions



Source: Commonwealth Fund State Scorecard on Health System Performance, 2007.

How well do different strategies meet principles for health insurance reform?

Principles for Reform	Tax Incentives and Individual Insurance Markets	Mixed Private-Public Group Insurance with Shared Responsibility for Financing	Public Insurance
Covers Everyone	0	+	+
Minimum Standard Benefit Floor	—	+	+
Premium/Deductible/Out-of-Pocket Costs Affordable Relative to Income	—	+	+
Easy, Seamless Enrollment	0	+	++
Choice	+	+	+
Pool Health Care Risks Broadly	—	+	++
Minimize Dislocation, Ability to Keep Current Coverage	+	++	—
Administratively Simple	—	+	++
Work to Improve Health Care Quality and Efficiency	0	+	+

0 = Minimal or no change from current system; — = Worse than current system;
+ = Better than current system; ++ = Much better than current system

Source: S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. C. Schoenbaum, ***A Roadmap to Health Insurance for All: Principles for Reform*** (New York: The Commonwealth Fund, Oct. 2007).

coverage under a public program called the State Health Insurance Plan. The legislation also mandates that insurance plans offer certain benefits, including hospital and surgical benefits, maternity benefits, and laboratory services. Today, nearly 90 percent of working-age adults in Hawaii are insured.

The 2008 presidential election campaign is focusing much-welcomed attention on the need for health reform. The Commonwealth Fund Commission on a High Performance Health System has explored different reform options and, in a recent report, set forth a "roadmap to health insurance for all."[5] In it, the Commission explored how various reforms could not only increase coverage for the uninsured, but could also improve quality and efficiency and rein in spiraling health care costs.

The Commission believes the most pragmatic approach for covering all Americans is a mix of private and public group insurance that builds on the best features of our current system, while minimizing dislocation for the millions of people who currently have good coverage. Importantly, the financing for this approach would be shared among individuals, employers, and government.

ALIGNED INCENTIVES FOR HIGH-VALUE CARE

Angela's Story

Angela smiled as she watched her small mutt chase the much-larger Great Dane around the dog park. What a glorious day, she thought, putting her face up to the sun. Paying medical bills that morning had been easy, since Angela's insurer paid the oncology center a single global

HIGH PERFORMANCE IN PRACTICE

Massachusetts is another state that is making affordable health coverage a priority. The Massachusetts Health Care Reform Plan, enacted in April 2006 and implemented in 2007, is grounded in the idea that individuals, employers, and government must share responsibility for health insurance. The plan includes an individual mandate stating that it is every person's responsibility to have coverage and to be able to pay for needed care.

To make it easier for individuals and small employers to find and purchase affordable insurance, the Massachusetts plan created a state-run marketplace called the Commonwealth Connector. On the Connector Web site, users can compare and contrast 42 health plan options. Subsidies make health insurance premiums more affordable for low-income individuals, while a modest expansion of the MassHealth program provides coverage for poor adults and children. The Massachusetts plan also features a minimum set of required benefits, as well as a schedule of premiums that are considered affordable for individuals and families based on income.

According to Massachusetts legislators, the plan is expected to cover 515,000 uninsured within three years, leaving less than 1 percent of the population unprotected. The Commonwealth Fund is supporting a project to track the plan over the next several years; a baseline analysis of the state's health care system has just been completed.[6]

fee for her breast cancer treatment for a year, and she was responsible for 5 percent of that one bill. She was grateful for the role the nurse practitioner in her oncologist's office had played in coordinating her care during the acute phase of her cancer treatment. Thanks to the bundled global fee for her care paid by Angela's insurance plan, Angela had received the kind of coordinated care shown to result in the best outcomes. She'd avoided unnecessary and duplicative testing. And since she had checked the excellent patient outcomes for her oncology team on the Internet, she felt confident that all her health care providers, from the hospital where she had her surgery to the outpatient center where she received her radiation therapy, had implemented systems designed to provide high-quality care while reducing complications, including medical errors that could result from episodic rather than systemic care.

The limitations of the predominant fee-for-service payment system—especially in promoting effective, coordinated, and efficient care—is becoming readily apparent. A major contributor to high costs in the United States is the way our system rewards hospitals and physicians for providing more care, not for more efficiently getting the results patients want.

Fundamental payment reform will be required to reward doctors for providing the highest quality care. This could include a blended payment system that features elements of fee-for-service along with explicit rewards for quality and efficiency; payment for entire "episodes" of care for certain acute conditions (such as heart attacks, hip replacements, and certain types of cancer), again with explicit rewards for quality; monthly payments to primary care practices that are accountable for the care provided over time to patients with various chronic conditions (such as diabetes) or health risks (such as high blood pressure); or a combination of payment methods.

Implementing a system of prospective payments for acute episodes of care is one of a number of fundamental payment reforms that could achieve significant savings, in large part by discouraging unnecessary or duplicative tests.[7] According to a report prepared for the Fund's Commission on a High Performance Health System, changing

Medicare's fee-for-service payment system into a blend of episode-based prospective payment and fee-for-service could generate net health system savings in the area of $229 billion over 10 years, assuming some private payers follow Medicare's lead.[8]

The report *Bending the Curve: Options for Achieving Savings and Improving Value in Health Spending* analyzed 15 reform options that could achieve health system savings while at the same time enhancing value. It concluded that slowing the growth in total health spending and providing coverage to all are both possible. It demonstrated how individual reforms—such as expanding the information available for making health care decisions, encouraging health promotion and disease prevention programs, aligning financial incentives with health quality and efficiency, and correcting price signals in the health care market—can yield health spending reductions on a much larger scale when they are implemented in combination.

HIGH PERFORMANCE IN PRACTICE

Geisinger Health System, an integrated health care delivery system in northeastern Pennsylvania, charges a flat rate for elective coronary-artery bypass grafting (CABG). This rate covers all care related to the procedure, including complications, up to 90 days after surgery. Thus, Geisinger has a strong financial incentive to develop systems that ensure good outcomes and reduce postsurgical complications.

In developing its payment method, Geisinger's seven cardiac surgeons agreed on 40 benchmark processes every patient undergoing this procedure would receive, most based on accepted clinical guidelines from the American College of Cardiology and the American Heart Association.[9]

If everyone in the United States had health insurance coverage, the synergistic effects of this combination of reforms—including improved health system performance and reduced total spending—would be that much greater.[10] In fact, the possible cumulative health system savings could amount to more than $1.5 trillion over 10 years. Rather than national health expenditures rising from 16 percent of gross domestic product (GDP) to 20 percent by 2017—as is currently projected—spending could be held to 18.5 percent of GDP.

ACCOUNTABLE, COORDINATED CARE

Angela's Story

Angela woke up on that October morning feeling just awful. She'd completed her radiation therapy two months before and knew the way she felt now was not treatment-related. She thought she might have the flu, but that didn't seem likely, since she'd had her flu shot earlier in the season—thanks to the automated reminders her doctor sent. Her throat was on fire. She reached for the phone and speed-dialed her family practitioner's office. Could she see Dr. F today? "Sure," the receptionist said. "Would 2 p.m. work?"

Angela arrived in time for her 2 p.m. appointment and had barely started a magazine article when she was called into the examining room. The nurse entered Angela's blood pressure, weight, and heart rate into the computer holding Angela's electronic medical record, congratulated her on losing a few pounds, updated her medications, and, seeing that Angela was being treated for breast cancer, asked how she was feeling. A couple of minutes later, Dr. F entered. She inquired about Angela's progress, noting she'd received an e-mail update from her radiation oncologist about the end of the treatment. She listened to Angela's heart and lungs; checked her throat, nose, and ears; and ordered a quick strep test, which turned out to

be positive. A few clicks on her computer and she found an antibiotic with no interactions with Angela's medications. "We want to keep a close eye on you to make sure this doesn't turn into something worse," Dr. F said.

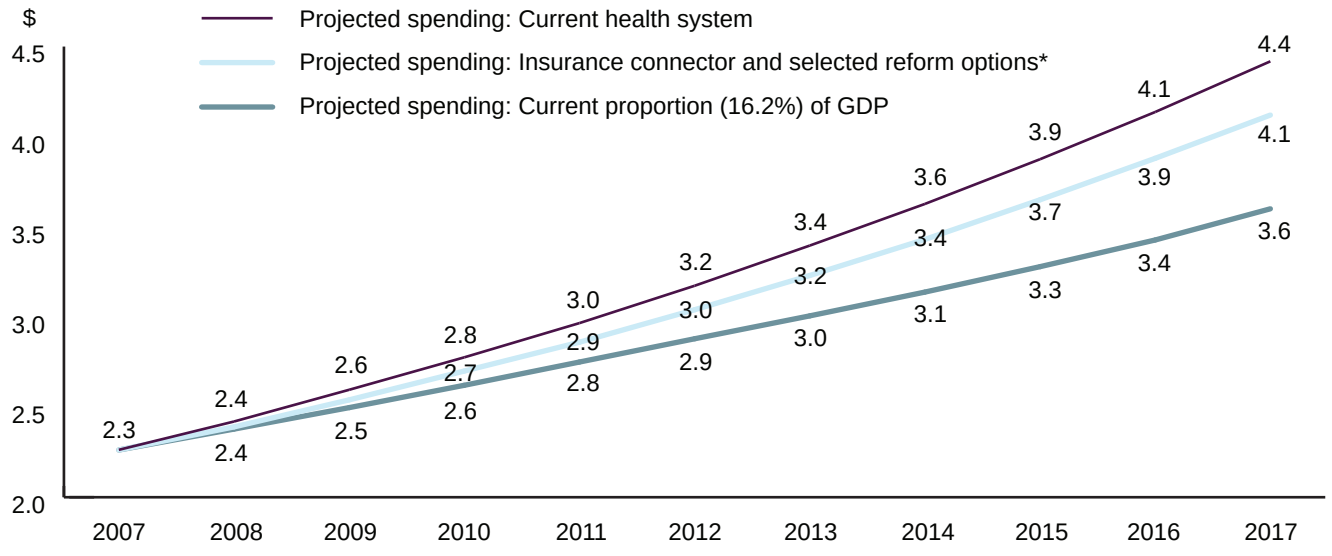
Two days later, Angela felt fine. That day, she received an automatically generated e-mail from Dr. F's office asking how she felt and urging her to check in. She replied, letting them know she was better. Angela smiled. Aren't automated medical records and systems just great?

One of the keys to better health system performance is ensuring that all patients are linked to a regular source of medical care—one that is accountable for coordinating all services and provides convenient access to appointments. This style of practice, sometimes called a "patient-centered medical home," allows patients to contact their provider by telephone, get same-day medical appointments as well as care or medical advice in the evening and on the weekend, and experience well-organized office visits—with their complete medical history readily available. The Commonwealth Fund has funded the National Committee for Quality Assurance to establish standards for a patient-centered medical home, a concept that has been endorsed by four primary care specialty societies.[11]

Patient-centered medical homes are also accountable for ensuring that patients receive appropriate preventive care. Preventive care can head off infectious diseases, reduce the incidence of debilitating flu and pneumonia, and detect cancer early when the prognosis for cure is better. Having a medical home substantially improves the likelihood that adults will receive reminders for routine preventive services such as cholesterol, breast cancer, and prostate cancer screening—as well as the likelihood they will receive

A combination of reforms, including health coverage for all, could yield total health system savings of $1.5 trillion over 10 years.

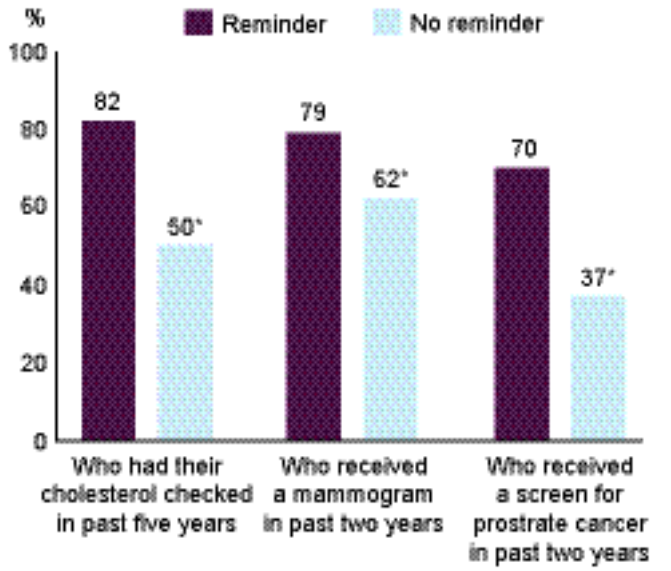
Dollars in trillions



* Selected options include: improved information for health care decision-making, payment reform, and public health initiatives.

Source: C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, ***Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*** (New York: The Commonwealth Fund, Dec. 2007).

When patients receive reminders from their physicians, they are more likely to receive preventive screening.



A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, ***Closing the Divide: How Medical Homes Promote Equity in Health Care—Results from The Commonwealth Fund 2006 Health Care Quality Survey*** (New York: The Commonwealth Fund, June 2007).

these services. However, according to a recent Commonwealth Fund report, just 27 percent of working-age adults currently have a medical home.[12]

Patients who receive effective preventive services and public health measures reap major benefits—from longer, more productive lives to lower medical costs. Yet only half of adults are up-to-date with recommended preventive care.[13] Insurance that covers preventive care is essential for improving this rate. But much more needs to be done to ensure that patients are reminded to get preventive care, to institute systems that facilitate appropriate screening and follow-up, and to encourage healthy behaviors.

A good example of medical homes in practice can be found in North Dakota. While predominantly rural, residents there are more likely than residents of most other parts of the country to receive low-cost, high-quality health care.

In recent years, North Dakota has focused on building its primary care capacity, particularly for vulnerable populations. For instance, the state's MeritCare Health System developed a collaborative, provider-based diabetes management pilot program linking patients with disease management nurses from their medical home. The program was designed to investigate the effects of a stable patient-provider relationship on the quality and cost of chronic disease management. The clinic participating in the pilot program saw an 18 percent increase in the number of patients receiving recommended diabetes care, while a comparison clinic exhibited no significant change.

One major barrier to the spread of medical homes is that public programs, such as Medicare and Medicaid, and private insurers pay disproportionately higher rates for specialized procedures than for preventive and primary care.[14] Fund-supported research is helping to develop and evaluate new payment methods that encourage more physicians to practice primary care, employ a team approach to care, and meet the standards of the patient-centered medical home. One promising model is Community Care of North Carolina's statewide approach to ensuring that Medicaid beneficiaries receive high-quality accessible and coordinated care.

AIMING FOR HIGHER QUALITY AND GREATER EFFICIENCY

Martin's Story

It was April 19, a date Martin always dreaded. His father, at age 60, had died from colon cancer on this date 15 years ago. Martin was intent on avoiding the same fate. Thanks to his health insurance plan, which provided 100 percent coverage for all preventive services, he wasable to act on his family physician's advice and schedule his first

HIGH PERFORMANCE IN PRACTICE

The nonprofit Community Care of North Carolina was established in 1998 to establish coordinated medical care at the local level—badly needed to control costs and improve quality of services. Community Care worked to build cost-saving networks that linked physicians with other community providers, including hospitals, health departments, and departments of social services. Today, 15 networks with more than 3,500 doctors provide medical homes to more than 715,000 enrolled patients.

North Carolina supports the program by providing $2.50 per month per Medicaid enrollee to the network and an additional $2.50 per month per enrollee to primary care providers for serving as a medical home and participating in disease management. As part of the program, Community Care launched statewide quality improvement initiatives, including standardized developmental screening in well-child care, asthma management, and diabetes management—all of which have led to improved care. Two new quality improvement initiatives will address mental health and chronic obstructive pulmonary disease. Community Care also provides physicians with quarterly feedback on their performance.

The state estimates that it has saved more than $230 million over two years from improved care and reduced hospitalization.[15]

colonoscopy when he turned 50. He would have had one earlier, given his family history, but he couldn't afford the out-of-pocket cost under his old, high-deductible plan. But now, since part of his family doctor's compensation was based on the quality of care provided, including preventive care, he received regular reminders about screenings and other preventive services. He also e-mailed the blood pressure and blood glucose readings he took at home to the nurse practitioner in his doctor's office, who kept an eye on them to spot problems early—before they could become more serious.

Choosing a doctor for his first colonoscopy had been simple. He'd logged onto his health plan's Web site, clicked under "screening tests," then "colonoscopy," then "facilities," to find one in his area. He scanned the list of facilities and fees and then clicked on the names of physicians linked to those facilities. Each physician's information included the average number of colonoscopies he or she performed annually, complication rates, and fees. He selected the doctor and facility with which he felt most comfortable, with what looked like the best price (even without deductibles and coinsurances for preventive care and screenings, he was no spendthrift), and the lowest rate of complications, and clicked on it to schedule an appointment.

Martin had the procedure and, while in the recovery area, listened carefully as the gastroenterologist explained his findings and told him what to expect next. Martin had had two polyps, which had been removed and sent to a pathology laboratory. A few days later, Dr. G called to say that the pathology lab had reported these to be adenomatous polyps, which are precancerous. Since the polyps had been removed, there was nothing to worry about, but Dr. G would follow Martin closely. Martin felt grateful: Thanks to his coverage, it had been possible to pick up this potentially life-threatening problem early.

Today's patients often want to be active, engaged partners in their care. A robust system of transparency and public reporting can help patients find the information they want, including measures of quality, prices, total cost of care, and health outcomes for major conditions treated by each provider, as well as information on treatment options.

Often patients are frustrated in their attempts to navigate today's fragmented, highly specialized health care system. They must repeat their medical history everywhere they go. Their medical records are not available when needed. And they are told different things by different physicians. A Commonwealth Fund survey found that patients are very frustrated with the fragmentation and lack of coordination they experience and long for one place that coordinates all their care.[19] Compared with people in other countries, Americans are more likely to report problems with care coordination.

HIGH PERFORMANCE IN PRACTICE

Four examples of transparent cost/quality information come from:

- Geisinger Health System, which provides a Web site clearly showing mortality and readmission rates, as well as costs for coronary artery bypass surgeries, for its two principal hospitals and for each cardiac surgeon at those hospitals.[16]
- The Centers for Medicare and Medicaid Services, which lists costs and Medicare payments for more than 60 procedures at ambulatory surgery centers and 40 inpatient procedures, in addition to quality measures for care of heart attack, congestive heart failure, and pneumonia.
- The California-based Integrated Healthcare Association, which provides clear, accessible information for participating providers on their clinical care outcomes, patient satisfaction scores, and use of information technology.[17]
- Massachusetts Health Quality Partners, a coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies that has a Web site offering accessible, searchable data on health care providers.[18]

A coordinated, team approach to care—one that appropriately utilizes the professional training and skills of physicians, nurses, pharmacists, technicians, and others—can improve the quality of patient care. For example, one study showed that integrated medical groups are more likely than independent practices to use care management processes, electronic medical records, and incentives for quality improvement.[20] Another demonstrated that the closer a managed care physician network is to a group model, the higher the network will perform on clinical quality measures.[21] Clearly, organized systems improve health care delivery as well as provider accountability.

Angela's Story

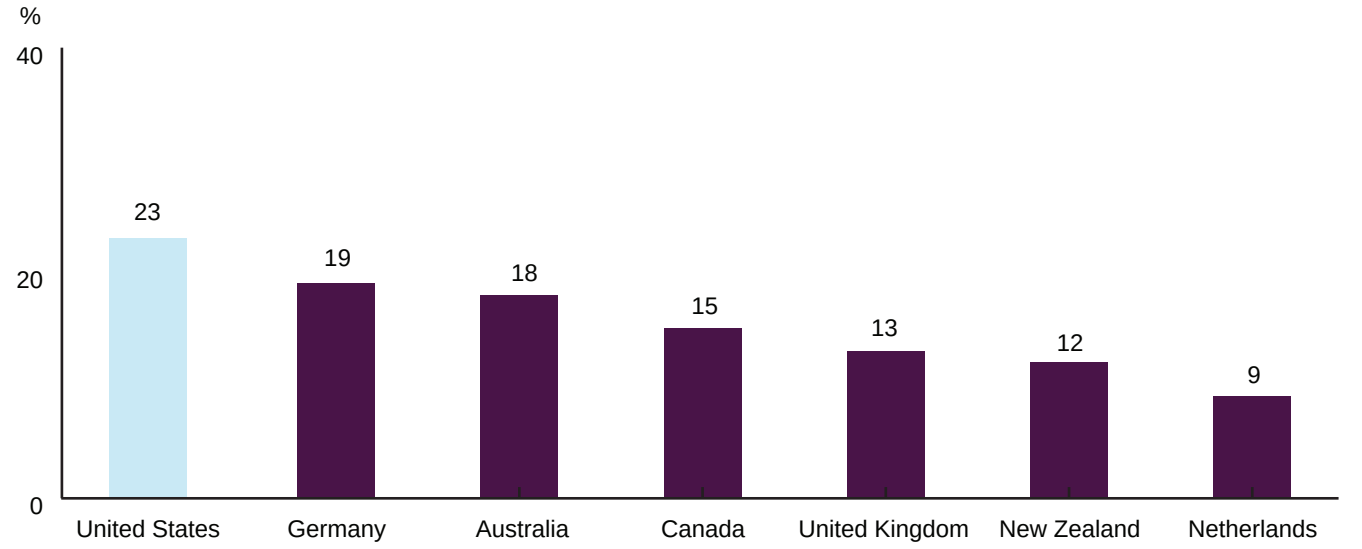
Angela washed her face, brushed her teeth, and took a puff from her metered-dose asthma inhaler. Thanks to the preventive medications her doctor prescribed and the time the nurse practitioner in Dr. F's practice had taken to explain how to manage her asthma, Angela had not had an asthma attack in three years.

Angela knew one reason for her good care was the financial bonus Dr. F received for every asthma patient she managed according to the latest National Asthma Education and Prevention Program guidelines, which include intensive patient education.[22] Armed with a written asthma action plan, Angela now knew how to handle her condition if it worsened. Her insurance plan even reimbursed her part of the cost of the hypoallergenic mattress cover and air purifier, recognizing that prevention was always less expensive than paying for a visit to the emergency room for an asthma attack.

Angela also knew that Dr. F provided great asthma care. The doctor's results, tracked via an electronic medical record system, were posted online and compared with benchmark outcomes from the highest-performing practices in the country. Dr. F always landed near the top. Plus,

Patients in the U.S. are more likely to experience problems with care coordination than patients in other industrialized countries.

Percent of adults answering yes to two coordination problems*



* Test results or medical records were not available at time of scheduled appointment and doctors ordered a medical test that you felt was unnecessary because the test had already been done.
Source: Based on C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," ***Health Affairs*** Web Exclusive (Oct. 31, 2007):w717–w734.

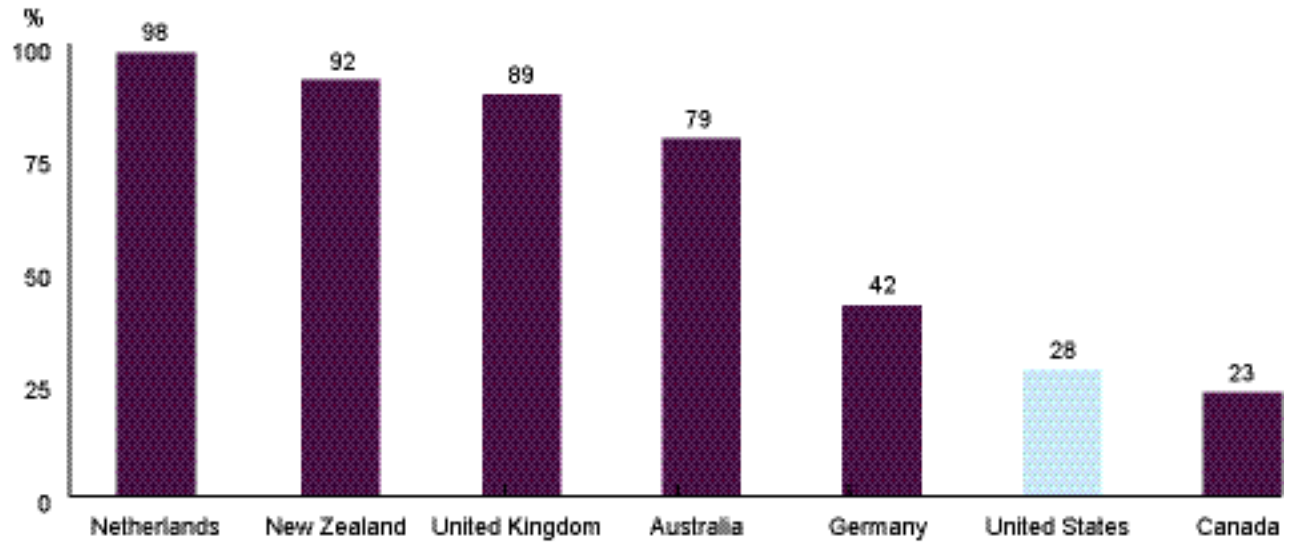
the electronic medical record made creating reports on patients by disease, medication, patient visit, and clinical parameter a breeze. With those reports, Dr. F—and the insurance plans that paid her—could clearly see where there was room for improvement.

The best health care systems use information technology to organize care for patients, track and measure the quality of care provided, and then compare that quality against agreed-upon benchmarks. The electronic medical record (EMR) plays a central role. An EMR system enables providers to access a patient's complete medical history, including outpatient, inpatient, and ancillary visits, as well as all test results and prescriptions, preventive services like mammograms and colorectal cancer screenings, and clinicians' notes. Such transparent, easily accessible information spurs innovation and improvement in hospitals and physician groups by appealing to their professionalism and helping them to identify areas for improvement.[23]

However, just 28 percent of primary care practices in the United States have access to EMRs, despite evidence that they can improve performance and possibly lower overall costs. Without them, it is impossible to track comprehensively the quality of care provided by individual physician offices and health care entities.

In Denmark, a country that has invested in a national central information system, nearly all primary care physicians have their own EMR systems that conform to national standards. Physicians report that the systems benefit them and their patients, and a study found that use of such systems led to "higher quality and throughput

Slightly more than a quarter of primary care practices in the U.S. use electronic patient medical records.



Source: Based on C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, J. Peugh, and K. Zapert, "On The Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," ***Health Affairs*** Web Exclusive (Nov. 2, 2006):w555–w571.

by individual general practitioners."[24] Denmark's investment in technology has been associated with a 20 percent increase in the number of general practitioner patient visits per day; reduced spending on medications; improved patient adherence to preventive care recommendations; and, thanks to preventive care reminders, a drop in mortality for cervical cancer.

Shared decision-making aids can make the latest scientific evidence on the risks and benefits of alternative treatments accessible to patients as well. Studies find that such tools are not only cost-effective,

HIGH PERFORMANCE IN PRACTICE

In 2004, Blue Cross Blue Shield of Massachusetts and Partners HealthCare, an integrated health system in Boston, signed a five-year contract that tied a substantial portion of individual physician payments to the adoption and use of an electronic medical record system. The long-term goal is not just the purchase of such systems (with financial support from Partners) but also their use to collect outcomes data and identify patients whose chronic diseases are not controlled. Between 2003 and 2006, the percentage of Partners' physicians adopting electronic medical records jumped from 6 percent to 64 percent, and Partners expects 100 percent adoption by the end of 2008.[25]

Information technology can also help physicians obtain easy access to medical decision support. By integrating into EMR systems the latest scientific evidence on the comparative effectiveness of prescription drugs, medical devices, and procedures for key conditions, providers would be better able to make the right decisions on treatment. In a recent report, the Fund's Commission on a High Performance Health System called for a health care system that is scientifically grounded, beginning with a substantial investment in new research to support evidence-based decision-making and effective organization and management.[26]

HIGH PERFORMANCE IN PRACTICE

The Dartmouth-Hitchcock Center on Shared Decision Making is a unique program designed to help patients and their families make complicated health decisions. The center's goal is to provide patients with information that is as objective, complete, and unbiased as possible—something that is often difficult to come by in today's complex medical environment, where cost savings, commercial interests, or physician training are likely to drive medical decisions.

The center's premise is based on the fact that people facing medical situations often have more than one choice of treatment, each with its own advantages and disadvantages. Often, there is no "correct" choice. As the center tells its patients, "What you choose depends on what is important to you."

The center provides patients with free one-on-one counseling, a Decision Aid Library containing print, video, and Web resources, and a Healthcare Decision Guide worksheet.

but they lead to better health outcomes. Yet patients are often left out of treatment decisions, lack information about the benefits and risks of different treatments, or receive little instruction or support to manage their care at home.[27]

ACCOUNTABLE LEADERSHIP

Health policy in the United States is shaped by the independent actions of the federal government, all 50 states, hundreds of insurance plans, more than 7,500 hospitals, 900,000 physicians, and nearly 10 million people working in the health care delivery sector. It should be no surprise, then, that some of these actions work at cross-purposes and cause our health care system to underperform.

Achieving the goal of a high performance health system requires new leadership from the federal government in conjunction with public-private collaboration. What our country could use is a single entity that:

- Sets national targets for health system performance and specific priorities for improvement.
- Ensures a uniform health information technology system.
- Generates information on the comparative effectiveness of drugs, medical devices, procedures, and health care services and disseminates that information to payers, clinicians, and patients.
- Develops the databases and compiles the information needed for assessing effective practices and for identifying and rewarding high performance of those who deliver health care.
- Reports regularly on health system performance and makes recommendations on how to meet desired targets.[28]

A Commonwealth Fund survey indicates that a majority of the nation's health care opinion leaders are in favor of creating such an entity to ensure the coordination of practices and policies that cut across public programs and private sector activities.[29]

At the same time, stronger partnerships between the federal government and the states—which together account for almost half of all U.S. health care spending—are needed to link payment to guidelines and performance standards. Federal and state governments should also lead by example through the establishment of financial incentives for Medicare and Medicaid providers that meet high levels of quality—something that has already begun.

CONCLUSION

Is there a better way to provide and pay for health care in the United States? Just ask Martin and Angela, who live in the world of a high performance health system.

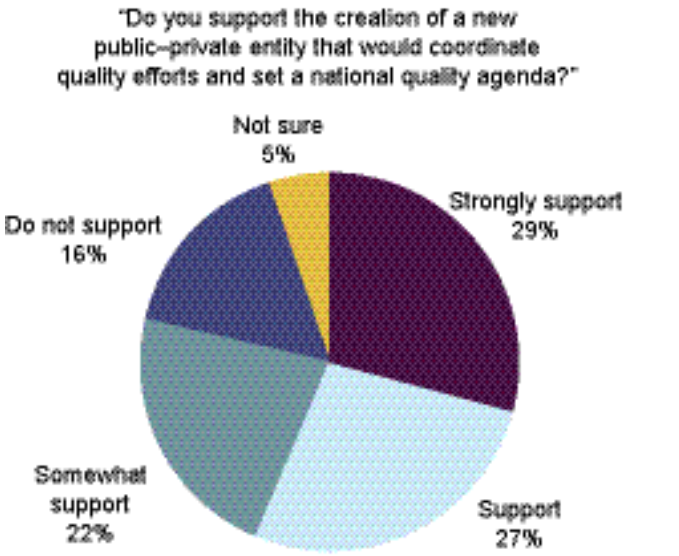
Martin and Angela's serious health conditions—a precursor to colon cancer for him and breast cancer for her—were identified early, thanks to routine screenings, which their affordable and comprehensive health insurance covers completely. There were no financial pressures preventing them from receiving recommended preventive care.

Both Martin and Angela have medical homes—a primary care practice where they have access to their physician 24/7; where the office is run efficiently; where their care is tracked through the use of an electronic medical record; and where they can be seen as needed without long waits. The time their family physicians were able to spend with them, thanks to a medical home fee paid by their insurer, helped them better manage their asthma, diabetes, and hypertension.

Because Martin and Angela's doctors receive a bonus for achieving good outcomes, they had a stake in ensuring that their patients received this level of care and in monitoring their progress carefully with a disease registry. And when their care required the use of specialists—as Angela's did with her breast cancer diagnosis and Martin's with his colon cancer—their family practitioners were again incentivized to remain involved with them and coordinate their care.

Angela and Martin's physicians and other health care providers are also rewarded for providing comprehensive, coordinated care pegged to national benchmarks, ensuring that the two receive the best care possible.

Health care opinion leaders agree on the need for a public–private entity to coordinate quality.



Source: K. K. Shea, A. Shih, and K. Davis, ***Health Care Opinion Leaders' Views on the Quality and Safety of Health Care in the United States*** (New York: The Commonwealth Fund, July 2007).

HIGH PERFORMANCE IN PRACTICE

Numerous public/private partnerships exist at the state level, including:

Washington State's Puget Sound Health Alliance. This broad group of public and private health care purchasers, providers, payers (health plans), and consumers, is working to develop public performance reports on health care providers and evidence-based clinical guidelines.

The Wisconsin Department of Employee Trust Funds (ETF). This state agency administers health benefits for state and local government employees. It is currently pursuing value through a variety of purchasing strategies and becoming involved in public-private collaboratives such as a statewide health data repository.

Martin and Angela don't have to worry about paying for the high-quality health care they receive. Both are covered by insurance plans that charge premiums based on income and do not penalize members for preexisting medical conditions. Martin and Angela's plans are funded through a combination of state, federal, employer, and individual contributions and are part of a national program of universal coverage.

Remember Harry and Louise? Well, they are older and wiser than they were 15 years ago, when health reform was last debated. Since that time, they have lived through managed care, consumer-directed health care, and gaps in insurance coverage. They've learned that efforts to reign in health care costs by increasing patient's plan deductibles and copayments have proven to be shortsighted.

Facing higher costs for health care has caused Harry and Louise to forgo both essential and discretionary care. This, in turn, has exacerbated their chronic conditions and increased the total cost of their care.[30] Without insurance and affordable access to care, Harry and Louise fail to receive preventive care and don't take the medications they need to control their chronic conditions.

And, as a result, the health system suffers. It doesn't have the resources needed to provide top-quality care as it tries to cope with the emergencies and high-cost consequences of failing to deliver care when problems first appear. Harry and Louise face an uncertain future. Right now they are hanging on until they reach age 65, when they qualify for Medicare.

★ ★ ★ ★

As the discussion about reforming health care gathers steam during 2008, The Commonwealth Fund, together with the Commission on a High Performance Health System, will continue to make the case for an integrated approach to system reform, one in which issues of access, quality, and cost are considered in tandem. We also will continue to stress the importance of shared responsibility—among business, government, insurers, providers, and patients—no matter what path reform takes.

By providing information on promising initiatives, assessing the likely impact of proposed policies, and offering new ideas, we hope to assist health care leaders and policy officials who are committed to making the U.S. health system truly the best it can be.

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The Audit & Compliance Committee of The Commonwealth Fund's Board of Directors is responsible for the foundation's fiscal controls and risk-management practices. Pictured here are Committee members Walter E. Massey (foreground), president emeritus of Morehouse College, and Committee chairman Samuel C. Fleming, president and CEO of Briland LLC.

John E. Craig, Jr.

High-Performing Foundations: The Role of Risk Management

With the collapse of Enron in 2000, the subsequent unexpected corporate failures and accounting scandals, and, most recently, the financial crisis induced by the breakdown of the subprime mortgage market, risk management has become a major focus of boardroom attention. The Sarbanes-Oxley Act of 2002, sparked by the Enron and Tyco scandals, has spurred the reorganization of audit and compliance committees to better inform corporate boards of the risks companies face, and to assist management in dealing with them.

While few of the Sarbanes-Oxley measures apply directly to nonprofit organizations, the legislation occurred at a time of elevated attention to best governance and operating practices within the nonprofit sector.[1] The sector's heightened concern about best practices arose from media attention to examples of misconduct in some nonprofits in the early 2000s, followed by the Senate Finance Committee's exploration of how best to address issues of their performance and accountability. The vigorous response by the Independent Sector, through its own Panel on the Nonprofit Sector, culminated in this year's publication of *Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations,* which provides a framework for addressing many of the recognized needs for self-regulation by nonprofits.

While "risk" is not quite the four-letter word in the nonprofit sector that it has become in the corporate world, many of the principles advanced by the Panel on the Nonprofit Sector implicitly address it—for example, ensuring effective governance, annually reviewing the chief executive's performance, maintaining appropriate separation of duties for key functions, undertaking periodic reviews of board performance, providing strong financial oversight, having plans in place for protecting assets, complying with all applicable federal laws and regulations, and managing conflicts of interest.

It is possible, even, that the principles do not go far enough in acknowledging that risk management is as important in the nonprofit world as in the corporate sector, and deserves conscious and concerted attention—with respect not only to avoiding harm

to institutions, but also to controlling risks so as to be able to seize opportunities. As Melanie Herman and colleagues at the Nonprofit Risk Management Center note, "[the nonprofit risk-management literature] often describes *minimizing* or *avoiding* risk as the ideal without paying any attention to the inherent and desirable risks that nonprofits must take to accomplish their missions. An organization that designs its risk-management activities solely around the goal of minimizing or avoiding risk will miss out on opportunities…. Risk taking is inherently positive."[2] Harvard Business School professor Robert Simmons elaborates on the constructive role that risk management plays in achieving organizational stability and strong performance as follows: "Taking risks is not in itself a problem—but ignorance of the potential consequences is an entirely different matter…. If managers are aware of the nature and magnitude [of risks], they can take appropriate steps to avoid the hidden dangers."[3]

On the face of it, private foundations—in contrast to other nonprofits and corporations—operate in a relatively low-risk zone: effectively managed, their endowments free them from the need to generate revenues through the sale of products and services or to access capital markets to fund growth or shore up balance sheets; with rare exceptions, foundations do not compete for clients; except when self-initiated or in extreme cases of misconduct, they receive little media attention; and they are not accountable to any electorate. Ironically, however, the very set of circumstances that protect foundations from market, media, and political forces expose them to fundamental risks. As noted in a Booz Allen Hamilton study of enduring institutions including the Rockefeller Foundation, a "negative effect of the robust risk-management system that endowments represent is that they can become insulating and shield the [foundation] from criticism and the pressure to perform well. Without a market test, the [foundation] must be motivated by loyalty and commitment to mission rather than by pressures from outside the organization. This can place a burden on the foundation to engage in constant and regular self-assessment."[4]

In the wake of Sarbanes-Oxley, a blue ribbon commission of the National Association of Corporate Directors published guidelines for audit committees that identified risk assessment and management processes as one of the three core responsibilities of these committees, along with financial reporting processes and the audit function.[5] In bringing their governance and oversight structures up to date in recent years, many foundations, including The Commonwealth Fund, have charged their audit and compliance committees with an annual review, together with management and the independent auditor, of significant operational and financial risk exposures and the steps management has taken to monitor and control such exposures, and with a similar review of the quality and adequacy of management's risk-management policies and procedures and its other internal controls.

In July 2006, the Fund's Audit and Compliance Committee initiated a process for formally assuring fulfillment of these charges, using the framework summarized in this report. Because the literature on risk management in nonprofits is very sparse, and that on foundations all but nonexistent, we thought the Fund's approach would be of interest to other foundations and the legislative and regulatory bodies that oversee them.

RISK EXPOSURE AND RISK MANAGEMENT AT THE COMMONWEALTH FUND

The Fund faces risk in eight principal areas:

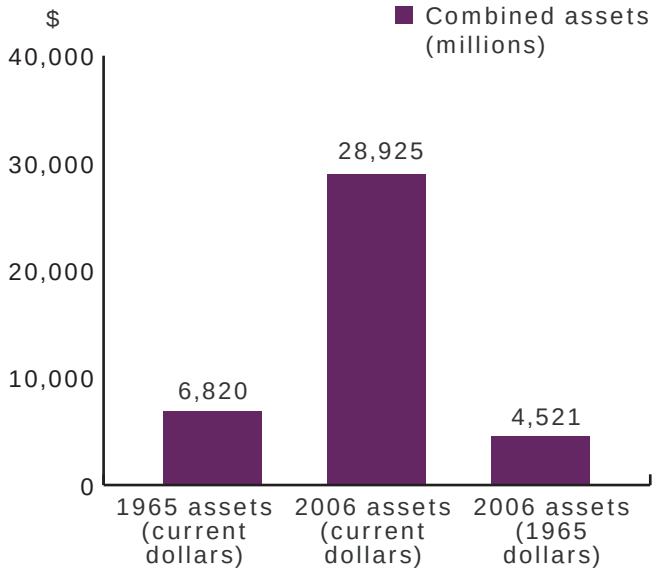
- the endowment
- the strength and continuity of its board, executive leadership, and professional staff
- its existence as a foundation enterprise, including its particular value-added operating model combining grantmaking and intramural research, program development, and communications
- its programs and program strategy
- its reputation and image
- the viability of New York City as an operational base in the event of a catastrophe impairing the city
- its landmark New York City headquarters building
- regulatory compliance with respect to 1) financial reporting, payment of taxes, and the federal annual payout requirement; 2) self-dealing regulations and executive/director compensation standards; and 3) human resources management.

The table on the following page outlines for each of these areas the nature of the risks, an assessment of the level of risk, and the potential degree of impact of an event on the foundation's well-being. Although not shown, the framework also includes the management strategies and measures that are in place to control risks. The arraying of risk areas in the figure is in descending order of probability and potential magnitude of impact should an event occur.

The Fund's Endowment

The Fund's endowment is its sole source of income, and the endowment's qualification as the highest area of risk is justified by market history and the experience of the Fund and other foundations in the 1970s, when a long period of stagflation (along with the high spending rate requirement between 1976 and 1984 discussed below) cut the purchasing power of endowments in half. Even with the boost of the powerful 1982–2000 bull stock market, the 10 largest mature foundations in the U.S. in 1965 with perpetuity as an objective had endowments in 2006 that, adjusted for inflation, were at just 66 percent of their value 21 years earlier. Reflecting both their loss in purchasing power and the emergence of numerous new large foundations, the average rank by assets of these 10 foundations fell from seventh place in 1964 to 39th place in 2006.[6]

Private foundations are a risky business: even with the boost of the powerful 1982–2000 bull stock market, the largest foundations in 1965 have still not recovered from the effects on purchasing power of stagflation and a high mandated spending rate in the 1970s and early 1980s.



Ten largest mature foundations in 1965 with perpetuity objective

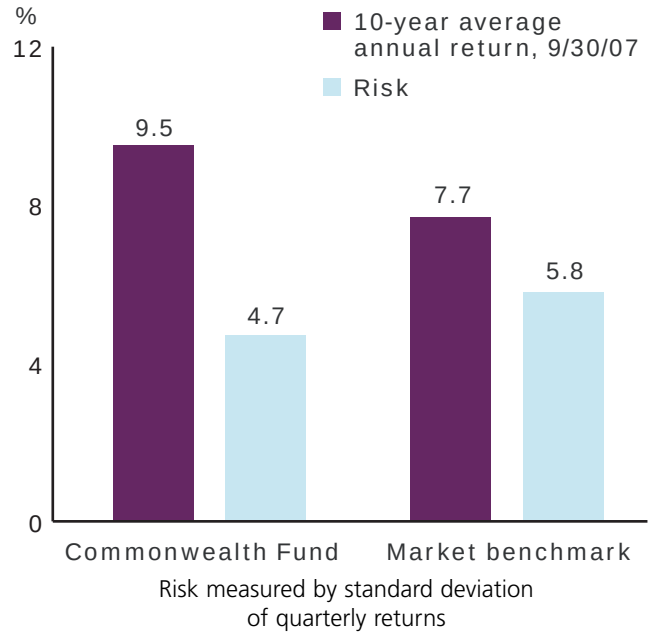
THE COMMONWEALTH FUND'S RISK ASSESSMENT PROFILE

AREA OF RISK	NATURE OF RISK	RISK ASSESSMENT	POTENTIAL IMPACT ASSESSMENT
Endowment	Catastrophic loss in market value/purchasing power; market value volatility incommensurate with objective of steady program spending; spending rate inconsistent with objective of perpetuity.	Moderate-to-high and noninsurable risk	High
	Unauthorized or fraudulent transactions.	Low and insurance-protected risk	Low
	Loss due to breakdown in securities custody/safekeeping.	Low and insurance-protected risk	Low
Governance, Leadership, and Professional Staff	Diminished performance of Fund leadership (Board/management); unexpected loss of CEO or other key executive(s); faulty presidential succession process; inability to recruit and retain strong professional staff.	Short-to-mid-term, low risk; long-term, moderate-to-high risk	High
Enterprise/ Operating Model	Legislative/regulatory actions threatening perpetual foundations, and particularly value-added foundations like the Fund.	Perennial moderate-to-high risk	Moderate-to-high
Programs	Misconceived programs; faulty execution of a program; weak communication of grant results to influential audiences; continuation of a program beyond period of meaningful impact.	Short-to-mid-term, low risk; long-term, moderate-to-high risk	High
	Grantee failure to deliver.	Low risk	Low-to-moderate
	Grantee malfeasance.	Very low risk	Low
Reputation/ Image	Publications/research damaging to the Fund's reputation for objective, scientific analyses.	Low risk	Moderate-to-high
	Activities undercutting the Fund's standing as an independent, nonpartisan contributor to sound public policy.	Low risk	Moderate-to-high
	Staff or Board member misconduct.	Low-to-moderate and largely insurance-protected risk	Low-to-moderate
Catastrophic Event	A terrorist or other catastrophic event fundamentally impairing New York City as the Fund's operating base.	Indeterminate but possibly high risk	High
New York City Headquarters Building	An event severely damaging the Fund's headquarters building, or decreased building functionality and value as a result of inadequate maintenance and attention to office use needs (e.g., upgrading of technology).	Low-to-moderate and largely insurance-protected risk	High short-term event impact; low long-term event impact
Regulatory Compliance			
Financial Reporting, Payments of Taxes, Meeting of IRS Payout Requirement	Failure to make tax payments, make required distributions, or perform filings required by regulatory agencies.	Low risk	Moderate-to-high
IRS Self-dealing Rules; Appropriate Executive/Director Compensation	Transgression of IRS self-dealing prohibitions; inappropriate compensation of executive or directors.	Low risk	Moderate-to-high
Human Resources	Failure to fulfill human resources regulatory requirements arising from a large body of employment laws and regulations.	Low risk (some risks insurance-protected)	Low

The Fund's investment strategy, endowment management structure, and spending policy are designed to control the risks of a catastrophic loss in market value/purchasing power, market value volatility incommensurate with the objective of steady program spending, or a spending rate inconsistent with the objective of perpetuity.

The Commonwealth Fund's risk-management measures include the following: a strong Board Investment Committee; diversified holdings and managers; strong staffing of the Investment Committee, including the use of high-level Cambridge Associates investment consultants; Investment Committee focus on asset class allocation and manager selection, with appropriate attention to correlations of returns across asset classes and managers; investment guidelines for each manager, including attention to use of derivatives; a 5 percent spending policy; a 60 percent/40 percent policy for the allocation of Fund resources between extramural grantmaking and intramural research, program development, and communications; and clear, timely endowment performance and budget reporting.

The Commonwealth Fund has been successful in achieving better-than-market returns, with lower risk, on its endowment.



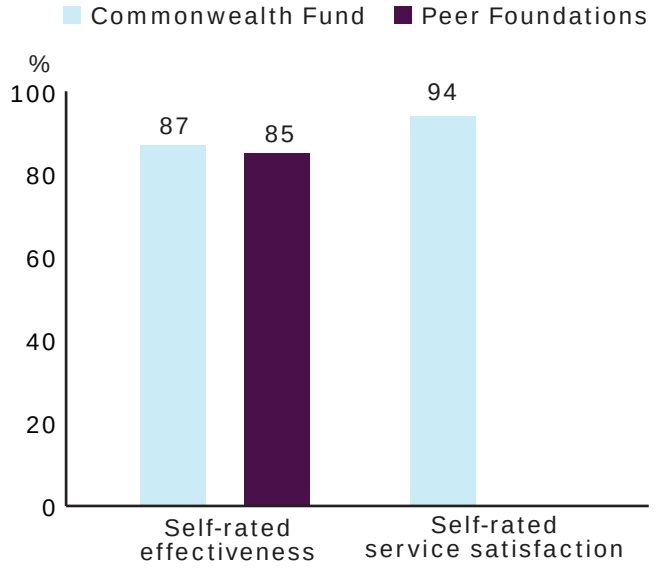
There are other risks associated with the endowment, e.g., unauthorized or fraudulent transactions and losses due to a breakdown in securities custody/safekeeping. However, given the controls in place for preventing events of these types, the insurance or indemnity coverage for most such events, and the relatively small order of magnitude of potential events, the risk of security breakdown in the endowment area is estimated as fairly low.

Governance, Leadership, and Professional Staff

Foundations—as vision- and ideas-driven professional organizations unexposed to market, electoral, or significant media tests of their capacities—are peculiarly vulnerable to life cycles of strength and weakness associated with the caliber of their governance, leadership, and staffing. Numerous histories of the foundation sector and of individual organizations—including studies of the Fund's own history—demonstrate the potential for decline or loss of vigor even in top-ranked institutions.[7]

A culture of adherence to best governance practices, accountability, high standards and expectations for management and professional staff, as well as focus on feedback and performance assessment, can be an effective antidote to this industry hazard. Specific measures at the Fund to promote such a culture include the following: best-practice Fund governance documents and processes; a diligent and active Board Governance & Nominating Committee, charged with

The Commonwealth Fund's Board participates in an annual survey to assess its own effectiveness.



Source: Center for Effective Philanthropy's 2007 Foundation Trustee Survey.

Board recruitment and oversight of the Board's participation in the Center for Effective Philanthropy's annual board development survey[8]; a vigilant Board Executive & Finance Committee, focused on executive compensation and retention issues as well as annual budget decisions; annual Board review of the Fund's own performance scorecard; annual performance reviews of the Fund's president and EVP–COO by the Executive & Finance Committee and Board; an interim presidential succession plan; timely formal presidential succession planning; periodic audience and grantee surveys to assess organizational performance and impact; effective human resource management including annual staff reviews, annual staff satisfaction surveys, management counseling of Fund supervisors when necessary, and attention to staff morale and development; and a strong human resources department.

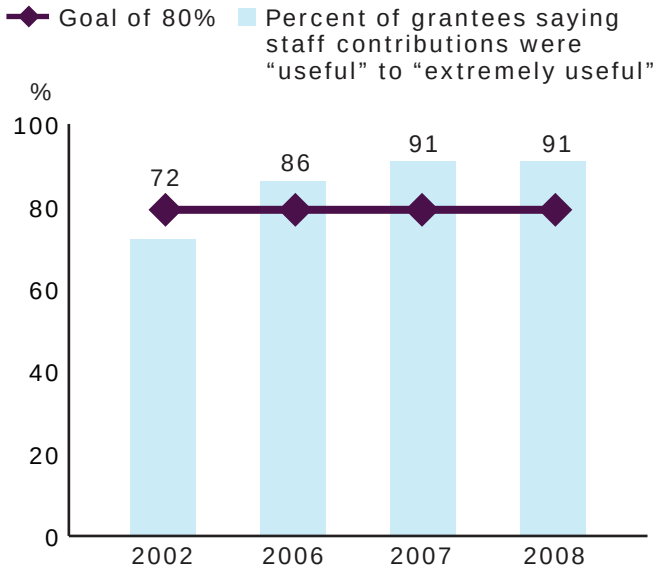
With the substantial battery of leadership and staffing risk-management measures in place at the Fund, short- to mid-term risk is rated as low, but the Fund's Board and management are mindful of the potentially significant long-term risks in this area.

The Private Foundation Enterprise/ Operating Model

Private foundations exist only with the continuing approval of the U.S. Congress under the federal tax code, and their affairs are subject to attention by their states' attorneys general. Congressional focus on the sector waxes and wanes, historically, over a 15–20-year cycle, and was recently at a high point. To cite one example of the real enterprise risk arising from Congressional action, Congress in 1976 mandated a payout requirement defined as the greater of 6 percent of endowment market value or all investment income (interest and dividends and net capital gains). The history of financial markets demonstrates that, over the long term, endowments can be expected to generate average annual inflation-adjusted returns of no more than 5 percent. Thus, Congress's 1976 policy amounted effectively to a "spend-down" requirement for foundation endowments, which remained in effect until 1984, when it was replaced with the current 5 percent payout rule.

Perpetual foundations, and particularly value-added foundations like the Fund, can therefore face considerable enterprise risk: mandated increases in the payout requirement beyond the 5 percent rate consistent with longevity; disallowance of intramural research, program development, and communications expenses as contributors to the annual payout requirement; burdensome regulatory requirements

A measure of Commonwealth Fund staff performance is grantees' assessment of the value added by staff contributions to their work.



Source: 2002 Harris Interactive Survey of Fund Grantees and 2006/2007/2008 Mathew Greenwald Audience and Grantee Survey.

increasing administrative expenses and detracting from focus on programs; intrusive regulations impairing the foundation's governance and management; and restrictions on some legitimate public policy activities of the foundation.

The Fund is very active in managing its enterprise and operating model risk, most recently in working with members of Congress during a 2003–04 congressional effort to disallow most intramural expenses in documenting fulfillment of the annual payout requirement. The foundation's risk-control measures include the following: Fund leadership in the foundation community in promoting best practices and alerting the sector to threats; Fund membership in and support of effective associations representing the foundation and nonprofit sectors in legislative/regulatory matters; proactive relationships with Congress on foundation regulatory issues, strengthened by the Fund's work with Congress on health care issues; clear presentation of functional allocations of Fund spending in the *Annual Report,* and public rebuttal when these are misrepresented in the press; and clear Board-approved guidelines to staff regarding appropriate public policy activities and safeguards against those activities prohibited by regulations (e.g., lobbying for specific legislation or engagement in political activity). The Fund's Executive Vice President–COO is assigned particular responsibility for vigilance to threats in this area, precautions for avoiding them, and defense as needed.

Programs

Foundations like the Fund are rightly often characterized as "social venture capitalists," and, as such, they are expected to take significant programmatic and grant-specific risks. At the same time, their resources are scarce and they operate in arenas populated with far more powerful and resource-rich players. Effectiveness is therefore achievable only through carefully designed program and communications strategies, strategy-driven grants portfolios, and risk management by skilled and experienced value-adding professional staff. As Joel Fleishman has written, "Before embarking on any strategic initiative, the extent of the risk must be examined, quantified if possible—and then embraced. This means accepting risk as an inevitable concomitant of innovation, much as business entrepreneurs or venture capitalists accept financial risk in pursuit of gain."[9]

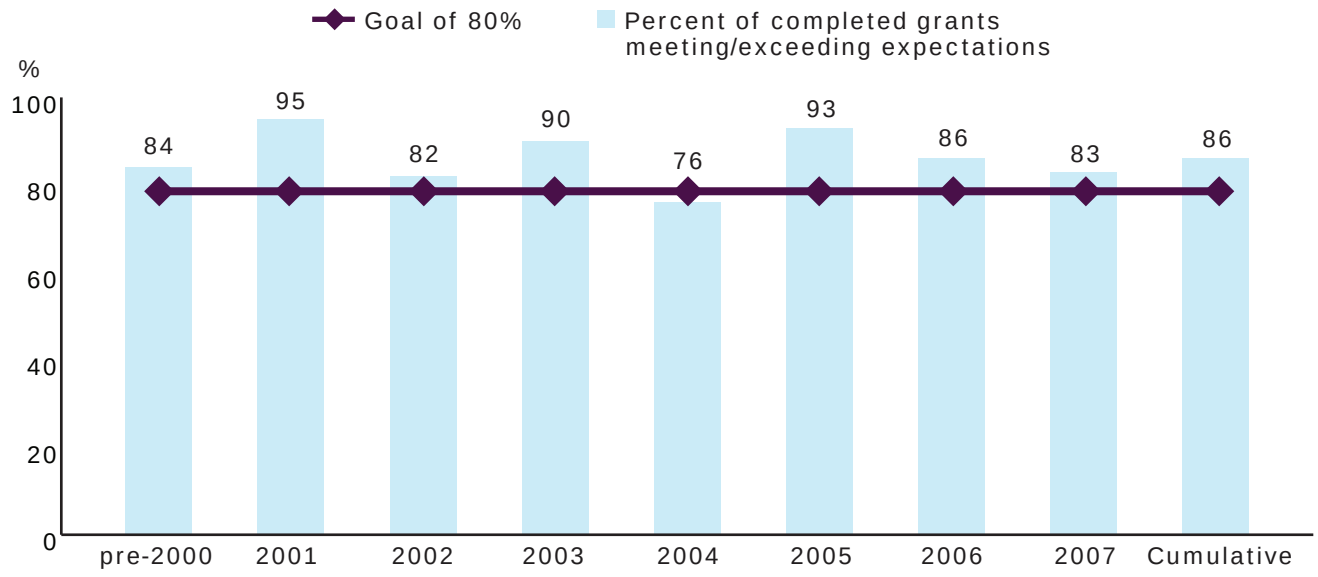
Program risk arises from the eventuality that programs are misconceived (e.g., poorly timed, not grounded in realistic market analysis, not geared to the Fund's strengths, or not coordinated with other Fund programs); faulty execution of a program as a

result of inadequate staffing or financing or unforeseen adverse external forces; weak communication of grant results to influential audiences; or continuation of a program beyond the period of meaningful impact.

The Fund's array of tools for assuring effective programs is substantial: periodic Board reviews of each program, supported by independent external reviews; an annual "Making a Difference" report on program accomplishments to the Board and review by the Board every five years of the Fund's entire program strategy, including strengths, weaknesses, opportunities, threats ("SWOT") analysis when necessary; preparation and critique of annual program plans, including assessments of work in progress and plans for grants in the coming year; robust Board grant and Small Grants Fund vetting processes; annual comprehensive assessments of the performance of all grants completed over the preceding 12 months and case studies of selected completed grants throughout the year, focused on lessons learned for grantmaking; annual program officer performance reviews; and an effective program officer recruitment system.[10] The short- to mid-term programmatic risk for the Fund is judged as low, but the long-term risk has to be regarded as substantial—dependent as program performance is on continuing strong leadership and staffing and on unforeseen external events.

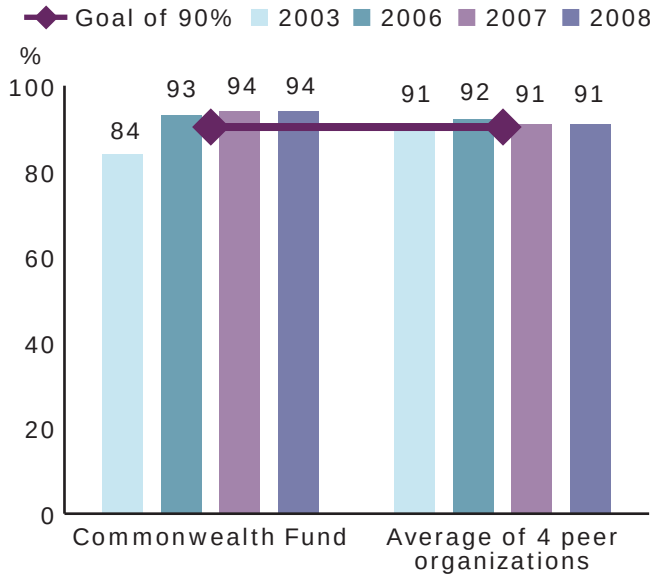
Program risk encompasses also the risks of grantees failing to deliver and of grantee malfeasance. These risks are regarded as low, given the careful vetting of projects, oversight of grantees' work by value-adding staff, and our strong Grants Management unit and processes.

To help assess program risk, The Commonwealth Fund rates the performance of all recently completed grants annually and draws lessons from the analysis.



Source: Annual Completed Grants Reports to the Commonwealth Fund Board of Directors.

The Commonwealth Fund regularly assesses its comparative success in reaching health policy change agents effectively.



Percent of Commonwealth Fund audience saying institution "effective" to "extremely effective" in reaching change agents

Source: 2003 Harris Interactive and 2006/2007/2008 Mathew Greenwald Commonwealth Fund Audience Surveys.

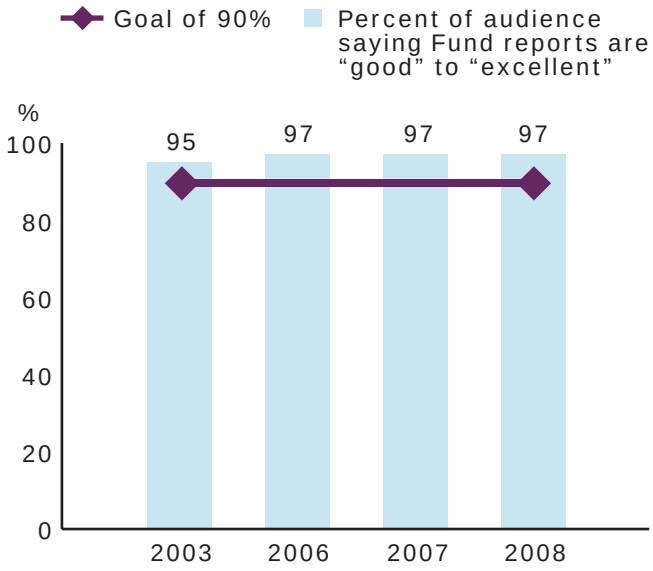
Reputation/Image

The Fund's reputation for objective scientific analyses and image as a first-class independent, nonpartisan contributor to sound public policy are central not only to achieving results through its programs and publications, but to protecting the foundation from punitive legislative/regulatory actions and to nurturing a wide array of partnerships with cofunders, professional and trade associations, and government agencies that leverage the Fund's own capacities. Quality control of publications and sponsored meetings, avoidance of partisan activities, and high standards of conduct for Board members and staff are therefore essential.

Risk-control measures respecting the Fund's reputation and image include the following: quality control of publications by the internal Publications Review Committee and Web Content Monitoring Committee, with external reviews of all Fund survey reports and, when needed, of grantee and other Fund reports; oversight by the Commission on a High Performance Health System of its reports; feedback from periodic audience and grantee surveys; and clear Board-reviewed guidelines to staff regarding appropriate public policy activities and safeguards against activities that could be perceived as partisan.

The Fund's reputation and image can also be damaged by staff or Board member misconduct (e.g., conflicts of interest, theft, misuse of the Matching Gifts program, plagiarism). Safeguards respecting such risks include the following: the Fund's Code of Ethics policy, with conflict-of-interest and whistleblower provisions, and division

The reputation of The Commonwealth Fund rests on providing credible, reliable, timely, and unique information that meets the needs of influential customers.



Source: 2003 Harris Interactive and 2006/2007/2008 Mathew Greenwald Commonwealth Fund Audience Surveys.

of duties among staff and among Board members/committees. The Fund's business insurance coverage limits the financial risk arising from staff or Board member misconduct.

Catastrophic Event

In the post-9/11 environment, New York City institutions must take seriously the risk of an event impairing the city as an operating base, and the Fund accordingly developed its *Business Continuity Planning Manual* in 2002. The manual is updated annually and distributed to all Board members and executive staff. The Fund has established backup arrangements with sister organizations, and its information technology system is regularly backed up in an underground facility in New Jersey and in the Fund's South Carolina emergency preparedness office. The foundation's strong administrative team and the development in 2005 of a Washington, D.C., office also augment the foundation's capacity for recovery from a catastrophic New York City event.

Landmark New York City Headquarters Building

The Fund's ownership of a major New York City landmark building and use of it as its operating base give rise to both operating and financial risks, i.e., an event severely damaging the Fund's headquarters building (e.g., fire) or decreased building functionality and value as a result of inadequate maintenance and attention to office use needs (e.g., information technology upgrades). Adequate building insurance helps protect against these risks, as does a strong program of building and office systems maintenance. Periodic appraisals of the value of the building are undertaken to assure adequate insurance coverage—although in a period of rapidly escalating market values for trophy East Side New York City properties, the adequacy of insurance coverage can never be certain. Even so, the solid construction of the building makes the likelihood of a total loss fairly low, and insurance coverage is judged adequate for covering the cost of temporary office space and building restoration. As with catastrophic event risk, a strong administrative team, backup arrangements with sister organizations, information technology systems backup in New Jersey and South Carolina, and the existence of the Washington, D.C., office also would reduce the impact of an adverse event on the Fund's capacity to recover and resume operations.

Regulatory Compliance: Financial Reporting and Payments of Taxes; Avoidance of Prohibited Self-Dealing Transactions and Excessive Executive/Director Compensation; Human Resources

In addition to meeting the annual IRS payout requirement, the Fund must pay the federal excise and unrelated business income taxes that foundations incur and, like any employer, assure withholding of federal, state, and local payroll taxes. It must file annually a federal tax return (990PF) and an operational report with the New York State Attorney General, and complete a variety of other required financial regulatory filings.

The Commonwealth Fund does not compensate its directors, but does reimburse them for meeting-related expenses. The foundation has procedures to assure that its compensation of executives is appropriate and in keeping with practices at peer institutions, and it obtains periodically from an independent executive compensation consultant firm an

opinion on its executive compensation practices—the most recent such opinion having been obtained in April 2007.

Additionally, like any employer, the foundation is responsible for a substantial array of regulatory requirements and filings in the human resources area. Under Sarbanes-Oxley and in keeping with best practices, the Fund must also have a formal document-retention policy and systems for implementing the policy.

These financial, compensation, human resource, and documentation regulatory requirements or best practices add up to more than 40 required filings, payments, or postings annually, and at each annual pre-audit meeting the Fund's Audit and Compliance Committee obtains assurance from management and the responsible officer that all regulatory requirements have been fulfilled. The Committee also at this time checks that all staff and Board members are in compliance with the requirement to complete each January the Fund's Conflict of Interest Disclosure form.

CONCLUSION

In his recent book on foundations, Joel Fleishman observed, "Foundations require skilled leaders with an entrepreneurial mindset among their board members and program staff who are comfortable in calculating risk if they are to negotiate the shoals of risk successfully."[11] Writing in *The McKinsey Quarterly,* Kevin Buehler and Gunnar Pritsch argue that good risk identification and risk-management practices free an organization to take on more risks that it could—and should—take on otherwise.[12]

Every foundation is subject to risks, and identifying them and developing processes and frameworks for addressing them are keys to achieving high performance. As Buehler and Pritsch conclude, "Without adequate risk-management programs, companies may inadvertently take on levels of risk that leave them vulnerable to the next risk-management disaster, or, alternatively, they may pursue 'recklessly conservative' strategies, forgoing attractive opportunities that their competitors can take."[13] Foundations are arguably particularly vulnerable to "recklessly conservative" strategies: they may avoid potentially high payoff projects or programs as a result of too much concern about the embarrassment of the possibility of failure and unwillingness to devote the staff resources needed to control project risks, for example; or they may hold too much of their endowment in "safe" fixed-income securities, ignoring the potential effects of inflation on such investments. Strong risk-management programs can help reduce this vulnerability.

All nonprofits, but especially private foundations, are also prone to focusing on routine risks like record-keeping and fiscal controls. While such risks are not to be ignored, thorough examination of risks faced by foundations—as indicated by the Fund's own analysis—will generally reveal that the big-ticket risks lie in the areas of long-term leadership, the performance of the endowment, current legislative and regulatory requirements governing foundations, and the vitality of their programs. Assessing and addressing such exposures is a far greater challenge than managing routine risks, and should be the principal focus of foundations' governing boards and chief executives.

The kaleidoscopic structure of the private foundation sector—tens of thousands of very small foundations, a few hundred midsize foundations, and a comparative handful of mega-foundations, each with uniquely faceted histories and operating principles,

and each with its own strategic direction—rules out a single set of guidelines for managing risk. But whatever approach a foundation takes to identifying and managing its risks, it will benefit from periodically addressing the following questions:

- Have board and senior managers communicated the core values of the foundation in a way that all understand and embrace?
- Have board and managers identified the specific actions and behaviors that are off-limits?
- Are board and board committee discussions structured to foster open, frank, and timely discussions of the major risks facing the foundation?
- Are control systems adequate for monitoring critical performance variables, bearing in mind that program success sometimes calls for new variables?
- Are control systems interactive and designed to stimulate learning?[14]

By addressing these questions, foundation boards, audit committees, and management can put their institutions on a stronger footing for achieving high performance.

NOTES

1 "The Sarbanes-Oxley Act and Implications for Nonprofit Organizations," Independent Sector and Board Source Jan. 2006.

2 M. L. Herman et al., *Managing Risk in Nonprofit Organizations: A Comprehensive Guide* (New York: John Wiley & Sons, Inc., 2004).

3 R. Simmons, "How Risky Is Your Company?," *Harvard Business Review,* May–June 1999, p. 92.

4 *Booz Allen Hamilton Lists the World's Most Enduring Institutions,* Dec. 16, 2004, pp. 10–11, www.boozallen.com.

5 The Foundation Center, *Audit Committees: A Practical Guide,* 2004 ed. (Washington, D.C.: National Association of Corporate Directors, 2004).

6 The Foundation Center, *The Foundation Directory, 3rd Edition* (New York, 1967); "Top 100 U.S. Foundations by Asset Size, 2005–06," (accessed at www.foundationcenter.org). A number of the 10 largest foundations in 1965 were slow to recognize that the very low investment returns resulting from stagflation in the 1970s would persist for more than a decade, and had spending rates in the early part of the period well beyond even the required level.

7 J. L. Fleishman, *The Foundation. A Great American Secret: How Private Wealth Is Changing the World* (New York: Perseus Books Group, 2007).

8 Center for Effective Philanthropy, *2006 Comparative Board Report,* 2006.

9 Fleishman, p. 174.

10 John E. Craig, Jr., "Foundation Performance Measurement: A Tool for Institutional Learning and Improvement," *The Commonwealth Fund 2005 Annual Report,* www.commonwealthfund.org.

11 Fleishman, p. 174.

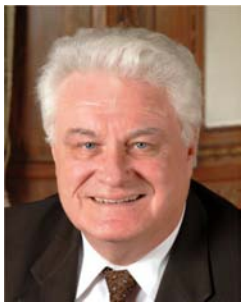
12 K. S. Buehler and G. Pritsch, "Running with Risk," *The McKinsey Quarterly,* 2003, no 4, p. 2.

13 Ibid., p. 5.

14 Adapted from R. Simmons, "How Risky Is Your Company?".

The Fund's Mission, Goals, and Strategy

The mission of The Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency—particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.



James R. Tallon
Chairman

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

The Fund's Board, including William Y.Yun, Benjamin K. Chu, M.D., and Robert C. Pozen, annually reviews one of the foundation's major programs and assesses overall Fund performance.

The Board of Directors has identified the following goals to be pursued by the Fund over the next three years:

Commission on a High Performance Health System

- *Move the United States toward a high-performing health care system that achieves better access, improved quality, and greater efficiency, and focuses particularly on the most vulnerable due to income, inadequate insurance, minority status, health, or age.* This goal is being advanced through the Fund's

Commission on a High Performance Health System, which is charged with setting and tracking national and state performance targets, developing policy options, and disseminating innovative practice changes that would improve the functioning of the U.S. health system. The Fund's grantmaking programs support and enhance the Commission's work.

Programmatic Goals Directly Associated with the Commission

- *Achieve an efficiently run health insurance system that makes available to all Americans comprehensive, affordable coverage,* by analyzing market- and policy-driven changes in employer-based insurance and public insurance programs for people under age 65 and determining how those changes may affect the numbers of people covered and the quality of coverage; by documenting the consequences of being uninsured and underinsured with regard to access to care, health, personal financial security, and economic productivity; and by developing and evaluating strategies to expand and stabilize health coverage, make it more affordable, and enhance efficiency in its administration.
- *Helping Medicare be an innovative leader in coverage, quality improvement, and value,* by enhancing the program's ability to ensure access to the health care needed by the nation's elderly and disabled and protecting the most vulnerable among them from financial hardship; by identifying ways in which Medicare can become more effective and efficient, so it can remain solvent and provide appropriate and high-quality care for an aging population; and by helping enable Medicare, as the nation's largest payer for health care, serve as a standard-setter and agent for promoting better performance throughout the health care system.
- *Improve the quality and promote the efficiency of health care services,* by encouraging the development and widespread adoption of health care quality and efficiency measures; by assessing and enhancing the capacity of health care organizations to provide better care more efficiently; and by stimulating the development and adoption of payment and incentive models that encourage providers to improve quality and efficiency.
- *Spur the redesign of primary care practices and health care systems around the needs of the patient,* by encouraging the collection of information on patients' experiences with health care and public reporting of that information as a way to stimulate quality improvement in primary care; by promoting the adoption of models and tools to help primary care practices restructure and improve care to meet patients' preferences; and by advancing improvements in policy that support patient-centered care.
- *Improve state and national health system performance,* by stimulating and spreading integrated, state-level strategies for expanding access to care and

promoting high-quality, efficient care, particularly for vulnerable populations. This goal includes supporting work in The Commonwealth Fund's own community, New York City.

Goals for Programs Addressing Special Populations

- *Improve the quality of health care delivered to low-income Americans and members of racial and ethnic minority groups and reduce racial and ethnic health disparities,* by promoting models of high-performance health systems for the underserved; by promoting health care that is culturally competent and patient-centered; and by supporting the development of public policy that will lead to improvement in health care systems serving minority and low-income populations.
- *Encourage, support, and sustain improvements in preventive care for young children—particularly those services dealing with their cognitive, emotional, and social development*—by promoting the establishment of standards of care as well as the use of these standards in quality measurement and monitoring; by identifying and disseminating models of pediatric practice that enhance the efficiency and effectiveness of care; and by encouraging reforms that remove barriers to the delivery of quality care and that align provider incentives with desired clinical practices.
- *Transform the nation's nursing homes and other long-term care facilities into resident-centered organizations that are good places to live and good places to work,* by identifying, evaluating, and spreading models of "resident-centered care"; by equipping nursing home operators to lead transformational change; and by promoting policy options that support resident-centered care.
- *Foster the growth of the knowledge, leadership, and capacity needed to address the health care needs of a growing minority population,* by training leaders and identifying policies and practices that will promote equitable health outcomes for minority, low-income, and other underserved populations, eliminate existing disparities in care, and enhance the performance of safety net systems of care.

Goals for the International Program

- *Promote international exchange on health care policy and practice,* by preparing future leaders committed to cross-national analysis of health policy and practice; by sustaining a growing international network of policy-oriented health care researchers and practitioners; by encouraging cross-national comparative research to identify international examples of high-performing health care systems and organizations; by helping to keep U.S. policymakers informed of developments in, and transferable lessons from, other industrialized societies; and by fostering the development of international collaborative

programs to improve care, including opportunities to learn from variations in performance across or within countries.

Goals for Communications/Dissemination

- *Augment the Fund's leadership in effectively and broadly disseminating credible, authoritative information* about policy options and innovative approaches to moving the United States toward a high-performing health care system, particularly for the most vulnerable due to income, minority status, health, or age, through the use of electronic publishing and other communication tools.

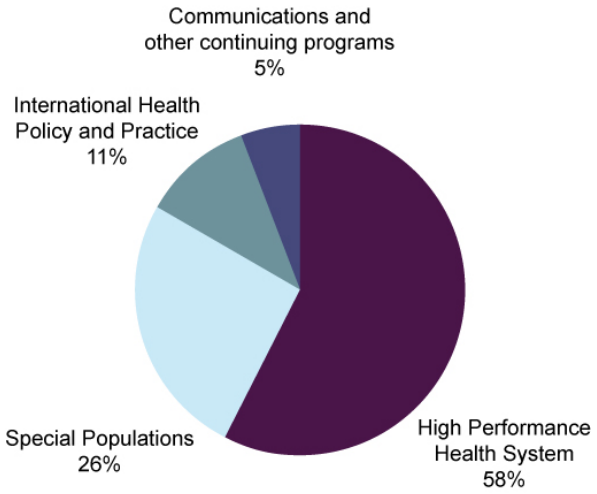
As a result of unexpectedly strong returns on the endowment for the last four years, the Fund's Board has approved a $32 million increase in planned programmatic spending over the next five years, making the total $205.6 million over the five-year period 2007 to 2012. Of that amount, it is anticipated that 69 percent, or $142.6 million, will be spent as grants, allocated across program areas as follows: 58 percent to promoting a high-performance health system, 26 percent to addressing the health care needs of special populations; 11 percent to international health policy and practice, and 5 percent to communications and other continuing programs. The foundation expects to spend approximately 7 percent of its extramural program budget on surveys, which have proven to be useful in informing policy debates and developing programs.

Reflecting the foundation's value-added approach to grantmaking, 31 percent of the total budget will be devoted to intramural units engaged in research, program development, and management, collaborations with grantees, and dissemination. This allocation includes $12.4 million to communicate the results of Fund-sponsored work and funds to operate programs directly managed by the foundation. The portion of the foundation's total budget devoted to administration is 6 percent.

Fifty-eight percent of the new funds for the next five years will be allocated for a few carefully selected new initiatives that build on the Fund's existing work and that will promote improvements aimed at achieving a high-performance health system:

- Transforming Safety Net Clinics and Physician Practices into Medical Homes ($9.2 million over five years)
- Reducing Unnecessary Re-hospitalizations and Readmissions ($4.5 million)
- Helping Health Care Organizations Achieve Consistent High Performance ($3.65 million)
- Assisting States to Improve Scorecard Performance ($1.15 million).

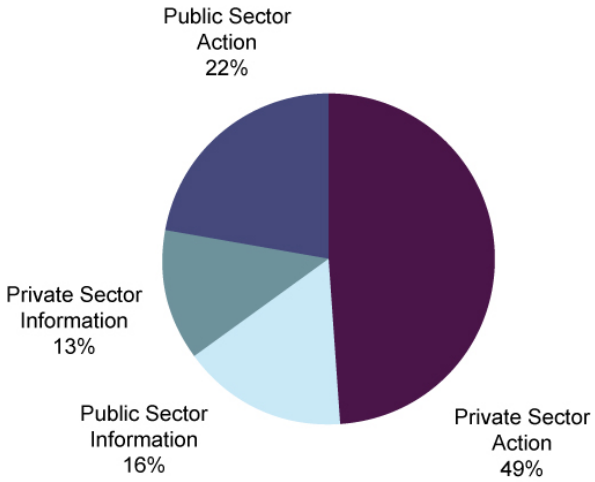
Planned extramural grants spending: $142.6 million for fiscal years 2007–08 through 2011–12



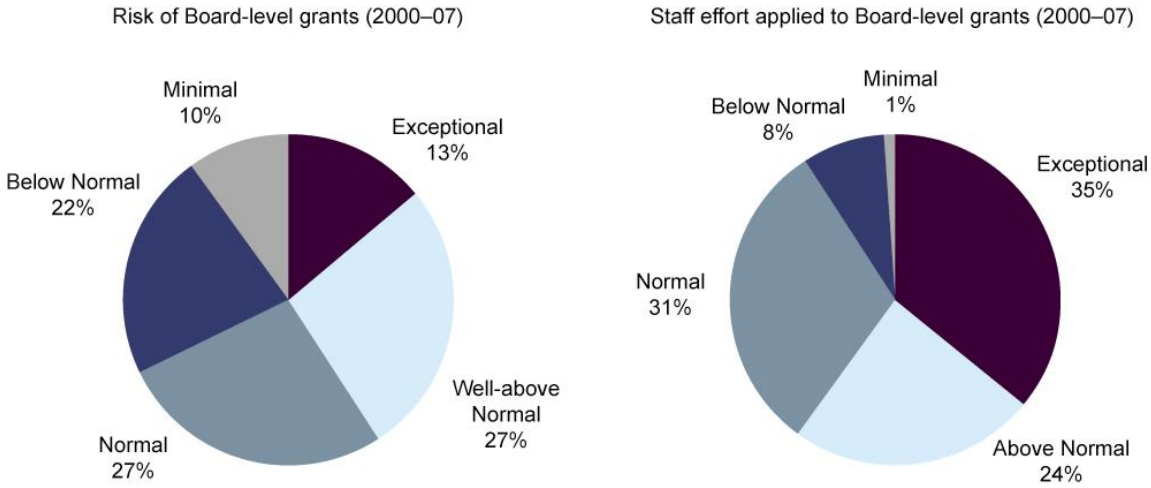
In all its work, The Commonwealth Fund seeks particularly to target issues that affect vulnerable populations. It also aims to achieve a balance between information-generating and action-oriented activities, and between public- and private-sector work. Other concrete objectives that help guide the Fund's grantmaking strategy include: keeping its doors open to new talent, working in partnership with other funders, being receptive to new ideas, undertaking appropriate risks, and contributing to the resolution of health care problems in its home base, New York City, while pursuing a national and international agenda.

In structuring programs and selecting grants, The Commonwealth Fund seeks to achieve an appropriate balance within each program between research and action-oriented work, and between public and private sector work

Distribution of Board-level grants, 1996–2007



An important role of The Commonwealth Fund's value-adding staff is to identify project risks and work closely with project directors in managing them to achieve success

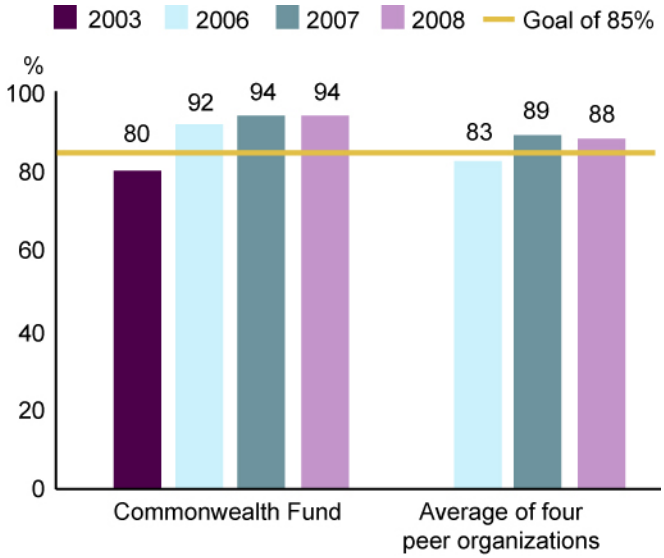


The Fund regularly reviews its major programs and activities to assess their effectiveness and reexamine their strategies. At its April 2007 Retreat, the Board of Directors closely examined the work of the Child Development and Preventive Care Program, assisted by an external review by Health Policy Alternatives, Inc. The review, which was led by Michael Hash, generated convincing evidence that the Fund is playing a unique role in ensuring that appropriate developmental and preventive child health services are available to all families, especially those with young children and low income. The next steps approved by the Board for the program include the following: a) increasing efforts at the national level to encourage building quality standards into the State Child Health Insurance Program (SCHIP) and Medicaid programs; b) working with states and Medicaid to spread state policy innovations in developmental services and encourage new financing models to promote services for young children; and c) encouraging health care practice improvements by promoting the development and adoption of new standards for preventive child health care and better referral, care coordination, and parent education services.

The Commonwealth Fund is one of only a handful of foundations that uses an annual performance scorecard to provide its board with a means of achieving a comprehensive assessment of the institution's overall performance and spotting weaknesses that require attention. The scorecard has 22 metrics, covering four dimensions: financial performance, audience impact, effectiveness of internal processes, and organizational capacities for learning and growth.

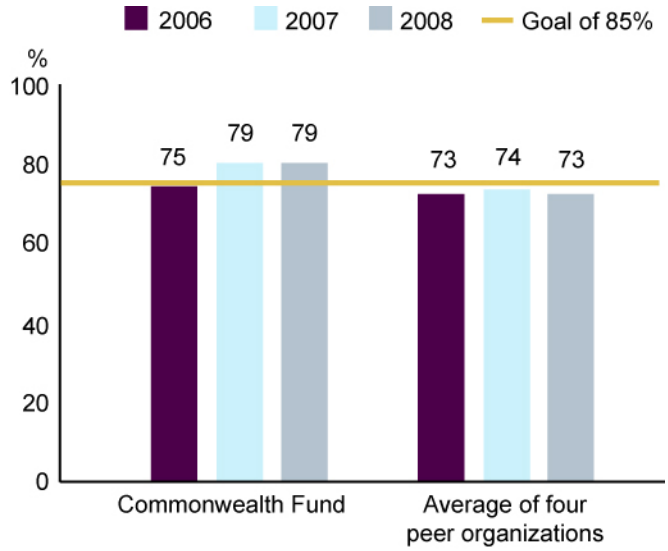
To help ensure a continued record of success and institutional vitality, the Fund's scorecard includes the objective of launching each year at least four new strategic initiatives to spur the foundation to take on new goals and strategies. The "stretch initiatives" for 2006–07 were as follows: development of the National Scorecard on U.S. Health System Performance and the State Scorecard on Health System Performance Scorecard; realization of a partnership with *Modern Healthcare* on the Health Care Opinion Leaders survey; development of the congressional comparative health legislation analysis; achieving a funding partnership with the Robert Bosch Foundation for German Harkness Fellows in Health Policy; development of the ChartCart feature on the Fund's Web site; and attention to policy translation in the Picker/Commonwealth Program on Quality of Care for Frail Elders. The first five of these initiatives, and more, were achieved, and we will continue to address how the Frail Elders program can have more influence on federal and state policies related to nursing homes.

The Commonwealth Fund's performance scorecard: making the most of a Web site to communicate results of produced work



Percent of Fund's audience rating the institution's Web site as "useful" to "extremely useful" in their work: 2003 Harris Interactive & 2006/2007 Mathew Greenwald Commonwealth Fund Audience Surveys.

The Commonwealth Fund's performance scorecard: improving health care access, quality, and efficiency



Percent of Fund audience saying institution "effective" to "extremely effective" in improving health care access, quality, and efficiency: 2006/2007 Mathew Greenwald Commonwealth Fund Audience Survey.

Annual Report 2007

Commission on a High Performance Health System

James J. Mongan, M.D.
Commission Chairman
President and CEO
Partners HealthCare System

Health care has risen to the top of the nation's public policy agenda. It is one of the top concerns of the nation's biggest corporations, which in the face of rising health care costs struggle to continue providing comprehensive health benefits to their workers while prospering in a fiercely competitive global economy. It is a top concern of virtually every state and locality, which face enormous fiscal pressures to rein in Medicaid and other public program costs and yet are still committed to meeting the health care needs of their most vulnerable residents. And it is most certainly a top concern of the 47 million Americans who have no health insurance, and of the millions more who are "underinsured."

Stephen C. Schoenbaum, M.D.
Commission Executive Director
Fund Executive Vice President

The Commonwealth Fund Commission on a High Performance Health System seeks to move the country toward a high-performing health system that provides all Americans with affordable access to high-quality, safe care while maximizing efficiency in its delivery and administration. The body's 19 members are distinguished experts and leaders representing every sector of health care, as well as the state and federal policy arenas, the business sector, professional societies, and academia.

During 2005–06, its inaugural year, the Commission ignited considerable public interest and attention. Its greatest accomplishments so far have been to highlight specific areas where health system performance falls short of what is achievable and to make the case for a holistic approach to reforming health care.

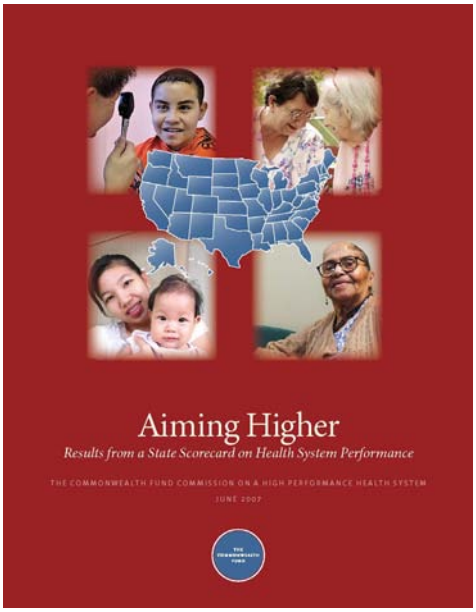
In June 2007, the Commission followed its groundbreaking National Scorecard on U.S. Health System Performance with the State Scorecard on U.S. Health System Performance, which continues to demonstrate its value as a benchmarking tool for state health care leaders and policymakers. In its efforts to identify models for reform, Commission members also made site visits to two high-performing health systems within the U.S. To meet its goal of informing national debate on health care, the Commission released an analysis of congressional bills on health care reform. The Commonwealth Fund-sponsored Bipartisan Congressional Retreat, meanwhile, afforded members the opportunity to engage in off-the-record discussions of items at the top of the Commission's policy agenda.

State Scorecard

Following on the heels of the National Scorecard on U.S. Health System Performance, published in 2006, the State Scorecard assessed state variation across five key dimensions of health system performance: access, quality, avoidable hospital use and costs, equity, and healthy lives. The findings, presented in the Commission report, *Aiming Higher: Results from a State Scorecard on Health System Performance,* point to wide variation among states and the potential for substantial improvement if all states approached levels achieved by the top states.[1]

The analysis pointed to five cross-cutting findings:

- There is wide variation in performance across states, and thus much potential for the country to improve.
- Leading states consistently outperform lagging states—an indication that federal and state policies and local and regional health systems make a difference.
- Strong links exist between access and quality, but *not* between cost and quality.
- Significant opportunities exist to reduce costs as well as improve access to care and quality of services.
- There is substantial room for improvement in every state.



State Scorecard on U.S. Health System Performance

Goal: To develop a state scorecard that highlights and tracks how well state health systems are performing overall relative to best achieved performance in the other states.

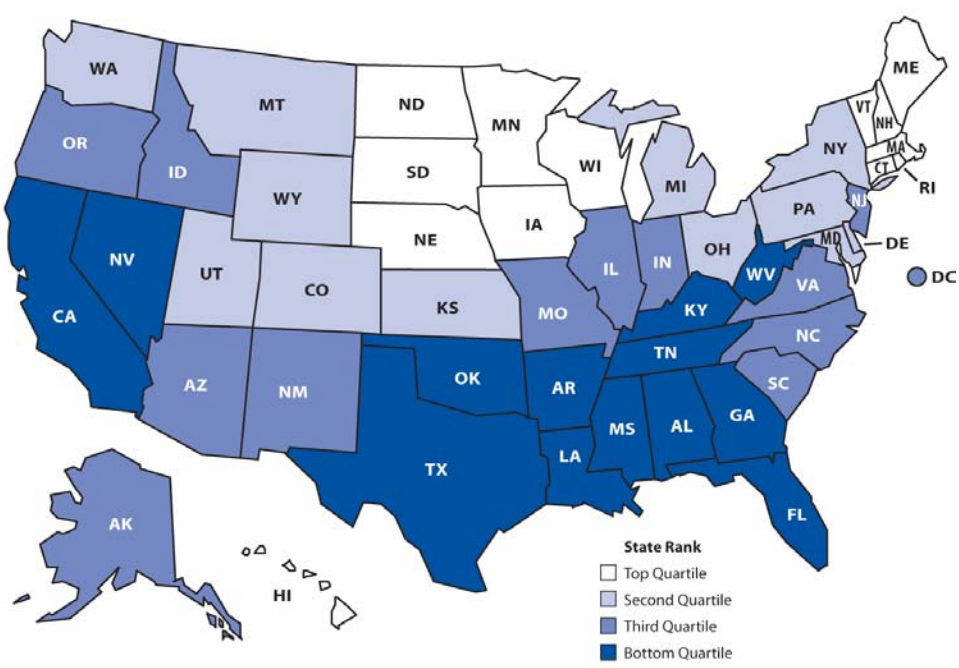
Award amount: $160,007

Timeframe: 4/1/06–7/31/07

Lead investigator: Joel C. Cantor, Sc.D., Rutgers, The State University of New Jersey

For more information: See *Aiming Higher: Results from a State Scorecard on Health System Performance* or contact Dr. Cantor at jcantor@ifh.rutgers.edu.

State Ranking on Overall Health System Performance



Source: Commonwealth Fund State Scorecard on Health System Performance, 2007

The Commission officially released the State Scorecard at a June 2007 briefing on Capitol Hill for congressional and administration staff, media, and representatives from national organizations. During the event, state representatives spoke about what the findings meant from their perspective. "The State Scorecard is unique in that the unit of measurement is the state," observed Rhode Island's Health Insurance Commissioner, Christopher Koller. "This is very valuable to us who are working in the trenches."

> If all states reached the levels achieved among the top-ranked states, almost 9 million more older adults would receive recommended preventive care, and almost 4 million more people with diabetes would receive care to help prevent disease complications. Likewise, about 33 million more adults and children would have a usual source of care or medical home to help coordinate care.

Peter Budetti, M.D., chair of the Department of Health Administration and Policy at the University of Oklahoma, added that the State Scorecard "has created momentum even in poor states—helping them focus their actions." His state ranked lowest overall on the scorecard.

"The wide variation across states points to opportunities to learn," said Commonwealth Fund vice president Cathy Schoen, a coauthor of the report. "We can look at the policies—public and private sector—behind these variations, and learn from each other."

Fund staff also presented the report's findings and methodology, state specific-results, and policy solutions in a series of forums to high-level stakeholders across the country. The goal was to stimulate and inform action and debate in states that are in a position to mobilize resources for health care reform. The forums also provided an opportunity to impart Commission messages about the importance of universal coverage and a better-organized health system, as well as the need to furnish technical assistance to those states that are ready to take steps to improve their results.

Highlights from the State Scorecard on Health System Performance

Access: The proportion of adults under age 65 who were uninsured in 2004–2005 ranges from a low of 11 percent in Minnesota to a high of 30 percent in Texas. The uninsured rate for children varies fourfold, from 5 percent in Vermont to 20 percent in Texas.

Quality: The proportion of adults age 50 or older who received all recommended preventive care ranges from a high of 50 percent in Minnesota to low of 33 percent in Idaho. Among those with diabetes, the rate of receiving basic preventive care services varies from 65 percent in Hawaii to 29 percent in Mississippi.

Potentially avoidable use of hospitals and costs of care. Rates of potentially preventable hospital admission among Medicare beneficiaries range from more than 10,000 per 100,000 beneficiaries in the five states with the highest rates to less than 5,000 per 100,000 in the five with the lowest rates. Similarly, there is a threefold variation in rates of hospital admission among nursing home residents, from 25 percent in Louisiana to only 8 percent in Utah.

Equity. Equity gaps by income and insurance status on quality indicators exist in most states. The gaps are widest in states that perform poorly overall on quality and access indicators.

Healthy Lives. There is a twofold range across states in the rate of deaths before age 75 from conditions that might have been prevented with timely and appropriate health care. Potentially preventable death rates in the states with the lowest mortality (Minnesota, Utah, Vermont, Wyoming, and Alaska) are 50 percent below rates in areas with the highest rates (District of Columbia, Tennessee, Arkansas, Louisiana, and Mississippi).

Visiting High Performing Health Systems

One way to identify programs and policies that can improve the U.S. health care system is by studying existing high-performing health systems. In the past year, the Commission members made site visits to two such systems, Kaiser Permanent Northern California (KPNC) and the University of Mary and Triumph Hospital in North Dakota. Both visits provided the Commission with an opportunity to view firsthand how different parts of health systems work and the types of incentives that are used to encourage high-quality, efficient care delivery.

Anne K. Gauthier
Commission
Senior Policy Director

Cathy Schoen
Commission Research Director
Fund Senior Vice President

Mary K. Wakefield, Ph.D., R.N., speaking at the Commission's visit to the University of Mary and Triumph Hospital in North Dakota in July 2007. Wakefield, one of the Commission's 19 members, is based at the University of North Dakota, where she is associate dean of the School of Medicine and health sciences director at the Center for Rural Health.

For example, after its visit to Kaiser Permanente, Commission staff identified four key areas responsible for the system's success:

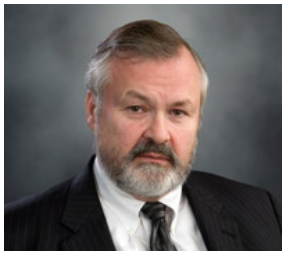
- **Culture.** The organization was founded with a mission to make quality health care accessible and affordable to all. To ensure quality, Kaiser incentives and rewards are generous and closely aligned to performance.

- **Mission.** Kaiser's mission is to be the world leader in improving health through high-quality, affordable, integrated care. The organization prides itself on "delivering the right care to the right patient, at the right time, in the most appropriate setting."

- **Methods.** While the Kaiser culture and structure may be unique, many of its performance improvement innovations can be replicated elsewhere. Among them are: strong executive and physician leadership promoting explicit goals based on sound research; clinical champions who vigorously market performance improvement to physicians and clinic staff; internal accountability through sharing of data, performance feedback, and incentives and rewards aligned to performance; and disease management focused on the highest-cost conditions.

- **Market.** Kaiser's leadership is passionate about anticipating where the market is going and then determining how the company can arrive there ahead of its competitors. Examples include its embrace of technological innovation and culturally competent care.

During the visit, Commission members were most impressed by Kaiser's ability to collect performance data on individual clinicians and use that information to drive dialogue and quality improvement. Peer-to-peer comparisons play on physicians' competitiveness, challenging them to strive for higher levels of performance.



George Halvorson
Commission Member
Chairman and CEO
Kaiser Foundation Health Plan

Informing the National Debate on Health Care

Especially now that the 2008 presidential campaign is shifting into high gear, one of the Commission's major goals is to inform the national debate on health care. In 2007, the Commission met this goal through its annual Bipartisan Congressional Retreat, seven health policy briefings and roundtables, and a retreat for senior congressional staff. The Commission also released reports analyzing the likely impact of different legislative health reform proposals, 15 options for reducing health care spending over the near and long term, and an "ambitious agenda" for the next president.

Congressional retreat. The Commonwealth Fund, in partnership with the Alliance for Health Reform, hosted the 10th Bipartisan Congressional Retreat in 2007, bringing together key members of Congress who are engaged in health policy and health care issues. The private setting—with no press or congressional staff present—allows members to discuss issues openly with experts and with one another while acquiring a depth of knowledge that is not possible in other venues. At the end of each retreat, members emerge with a fuller understanding of health policy choices and their potential implications. They also learn about proposals being considered by their colleagues across the aisle—and about opportunities for bipartisan cooperation.

Edward F. Howard, J.D.
Executive Vice President
Alliance for Health Reform

Congressional Retreat: Who's Participating
Over the last decade, 65 members of the House and Senate have attended the Bipartisan Congressional Retreat. Feedback has been extremely positive, with success reflected in the repeat attendance of many members.

But the retreats do much more than educate and inform. They also strengthen ties between the Fund and key congressional members, help members identify experts to testify before Congress, and inform thinking about the complex issues behind legislative proposals. With the formation of the Commission on a High Performance Health System in 2005, the Commission's policy agenda became linked to the retreat.

"Overall, I thought this was one of the best conferences I have attended," said Senator George Voinovich (R-OH) of the 2007 retreat, the sixth he has attended. His comments were echoed by Representative Carolyn McCarthy (D-NY), who added: "I just wish more of my colleagues would come to this conference. It's bipartisan. . . [and is] one of the best things for

the country."

Congressional briefings and policy roundtable. This year, the Commission held seven health policy briefings for congressional staff on Capitol Hill that attracted more than 2,000 registrants. The briefings focused on state health reform initiatives, comparative effectiveness research, pay-for-performance and Medicare, health policy issues in 2007, the State Children's Health Insurance Program, options for expanding health coverage, ways to improve the quality of medical decisions, and the previously described State Scorecard results. And in July 2007, 44 experts in health care policy convened to discuss prospects for diffusing the medical home model of care throughout the safety net.

Commonwealth Fund Bipartisan Congressional Retreat, 2007

Goal: To give members of Congress the opportunity to learn about timely health policy issues and engage in substantive discussion while enabling the Fund to reach an influential audience directly.

Award amount: $379,581

Timeframe: 7/15/06–7/14/07

Lead investigator: Edward F. Howard, J.D., executive vice president, Alliance for Health Reform

For more information: Contact Anne K. Gauthier, Commission senior policy director, at ag@cmwf.org.

Comparing health reform proposals. In March 2007, The Commonwealth Fund released the first of a two-part analysis comparing leading health care reform proposals in 2005–2007, including bills introduced by members of Congress and a proposal advanced by the President. Led by Fund assistant vice president Sara Collins, Ph.D., and colleagues, the study showed that while the congressional plans vary greatly in their scope and details, they would all significantly reduce the number of uninsured in the U.S. while lowering overall health care expenditures, including those for insurance administration and prescription drugs. It also found that the Bush administration proposal, which relies on tax deductions and tax increases to encourage more employers to provide health insurance and more Americans to purchase it, would cover far fewer of the uninsured than the other options.

The proposals fall into three broad categories:[2]

- Fundamental reforms of the nation's health insurance system, such as health insurance tax deductions, federal-state partnerships to expand health insurance, and coverage through Medicare.
- Expansions of existing public insurance programs, including proposals to allow older adults to "buy in" to Medicare and a proposal for universal coverage for children.
- Strengthening employer-based health insurance, for example, by requiring large employers to cover their workers and establishing pools for small businesses with premium protections and federal reinsurance.

The Fund researchers found that even the more modest proposals hold promise for reducing the 47 million uninsured in the U.S. and could serve as a first step toward universal

coverage. The reforms likely to be the most efficient would pool health risk by covering people in large groups; such policies could produce insurance administrative cost savings of anywhere from $57 to $74 billion a year.

A companion Fund report released in July 2007 evaluated major bills designed to advance the quality and efficiency of the health system, whether through provider payment reform, greater transparency in price and quality, expanded use of health information technology, medical liability reform, or other means.[3] According to lead author Karen Davis, while the bills would help address serious deficiencies in the U.S. health care system, they all lack something crucial: an overarching strategy for ensuring accessible, high-quality, efficient care for all Americans.

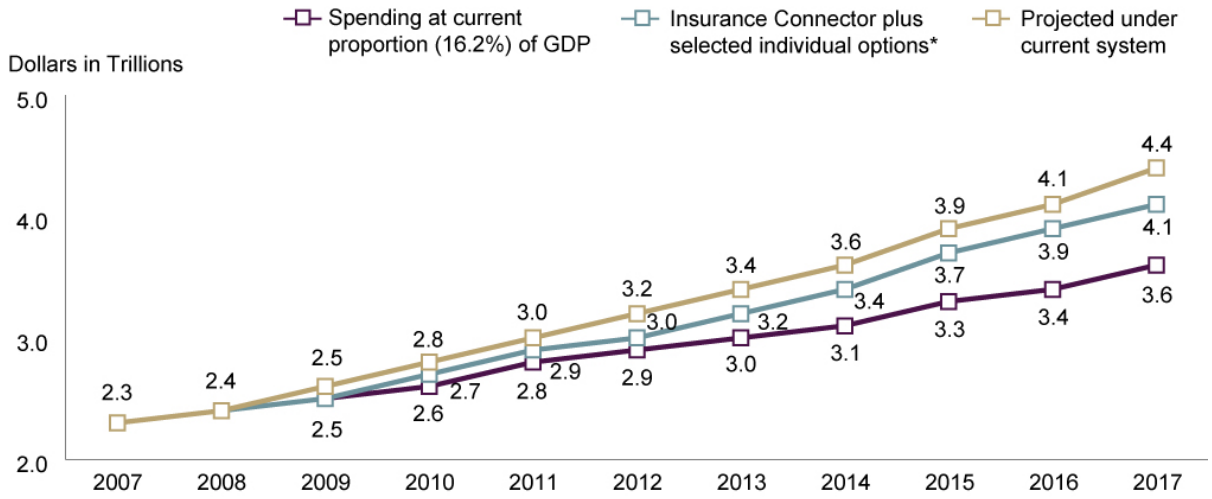
As an example, none of the bills recommend a coordinated policy strategy encompassing national goals to guide improvement efforts, establish priorities, ensure implementation of effective strategies, and monitor their impact. Nor would any advance fundamental payment reform to replace the current fee-for-service model with a more rational system—such as payment based on population- or episode-based care. Still, the proposals would have value in establishing building blocks to support future innovation and improvement.

Options for health system savings. Late in 2007, the Commission on a High Performance Health System released one of its most important reports to date: *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending.*[4] Prepared by Commonwealth Fund researchers with analytical support from the Lewin Group, the report reviewed 15 federal health policy options for their potential to lower spending over 10 years and yield higher value for the nation's investment in health care.

While there is broad agreement that the U.S. health care system is in need of serious reform, the price tag associated with enacting major changes is sometimes viewed as prohibitively expensive. But according to the analysis, comprehensive health reform can lead to surprising savings in both the near and long term.

The authors focused on policies that seek to: produce and use better information, promote health and disease prevention, align incentives with quality and efficiency, and correct price signals in the health care market. What they found was that guaranteeing health insurance for all, when combined with policy options aimed at improving health system performance, could yield $1.5 trillion in reduced spending over the next decade.

Projected Total National Health Expenditures, 2008–2017



* Selected individual options include improved information, payment reform, and public health. Source: C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

"The report illustrates that it is possible to insure everyone and achieve savings," said James J. Mongan, M.D., Commission chair and president and CEO of Partners HealthCare System in Boston.

Imagining the shape of health reform. Ensuring that everyone in the United States has health insurance is essential, but doing so is alone not enough to drive the kind of reform the health system needs. That was the takeaway message of the Commission's report, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President*,[5] which discusses concrete goals—and the strategies for achieving them—that should be on the next U.S. president's health care agenda:

- guaranteeing affordable health insurance for all;
- containing growth in health care costs, including changing the way doctors and other health care providers are paid;
- improving the organization and coordination of care delivery;
- implementing an electronic information system within five years and investing in public reporting, evidence-based medicine, and the infrastructure necessary to support the health care system; and
- establishing national goals and exerting the strong leadership needed to reach them.

"This report outlines how essential it is that we pursue improvements in health care quality and efficiency at the same time as we pursue universal coverage," said Dr. Mongan, the Commission chair. "We cannot, and should not, hold either of these facets of reform hostage

while we wait for the other to happen."

Looking Ahead

Now in its third year, the Commission on a High Performance Health System is moving into a new phase of work: devising detailed recommendations for specific actions needed to reach and raise benchmark levels of health system performance. The Commission will be focusing on such topics as the organization of the health care delivery system, the health system's capacity for innovation and improvement, and national accountability for system performance. As the prospects for real health reform appear to brighten, the Commission's work in these and other areas will be needed more than ever.

Notes

[1] J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund Commission on a High Performance Health System, June 2007).

[2] S. R. Collins, K. Davis, and J. L. Kriss, *An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part I Insurance Coverage* (New York: The Commonwealth Fund, March 2007).

[3] K. Davis, S. R. Collins, and J. L. Kriss, *An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part II, Quality and Efficiency* (New York: The Commonwealth Fund, July 2007).

[4] C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

[5] Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, Nov. 2007).

The Future of Health Insurance

Sara R. Collins, Ph.D.
Assistant Vice President

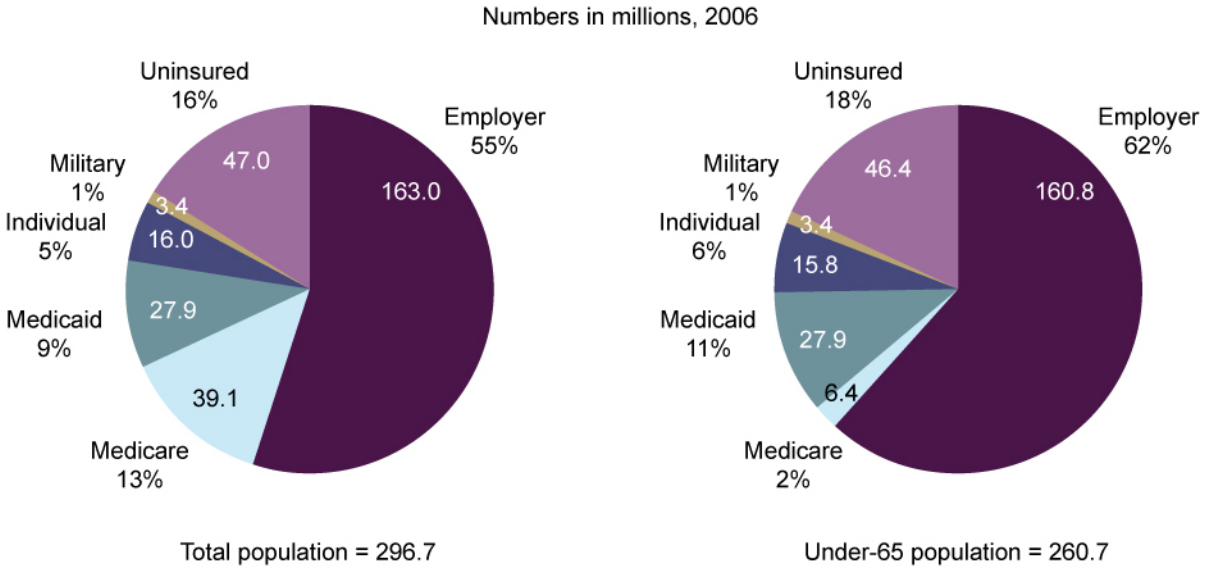
The Commonwealth Fund's Program on the Future of Health Insurance seeks to inform the unfolding debate over reform of the U.S. health care system. The research it supports focuses on:

- analyzing changes in employer-based health insurance and public insurance programs to determine how they affect the number of people covered and the quality of coverage;
- documenting how being uninsured or underinsured affects people's health and their access to health care, as well as their financial security and economic productivity; and
- developing and evaluating strategies to expand and stabilize health coverage in the U.S., while making it more affordable and more efficient.

Highlighting gaps in health insurance coverage for children and young adults—and identifying feasible policy solutions—is just one of several areas on which the Fund's Future of Health Insurance program focuses.

Employer-based coverage forms the backbone of America's voluntary health insurance system. Health plans offered by employers cover more than 160 million workers and their dependents, or 62 percent of the under-65 population. But rising health care costs have led employers to shift a greater share of their costs to employees or—as many small businesses have already done—to stop providing coverage altogether. In 2006, the ranks of the uninsured rose to 47 million, an increase of 8.6 million since 2000. About 16 million additional adults could be considered "underinsured," with high out-of-pocket health care costs relative to their income.

Employers provide health benefits to more than 160 million U.S. workers and their family members.



Source: S. R. Collins, C. Schoen, K. Davis, A. K. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007); data from Current Population Survey, March 2007.

In recent national polls, Americans said expanding access to affordable health insurance is the most critical domestic challenge facing the nation. Opinion leaders in health policy, delivery, and finance share this view, with eight of 10 saying that expanding coverage is a top priority for Congress, according to a Commonwealth Fund survey. Policymakers appear to be listening: Massachusetts and other states are taking the lead on health care reform; several of the 2008 presidential candidates have unveiled health care reform proposals; and congressional leaders have introduced legislation to expand insurance coverage.

Health Care Reform: It's Everybody's Business

A recent Commonwealth Fund issue brief made the case for building a partnership among employers, individuals, government, and other stakeholders to create amore equitable, rational, and high-performing health care system.[1]

Authored by Assistant Vice President Sara R. Collins, Ph.D., and colleagues at the Fund, *Whither Employer-Based Health Insurance?* noted the considerable advantages inherent to employer-based coverage:

- Employer-based coverage forms natural risk pools, lessening the risk of "adverse selection"—since people enroll in coverage when they take a job rather than when they get sick.
- Insurance premiums in the employer group market are far more in line with actual medical expenditures than those in the individual market.

- People with employer-provided insurance have more stable coverage than those with individual market coverage.

Despite these advantages, weaknesses in the employer-based system are driving the relentless annual growth in the number of uninsured Americans. For example, people who work for small firms or earn low wages are less likely to be covered through their job than those who work for large firms or earn higher wages. Small firms also face higher premium and administrative costs per worker than do large businesses—and therefore are less likely to offer coverage.

Collins presented the findings at a September 2007 conference of business leaders and policy experts, cosponsored by The Commonwealth Fund, the Century Foundation, and AARP. The 170 participants—among them, the CEOs of Blue Shield of California, Kelly Services, and Pitney Bowes, as well as General Electric's director of global health—discussed the potential paths for health care reform and the future of employer-based coverage.

Employers and National Health Reform

Goal: To convene business leaders and policy experts at a one-day conference to discuss the future of employer-based coverage and prospects for universal health coverage.

Award amount: $15,062

Timeframe: 3/15/07–10/1507

Lead investigator: Greg Anrig, Jr., The Century Foundation

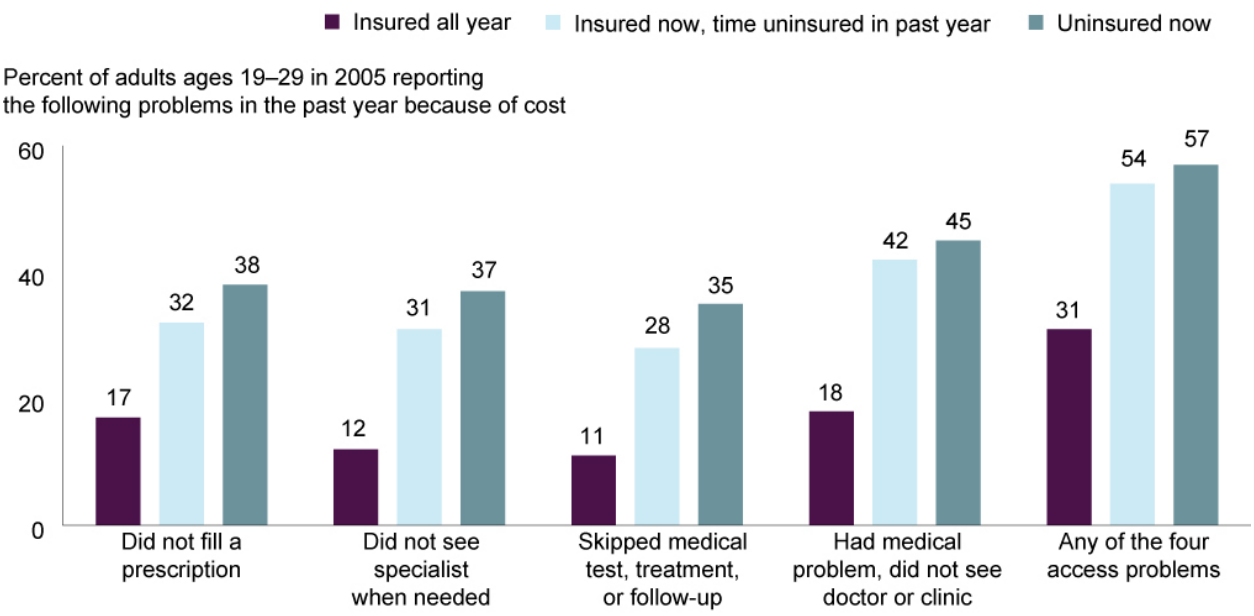
For more information: Contact Mr. Anrig at anrig@tcf.org.

Growing Number of Young Adults Lack Coverage

Young adults (ages 19 to 29) are the fastest-growing segment of the uninsured population. Since 2003, the Future of Health Insurance program has been documenting trends in young adults' health coverage and outlining policies that could expand their access to affordable coverage.

In an issue brief updated in August 2007, Fund researchers reported further deterioration of coverage for this age group, with the number of uninsured young adults climbing to more than 13 million.[2] Between 2004 and 2005, young adults accounted for 30 percent of the increase in the number of uninsured Americans under age 65. More than half of those who were uninsured for the entire year or had a time without coverage said they had gone without needed health care because of the cost—meaning they failed to fill a prescription, did not see a doctor or specialist when they were sick, or skipped a recommended test, treatment, or follow-up visit.

Being uninsured for any length of time puts young adults' access to care at risk.



Source: S. R. Collins, C. Schoen, J. L. Kriss, M. M. Doty, and B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, Aug. 8, 2007).

The study pointed to some promising signs as well, as a number of states have expanded coverage to young adults as part of broader health reform strategies. For example, as part of Massachusetts' health insurance expansion law, young adults are considered dependents for insurance purposes up to age 26 or for two years after they are no longer claimed on their parents' tax returns, whichever comes first. The state's new Commonwealth Choice Program also provides lower-cost insurance options for young adults ages 18 to 26. Since 2003, 16 states have enacted legislation requiring that private insurance policies cover dependent young adults past the age of 19.

Extending eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP) beyond age 18, the Fund researchers say, is another way to provide coverage for this population.

"State-level efforts to cover young adults are very important, and it is exciting to see the momentum in this area," says Karen Davis, The Commonwealth Fund's president. "Most uninsured young adults do not have access to private coverage through their parents' plans. For these young adults, extending Medicaid and SCHIP coverage beyond age 18 can make a real difference."

Young Adults Want Health Insurance
Contrary to conventional wisdom, young adults appear to value the protection that health insurance provides. Nearly three-quarters (73%) of employed young adults accept health coverage when their employer offers it to them, only slightly less than the take-up rate (82%) among workers age 30 or older.

The Consequences of Being Uninsured

A substantial body of evidence shows that an individual's access to care affects the quality of care they receive, as well as their overall health status. In the past year, Fund-supported investigators deepened our understanding of the consequences of being without health insurance.

Access to care and quality of care among women with breast cancer. Cathy Bradley, Ph.D., a professor at Virginia Commonwealth University, found that uninsured women are more likely than insured women to be diagnosed with advanced cancers. At the June 2007 annual research meeting held by AcademyHealth, the leading professional society for health services researchers, Bradley reported that uninsured women also experience longer periods from the date of diagnosis to surgery or chemotherapy and take longer to complete adjuvant chemotherapy regimens.

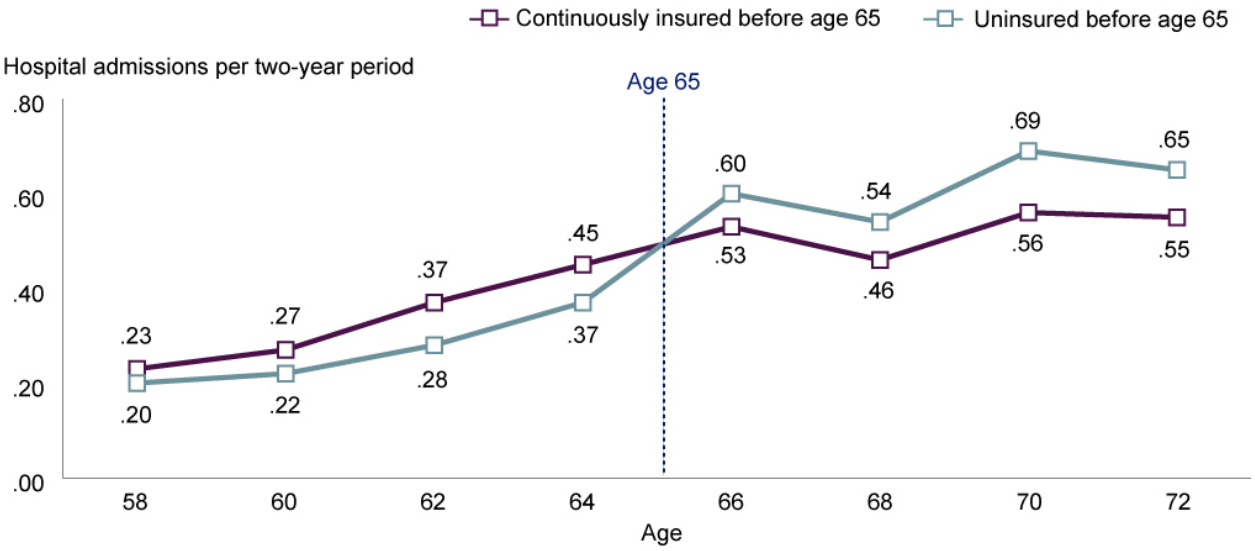
Low-wage workers, health insurance, and use of health services. Evidence points to growing inequality in terms of workers' access to health care, says Sherry A. Glied, Ph.D., professor and chair of Health Policy and Management Department at Columbia University's Mailman School of Public Health.[3] In a paper presented at AcademyHealth's annual research meeting, Glied reported that, between 1996 and 2003, the rate of uninsurance in low-wage workers climbed, while the coverage rate for higher-wage workers remained about the same. During that time, higher-wage workers increased their use of physician services, prescription drugs, and preventive care services; use of these services among low-wage workers grew only slightly or declined.

Sherry Glied, Ph.D.
Columbia University

Use of health services by previously uninsured Medicare beneficiaries. Uninsured individuals with chronic illness often delay or avoid treatment during the early stages of their condition, when the costs of care are relatively inexpensive. In a July 2007 article published in *The New England Journal of Medicine* and featured in the *New York Times*, J. Michael McWilliams, M.D., and colleagues at Harvard Medical School found that many previously uninsured older adults have untreated health problems that require intensive and costly care.[4] Once they received Medicare coverage at age 65, they had higher total medical expenditures than previously insured adults, with the difference persisting through age 72.

The findings suggest that providing insurance coverage for uninsured adults in late middle age could improve their health outcomes, reduce their health care use and spending once they enter Medicare, and ultimately help to offset the costs of expanding coverage. "Our findings have important policy implications," the authors noted in the article. "Providing earlier health insurance coverage for uninsured adults, particularly those with cardiovascular disease or diabetes, may have considerable social and economic value for the United States by improving health outcomes."

Previously uninsured Medicare beneficiaries with a history of cardiovascular disease or diabetes have much higher self-reported hospital admissions after enrolling in Medicare than those previously insured.



Source: Adapted from J. M. McWilliams, E. Meara, A. M. Zaslavsky et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine,* July 12, 2007 357(2):143–53.

Interruptions in Medicaid coverage and preventable hospitalizations. What happens when someone who is already at a disadvantage because of low income also experiences an interruption—even a temporary one—in their health insurance coverage? That was the question addressed by Andrew Bindman, M.D., and colleagues at the University of California, San Francisco, in their Fund-supported study.

Presenting at the June 2007 AcademyHealth research meeting, Bindman reported that interruptions in Medicaid coverage for adults and children—which can occur when program eligibility rules are tightened, or when enrollees are charged premiums for the first time—are associated with higher rates of hospital admissions, deaths, and costs for conditions that are normally treated in primary care settings.[5]

Andrew Bindman, M.D.
University of California, San Francisco

Adults and children with Medicaid coverage gaps experienced nearly a fourfold increased risk of a preventable hospitalization, compared with those with continuous coverage.

According to the researchers, the findings suggest that any short-term savings gained from restricting Medicaid eligibility, or from imposing premiums, could be negated in the longer term by the costs associated with avoidable hospitalizations.

Greater share of income spent on health care.

Peter Cunningham, Ph.D.
Center for Studying Health System Change

Between 2000 and 2007, while health insurance premiums rose substantially, incomes grew at a much slower rate. In a Fund-supported study published in *Health Affairs*, Peter Cunningham, Ph.D., of the Center for Studying Health System Change, and Jessica Banthin, Ph.D., of the Agency for Healthcare Research and Quality, found that the share of families spending more than 10 percent of their disposable income on premiums and out-of-pocket health costs climbed from 15.9 percent to 18.8 percent between 2001 and 2004.[6] Families with income below the federal poverty level as well as people who purchased coverage in the individual market were the most vulnerable: more than half of those in these two groups spent 10 percent or more of their disposable income on premiums and out-of-pocket costs.

Fund senior vice president Cathy Schoen has described those who have high out-of-pocket health costs, relative to their income, as being "underinsured." The Fund's associate director of research, Michelle Doty, Ph.D., presented work at the 2007 AcademyHealth research meeting showing that an estimated 9 percent of adults ages 19 to 64—16 million people—were underinsured in 2005. Using data from the Commonwealth Fund Biennial Health Insurance Survey, Doty identified the underinsured as those who spent 10 percent or more of their income on out-of-pocket costs (or, for those with incomes below 200 percent of the federal poverty level, 5 percent or more) and/or had deductibles that were 5 percent or more of their annual income. According to her analysis, the underinsured are nearly as likely to report that they do not seek out needed health care because of cost as people without any health coverage at all.

Women and Health Coverage: The Affordability Gap

Judith Waxman, J.D.
National Women's Law Center

Because of their relatively lower incomes and greater use of health care services, women are more likely to be underinsured than men. In the Fund issue brief *Women and Health Coverage: The Affordability Gap,* Elizabeth M. Patchias, M.P.P., and Judith G. Waxman, J.D., of the National Women's Law Center found that 38 percent of women struggle to pay their medical bills, compared with 29 percent of men.

Among their other findings:

- Thirty-three percent of insured women and 68 percent of uninsured women do not obtain needed health because of cost. In contrast, 23 percent of insured men and 49 percent of uninsured men avoid necessary care because of cost.
- Sixteen percent of women are underinsured, compared with 9 percent of men. Women's greater health care needs and use of services, combined with their lower incomes, result in higher out-of-pocket costs.
- Women are more than twice as likely as men to get employer-sponsored insurance through their spouse (24% vs. 11%), and thus face more instability in their coverage.

"These findings show that comprehensive health care coverage that doesn't require high out-of-pocket costs is vital to ensuring that women get the care they need to be healthy," said the Fund's Sara Collins.

Monitoring the Impact of High-Deductible Health Plans

Last year, The Commonwealth Fund joined with the Employee Benefit Research Institute (EBRI) to conduct the second annual Consumerism in Health Care Survey—one of just a handful of national data sources tracking the proliferation of high-deductible health plans and the experiences of those enrolled. The plans have become the primary component of the "consumer-driven" health care movement, which is premised on the theory that consumers will be less inclined to use unnecessary health services if they are exposed to a greater share of the costs—which, in turn, would be expected to reduce overall health spending.

A December 2006 issue brief based on the survey's findings by EBRI's Paul Fronstin, Ph.D, and the Fund's Sara Collins, Ph.D., reported that people enrolled in high-deductible plans continued to be less satisfied with their coverage than those with more comprehensive health insurance, regardless of whether the plan is paired with a health savings account.[7] It also found that people in high-deductible health plans were more likely to report avoiding or delaying needed care because of the cost, and less likely than those enrolled in comprehensive health plans to have been uninsured prior to enrollment.

Paul Fronstin, Ph.D.
Employee Benefits Research Institute

For high-deductible health plans paired with health savings accounts, employers are legally able to exclude preventive care from the deductible. With Fund support, a project led by John Hsu, M.D., of Kaiser Permanente is examining whether enrollees in high-deductible plans understand what constitutes preventive care and which services are excluded from deductibles, and whether this exclusion affects enrollees' use of health care services.

EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006

Goal: This survey assessed trends in consumer-driven plan enrollment and considered the impact of these plans on care utilization. The findings are being used to inform federal and state policymakers as well as employers considering such plans for their benefit programs.

Award amount: $132,900

Timeframe: 7/1/06–1/31/07

Lead investigator: Paul Fronstin, Ph.D., Employee Benefit Research Institute

For more information: fronstin@ebri.org

Health Care Reform Returns to the National Agenda

Health care reform has returned to the top of the national agenda. The latest Health Confidence Survey by the Employee Benefit Research Institute, which is partly supported by the Fund, found that the percentage of Americans who say they are dissatisfied with the health care system has doubled since 1998—primarily because of the rising cost of care.[8] In addition, national polls show that health care is near the top of the list of issues the public wants to hear about from the 2008 presidential candidates.[9]

Many current proposals to cover the uninsured would offer tax credits to help people purchase private coverage. In a Commonwealth Fund issue brief, the Urban Institute's Stan Dorn, J.D., examined one such model: the federal Health Coverage Tax Credits program, which pays 65 percent of health insurance premiums for workers displaced by international trade and early retirees.[10] The tax credits can be claimed after the end of the year, when annual income tax forms are filed, or advanced monthly to health insurers to help pay premiums. Dorn focused on the administrative costs of the program incurred by the IRS and by private insurers.

While administrative costs in the program have declined over time, they still consume a third of its expenditures. Dorn says that broad risk-pooling is needed to help reduce the costs of program administration.

Looking Ahead

During the coming year, several projects supported by the Future of Health Insurance Program will provide critical information to policymakers and the public in the national discussion over health care reform. For example, Peter Cunningham, Ph.D., of the Center for Studying Health System Change will examine trends in the percentage of Americans who have problems paying medical bills, and the causes and consequences of these problems. His analysis will take into account the role of health care providers in providing assistance to patients burdened with high medical expenses.

To identify lessons for the United States, Columbia University's Sherry Glied, Ph.D., and colleagues will examine the experience of other industrialized countries in expanding and improving health coverage and controlling costs. Since most national health reform proposals call for a mix of private and public approaches, the research team will focus on countries that achieve universal coverage through both public and private insurance.

In a new project, Jon Gabel, M.A., senior fellow at the National Opinion Research Center, will document the comparative affordability of small group, large group, and individual market insurance plans, taking into account premiums and out-of-pocket expenses to provide a comprehensive measure of affordability. The findings will illustrate the importance of benefit design in assessing what constitutes affordable health coverage under various health care reform strategies.

Finally, as the 2008 presidential campaign intensifies, the Future of Health Insurance program will continue to provide objective information about the 2008 presidential candidates' health care reform proposals, including their potential to expand insurance coverage and put the health care system on a path to high performance.

Notes

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[9] Kaiser Family Foundation Health Tracking Poll: Election 2008, Aug. 2007.

[10] S. Dorn, *Administrative Costs for Advance Payment of Health Coverage Tax Credits: An Initial Analysis* (New York: The Commonwealth Fund, March 2007).

State Innovations

Rachel S. Nuzum
Program Officer

The Commonwealth Fund's State Innovations program, now in its third year, aims to improve health system performance by supporting, stimulating, and spreading state strategies for expanding access to care and by promoting high-quality, efficient care, particularly for vulnerable populations.

The program is one of several that supports the goals of the Fund's Commission on a High Performance Health System to improve health care quality, expand access to care, promote greater efficiency, and build the health system's capacity to improve. It does so by:

- identifying and evaluating promising public and private sector policies;
- disseminating lessons learned from state innovations;
- evaluating health reform proposals; and
- responding to states' needs for technical assistance and analysis.

As "laboratories of innovation," the states can point the nation toward promising approaches to improve the performance of the U.S. health care system. They hold significant purchasing power for vulnerable populations and state employees, regulate individual insurance markets, license health care providers, and provide important public health services. In addition, with little movement at the federal level, states have been experimenting with ways of expanding health insurance coverage.

Pennsylvania stands out for its efforts to ensure patient safety. The state's Patient Safety Authority, for example, identifies causes of medical errors in hospitals, ambulatory surgical facilities, and birthing centers and recommends solutions. With Fund support, the National Academy for State Health Policy is conducting a "learning exchange" that will help patient safety officials in other states learn from Pennsylvania's innovations.

During 2007, several publications reported on the results of The Commonwealth Fund's support for innovative state strategies. Here, we highlight four reports: two analyses of efforts in Massachusetts and Maine to achieve universal health coverage; a progress report on the Return on Investment Purchasing Institute; and a case study of Minnesota's value-based purchasing initiative.

Evaluating State Efforts

Maine

In 2003, Maine became the first state in more than 10 years to take a comprehensive approach to the problem of the uninsured. The state's motto, "Dirigo"—"I lead" in Latin—is a fitting name for the Dirigo Health Reform Act, which aims to make affordable health coverage available to all residents by 2009, while simultaneously slowing the growth of health costs and improving the quality of care. The Commonwealth Fund, together with the Robert Wood Johnson Foundation, is supporting an evaluation of this effort.

Evaluation of Maine's Dirigo Health Reform Plan

Goal: To examine the effects of the state's new insurance program, DirigoChoice, which offers subsidized coverage to small businesses and families with low and moderate incomes.

Award amount: $234,529

Timeframe: 5/1/06–8/31/07

Lead investigator: James M. Verdier, J.D., senior fellow at Mathematica Policy Research, Inc.

For more information: See *Leading the Way: Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms*.

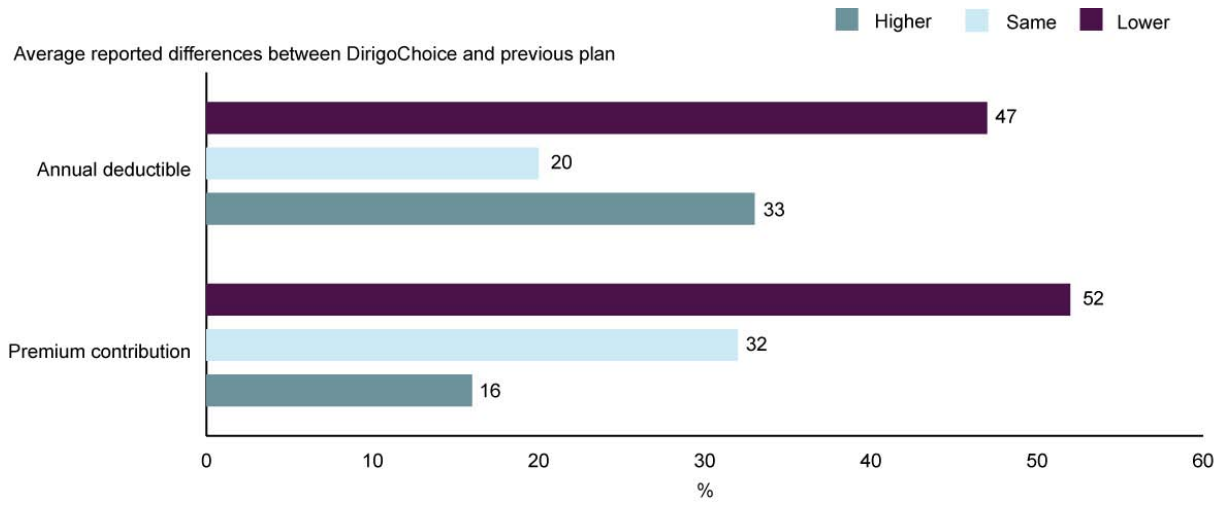
Is Maine leading the way toward universal coverage? In 2002, an estimated 136,000 of the state's residents were uninsured, according to principal investigator James M. Verdier, J.D., senior fellow at Mathematica Policy Research, Inc., and Debra J. Lipson, senior health researcher at Mathematica. The researchers found that as of September 2006, between 26,000 and 36,000 individuals were covered through DirigoChoice, a subsidized health insurance program for small businesses, self-employed workers, and individuals, and an expansion of MaineCare, the state's Medicaid system. Between 9,000 and 11,000 of these residents had previously been uninsured.[1]

The study found that Dirigo's coverage expansions made insurance more affordable to individuals and families. Nearly 80 percent of DirigoChoice members qualified for subsidies based on their low incomes. As of September 2006, about 700 small firms had enrolled in DirigoChoice—of which half had not previously offered coverage to their employees. Yet participation by small businesses has been less than anticipated, requiring the state to subsidize a greater number of individual premiums and deductibles and substantially increasing overall costs.

Debra J. Lipson
Mathematica Policy Research

Maine was one of the few states to reduce its uninsured rate for adults between 2000 and 2006, and in fact has one of the lowest uninsured rates in the nation. Still, the impact of Dirigo has been modest. Maine planned to finance much of the cost of Dirigo by reducing the costs it pays to providers for uncompensated care. But these savings have not yet materialized, which has led to calls for more reliable funding sources to sustain the program.

For the large majority of employers in Maine, the amount contributed to employee coverage under DirigoChoice was the same as or lower than before.



Source: D. J. Lipson, J. M. Verdier, and L. Quincy, *Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms* (New York: The Commonwealth Fund, Dec. 2007).

The Fund-sponsored evaluation pointed to several lessons from Maine's experiences during the first three years of this health reform effort:

- States with low rates of employer-sponsored health coverage may need to use incentives or mandates to expand employer coverage.
- Coverage expansions without forceful cost-control mechanisms will eventually run into affordability problems.
- Partnerships between states and insurers must be carefully crafted based on a realistic assessment of market conditions and shared responsibilities.

> *"The bottom line is that each state faces a very unique set of factors—market dynamics, regulatory history, financing options, and political environments—in addressing the uninsured issue. While Maine offers some lessons for other states, it also underscores the notion that each state must craft a strategy that reflects their own circumstances."*
>
> —Debra J. Lipson, Mathematica Policy Research, Inc.

Massachusetts

In April 2006, Massachusetts enacted a health care reform bill designed to extend insurance coverage to nearly all residents. The legislation includes several innovative approaches:

- expanding Medicaid to children in families with income up to three times the federal poverty level, and eliminating caps on enrollment for long-term unemployed adults, disabled working adults, and individuals with HIV/AIDS;
- subsidizing private coverage for adults with family incomes up to three times the poverty level;
- creating a "connector" agency to help individuals and small business employees secure affordable coverage;
- combining small group and individual health insurance markets in an effort to reduce the cost of premiums in the individual market;
- requiring employers with more than 10 employees who do not make a "fair and reasonable" contribution toward their workers' health insurance to pay annual assessments; and
- requiring health plans to offer coverage, regardless of an applicant's health status, and mandating that all adults acquire coverage.

With support from The Commonwealth Fund, Urban Institute researchers will survey Massachusetts residents to establish a baseline assessment against which to measure the impact of the reform legislation. "We need to understand how these models work, what the impacts are in terms of insurance coverage, what it means for access and use of care, and how they address barriers and unmet needs," explains Sharon K. Long, Ph.D., principle research associate at the Urban Institute. "In the absence of such comprehensive evaluations, we don't have data, just assumptions."

Monitoring the Impact of Health Care Reform in Massachusetts

Goal: Survey state residents to collect baseline information on rates of health coverage, access to care, utilization of services, and out-of-pocket costs prior to implementation of the reform measures.

Award amount: $130,345

Timeframe: 9/1/06–8/31/07

Lead investigator: John Holahan, Ph.D., director, Health Policy Center, The Urban Institute

For more information: Visit the Urban Institute Web site.

Long and her colleague, research associate Mindy Cohen, M.P.H., found that, as of the fall of 2006, 13.3 percent of Massachusetts adults were uninsured—a higher rate than prior estimates. The uninsured were disproportionately young, male, Hispanic, and noncitizens. Most of them were working, yet just 28 percent said they had access to employer-sponsored coverage. Uninsured adults were more likely than insured adults to report not getting health care services, primarily because of cost. Sixty-three percent of insured adults and 51 percent of uninsured adults had annual out-of-pocket costs amounting to $500 or more.

"The thing that is so impressive about Massachusetts is how all sides of the issue have come together and stayed together. It gives you optimism that system change is possible."

—Sharon K. Long, Ph.D., The Urban Institute

With support from The Commonwealth Fund and other organizations, the research team will perform follow-up surveys over the next few years to monitor how many state residents gain coverage, their access to care and use of services, the adequacy of coverage, and the public awareness of non-group and public coverage options.

Return on Investment Purchasing Institute

With rising health costs and tight budgets, policymakers and purchasers are demanding greater value for the money spent on care. What if there were an easy way to explore whether efforts to improve health care quality could also help to control costs? That's the thinking behind the Return on Investment Forecasting Calculator, a decision-support tool developed by researchers at the Center for Health Care Strategies, Inc., to help states assess the potential return on investment from proposed quality improvement initiatives.

In the Return on Investment Purchasing Institute, Center for Health Care Strategies experts are working with Medicaid agencies in eight states—Arizona, Colorado, Connecticut, Idaho, Louisiana, Oklahoma, Pennsylvania, and Washington—to weigh the potential costs and benefits of various quality improvement efforts.

Developing State Capacity to Forecast Return on Investment from Quality Improvement Initiatives

Goal: To test the utility of a Return on Investment Forecasting Calculator for projecting the benefits and costs of quality improvement initiatives in eight states.

Award amount: $179,689

Timeframe: 12/1/06–5/31/08

Lead investigator: Melanie Bella, M.B.A., Senior Vice President, Center for Health Care Strategies, Inc.

For more information: Visit the Center for Health Care Strategies, Inc., Web site.

"We work with Medicaid agency staff who may not have fully worked through the long-term financial impact of their initiatives," explains Allison Hamblin, M.S.P.H., a program officer at the Center for Health Care Strategies. "We're trying to emphasize that investments in quality can be a long-term strategy for controlling costs and improving the quality of care for beneficiaries."

Participating states are sharing lessons learned and best practices. Eventually, the goal is to help state agencies incorporate this tool into their budget models and to make the Return on Investment Forecasting Calculator widely available.

"We are learning to ask the right questions when considering a new quality initiative. Instead of asking, 'How much will that cost?' We now ask, 'Will this intervention pay off in terms of cost effectiveness and quality?' Several of our disease management programs target a small but costly portion of our chronically ill population. We were able to use the ROI tool to confirm that, although we are not touching a large population with this intervention, we can provide high-quality care to a costly population and realize a return on that investment."

—Quality Compliance Specialist with the Colorado Department of Health Care Policy and Financing

The Center for Health Care Strategies' is developing a Web-based "Return on Investment Forecasting Calculator" that will help states assess the potential return on investment from proposed quality improvement initiatives.

Value-Based Purchasing to Improve Health System Performance

Over the past decade, several states have been collecting and reporting data on the quality and costs of care and providing incentives to health plans and providers to improve their performance. Such "value-based purchasing" efforts aim to improve both the effectiveness and efficiency of health care.

To better understand trends in value-based purchasing and their policy implications, The Commonwealth Fund provided support to Sharon Silow-Carroll, M.S.W., M.B.A., a health policy analyst at Health Management Associates, and her team to conduct four case studies and an analysis of public and private value-based purchasing initiatives.[2]

Value-Based Purchasing to Improve Health System Performance: Case Studies and Analysis

Goal: To provide an objective source of information about state and public–private purchasing activities designed to improve effectiveness and efficiency in health care.

Award amount: $177,258

Timeframe: 5/1/06–4/30/07

Lead investigator: Sharon Silow-Carroll, M.S.W., M.B.A., Health Management Associates

For more information: See *Value-Based Purchasing: Four States That Are Ahead of the Curve* or contact Sharon Silow-Carroll at ssilowcarroll@healthmanagement.com.

Silow-Carroll and her team focused on four value-based purchasing initiatives:

- The Massachusetts Group Insurance Commission, which provides and administers health insurance and other benefits to state employees, retirees, and their dependents and survivors. The Commission requires contracted health plans to assign providers to different tiers, based on evidence of the quality and efficiency of their care. Health plan members are then offered lower copayments when they choose hospitals and providers in higher-efficiency tiers.
- The Minnesota Smart Buy Alliance, which includes public and private health care purchasers, business coalitions, and labor unions. As described below, alliance members are developing common principles and sharing value-based purchasing strategies.
- Washington State's Puget Sound Health Alliance, a group of public and private health care purchasers, providers, payers, and consumers. The alliance is developing public reports on health care provider performance and evidence-based clinical guidelines.
- The Wisconsin Department of Employee Trust Funds, an agency that administers health benefits for state and local government employees. The agency is pursuing a variety of value-based purchasing strategies and taking part in public–private initiatives, including creation of a statewide health data repository.

A Closer Look: Minnesota's Smart Buy Alliance

The Smart-Buy Alliance is a coalition of stakeholder groups intended to drive quality and value in the health care market. Its members—public and private health care purchasers, business coalitions, and labor unions—represent about three-fifths of the state's residents.[3]

In spite of evidence that health care quality varies greatly among health plans and providers, alliance members recognized that many purchasers and consumers focus mainly on costs when selecting plans, hospitals, and physicians. They also realized that varying performance measurement requirements had become a barrier to value-based purchasing efforts. The member groups formed the alliance to work together to demand accountability in the health care marketplace.

To lead by example, Minnesota's Governor Tim Pawlenty launched a value-based purchasing effort in July 2006. Under QCare (Quality Care and Rewarding Excellence), all of the state's contracts with health plans and providers will include incentives and requirements to report cost and quality data and meet improvement targets in key areas, starting with diabetes, hospital stays, preventive care, and cardiac care. The Smart Buy Alliance encourages its members to adopt QCare standards.

Alliance members have also promoted use of the eValue8 tool, a Web-based system through which health plans report data on provider performance, use of health information technology, disease management, patient safety, and other measures. Members can use the tool to make comparisons between health plans, inform discussions around pricing, and stimulate performance improvements. The state's five largest health plans now report data through eValue8 and the Medicaid agency is hoping to adopt this model.

Recognizing that a small percentage of claims make up the bulk of total health costs, and that providers who treat greater numbers of patients with a given condition tend to achieve better health outcomes, alliance members created the Patient Advocacy–Best in Class Program. Using data on patient volume and provider performance, program administrators certify medical practices and hospitals as "best in class" for certain specialty procedures, including cardiac care, high-risk pregnancies, organ transplants, and other conditions. A telephone-based support system offers patients information on "best in class" providers and helps them with scheduling and referrals.

Looking Forward

In the coming year, the State Innovations program will continue to respond to state needs for technical assistance and analysis, identify public and private policies that have the potential to improve health system performance, evaluate health reform proposals, and disseminate lessons learned from state innovations to leaders at the state and federal levels.

The June 2007 publication of the Commonwealth Fund Commission on a High Performance Health System's State Scorecard on Health System Performance http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551 has encouraged many states to improve the performance of their health systems. Future State Innovations projects will build on this momentum by helping states launch sustainable quality improvement efforts. For instance, Melanie Bella, M.B.A., and colleagues at the Center for

Health Care Strategies will provide technical assistance to five states to implement targeted and scalable initiatives that improve quality and reduce costs.

In response to requests from state policymakers, a survey on interstate and intrastate health information technology and exchange activities among all 50 states, U.S. territories, and the District of Columbia is being conducted by Vernon Smith, Ph.D., from Health Management Associates in partnership with the National Governors Association Center for Best Practices. Policymakers will be able to use this information to focus their efforts on the most effective strategies for using technology to improve health system performance. Survey findings also will be incorporated into recommendations made to the State Alliance for eHealth.

Notes

[1] D. J. Lipson, J. M. Verdier, and L. Quincy, *Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reform* (New York: The Commonwealth Fund, Dec. 2007).

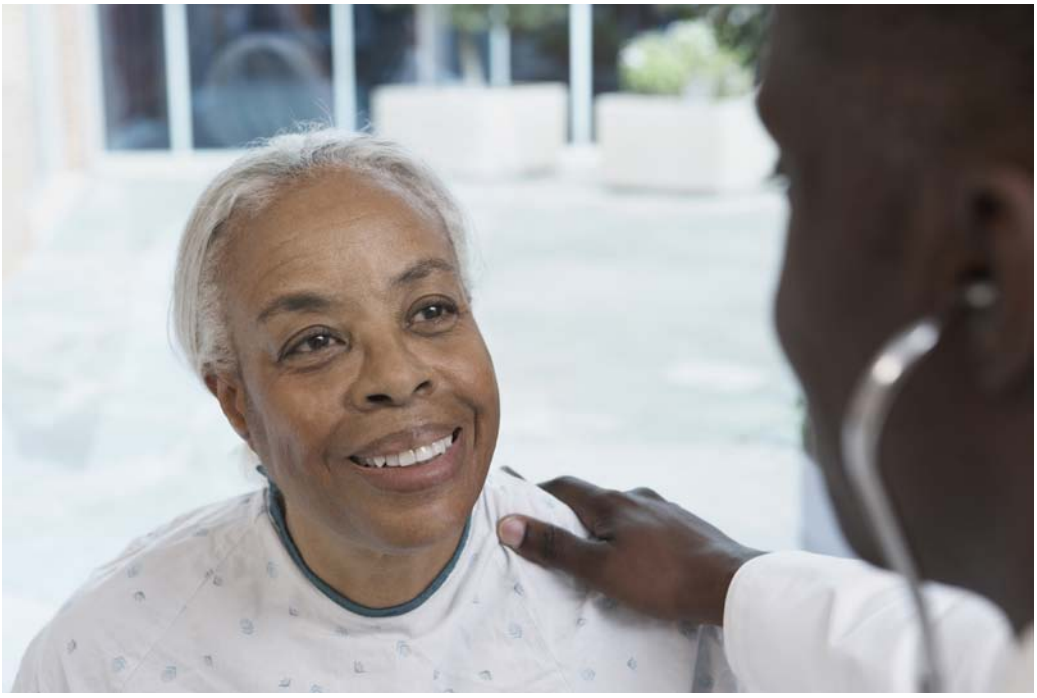
[2] S. Silow-Carroll and T. Alteras, *Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve* (New York: The Commonwealth Fund, Aug. 2007).

[3] S. Silow-Carroll and T. Alteras, *Value-Driven Health Care Purchasing: Case Study of Minnesota's Smart Buy Alliance* (New York: The Commonwealth Fund, Aug. 2007).

Medicare's Future

Stuart Guterman
Senior Program Director

Medicare provides health care coverage to more than 43 million elderly and disabled Americans, making it one of the largest and perhaps the most influential health programs in the United States. The program faces tremendous challenges: an aging population, increasing costs, and pressure to demonstrate the quality of care received for the more than $400 billion spent on the program each year. In response, the federal Centers for Medicare and Medicaid Services (CMS) has instituted demonstration projects and other initiatives designed to spur innovation, reduce costs, and improve quality. The past few years have brought tremendous changes in the program as the provisions of the Medicare Modernization Act of 2003 were implemented, including a new prescription drug benefit and an expanded role for private plans under Medicare Advantage.



A primary goal of the Program on Medicare's Future is to enhance Medicare's ability to protect the most vulnerable seniors from financial hardship while ensuring access to needed health care services.

Through its Program on Medicare's Future, The Commonwealth Fund works to:

- enhance Medicare's ability to meet the health care needs of the nation's elderly and disabled and protect the most vulnerable among them from financial hardship; and
- identify ways in which Medicare can become more effective and efficient, so that it can serve both as an example and a means of disseminating better performance throughout the health care system.

Over the past year, the Fund has been evaluating the outcomes of changes to the Medicare program and other policies that affect Medicare beneficiaries. The projects highlighted here focus on:

- identifying potential improvements in the new drug benefit;
- examining the impacts of Medicare Advantage;
- documenting the effects of the two-year waiting period for Medicare coverage on disabled people under age 65;
- investigating patterns of drug utilization among Medicare beneficiaries with significant morbidities; and
- considering the establishment of a research center to produce comparative information on clinical effectiveness.

Identifying Potential Improvements to Medicare's Drug Benefit

In 2006, prescription drug coverage became available under Medicare Part D—the most significant change to the program since its inception. With support from The Commonwealth Fund, Georgetown University senior researcher Laura Summer, M.P.H., and colleagues evaluated beneficiaries' early experiences with the prescription drug benefit, focusing particularly on those most vulnerable to poor health or low incomes.[1]

Improving the Medicare Part D Benefit for the Most Vulnerable Beneficiaries

Goal: To evaluate the experiences and challenges facing vulnerable Medicare beneficiaries using Part D and recommend ways to strength the benefit.

Award amount: $222,626

Timeframe: 5/1/06–4/30/07

Lead investigator: Laura Summer, M.P.H., senior researcher at Georgetown University's Health Policy Institute

For more information: See *Improving the Medicare Part D Program for the Most Vulnerable Beneficiaries* or contact Ms. Summer at lls6@georgetown.edu.

The Low-Income Subsidy

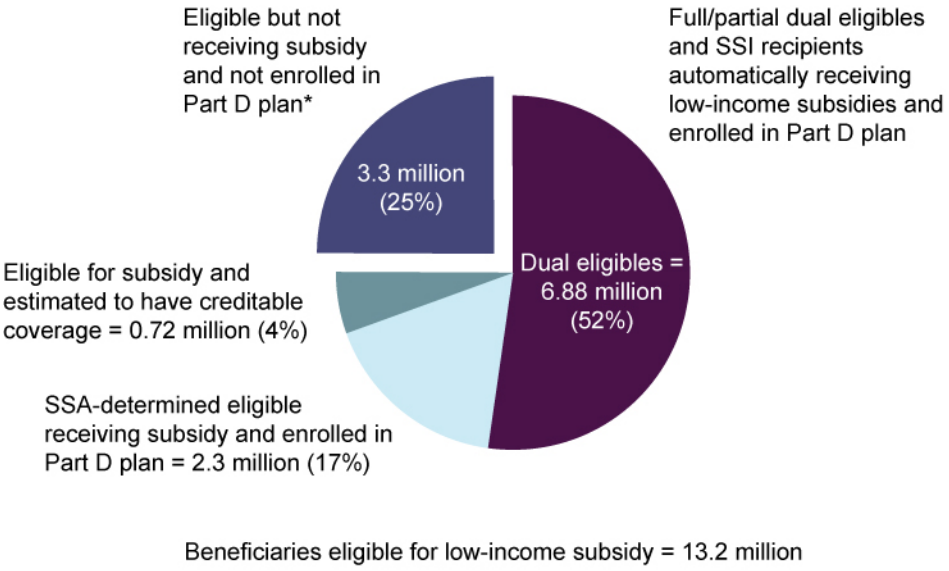
About 13.2 million beneficiaries are eligible for subsidies to help them pay Part D premiums and copayments for medications. While this could help the most needy obtain coverage, as of January 2007, an estimated 3.3 million of these beneficiaries had not yet enrolled in a Part D plan.

Laura Summer
Georgetown University

To encourage more eligible beneficiaries to enroll, the researchers recommend eliminating or amending the required

resource test, which makes savings and other assets a barrier to low-income applicants. In addition, the Social Security Administration and state Medicaid offices, which handle applications for the low-income subsidy, could do a better job in promoting the program and providing assistance in enrolling. They should also take steps to ensure that eligible beneficiaries are not dropped during reenrollment periods, the researchers say.

A snapshot of eligibility and participation in Medicare Part D's subsidy for low-income beneficiaries.



*Includes future anticipated facilitated enrollment of 0.03 million beneficiaries.
Source: L. Summer, P. Nemore, and J. Finberg, *Improving the Medicare Part D Program for the Most Vulnerable Beneficiaries* (New York: The Commonwealth Fund, May 2007).

Transition from Medicaid to Medicare Drug Coverage

In creating the new drug benefit, special provisions were made for "dual eligibles," or those eligible for both Medicaid and Medicare. Under Part D, prescription drug coverage for these beneficiaries shifts from Medicaid to Medicare. To ease this transition, dual eligibles are automatically enrolled in a Medicare drug plan if they do not choose one and are allowed to switch plans at any time. Still, there have been problems reported, including denied access and interrupted coverage.

To ensure these vulnerable beneficiaries have access to medications, the researchers recommend using information that is already available to Medicaid programs to assign beneficiaries to the most appropriate Medicare drug plans. They also suggest an expansion of the "point-of-service system," under which pharmacies can bill third-party contractors if they are unable to find a record of beneficiaries' plan assignments. This could ensure access to care for dual eligibles and help to document problems with the current system.

Formularies and Utilization Management

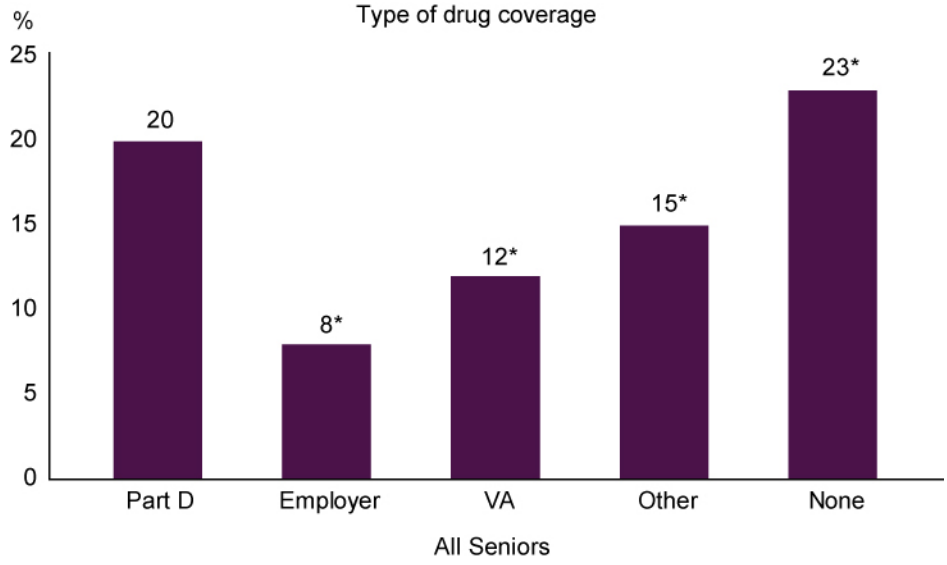
Part D plans have broad discretion to choose what medications they will cover and can change their drug formularies with only 60 days' notice. In addition, they can use various management tools, such as requiring prior authorization to have certain prescriptions filled, to control drug usage and costs.

Part D: Progress and Challenges

An analysis of a Commonwealth Fund–supported survey of 16,000 Medicare beneficiaries found that the share of seniors without drug coverage dropped significantly with the introduction of Medicare Part D. However, the analysis found that beneficiaries who enrolled in Part D experienced relatively high out-of-pocket spending in 2006. They also were more likely to skip prescribed medication than those who relied on other sources of drug coverage, such as employer-sponsored coverage or benefits from the Department of Veterans Affairs.[2]

The researchers suggest that drug plans need to do a better job of informing beneficiaries about the coverage determination process and standardizing the procedures used in exceptions and appeals process, whereby beneficiaries can ask plans to cover an off-formulary drug or waive certain utilization rules.

One of five seniors with Part D drug coverage in 2006 did not fill or delayed filling one or more prescriptions because of the cost.



Notes: Sample excludes institutionalized seniors. "Did not fill/delayed filling" refers to not filling or delaying filling or refilling of a prescription because of cost in the past 12 months. VA refers to the Department of Veterans Affairs.
Source: Kaiser/Commonwealth/Tufts-New England Medical Center National Survey of Seniors and Prescription Drugs, 2006.

The Role of Private Plans

The Medicare Modernization Act of 2003 expanded the role of the private sector in Medicare, greatly increasing payments to private Medicare Advantage plans and creating a new prescription drug benefit available only through private plans. With support from The Commonwealth Fund, Brian Biles, M.D., and his team at George Washington University examined these changes, particularly with regard to their impact on the benefits available to Medicare beneficiaries.

Expanding Medicare Plans: Issues for Beneficiaries

Goal: To assess the impact that provisions in the Medicare Modernization Act have on beneficiaries and the Medicare program itself.

Award amount: $250,510

Time frame: 12/1/05–9/30/07

Lead investigator: Brian Biles, M.D., professor, George Washington University

For more information: See *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised* or contact Dr. Biles at bbiles@gwu.edu.

The researchers calculated the costs of the nation's investment in Medicare Advantage and examined what this investment has purchased for beneficiaries.[3] It found that in 2005, payments to Medicare Advantage plans averaged 12.4 percent more than payments in traditional Medicare—totaling over $5.2 billion, or $922 for each of the 5.6 million enrollees. Eliminating those extra payments could save Medicare about $30 billion over five years, the analysis showed. In addition, the study documented administrative costs in Medicare Advantage plans between 11 and 13 percent, compared with 2 percent in the traditional Medicare program.

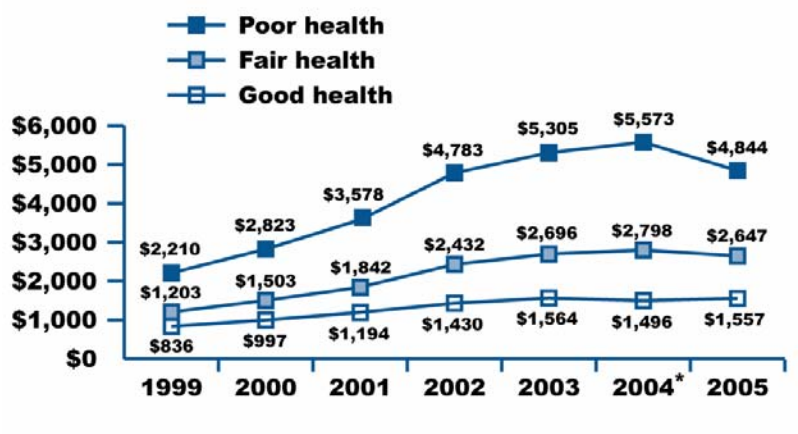
The creators of Medicare Advantage envisioned that, as a result of extra payments, these plans would offer seniors and disabled beneficiaries richer benefit packages with lower out-of-pocket costs than in fee-for-service Medicare. But Biles and his team concluded that, in spite of extra payments, Medicare Advantage plans do not always provide greater value for beneficiaries. Some of the extra payments do go toward extra benefits. The additional spending, however, is not equitably distributed across the country, and Medicare Advantage enrollees in poor health often have higher costs than they would have incurred in traditional Medicare.

Brian Biles, M.D.
George Washington University

"While encouraging enrollment in private plans was billed as a way to reduce costs for the program, Medicare Advantage actually costs Medicare money because of the extra payments. If traditional Medicare and private plans are ever to compete fairly, they need to compete on a level playing field, which would require eliminating those extra payments."

—Brian Biles, M.D., professor, George Washington University

Estimated total annual out-of-pocket spending for Medicare Advantage enrollees by health status, 1999–2005



*2004 data are for March-December only.
Source: L. Achman & L. Harris, "Early Effects of the Medicare Modernization Act: Benefits, Cost-Sharing, and Premiums of Medicare Advantage Plans, 2005" (AARP Public Policy Institute, Apr. 2005); M. Gold, L. Achman, J. Mittler et al., "Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage" (Washington, D.C.: Mathematica Policy Research, Inc., Aug. 2004).

Medicare Coverage for the Disabled

While many people think of Medicare only in terms of its services for the elderly, the program also provides health coverage for 6 million Americans under age 65 with severe and permanent disabilities. However, once the Social Security Administration deems an individual eligible for Social Security Disability Insurance (SSDI), they must wait two years before receiving Medicare coverage. At any given time, as many as 1.5 million men and women who are too disabled to work are waiting for Medicare coverage. Of these, nearly 39 percent are uninsured for at least some of the time and 26 percent have no insurance throughout the entire waiting period.[4]

Robert M. Hayes
President
Medicare Rights Center

To document the human costs of this waiting period, The Commonwealth Fund provided support to the Medicare Rights Center to develop 12 case histories of people who had completed the two-year waiting period and eight case histories of individuals still waiting for coverage. Below are two of these stories.

Stan White's Story

A stroke paralyzed Stan White in January 2002, forcing him to leave his job and apply for disability benefits. He was able to retain health coverage through COBRA, but only because his former employer helped him pay for it. Soon after his stroke, Stan was diagnosed with an aggressive form of brain cancer. He joined an experimental treatment program, paid in part by his COBRA coverage and the clinical trial compensation, which eradicated the cancer. Then in 2003, Stan's former employer went out of business. With no one to help pay COBRA premiums, no savings beyond the retirement funds he refused to touch for the sake of his family, SSDI

payments that made his income too high to qualify for Medicaid, and unable to find private insurance, given his preexisting conditions, White became one of the 47 million uninsured Americans.

In February 2003, less than a year before he would become eligible for Medicare, Stan's cancer returned. Thanks to his sister's advocacy, he was eventually admitted into the same experimental treatment program as a charity case. Normally, treatments that fail to put cancer into remission are not repeated because they often prove even less successful the second time, but the charity care required that he receive the same treatment he had earlier. The treatment was not successful, and Stan received Medicare coverage only in time to enter hospice care. Stan died in September 2004.

> *"My brother worked for over 40 years paying taxes, and he had paid into Medicare since it was established. He worked hard to take care of his family, neighbors, and country (Stan was a veteran), but never received the benefits of the system he supported."*
>
> —Marlene Walker, sister of Stan White

Roxianna McCutchan's Story

Born with a rare muscle disease called arthrogryposis multiple congenita, Roxianna McCutchan beat her doctors' predictions that she would die by age 13. By her early 30s, she was working as a clerk and dispatcher for the Rockport Police Department in Victoria, Tex. But over the years, her underdeveloped muscles and compressed lungs began to make simple office tasks, like speaking on the telephone, difficult. She required oxygen around the clock and suffered from a cough that was not strong enough to dispel fluid from her lungs, predisposing her to infection and transforming common colds into pneumonia.

In 2002, at age 33, Roxianna applied for disability benefits. She became eligible the same year. But when the first SSDI check arrived, she was surprised to learn she was not eligible for health insurance. With a life history of health problems that discouraged insurers and insufficient resources to purchase insurance through COBRA, she had no coverage when she most needed it.

Roxianna was able to visit her primary care physician because he agreed not to charge her, but she could not see specialists or fill prescriptions. Therefore, illnesses often developed into serious conditions; in 2003, she was hospitalized four times for conditions that could have

Waiting for Medicare Coverage: What It Means for the Disabled

Goal: To document the costs and consequences of the two-year wait for Medicare coverage through the stories of disabled individuals.

Award amount: $100,205

Timeframe: 5/105–10/31/06

Lead investigator: Robert M. Hayes, president, Medicare Rights Center

For more information: See *Too Sick to Work, Too Soon for Medicare: The Human Cost of the Two-Year Medicare Waiting Period for Americans with Disabilities* or contact Mr. Hayes at rhayes@medicarerights.org.

been ameliorated with basic care. Unable to afford the oxygen she required, Roxianna depended on the charity of her church.

In January 2005, she finally became eligible for Medicare. By then, she weighed just 73 pounds and was $20,000 in debt. "The stress level decreased dramatically when Medicare started," she said. "I got some of my self-respect back. I am now able to get the things I need to make my life easier and less painful."

> *"Statistics change minds. Human stories change hearts. Progress demands changed hearts and minds."*
>
> —Robert M. Hayes, president of the Medicare Rights Center

Medication Use Among Medicare Beneficiaries

While it is well known that Medicare beneficiaries are heavy users of prescription medications, much less is known about the quality and effectiveness of their medication use. There are no evidence-based guidelines to evaluate the medication regimens of older patients, particularly those with complex or multiple conditions. To begin building this evidence base, The Commonwealth Fund supported research examining the medication patterns of Medicare beneficiaries with one or more of eight medical conditions. The findings were published in a chartbook by Bruce Stuart, Ph.D., and his colleagues at the University of Maryland's School of Pharmacy.[5]

"Until 2006, most of the concern about prescription medications in Medicare related to access to drug coverage," says Stuart. "Now we're slowly realizing how important it is to pay attention to the value of the prescription drug benefit and the quality of the medications provided under it."

Stuart and his team analyzed the prescription drug use of 8,455 beneficiaries who had one or more of the following conditions: diabetes, depression, dementia, chronic obstructive pulmonary disease, arthritis, hypertension, ischemic heart disease, and congestive heart failure. Their goal was to see how drug utilization patterns varied by the severity of illness. What they found was that, with rare exception, the prevalence and persistency of prescription medication use were lower at both ends of the disease spectrum, compared with the middle. In many instances, the sickest people failed to receive medications called for in treatment guidelines, and the

Chartbook on Medication Use by Aged and Disabled Medicare Beneficiaries

Goal: To examine relationships between medication use and morbidity for Medicare beneficiaries with one or more of eight medical conditions as a first step in building the evidence base for appropriate drug therapy for Medicare beneficiaries.

Award amount: $47,141

Award dates: 3/106–7/31/07

Principal investigator: Bruce Stuart, Ph.D., professor and director, The Peter Lamy Center on Drug Therapy and Aging, University of Maryland School of Pharmacy

For more information: See *Profiles of Medication Use by Aged and Disabled Medicare Beneficiaries: A Chartbook* or contact Dr. Stuart at bstuart@rx.umaryland.edu.

persistency of use among those who did receive these medications was generally far below optimal levels.

The most appropriate utilization patterns occurred in the middle of the spectrum of disease burden, when medication intensity and persistency reached peak levels. This suggests a type of "Goldilocks phenomenon," in which the disease burden must be "just right" to produce the most appropriate levels of pharmacotherapy, the researchers noted. "It would appear that disease burdens that are either 'too little' or 'too much' may both lead to suboptimal therapy," Stuart said.

Developing Better Evidence for Medical Decision-Making

Goal: To examine the policy context in which the establishment of a mechanism to examine the benefits, risks, and costs of new medical treatments, procedures, and technologies and inform medical decision-making would be considered.

Award amount: $49,965

Time frame: 12/1/06–6/30/07

Lead investigator: Gail Wilensky, Ph.D., senior fellow, Project HOPE/The People-to People Health Foundation, Inc.

For more information: See "Developing a Center for Comparative Effectiveness Information" (*Health Affairs* Web Exclusive, Nov. 7, 2006) or contact Ms. Wilensky at gwilensky@projecthope.org.

Creating a Comparative Clinical Effectiveness Center

There is significant variation in Medicare spending across the United States, with evidence that higher spending per beneficiary does not necessarily yield greater value in terms of clinical outcomes or patient satisfaction.[6] Research into the clinical effectiveness of medical therapies and technologies could inform health care decision-making for the Medicare program and other purchasers. "Spending smarter" has the potential to control health costs and improve the quality of care for beneficiaries and other patients.

In a Commonwealth Fund-supported analysis, Gail Wilensky, Ph.D., a senior fellow at Project HOPE who previously oversaw the Medicare and Medicaid programs under President George H.W. Bush., assessed the feasibility of an agency devoted to comparative clinical effectiveness research and examined various options for its structure, financing, and functions. Her findings were published by the journal *Health Affairs* as a Web Exclusive.[7]

Gail Wilensky
Senior Fellow
Project HOPE

The need for such a center became clear to Wilensky during the debate over the Medicare prescription drug benefit and whether CMS should be allowed to negotiate directly with drug companies on pricing. "Why pay more for a drug if it doesn't do more?" she asked. "It makes much more sense to drive reimbursement based on comparative clinical effectiveness." When she began talking to clinicians, however, she learned there was little information regarding the most appropriate treatment for patients with particular clinical symptoms and conditions.

Wilensky envisions a center for comparative effectiveness research as a federally funded research and development entity, linked to the Agency for Healthcare, Research, and Quality but operating as an independent nonprofit entity. To be most useful, she argues that a comparative effectiveness center should actively pursue investigations of key questions for which evidence is missing, in addition to reviewing existing research.

> *"It is a little scary about how little we really know as payers, clinicians, and patients about the probability of a good clinical outcome from a given procedure given the symptoms that patients come in with."*
>
> —Gail Wilensky, Ph.D., Senior Fellow at Project HOPE

The idea of such a center is taking hold. By the summer of 2007, three legislative proposals advocating comparative effectiveness research had been introduced in Congress, and the Blue Cross and Blue Shield Association and America's Health Insurance Plans have jointly called for creation of a public–private entity to compare the safety and efficacy of medical procedures and technologies. Finally, the Institute of Medicine has convened a Roundtable on Evidence-Based Medicine.

Looking Ahead

During 2008, the Program on Medicare's Future will focus on strengthening and improving the program to ensure it will continue to meet the needs of the country's elderly and disabled. For instance, Marilyn Moon, Ph.D., of the American Institutes for Research, will develop proposals for the creation of Medicare Extra, a comprehensive benefit under traditional Medicare that would have a uniform deductible and out-of-pocket spending limit. The Fund will also support research into the role of private plans in Medicare. Brian Biles, M.D., of George Washington University, will continue his analysis of Medicare Advantage payments and benefits, and Charles Milligan, Jr., J.D., M.P.H., of the University of Maryland–Baltimore County, will report on how well Medicare Special Needs Plans are working for beneficiaries eligible for both Medicare and Medicaid.

As additional data on costs and effectiveness of Medicare Part D become available, the Fund will support further analysis of the program. For example, the work of John Hsu, M.D., of Kaiser Permanente will offer insight into the spending and utilization experience of beneficiaries enrolled in different types of Part D plans.

These and other Fund-supported projects will demonstrate how changes to Medicare are affecting beneficiaries and the program's overall efficiency, and will help point the way to additional changes that could strengthen the ability of Medicare to serve America's elderly and disabled.

Notes

[1] L. Summer, P. Nemore, and J. Finberg, *Improving the Medicare Part D Program for the Most Vulnerable Beneficiaries* (New York: The Commonwealth Fund, May 2007).

[2] P. Neuman, M. K. Strollo, S. Guterman, W. H. Rogers, A. Li, A. M. Rodday, and D. G. Safran, "Medicare Prescription Drug Benefit Progress Report: Findings from a 2006 National Survey of Seniors," *Health Affairs* Web Exclusive (Aug. 21, 2007):w630–w643.

[3] B. Biles, L. Hersch Nicholas, B. S. Cooper, E. Adrion, and S. Guterman, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised,* The Commonwealth Fund, November 2006.

[4] R. M. Hayes, D. Beebe, and H. Kreamer, *Too Sick to Work, Too Soon for Medicare: The Human Cost of the Two-Year Medicare Waiting Period for Americans with Disabilities* (New York: The Commonwealth Fund, Apr. 2007).

[5] See *Profiles of Medication Use by Aged and Disabled Medicare Beneficiaries: A Chartbook. Addressing the Challenge of Improving Quality of Pharmacologic Treatment Across the Spectrum of Morbidity* (Peter Lamy Center on Drug Therapy and Aging, University of Maryland School of Pharmacy, May 9, 2007).

[6] Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, Sept. 2006).

[7] G. Wilensky, "Developing a Center for Comparative Effectiveness Information," *Health Affairs* Web Exclusive, Nov. 7, 2006, w572–w585.

Health Care Quality Improvement and Efficiency

Anthony Shih, M.D.
Assistant Vice President

Performance measurement, capacity for improvement, incentives for improvement—these are the underpinnings essential to any effort focused on raising the quality and efficiency of health care. And there is no doubt that health care in the United States requires improvement. The National Scorecard of U.S. Health System Performance released by The Commonwealth Fund Commission on a High Performance Health System in 2006 estimated that between 100,000 and 150,000 deaths could be prevented annually, and at least $50 to $100 billion saved, if the nation as a whole achieved performance benchmarks set by individual states and health care organizations both here and abroad.[1]

Supporting providers and health systems in their efforts to reach higher levels of quality and efficiency is the mission of the Fund's Program on Health Care Quality Improvement and Efficiency. The program pursues its goal through three strategies:

The Commonwealth Fund is supporting the testing of new physician payment models, including the "evidence-informed case rate," which covers all providers involved in a patient's care for a specific procedure or medical condition.

1. Promoting the development and widespread adoption of quality and efficiency measures.
2. Assessing and expanding the capacity of organizations at all levels to improve quality and efficiency.
3. Promoting the development and adoption of incentives for improving quality and efficiency.

In the past year, Fund-supported projects in the quality and efficiency arena centered on hospital quality improvement efforts, public reporting of performance data, pay-for-performance activities, and health system financing.

Hospital Quality Improvement Efforts

Problems with quality in the U.S. health care system, and within hospitals in particular, have been well documented in recent years.[2, 3, 4] Yet more than seven years after the release of the Institute of Medicine's report To Err is Human: Building a Safer Health System, progress toward a redesigned national system focused on quality and patient safety remains "slow and insufficient."[5, 6]

Until recently, relatively little has been known about the extent to which individual hospitals have been actively engaged in quality improvement activities. To uncover this information, the Fund, in partnership with the Health Research and Educational Trust, supported Alan B. Cohen, Sc.D., and Joseph D. Restuccia, Dr.P.H., of Boston University's Health Policy Institute, to develop and implement a national survey of hospital quality improvement activities.

Survey to Assess the Current State and Impact of Quality Improvement Activities in U.S. Hospitals

Goal: To assess the quality improvement activities of hospitals nationwide.

Award amount: $326,195

Timeframe: 9/1/05–2/28/07

Lead investigator: Alan B. Cohen, Sc.D., Boston University Health Policy Institute

For more information: Contact Dr. Cohen at abcohen@bu.edu.

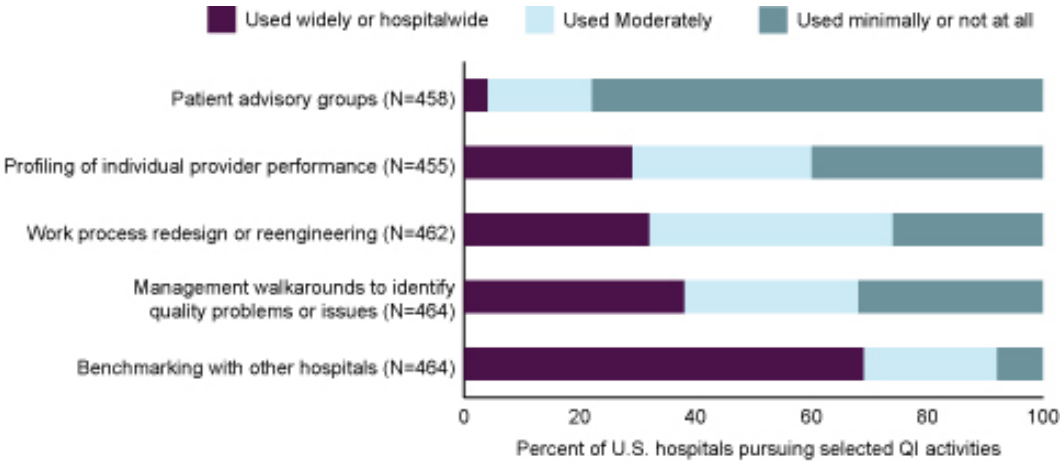
The final survey results included responses from chief quality officers at 470 hospitals about their institution's quality improvement activities as well as responses from over 5,300 front-line clinicians—physicians and nurses—from those hospitals.

Overall, the survey found that a majority of U.S. hospitals are actively engaged in patient care improvement efforts, although there is considerable variation in how individual hospitals approach this goal. For example, while most hospitals (69%) benchmarked their performance, relatively few (29%) utilized individual provider profiling. Furthermore, some proven quality improvement interventions were not widely utilized—fewer than half of hospitals (49%), for instance, implemented standing orders.

> *"Quality improvement is a dynamic, continuous, and evolutionary process. Although progress toward improved patient care clearly is being made in many U.S. hospitals, it will take time, innovation, and concerted effort by managers, clinicians, and policymakers to achieve organizational and systemwide quality and efficiency goals."*
>
> —Alan B. Cohen, Sc.D.

In the next step, the investigators will analyze how specific quality improvement activities relate to performance on measures of quality, efficiency, and patient experience.

A look at quality improvement (QI) activities, strategies, and approaches in U.S. hospitals



Source: Boston University Medical Center 2006 Quality Improvement Activities Survey (unpublished data).

Pay-for-Performance

The past five years has seen phenomenal growth in the use of pay-for-performance across health care. These new programs generally reward physicians for meeting certain quality and efficiency threshold levels or improvement goals. But while pay-for-performance programs may make intuitive sense as a means for improving patient outcomes, little has been done to assess these programs across health care settings—namely, to examine how they work and what results they have achieved.

"We understand we need payment reform," said Meredith B. Rosenthal, Ph.D., associate professor of health economics and policy at Harvard School of Public Health and the lead investigator on several Fund-sponsored grant awards to evaluate pay-for-performance programs. "But we need better evidence about pay-for-performance programs that is useful in a variety of different settings, from Medicaid agencies to commercial health plans to Medicare."

Without such information, she said, such programs can yield unintended consequences. For instance, some worry that if health care providers focus only on measurable benchmarks, other aspects of care that cannot be measured will not receive the attention they deserve.

Currently, Rosenthal is evaluating a novel program at the Hudson Health Plan, a Medicaid managed care plan in New York State that pays providers $200 for every child who is fully immunized. "That's a substantial reward," she said. The hope is that the bonus will spur providers and administrators to develop systems to contact parents and find ways to get them into doctor's offices for their vaccines—common obstacles to full vaccination in Medicaid populations. As part of her evaluation, she is examining the impact of the program on racial and ethnic disparities.

Strategies to Improve the Value of Health Benefit Spending for Low-Wage Workers

Goal: Evaluate outcomes of pay-for-performance programs in various health care settings.

Award amount: $253,719

Timeframe: 8/1/05–9/30/07

Lead investigator: Meredith B. Rosenthal, Ph.D., Harvard School of Public Health

Evaluating the Impact of a Novel Pay for Performance Program in a Medicaid Managed Care Plan

Award amount: $166,788

Timeframe: 8/1/07–10/31/08

Lead investigator: Meredith B. Rosenthal, Ph.D., Harvard School of Public Health

For more information: Contact Dr. Rosenthal at meredith_rosenthal@harvard.edu.

Rosenthal is also completing an evaluation of a preferred provider organization (PPO) that insures low-wage workers and provides financial incentives to both providers as well as patients. The PPO has implemented several approaches to increase value, including profiling physicians in its network and narrowing the network, in an attempt to drive patients to the best-performing physicians. Patients are incentivized as well; expectant mothers, for example, qualify for financial awards when they obtain appropriate prenatal care.

While pay-for-performance is an important option in payment reform, it is not likely to be the answer to our health care financing woes, said Rosenthal. Eventually, the health system must turn away from fee-for-service and its inherent flaw—the rewarding of quantity over quality.

Public Reporting of Performance Data

Measuring the quality and value of health care delivered to patients and reporting that information publicly are both essential to performance improvement. After all, to deliver better care, health care providers must first understand how their performance compares with their peers. Publicly available performance information not only motivates providers to improve, but it allows health plans to use it to reward quality and patients to make more informed care choices.

The Commonwealth Fund has been supporting the Massachusetts Health Quality Partners (MHQP)—a coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies—as it works to develop quality measures, collect data, and publish public reports.

Massachusetts Health Quality Partners, Inc.

Goal: To develop meaningful reports on provider efficiency to stimulate performance improvement and help inform consumers.

Award amount: $322,832

Timeframe: 1/1/06–6/30/08

Lead investigators: Janice Singer M.P.H., and Melinda Karp, M.B.A.

For more information: Visit www.mhqp.org.

The coalition's efforts have already shown significant results. For instance, when MHQP first released its report comparing the quality of care delivered by nine physician networks across Massachusetts in 2005, the second-ranked health system used the results to revamp its budget and implement a centralized health information system. Another physician group—which was too small to even be included in the original data comparison—implemented electronic health records years earlier than originally planned so it could improve from its current status to the benchmark level.

> *"What we've found from doctors is that they want accurate, useable information. They really accept that there's a need to measure value. They want to know how they're doing, and how others are doing, and what they can do to change their practice and become more efficient."*
>
> —Barbra Rabson, Executive Director, MHQP

The Fund is currently supporting MHQP's effort to develop meaningful reports on provider efficiency. Massachusetts Health Quality Partners is testing these profiles through focus groups to see how purchasers, health plans, physicians, and consumers can use them to improve the efficiency of care delivered.

Why is testing with consumers important? "When patients hear the word 'efficiency,' they think someone is trying to limit the amount of care they can receive, as opposed to the idea that overutilizing services is really bad for you," explains MHQP executive director Barbra Rabson.

Barbra Rabson
Executive Director
Massachusetts Health Quality Partners

Health System Financing

The PROMETHEUS provider payment model seeks to turn traditional health care financing inside out.[7] Developed by a multidisciplinary team of experts, it is intended to "create a payment environment where doing the right things for the patient helps providers and insurers do well for themselves." Specifically, the new payment system is designed to:

- Improve quality
- Reduce administrative burden
- Enhance transparency
- Support a patient-centric and consumer-driven environment.

The basis for PROMETHEUS is the evidence-informed case rate, a single, risk-adjusted, prospective or retrospective payment that covers providers across all care settings to care for a patient with a specific medical condition. Payment is based on the resources required to provide the level of care recommended in well-accepted clinical practice guidelines; furthermore,

payment is adjusted for severity of illness as well as potential complications that are beyond a provider's control.

To further promote quality, a portion of the final payment is withheld and redistributed based on provider performance on measures of clinical process, outcomes of care, and patient experience. With support from The Commonwealth Fund, the project has moved into late-stage development: prototype payment rates have been completed, and efforts are under way to demonstrate the feasibility of the technical approach.

> *"PROMETHEUS holds providers accountable for the efficient use of resources, but it frees them to manage those resources in any way they see fit and removes current artificial barriers to innovate."1*
>
> —Alice G. Gosfield, J.D.,
> PROMETHEUS Design Team

"To me, the exciting part of this work is to get out of this debate about 'my patients are sicker,' and so I should receive a higher payment or be held to different standards," said PROMETHEUS National Coordinator François de Brantes. "Part of this is that we're starting to have a very different type of dialogue about the types of risk factors that legitimately require a greater intensity of care and adjusted care episodes. It's an exciting change in the dialogue and in how we price care."

Advancing Payment for Health Care Quality and Efficiency Through an Evidence-Based Case Rate Approach

Goal: Demonstrate the feasibility of and develop prototype evidence-informed case rates for a new episode based payment system.

Award amount: $300,000

Timeframe: 1/1/07–2/28/08

Lead investigator: François de Brantes, M.S. M.B.A.

For more information: See Evidence-Informed Case Rates: A New Health Care Payment Model or contact Mr. de Brantes at francois.debrantes@bridgestoexcellence.org.

The success of the payment model is dependent on providers' use of systems that support clinical coordination across specialties and sites of care. "Because of the impact of the care rendered by everyone treating the patient on the provider's financial success, providers have a real motivation to refer to higher quality and more efficient collaborators," said payment system designer Alice G. Gosfield, J.D., in an editorial on the program published in the American Journal of Medical Quality."[8]

François de Brantes
PROMETHEUS
National Coordinator

So far, the modeling has been going "phenomenally well," according to De Brantes. "We've been able to clearly demonstrate that

the different elements of risk can be quantified and clearly distinguished from each other, providing very simple principles upon which to further model case rates."

Looking Ahead

The field of quality improvement and efficiency is evolving quickly. The Commonwealth Fund continues to support research in critical areas to improve the U.S. health care system's performance. Recently awarded grants to watch include an examination of U.S. health plans' quality and resource use in an effort to identify best practices in promoting high-value care (led by Robert Berenson, M.D., of the Urban Institute, and L. Gregory Pawlson, M.D., of the National Committee for Quality Assurance); an evaluation of a national effort to improve heart attack care (led by Elizabeth Bradley, Ph.D., and Harlan Krumholz, M.D., at Yale University School of Medicine); and an assessment of the use of Internet, cellular, and telemedicine technologies to engage underserved patients in their own care, led by James O. Kahn, M.D., of the University of California, San Francisco.

Notes

[1] C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive, Sept. 20, 2006: W457–w475 (2006).

[2] K. T. Kohn, J. M. Corrigan, and M. S. Donaldson, eds., *To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000).

[3] J. M. Corrigan, M. S. Donaldson, and L. T. Kohn, eds., *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academy Press, 2001).

[4] E. A. McGlynn, S. M. Asch, J. Adams et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine*, June 26, 2003 348(26): 2635–45.

[5] L. L. Leape and D. M. Berwick, "Five Years After 'To Err Is Human': What Have We Learned?" *Journal of the American Medical Association*, May 18, 2005 293(19):2384–90.

[6] R. M. Wachter, "The End Of The Beginning: Patient Safety Five Years After 'To Err Is Human'," *Health Affairs* Web Exclusive, Nov. 30, 2004:W4-534–W4-545.

[7] PROMETHEUS stands for Provider payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence, Understandability, and Sustainability.

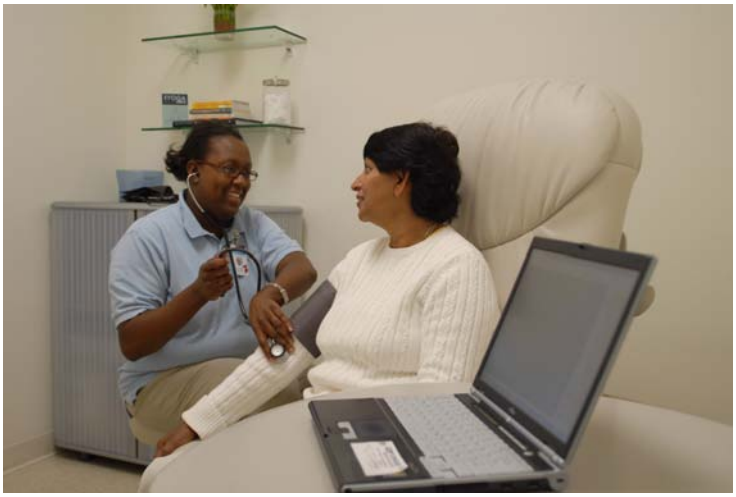
[8] A. G. Gosfield. "A New Payment Model For Quality: Why Care Now?" *American Journal of Medical Quality*, May–June 2007 22(3):145–47.

Patient-Centered Primary Care

Melinda K. Abrams
Senior Program Officer

The driving principle of patient-centered primary care is a relatively simple one: the health care system should be designed around the patient—not around administrators, physicians, or financing. After all, what else is health care about if not the patient?

Yet today's health care system has difficulties focusing on the patient. Care is generally reimbursed with little or no regard for medical outcomes; physician offices rarely schedule patient appointments in the evenings or weekends when patients are free; patients' access to physicians typically requires a face to face appointment, rather than an e-mail or phone call; and there is little coordination between primary and specialty care.



To be a patient-centered medical home, a physician practice must have the needs and preferences of its patients in mind.

As defined by the Institute of Medicine, patient-centered care is "health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care."[1] In primary care, such care is best provided in a medical home—a place or network that provides patients with enhanced access to the personal clinician (for example, at nights and on weekends), coordinates care, and engages in continuous quality improvement.[2]

The goal of the Fund's Patient-Centered Primary Care Initiative, established in 2005, is to improve the quality of primary care by making it more patient- and family-centered. The projects it supports seek to:

- promote the collection of information on patient experiences and the delivery of care to facilitate public reporting and quality improvement;
- promote effective practices, models, and tools to improve patient- and family-centered care in primary care practices; and
- improve policy to encourage patient- and family-centered care in medical homes.

The Tenets of Patient-Centered Primary Care

- Superb access to care
- Patient engagement in care
- Clinical information systems that support high-quality care, practice-based learning, and quality improvement
- Care coordination between primary and specialty care
- Integrated and comprehensive team care between physicians, nurses, and other health professionals
- Routine patient feedback to doctors to help inform treatment plans
- Publicly available information on physicians to help patients choose a practice that meets their needs

Measuring Patient-Centered Care

In health care, unless you can measure something, you cannot truly determine if it is working, nor can you align incentives to improve it. That's why The Commonwealth Fund supported Sarah H. Scholle, Dr.P.H., M.P.H., and her team at the National Committee for Quality Assurance (NCQA) to develop and test measures and tools that define and evaluate the quality of patient-centered care in physician practices. Although survey tools are available for assessing patient experiences with care at the practice or physician level, they have not been widely implemented. Nor have they been linked to practice systems that support patient-centered care.

To develop these metrics, Dr. Scholle's team has been conducting extensive research on patient-centered care. The researchers have found that while there is agreement on the principles of patient-centeredness, physician practices differ markedly in how they apply them. They have also identified concerns about whether certain components of patient-centered care, such as language services, should be expected of all practices. Overall, however, physicians are generally positive about including patient-centered care metrics in pay-for-performance initiatives, and they want to be rewarded based on the quality of their patients' experiences.

Enhancing Patient-Centered Care in Office Practices

Goal: Develop and test measures and tools to define and evaluate the quality of patient-centered care in office practices.

Award amount: $300,716

Timeframe: 7/1/05–12/31/06

Lead investigator: Sarah H. Scholle, Dr.P.H., M.P.H., National Committee for Quality Assurance

For more information: Contact Dr. Scholle at scholle@ncqa.org.

Next Steps. NCQA has incorporated 18 patient-centered care measures into the standards for its Physician Practice Connections program, which recognizes practices that use information systems to improve patient care. In March 2007, the Fund provided NCQA with a small grant to work with the four primary care specialty societies—representing internists, family physicians, pediatricians, and osteopaths—to reach consensus on how to use these measures to designate practices as "patient-centered medical homes." This activity resulted in the recent release of updated measures for office systems.

> *"As a doctor, you have to partner with the patients. Instead of saying, 'Do this, do that,' a lot of times I'll give patients options and say, 'Which ones do you think will work best for you?' Because sometimes, lifestyle wise, it may not work for them."*
>
> —Physician interviewed by NCQA researchers as part of its Physician Practice Connections program

The Fund continues to support NCQA to disseminate the measures nationally, further develop and test measures to enhance patient-centered care (physician–patient communication, care coordination) and examine the relationship between medical homes' clinical practice systems and efficiency of care.

Patient Experiences and Clinical Quality and Outcomes

It makes intuitive sense that patient-centered health care provided through a medical home would lead to high-quality health care. Yet there is sparse evidence linking improved clinical outcomes with the adoption of quality measurement and improvement activities centered on meeting the needs of patients.

Researcher Dana Safran, Sc.D., and her team from the Health Institute at Tufts–New England Medical Center examined the association between patient-centeredness and clinical quality outcomes at the practice and physician levels. The Fund-supported survey involved practice site–level data from 310 adult primary care practices in Massachusetts and physician-level data from 120 primary care physicians at 14 health centers.

> *"The team, the practice, the staff, and the doctor can influence how often patients get screened and monitored. Interpersonal skills are not just "fluff"; they make a difference in how well we provide clinical care to patients."*
>
> —Melinda K. Abrams, Senior Program Officer

The first results were presented at the May 2007 annual meeting of the Society of General Internal Medicine in Boston. The researchers found that good clinical team interactions and care coordination were positively and significantly associated with preventive care (e.g., cancer screening) and disease management (e.g., monitoring of hemoglobin A1c) process measures at the practice level. At the individual physician level, good communication, health promotion support, and clinical team interactions were strongly related to preventive care.

Linking Patients' Experience with Health Care to Clinical Quality and Outcomes

Goal: To determine whether specific components of the patient experience, such as communication or trust, are more strongly associated with clinical quality, and whether the relationship between patient satisfaction and clinical performance sometimes depends on the level of patient adherence required for treatment.

Award amount: $101,378

Timeframe: 12/1/05–11/30/06

Lead investigator: Dana Safran, Sc.D., Director of the Health Institute at Tufts–New England Medical Center

For more information: Contact Dr. Safran at dana.safran@bcbsma.com.

Building the Capacity of Practices to Provide Patient-Centered Care

In 2002, a group of purchasers, health plans, and physician groups launched a pay-for-performance program in California to reward physicians for delivering high-quality care. Feedback from patients, however, indicated there had been little improvement in patients' ratings about their health care encounters. In response, the Pacific Business Group on Health (PBGH), a member of the pay-for-performance program, created a learning collaborative to provide 13 physician practices with special training on improving aspects of care, including doctor–patient communication, timely access to care, and coordination of care. The Commonwealth Fund supported an assessment of the program to determine which aspects of the program actually improved patient experience scores as well as physician and staff satisfaction.

Assessing the Effectiveness of a Collaborative Approach to Achieving Patient-Centered Care

Goal: To evaluate if efforts by the Pacific Business Group on Health (PBGH) to help physicians provide patient-centered care in fact results in better patient experience.

Award amount: $80,737

Timeframe: 8/1/06–7/31/07

Lead investigator: Tammy Fisher, M.P.H., senior manager, Pacific Business Group on Health

For more information: Contact Ms. Fisher at tfisher@pbgh.org.

With data for three measurement periods analyzed so far, aggregate results show improvements in "overall rating of care" across all measurement periods, particularly in care coordination. In addition, 80 percent of physicians reported increased job satisfaction and practice culture, and 72 percent reported a better relationship with their independent practice association (IPA). All were confident that they would sustain changes.

The continuing evaluation will assess the magnitude of the changes and their sustainability six months after the collaborative was completed.

Patient-Centered Care: The Employer Perspective

Paul Grundy, M.D., who directs health care technology and strategic initiatives for IBM, realized that pay-for-performance reimbursement strategies and other efforts would never improve care until fundamental issues in the delivery and reimbursement of health services were addressed first. "We had to stop doing things *to* the doctors, and start collaborating *with* the doctors," he said.

Dr. Grundy reached out to his colleagues at other large firms throughout the country, to the large health plans that covered their employees, and to major primary care professional organizations, like the American Academy of Family Physicians, to create the kind of primary care practices he wanted IBM employees to be able to access. The result is the Patient Centered Primary Care Collaborative (http://patientcenteredprimarycare.org/), a coalition of major employers, consumer groups, and other stakeholders that have joined with organizations representing primary care physicians to develop and advance the patient-centered medical home.

"The failure we are experiencing today is a failure in our primary care system," said Dr. Grundy. "Any initiative that strives to improve the overall quality and cost of care must focus on primary care." This will require a complete overhaul of the primary care system and its financing, he said. The collaborative, whose members represent all 333,000 primary care physicians in the country and more than 50 million covered lives, is ideally suited to do just that. "The Collaborative is about getting to the list of patient-centered primary care guidelines The Commonwealth Fund and others have developed," said Dr. Grundy. "For the first time in history, we have both the knowledge and the capabilities to force substantial change in health care."

Improving Primary Care in Response to Patient Feedback

The quality of the patient–physician relationship is essential to good primary care. Yet one of five American adults has trouble communicating with their doctors, and one of 10 reports being treated with disrespect during an office visit. Patients also report problems with test results or medical records not being available at the time of scheduled appointments, as well as receiving conflicting information from their providers.[3,4]

To address these issues, and to show that it is possible for even solo physicians to become patient-centered care practices, The Commonwealth Fund is supporting in Missouri the Ideal Medical Practices (IMP) program, which is devoted to helping primary care physicians develop patient-centered, efficient, accountable, and accessible practice styles with low overhead. An IMP is a patient-centered practice that demonstrates improved chronic condition management through enhanced patient education and self-management; provides follow-up support; and offers the opportunity for "group visits" with patients who have similar medical problems.

Improving Primary Care in Response to Patient Feedback

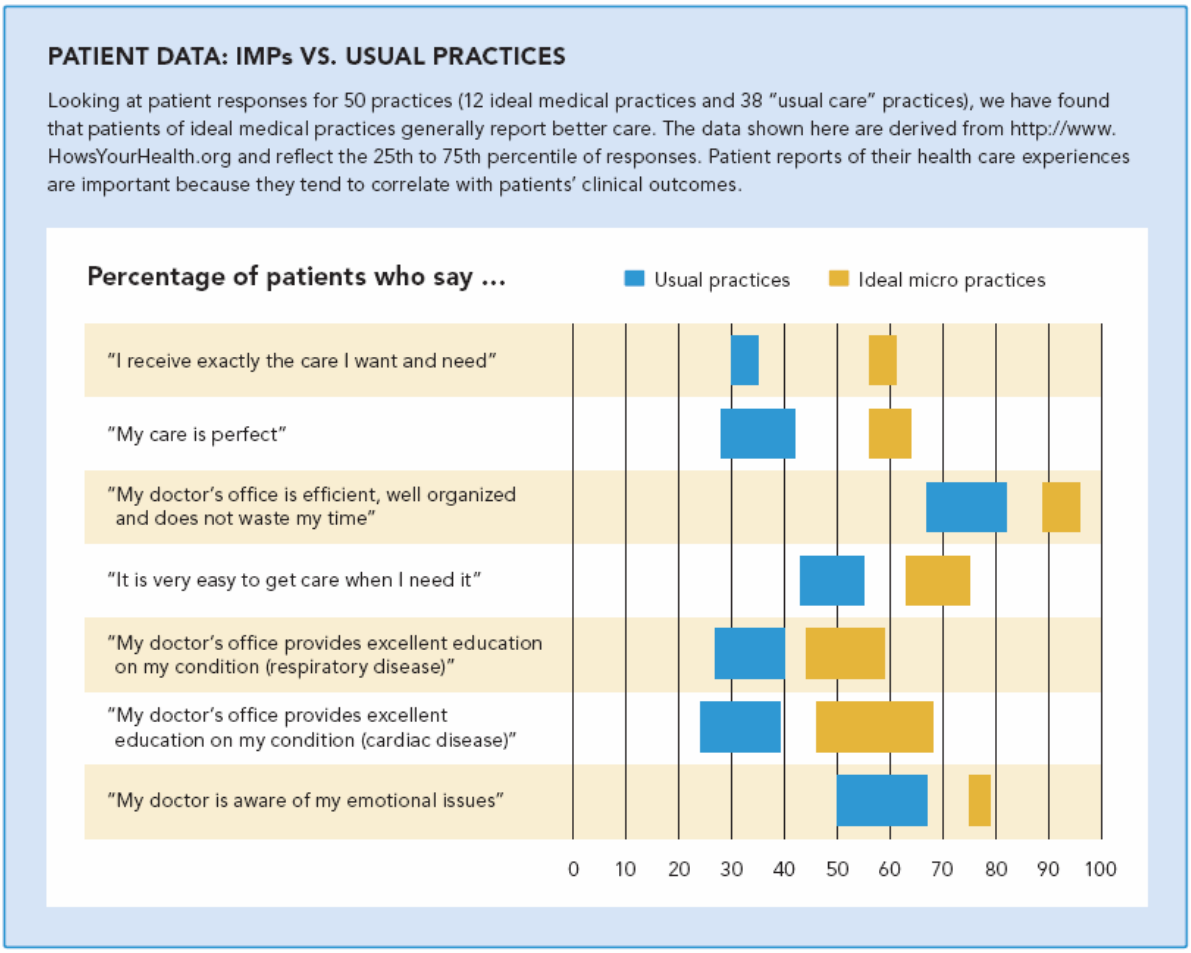
Goal: To package the How's Your Health survey with other patient-centered technologies and, in collaboration with a Medicare Quality Improvement Organization, integrate them in up to 24 primary care practices, coaching the practices on how to use the patient feedback obtained from these tools to provide patient-centered care.

Award amount: $249,937

Timeframe: 6/1/06–11/30/07

Lead investigator: John H. Wasson, M.D., Professor of Community and Family Medicine, Dartmouth Medical School

For more information: Visit www.impmo.org or contact Dr. Wasson at john.h.wasson@dartmouth.edu.



Source: L. Gordon Moore and John H. Wasson, *The Ideal Medical Practice Model: Maximizing Efficiency, Quality, and the Doctor-Patient Relationship*; accessed at http://www.impmo.org/FPM_Moore_Wasson_Sept_2007.pdf.

John H. Wasson, M.D.
Dartmouth Medical School

The cornerstone of an IMP is the How's Your Health patient assessment tool. The Commonwealth Fund has supported the implementation and assessment of How's Your Health since 2001. It is designed to help physicians and patients "cross the quality chasm" by communicating more fully. Patients complete the tool, which helps identify potential health problems, level of functioning, and clinical symptoms, and measures satisfaction with care. It also automatically populates a patient registry for the physician that summarizes the patient's health needs and concerns, tracking interventions, results, and changing needs over time.

The 24 Missouri practices that have begun using the tool and other elements of the IMP program find it is positively transforming many aspects of the way they care for patients. In particular, they note that they and their patients are more often "on the same page," the practice

and patient are much better at providing patient self-management support, and the practice becomes more efficient.

Looking Ahead

In the year ahead, the Fund plans to step up its efforts to promote the patient-centered medical home, particularly in safety-net settings. In spring 2008, the Fund will launch a five-year demonstration to support 50 safety-net clinics in four regions of the country to become patient-centered medical homes with benchmark performance in quality, patient experience, and efficiency.

Another priority is to gain a better understanding of the impact of the patient-centered medical home on clinical quality, patients' experiences, and health care costs. While elements of the medical home model have been shown to be associated with higher quality and improved patient experience, there have been no published evaluations of the model as a whole. To build an empirical basis and assess the impact on quality and cost, the Fund is also committed to supporting evaluations of multipayer medical home demonstrations being launched by commercial and public payers.

Notes

[1] Institute of Medicine, *Envisioning the National Health Care Quality Report* (Washington, D.C.: National Academy Press, 2001).

[2] American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics, and American Osteopathic Association, "Joint Principles of the Patient-Centered Medical Home," Feb. 2007.

[3] K. S. Collins, D. L. Hughes, M. M. Doty et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (New York: The Commonwealth Fund, March 2002).

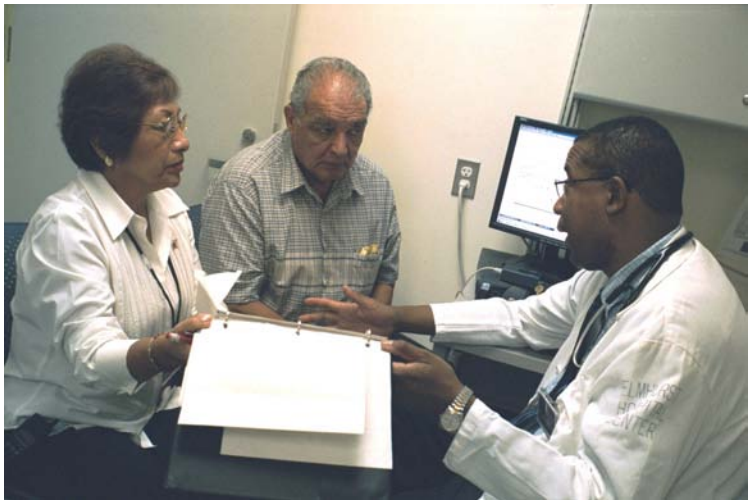
[4] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care* (New York: The Commonwealth Fund, June 2007).

Program on Quality of Care for Underserved Populations

Anne C. Beal, M.D.
Assistant Vice President

The goal of The Commonwealth Fund's Program on Quality of Care for Underserved Populations is to improve the quality of health care delivered to populations who are not well served by the nation's health system—low-income Americans and members of racial and ethnic minority groups—and to reduce health care disparities. The program's work focuses on safety-net institutions and other health care settings that serve large numbers of low-income and minority patients. Its strategies include:

- finding and promoting models of high performance safety-net health systems that provide accessible, effective, safe, and efficient health care;
- promoting health care that is culturally competent and patient-centered; and
- supporting the development of public policy that will lead to improvement in health care systems serving minority and low-income populations.



A diabetes patient at Elmhurst Hospital, a safety-net provider in Queens, New York, meets with his doctor to learn how to manage his condition. The Commonwealth Fund supports several efforts that seek to improve chronic disease management for patients in underserved communities.

Previous Commonwealth Fund research has documented disparities in health care access and quality of care among different racial and ethnic populations. While some of these disparities can be explained by differences in income, insurance status, and medical need, racial and ethnic disparities persist even after accounting for these factors. Fund work in the past year helped to identify models of care that could ameliorate disparities and build high-performance health systems for minority patients.

In particular, the "cultural competency" of health care providers has been recognized as a key to improving care for the underserved. Culturally competent health care providers show respect for patients' preferences and their cultural, social, and economic backgrounds, and engage them in health care decision-making. Recent Commonwealth Fund work has helped to develop standards for delivering culturally competent care.

Exploring the Potential of Medical Homes

Both practitioners and policymakers are looking to the medical home model as a way to improve the quality of primary health care for all Americans. Commonwealth Fund research conducted in 2007 suggests that ensuring access to a medical home—a primary care setting that provides timely, well-coordinated care and enhanced access to physicians—may also provide a way to reduce health care disparities.

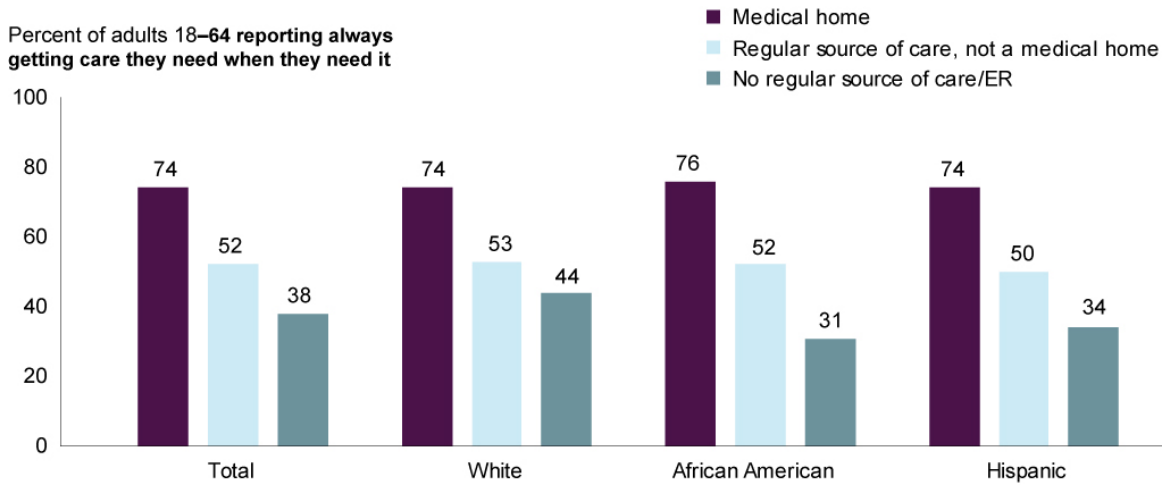
For the Commonwealth Fund's 2006 Health Care Quality Survey, researchers used the following measures to gauge whether people had medical homes:

- if they had a regular provider or place of care;
- if they experienced no difficulty contacting their provider by phone;
- if they had no difficulty getting care or advice on weekends or evenings; and
- if they reported that their office visits are always well organized and on schedule.

Commonwealth Fund assistant vice president Anne C. Beal, M.D., discusses the Fund report *Closing the Divide,* whose findings demonstrate the importance of a medical home in reducing health care disparities.

The survey found that few providers offer this kind of comprehensive primary care: only 27 percent of adults reported having all four measures of a medical home. Still, the survey findings suggest that racial and ethnic health disparities are not immutable. When adults have insurance coverage and a medical home, disparities related to health care access and quality are reduced or even eliminated. No matter their race, ethnicity, or income, patients with medical homes had greater access to needed care, higher rates of routine preventive screenings, and better management of chronic medical conditions.[1]

Racial and ethnic differences in getting needed medical care are eliminated when adults have medical homes.



Source: A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health* (New York: The Commonwealth Fund, June 2007).

The survey also found evidence that Hispanics and African Americans are quite vulnerable:

- among adults ages 18 to 64, nearly half of Hispanics (49%) and more than one of four African Americans (28%) were uninsured during 2006, compared with 21 percent of whites and 18 percent of Asian Americans; and
- as many as 43 percent of Hispanics and 21 percent of African Americans report they have no regular doctor or source of care, compared with 15 percent of whites and 16 percent of Asian Americans.

Survey on Health System Performance: The Patient's Perspective

Goal: To conduct a follow-up survey to the Fund's 2001 Health Care Quality Survey that explores the performance of the health system from the patient's perspective, focusing on care coordination, communication, safety, and the extent to which patients have timely access to primary and preventive care.

Award amount: $404,250

Timeframe: 12/1/05–5/30/06

Lead investigator: Mary McIntosh, Ph.D., Princeton Survey Research Associates International

For more information: See *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814 or contact Mary McIntosh at mary.mcintosh@psra.com.

Using Technology to Target Health Disparities

With Commonwealth Fund support, Neil Calman, M.D., president and CEO of the Institute for Urban Family Health in New York, used clinical data from electronic health records to identify factors that contribute to improved health outcomes for diabetes patients. Calman and his colleagues are now using that information to develop best practices to improve diabetes care and reduce racial and ethnic disparities.

Neil Calman, M.D.
President and CEO
Institute for Urban
Family Health

After the institute implemented electronic health records in its 15 community health centers in New York's Manhattan, Bronx, Ulster, and Dutchess counties, health care providers were able to examine the quality of care and health outcomes by race and ethnicity. What they found surprised them. "We found that people of color within our practice had poorer levels of control for their diabetes than white patients," says Calman. The differences didn't appear to be related to differences in care. Instead, minority patients entered the system with poorer control of their diabetes than whites; even with comparable services, they did not always catch up.

Using Electronic Health Records to Improve Quality and Reduce Disparities in Diabetes Care

Goal: To use clinical data obtained from electronic health records to identify factors that contribute to high-quality care and improved health outcomes for diabetes patients, and then develop a set of best practices to improve diabetes care and reduce racial and ethnic disparities.

Award amount: $266,363

Timeframe: 7/1/06–6/30/08

Lead investigator: Neil Calman, M.D., president and CEO of the Institute for Urban Family Health

For more information: See "Case Study: Using Information Technology and Community Action to Improve the Health of a Diverse Patient Population" or contact Dr. Calman at ncalman@institute2000.org.

Calman's findings illustrate an important point about racial and ethnic disparities: providing the same health services to white and minority patients may not eliminate disparities, just as equal-opportunity hiring procedures have not done so in the workplace. Instead, a kind of "affirmative action" may be required, Calman says, in which health care systems create special programs for patients with poorer levels of diabetes control. Such programs, now under development at the Institute for Urban Family Health, might include more frequent visits for patients with poor control of their diabetes and intensive intervention by a nutritionist.

Disparities Driven by Place of Care

The old adage employed in the real estate business—location, location, location—may turn out to be just as applicable to health care. A Fund-supported study published in the June 2007 issue of *Archives of Internal Medicine* examined data reported by 123 U.S. hospitals through the Hospital Quality Alliance.[2] The data measure how often hospitals delivered certain evidence-based care processes for acute myocardial infarction, congestive heart failure, and pneumonia.

The researchers, led by Romana Hasnain-Wynia, Ph.D., of the Health Research and Educational Trust (HRET), found that, compared with white patients, minority patients receive lower-quality care, and that lower-performing hospitals tend to serve a larger proportion of minority patients.

Romana Hasnain-Wynia, Ph.D.
Health Research and Educational Trust

The researchers note that low-performing hospitals may be "under-resourced" in a number of ways, from a shortage of nurses to inadequate budgets and a lack of health information systems. "We need to drill down further into hospital characteristics to look not only at what works, but also to understand where there is clearly room for improvement and what would facilitate that improvement," says Hasnain-Wynia.

Linking Race and Ethnicity Data with Inpatient Quality-of-Care Measures in Private Hospitals

Goal: To collect and analyze data based on 10 hospital quality indicators stratified by race, ethnicity, and primary language to measure disparities in inpatient care; conduct case studies to assess the hospitals' response to reporting quality data by race/ethnicity; and assess the feasibility of implementing a uniform framework for collecting data on race, ethnicity, and primary language.

Award amount: $299,966

Timeframe: 9/1/04–8/31/06

Lead investigator: Romana Hasnain-Wynia, Ph.D., Health Research and Educational Trust

For more information: See "Disparities in Health Care Are Driven by Where Minority Patients Seek Care" or contact rhasnain@aha.org.

Cultural Competency: What Do Patients Think?

Provision of culturally competent medical care is one of the strategies advocated for reducing or eliminating racial and ethnic health disparities. But what does cultural competency in health care mean from a patient's perspective? This is the question Quyen Ngo-Metzger, M.D., a former Commonwealth Fund/Harvard University Fellow in Minority Health Policy now based at the Center for Health Policy Research at the University of California, Irvine, set out to discover with her colleagues in a review of the research literature.

Quyen Ngo-Metzger, M.D.
University of California, Irvine

Their research, presented at a Fund-sponsored roundtable on cultural competency and published as a Commonwealth Fund report, found that culturally competent care is critical to patient satisfaction, adherence to recommended care, and outcomes.[3] From a patient's perspective, patient–provider interactions are an important—if not the most important—aspect of good care. The research showed that minority and low-income populations are more likely than white or higher-income patients to feel disenfranchised in health care decision-making and to perceive a lack of respect for their preferences.

"Doctors may treat patients differently, even if unconsciously," says Ngo-Metzger, suggesting, for example, that some may provide more information to patients they think have more education or come from higher socioeconomic groups.

Ngo-Metzger's research, which included focus groups with patients, shows how important it is to consider their perspectives. "A lot of times we assume we're doing things that are culturally competent, but unless you ask your patients, you won't know if what you're doing is right," she says.

Cultural Competency Expert Roundtable

Goal: To host a roundtable meeting of experts in cultural competency and patient-centered care to determine future directions for the field.

Award amount: $37,000

Timeframe: 3/1/06–4/30/06

Lead investigator: Anne Beal, M.D., M.P.H., assistant vice president, The Commonwealth Fund

For more information: See the multimedia presentation, "Cultural Competency: Understanding the Present and Setting Future Directions," or contact acb@cmwf.org.

Ngo-Metzger and her colleagues made several recommendations to improve patient–provider interactions:

- monitor patients' experiences with care through quantitative and qualitative data collection methods;
- work with patients to select treatments that take into account their values, weighing available treatment options and patient preferences;
- implement policies throughout the health care system to democratize the decision-making process among patients, their families, and providers; and
- assess patients' health literacy and language needs and adopt strategies to improve written and oral communication with patients.

Around the Table

The Commonwealth Fund–supported Cultural Competency Roundtable yielded five reports, all of which are available on the Fund's Web site:

Cultural Competency and Quality of Care: Obtaining the Patient's Perspective
Q. Ngo-Metzger, J. Telfair, D. H. Sorkin et al.

Researchers identify the five domains of culturally competent care that can best be assessed through the patient's perspectives. Incorporating patients' perspectives on cultural competence into existing measures of health care quality, they say, will create opportunities for providers and health plans to make improvements.

The Evidence Base for Cultural and Linguistic Competency in Health Care
T. D. Goode, M. C. Dunne, and S. M. Bronheim

Does the provision of culturally competent health care affect patients' health outcomes? A review of the literature found scant research addressing this question, though a few promising studies found evidence that cultural and linguistic competence can affect physical and mental health outcomes. Further research is also needed to see whether culturally competent care could lead to more efficient care.[4]

Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care
J. R. Betancourt

This report draws connections between efforts to promote cultural competency care and efforts to achieve quality improvements throughout the health care system. Focusing on the Institute of Medicine's goals for a high-quality health system, the author shows how cultural competence is central to achieving them.[5]

The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality
M. C. Beach, S. Saha, and L. A. Cooper

Efforts to promote "patient-centered care" emphasize the need for providers to evaluate health care from the patient's perspective. Cultural competency considers how patients are treated by the health care system more generally, taking into account patient–provider relationships as well as broader issues such as language barriers and racism. According to this report, both approaches hold promise for improving the quality of health care for minority populations.[6]

Taking Cultural Competency from Theory to Action
E. Wu and M. Martinez

This report offers six principles for implementing cultural competency initiatives. The researchers offer best practices and important lessons in the implementation of cultural competency initiatives, drawn from interviews with providers in the field.[7]

Looking Ahead

In the coming year, the Program on Quality of Care for Underserved Populations expects to see results from several important projects. For example, a research team led by Robert Weech-Maldonado, Ph.D., an associate professor at the University of Florida in Gainesville, is investigating whether the implementation of U.S. Office of Minority Health national standards for culturally and linguistically appropriate services (CLAS) actually improves minority patients' care. Using several data sources, Weech-Maldonado is evaluating whether patients in hospitals that adhere to the CLAS standards have better experiences in terms of communication with doctors and nurses, staff responsiveness, pain control, and other measures.

The Fund is also providing support to the National Quality Forum to produce a nationally accepted set of voluntary standards for measuring and reporting on cultural competence in the delivery of health care. Once that is achieved, the project team will develop performance measures based on these consensus standards.

Through these projects and others, the Program on Quality of Care for Underserved Populations will continue its support of cutting-edge research that addresses the health care challenges facing many economically disadvantaged and minority Americans.

The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: 2007–2008 Fellows

Addressing pervasive racial and ethnic disparities in health and health care requires trained, dedicated physician leaders who can promote policies and practices that improve minority Americans' access to high-quality medical care. The 12-year-old Fellowship in Minority Health Policy program has played an important role in addressing this need. During the year-long fellowship, physicians undertake intensive study in health policy, public health, and management, all with an emphasis on minority health policy issues. Fellows also participate in leadership forums and seminar series conducted by senior Harvard University faculty and nationally recognized leaders in minority health and public policy, and have supervised practicums and "shadowing" opportunities.

Since 1996, 73 fellows (including 14 supported by the California Endowment and three supported by Delta Dental) have completed the program and received a master's degree in public health or public administration from Harvard. The following five fellows make up the class of 2007–08.

- **Constance Gistand, M.D.,** is a hospitalist at West Jefferson Medical Center in Marrero, La., and an assistant professor of medicine at Tulane University Health Sciences School of Medicine. The Louisiana native has long been involved with community-based projects, ranging from voter registration drives to outreach programs for the homeless. Since Hurricane Katrina, Dr. Gistand has focused on Louisiana's health care crisis and rebuilding efforts. Dr. Gistand received her medical degree from the University of Iowa in 1996 and completed her internal medicine residency at the Ochsner Foundation Hospital, New Orleans, in 2001.

- **Keila Lopez, M.D.,** is pediatric chief resident at the University of Chicago Comer Children's Hospital. As a 1999 Dean's Summer Research Fellowship recipient, Dr. Lopez studied the discrepancy in health care for women in public hospitals, compared with private hospitals, in different Brazilian urban centers. As a 2002 Josiah Macy Jr. Foundation Substance Abuse Fellow, she worked at the University of Pennsylvania with health care professionals specializing in treating HIV patients with substance abuse. Her work with the National Hispanic Medical Association resulted in her receiving a National Institutes of Health travel award. Dr. Lopez received her medical degree from Rush Medical College in 2003 and completed her pediatric residency at the University of Chicago in 2006. She begins a pediatric cardiology fellowship at Baylor Texas Children's Hospital in 2008.

- **Audra Robertson, M.D.,** completed a residency in obstetrics and gynecology at Brigham and Women's Hospital in Boston in June 2007. Her interests include assisted reproductive technology and improving access to such technology for all women, regardless of income. She chaired the Massachusetts General Hospital Organization for Minority Residents and was named president of her class in 2003. In 2005, Dr. Robertson received the Harvard Medical School Excellence in Resident Teaching Award. Dr. Robertson received her medical degree from the University of Texas Health Science Center in 2003.

- **Judith Steinberg, M.D.,** is an assistant clinical professor of medicine at Boston University School of Medicine and an attending physician in the Division of Infectious Diseases at Boston Medical Center. She is also the medical director of Neponset Health Center in Boston. After completing a clinical fellowship in medicine at Beth Israel Hospital, Brigham and Women's Hospital, and Dana Farber Cancer Institute, Dr. Steinberg joined the faculty at Boston University School of Medicine, where she focused on HIV/AIDS and other sexually transmitted diseases. Her major research interests lie in community-based

- health care delivery models for patients with chronic diseases. Dr. Steinberg received her medical degree from the University of Texas at Dallas Southwestern Medical School in 1982, and completed her residency in Internal Medicine at Beth Israel Hospital, Boston, in 1985.

- **Mallory Williams, M.D.,** is a fellow in surgical critical care at Brigham and Women's Hospital/Massachusetts General Hospital, in Boston. He is also a major in the U.S. Army Reserve Medical Corps. From 2003 to 2005, Dr. Williams was a research fellow through a National Institutes of Health training grant in trauma and burns at Wayne State University/Detroit Medical Center. His record of community service includes work on behalf of the National Urban League, the NAACP, the Maryland and Michigan State Special Olympics, and various police and firefighter organizations. He is interested in moving into the health policy arena, with a focus on improving the health of vulnerable populations. Dr. Williams received his medical degree from the University of Maryland School of Medicine, Baltimore, in 1999, and completed his surgical residency at Wayne State University/Detroit Medical Center in 2006.

Notes

[1] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007)

[2] R. Hasnain-Wynia, D.W. Baker, D. Nerenz et al., "Disparities in Health Care Are Driven by Where Minority Patients Seek Care," *Archives of Internal Medicine,* June 25, 2007 167(12):1233–39.

[3] Q. Ngo-Metzger, J. Telfair, D. H. Sorkin et al., *Cultural Competency and Quality of Care: Obtaining the Patient's Perspective* (New York: The Commonwealth Fund, Oct. 2006).

[4] T. D. Goode, M. C. Dunne, and S. M. Bronheim, *The Evidence Base for Cultural and Linguistic Competency in Health Care* (New York: The Commonwealth Fund, Oct. 2006).

[5] J. R. Betancourt, *Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care* (New York: The Commonwealth Fund, Oct. 2006).

[6] M. C. Beach, S. Saha, and L. A. Cooper, *The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality* (New York: The Commonwealth Fund, Oct. 2006).

[7] E. Wu and M. Martinez, *Taking Cultural Competency from Theory to Action* (New York: The Commonwealth Fund, Oct. 2006).

Program on Child Development and Preventive Care

Edward L. Schor, M.D.
Vice President

Children's success in school and later in life depends on their early experiences and the ability of their parents and caretakers to anticipate and meet their developmental needs. Through their regular contact with parents and young children, child health care providers have a unique opportunity to foster positive parenting behaviors, promote optimal development, and initiate early intervention when problems appear imminent.

Yet in the United States, the quality of pediatric preventive care—commonly referred to as well-child care—is highly variable. Despite the commitment of considerable resources by physicians and other child health professionals, many children and their families do not get the care they need. Pediatricians themselves say there are several obstacles, including time constraints, inadequate reimbursement, lack of training in child development, limited access to community support services for patients, and few external incentives.

Addressing developmental needs early in life is essential fo ensuring children are prepared when they enter school.

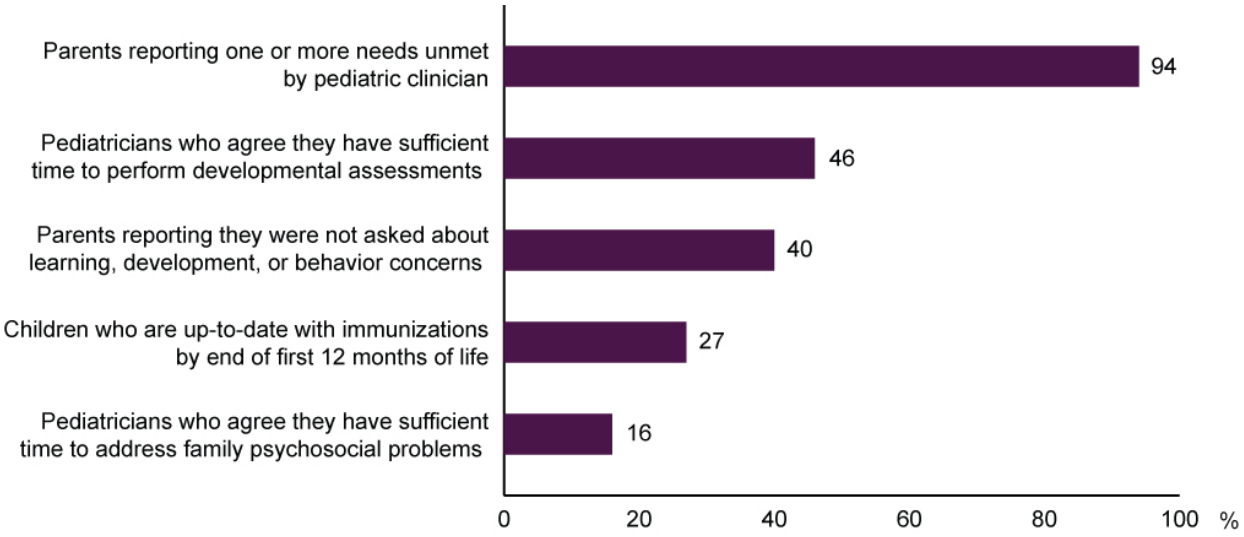
The Commonwealth Fund's Child Development and Preventive Care Program seeks to encourage, support, and sustain improvements in preventive care for young children—particularly services focused on their cognitive, emotional, and social development. It does so by:

- promoting the establishment of standards of care and use of these standards in quality measurement and monitoring;

- identifying and disseminating models of pediatric practice that enhance the efficiency and effectiveness of care provided; and
- encouraging reforms that would remove barriers to delivering quality care and align incentives with desired clinical practices.

In fiscal year 2007, Fund grantees reported progress in several projects designed to strengthen preventive and developmental care.

The State of Well-Child Care: A Snapshot



Source: Multiple studies, cited in E. L. Schor, "Rethinking Well-Child Care," *Pediatrics*, July 2004 114(1):210–16.

Integrating Basic Science into Clinical Practice

Thanks to functional imaging, genetic research, and behavioral studies, our knowledge of how children's development influences their health and functioning continues to expand. Now the challenge becomes: How do we relay that information to the pediatricians of today and tomorrow?

Commonwealth Fund support enabled pediatric chairs from four medical schools to grapple with this question. They shared their conclusions in an article published in the *Archives of Pediatrics and Adolescent Medicine* and in a presentation at the plenary session of the 2006 annual meeting of the Association of Medical School Pediatric Department Chairs.[1] To train future generations of pediatricians, they suggest a case analysis approach, whereby medical students would take into account children's physiologic and psychological development in their clinical decision-making. .

With continued Fund support, representatives from 11 medical schools then developed the Integrating Basic Sciences into Clinical Teaching Initiative. The core goal of the initiative is to develop 30 case studies that ask medical students to consider the following:

- Why did the illness or condition strike this child at this particular time?
- What could have been done to prevent it?
- Does the illness change the risk for subsequent generations?
- How will the family cope?
- What skills does the pediatrician need to help the parents and patient?
- Does this change future care for the patient and family?

The Science of Children's Development: A Curriculum for Pediatric Residency Education

Goal: To develop clinical cases that emphasize how an understanding of a child's physiologic and psychological development should influence clinical decision-making and care.

Award amount: $23,175 (in partnership with the Josiah Macy, Jr. Foundation)

Timeframe: 7/1/06–6/30/08

Lead investigators: Jeff Clark, M.D., and Bonita Stanton, M.D., Wayne State University

For more information: Contact Dr. Clark at jclark@med.wayne.edu.

"When I teach residents, I find that their approach [to diagnosis and care] is much more haphazard and much less based on the child's underlying physiology than it should be," said project co-investigator Jeff Clark, M.D., an assistant professor of pediatrics at Wayne State University School of Medicine.

So far, case studies have been tested at seven institutions. When medical residents were asked to rate the value of their various educational activities, the initiative's teaching ranked first.

Engaging Pediatric Nurse Practitioners

Providing high-quality preventive and developmental services requires a team effort, with pediatric nurse practitioners playing a key role. Pediatric nurse practitioners provide a substantial proportion of care for young children and often maintain strong relationships with parents. Yet there is evidence that training programs are not adequately preparing nurse practitioners to identify and address children's developmental issues, particularly those related to behavioral and mental health.

Preparing Pediatric Nurse Practitioners to Assess, Manage, and Prevent Current Morbidities of Childhood

Goal: This project will engage leaders in pediatric nurse practitioner education in the development, implementation, and evaluation of a new prevention curriculum for child development and behavior.

Award amount: $258,907

Timeframe: 9/1/04–8/31/07

Lead investigator: Bernadette Mazurek Melnyk, M.S.N., Ph.D., dean and professor in nursing, Arizona State University College of Nursing and Healthcare Innovation

For more information: Contact Dr. Melnyk at bernadette.melnyk@asu.edu.

"The existing curriculum has been very comprehensive in preparing high-quality pediatric nurse practitioners, but behavioral and mental health has always been a weak area," said lead investigator Bernadette Mazurek Melnyk, M.S.N., Ph.D. "A lot of faculty don't have the in-depth skills they need to teach this type of content and make sure it is integrated throughout the program." Melnyk says that as many as one of four children and adolescents suffers from a behavioral or mental health condition, yet fewer than 30 percent of children at risk receive the treatment they require.

Bernadette Mazurek Melnyk
Arizona State University

The Commonwealth Fund supported the creation of a comprehensive curriculum to prepare pediatric nurse practitioners to provide high-quality developmental and preventive care.

Using the Web to Reach Pediatric Providers

Major depression affects one of 10 mothers, as well as many fathers, during their child-rearing years. Pediatric health providers have the opportunity to detect parental depression and help families find support. To enhance professionals' knowledge about parental depression, The Commonwealth Fund supported a continuing education web conference, "Screening for Maternal Depression: An Opportunity for Providers of Pediatric Healthcare," developed by the Clinicians Enhancing Child Health Network at Dartmouth Medical School and hosted by Medscape. More than 17,000 physicians and other health care professionals have viewed the program, and 6,060 had received educational credits for completing a related test.

Another webcast, "Child Behavior Screening in Primary Care," presented in cooperation with the American Academy of Pediatrics and the National Association of Pediatric Nurse Practitioners, has been viewed by 18,000 health care professionals, with nearly 6,000 earning continuing medical education credits. In both cases, 85 percent of viewers said that what they learned in the webcasts would influence how they practiced.

Rethinking Well-Child Care

It has been 40 years since the last substantial revision of national recommendations for well-child care. In the intervening years, there have been great advances in our knowledge of children's health and development as well as significant changes in the needs of children and families. The American Academy of Pediatrics' recommendations for preventive pediatric health care—also known as the "periodicity schedule" for well-child visits—is based mainly on immunization requirements, not on pediatrics' traditional holistic consideration of a child's health and development.

The Commonwealth Fund believes it is past time to rethink the provision and timing of well-child care. Since June 2005, the Fund has supported the efforts of J. Lane Tanner, M.D., based at the Children's Hospital at Oakland, and Martin Stein, M.D., based at the University of California, San Diego, in a major effort to inform the redesign of well-child care.

The need for an overhaul is abundantly clear. While well-child care accounts for one-fifth of an average pediatrician's patient contacts and more than half of all clinical visits for infants up to 12 months—as well as a substantial part of child health care expenditures—94 percent of U.S. parents report that their needs for guidance, education, or screening by pediatric clinicians are not met.

Rethinking Well-Child Care

Goal: To produce new recommendations for the content and scheduling of well-child care.

Award amount: $332,939

Timeframe: 6/1/05–5/31/07

Lead investigators: J. Lane Tanner, M.D., associate director of the Division of Developmental and Behavioral Pediatrics at Children's Hospital and Research Center Oakland, Martin Stein, M.D., professor of pediatrics at the University of California at San Diego, and Lynn Olson, Ph.D., co-director of the American Academy of Pediatrics' Department of Practice and Research

For more information: Contact Dr. Tanner at LTanner@mail.cho.org.

In addition, there are missed opportunities to assess children's development and intervene early when problems are evident. In one study, only 57 percent of parents said their child's development had ever been assessed during a pediatric visit. And children attend only about 60 percent of the recommended well-child visits, even when there are no financial barriers to doing so.

J. Lane Tanner, M.D.
Children's Hospital and Research Center Oakland

As part of their project, Tanner and Stein interviewed national child health care leaders, child development experts, practitioners, and parents; conducted a series of focus groups around the country with pediatricians as well parents; and reached out to influential child health organizations. They identified several important issues for consideration in drafting new guidelines for well-child care, including:

- the need to individualize care and establish relationships with children and their families;
- the importance of using developmental screening tools and a uniform, structured format for the content, goals, and conduct of the well-child visit; and
- the need to delineate the roles of physicians and other community resources.

> *"Despite its importance, the current periodicity schedule for well-child care has become anachronistic and, like its predecessors, it is not a scientific document."*
>
> —Commonwealth Fund vice president Edward L. Schor, M.D.

Tanner and Stein have been presenting their findings to professional audiences around the country, and they will be conducting a workshop at the annual meeting of the Pediatric Academic Societies in the spring of 2008.

Promoting Healthy Development

To help practices meet new standards of well-child care and developmental services, we need data about their performance. Since 1998, The Commonwealth Fund has supported the creation, testing, and implementation of the Promoting Healthy Development Survey—the only measure of health care focused exclusively on the content and quality of preventive and developmental services for young children. Most recently, Fund support enabled the survey to be administered and scored online, and it helped in efforts to promote use of the survey among national organizations, state health policy officials, health plans, and health care providers.

The Promoting Healthy Development Survey, which is completed by parents of children ages 3 to 48 months, gauges the quality of preventive and developmental services by focusing on:

- the anticipatory guidance and parental education given by a doctor or other provider;
- the provision of health information;
- the assessment of parental health and well-being, safety issues (e.g., smoking or drug and alcohol use in the family), parental concerns;
- follow-up with children who are at risk for developmental, behavioral, or social delays;
- family-centered care that promotes trust and partnerships with parents; and
- the helpfulness and effectiveness of care provided.

Individual state agencies and health care organizations have used results from the survey to modify health care delivery. A few examples:

- Maine's Medicaid agency modified its contracts with pediatric providers to encourage screening for child development and maternal depression as a result of survey data.
- Washington State launched a learning collaborative to improve well-child services.
- Kaiser Permanent Northwest strengthened online pre-visit assessment tools and educational materials for providers and parents.

Expanding the Use of the Promoting Healthy Development Survey

Goal: To develop the tools to administer, complete, and score the Promoting Healthy Development Survey on the Web and implement a strategic plan to disseminate the survey to national organizations, state health policy officials, health plans, and health care providers.

Award amount: $324,768

Timeframe: 8/1/06–7/31/08

Lead investigator: Christina Bethell, Ph.D., associate professor/founding director,

The Child and Adolescent Health Measurement Initiative, Oregon Health and Science University

For more information: Contact Dr. Bethell at bethellc@ohsu.edu.

In July 2007, the National Quality Forum (NQF), which is charged with implementing a national strategy to improve health care measurement, endorsed the Promoting Healthy Development Survey as a valid and reliable tool to assess parents' experiences in pediatric ambulatory care settings. Because NQF endorsement is widely considered the "gold standard" for health care performance measurement in the United States, it is expected to boost Fund-supported efforts to spur broader use of the survey for measuring the quality of child development and preventive care services and identifying areas for improvement.

Assuring Better Child Health and Development: Working with States

Since 2000, The Commonwealth Fund has worked with a number of state Medicaid agencies through its Assuring Better Child Health and Development (ABCD) initiative to test innovations in service delivery and financing of care for low-income children. The models and policies developed through ABCD are now serving as a roadmap for states around the nation.[2]

In 2004, the Fund supported a five-state learning collaborative, led by Neva Kaye of the National Academy for State Health Policy, that explored ways to improve care for young children at risk for or with emotional or behavioral problems. Research suggests that many such disorders can be avoided or ameliorated through screening, preventive services, and intervention. Yet many problems go unrecognized, and many others are not treated as early or as effectively as they could be.

Minnesota, one of the participating states, aimed to expand healthy mental development screenings for young children and to train pediatric practices to better address and promote healthy mental development. Since then, the state has made considerable progress, including:

Neva Kaye
National Academy for State Health Policy

- implementing pay-for-performance incentives for standardized developmental and behavioral health screening through the managed care plans that contract with Medicaid;
- updating its Early and Periodic Screening, Diagnosis, and Treatment Program training manual to better address children's mental health, and conducting continuing medical education training;
- reviewing and recommending developmental screening instruments;
- collaborating with Head Start and Early Head Start, publicly funded programs that have begun to target children's mental development;
- testing the use of handheld computers in order to reduce the time required for developmental screening;
- implementing a new benefit under the Medicaid program for children diagnosed with an emotional disturbance; and
- adopting a diagnostic classification to describe developmental and relational disorders among infants and young children and training mental health providers on its use.

In August 2006, the Fund launched the ABCD Screening Academy to extend such learning and innovation. In the Screening Academy, 21 states, along with Puerto Rico and the District of Columbia, are learning about proven strategies for strengthening developmental services and receiving technical assistance in ways to integrate valid and standardized screening tools into preventive health care practice.

Building State Medicaid Capacity to Support Children's Healthy Mental Development

Goal: To engage leaders in pediatric nurse practitioner education in the development, implementation, and evaluation of a new prevention curriculum for child development and behavior.

Award amount: $313,249

Timeframe: 8/1/04–7/31/05

Lead investigator: Neva Kaye, Center for Health Policy Development, National Academy for State Health Policy

For more information: Contact Ms. Kaye at nkaye@nashp.org

Participants in an ABCD Screening Academy learning session, held in July 2007 in Houston, Tex., for Medicaid officials, child health care providers, and others.

Looking Ahead

In the coming year, the Child Development and Preventive Care program will continue to promote the adoption of structured developmental screening as a standard of care in child health care practices. Since the identification of developmental concerns should be followed by more extensive assessment and appropriate intervention, the program also will explore opportunities to facilitate children's receipt of these services through care coordination and by linking practices to other community service providers.

Efficiently providing developmental services will require further innovation in the organization and provision of children's care, which the program hopes to identify and support. Another priority will be to inform policymakers about the contributions child health providers make to children's developmental outcomes.

Notes

[1] A. Friedman, E. Schor, B. Stanton et al., "Returning to the Basics: A New Era in Pediatric Education," *Archives of Pediatrics and Adolescent Medicine*, May 2006 160(5):466–7.

[2] N. Kaye, J. May, and M. Abrams, *State Policy Options to Improve Delivery of Child Development Services: Strategies from the Eight ABCD States* (National Academy for State Health Policy and The Commonwealth Fund, Dec. 2006.

2006 Annual Report

Picker/Commonwealth Program on Quality of Care for Frail Elders

Mary Jane Koren, M.D.
Assistant Vice President

The Picker/Commonwealth Fund Program on Quality of Care for Frail Elders aims to improve the quality of nursing home care across the United States. It does so by:

- identifying, testing, and disseminating effective models of "resident-centered" care, or care that is provided according to the needs and desires of residents; and
- supporting policy initiatives that promote resident-centered care.

As baby boomers age and the number of older Americans grows, care for the elderly—particularly those residing in nursing homes or assisted living facilities—is becoming an area of personal interest for more and more families.

Supporting efforts to make nursing homes comfortable, welcoming places to live is a primary goal of the Picker/Commonwealth Program on Quality of Care for Frail Elders.

The Nursing Home Reform Act of 1987 tightened regulation of nursing homes in response to evidence of substandard care and neglect, and there have been some improvements since then. Still, there are serious deficiencies at the nation's 16,000 nursing homes, exacerbated by chronic staff shortages and high turnover. The reform legislation established statutory rights for residents, including the right to privacy, dignity, and self-determination. Some advocates argue that in order to deliver on this promise, nursing homes need "culture change"—moving from hospital-like institutions with rigid routines to places that accommodate residents'

preferences and interests as well as their physical needs. In other words, they should provide a good quality of life as well as good medical care.

In 2007, Fund-supported research documented disturbing evidence of racial disparities in the quality of nursing home care. Fund work also pointed to potential models of nursing home improvement. One study provided conclusive evidence of the benefits of small, resident-centered nursing homes, while another explored a new payment mechanism for long-term care that would link reimbursement to quality of care and efficiency. The Fund also continued its support of the Pioneer Network, a national coalition dedicated to encouraging grassroots efforts to improve the nation's nursing homes.

Identifying Racial Disparities in Nursing Home Care

Examining Racial Concentration and Disparities in Nursing Home Quality of Care

Goal: This project examined racial and ethnic segregation in U.S. nursing homes and evaluated its impact on quality of care.

Award amount: $121,917

Timeframe: 7/1/05–12/31/06

Lead investigators: Vincent Mor, Ph.D., Brown University, and David Barton Smith, Ph.D., Temple University

For more information: Contact Dr. Mor at vincent_mor@brown.edu, or Dr. Smith at dbsmith@temple.edu.

In the past several years, research has documented the effects of racial segregation on access to good-quality hospital and primary care. With Fund support, Temple University's David Barton Smith, Ph.D., looked at how racial segregation affects care in the nation's nursing homes. His evaluation, published in the journal *Health Affairs*, found that blacks were much more likely than whites to live in nursing homes with serious deficiencies on inspections, lower staff-to-resident ratios, and greater financial vulnerability.[1] The analysis took into account 7,196 nursing homes and their 837,810 residents, representing more than half of all U.S. nursing home residents. It found that 10 of the 20 nursing homes with the greatest racial disparities were located in just four states: Wisconsin, Indiana, Ohio, and Michigan.

To ensure access to high-quality care for all residents, the researchers recommended the following policy changes:

- increasing payments to nursing homes with a high proportion of Medicaid residents;
- closing the gap between the amounts paid to nursing homes by Medicaid and private payers;
- initiating regional planning to respond to quality problems; and
- monitoring admissions practices to ensure they meet the requirements of the Civil Rights Act.

Changing the Culture of Nursing Homes

Since its inception a decade ago, the nonprofit Pioneer Network has promoted nursing home culture change, providing information and resources to nursing home quality improvement organizations, providers, and researchers. Fund support during the past fiscal year has enabled

the Pioneer Network to host a workshop on coalition-building for representatives from 28 statewide nursing home reform coalitions. Such coalitions continue to grow and look to the Pioneer Network for leadership.

In addition, the Pioneer Network created videos to educate consumers about resident-centered nursing home care and engage them in reform and advocacy efforts. One of the videos will be used as part of the "National Medical Report" series, which is distributed to public television stations around the country. Another video will be disseminated via e-mail, along with the *Consumer Guide to Resident-Centered Care*, to over 1 million AARP members.

Bonnie Kantor, Sc.D.
Executive Director
Pioneer Network

In addition, the Pioneer Network added several new tools to its Web site, including:

- video clips demonstrating innovative models of nursing home care as well stories from the field;
- interactive tools to teach consumers and nursing home providers about resident-centered care; and
- a collaborative blog about nursing home transformation.

Innovative ideas for nursing home reform developed by the Pioneer Network and other trailblazers are being put into practice by the Mississippi-based Green House Project, which is seeking to "deinstitutionalize" nursing home care.

Supporting the Nursing Home Culture Change Movement

Goal: This grant will enable the Pioneer Network to meet the demand for resources and information on nursing home culture change from quality improvement organizations, providers, researchers, and others.

Award amount: $159,784

Timeframe: 7/1/06–6/30/07

Lead investigator: Bonnie Kantor, Sc.D., executive director, Pioneer Network

For more information: Visit www.pioneernetwork.net or contact Dr. Cantor at bonnie.kantor@pioneernetwork.net.

Green Houses are small dwellings, housing up to 10 residents who require long-term care. The homes have private bedrooms and bathrooms clustered around shared living rooms, dining rooms, and kitchens. Instead of hospital-like features such as medication carts, public address systems, and nurses' stations, necessary medical features are built into the Green House design. Residents, with support from certified nursing assistants, make daily decisions about their lives and care. Professional services such as medical therapies and social work are provided by clinical teams, which visit at scheduled times—as if they were making home visits.

With support from the Fund, Rosalie A. Kane, Ph.D., of the University of Minnesota School of Public Health, evaluated whether Green Houses are delivering on their promise to improve residents' quality of life while still ensuring their health and safety. Her analysis compared health outcomes and measures of quality of life, including physical comfort, privacy,

autonomy, and ability to engage in meaningful activities, among residents of four Green Houses built by Cedars Health Care Center in Tupelo, Miss., and residents at two conventional nursing homes nearby. The analysis, published in the *Journal of the American Geriatrics Society*, found that Green House residents experienced a better quality of life—with the same or better quality of care than those in the conventional homes.[2]

Nursing homes that have undergone culture change provide their residents with opportunities to engage in an array of physical, intellectual, and social activities.

Kane's analysis found no statistically significant differences across the facilities in terms of residents' self-reported health status or their ability to perform various activities. What's more, compared with residents at one of the conventional nursing homes, Green House residents scored much higher on measures of their emotional well-being, such as happiness and ability to look forward to the future. Compared with residents at both of the conventional nursing homes, Green House residents expressed greater satisfaction with their institution and were more likely to recommend their facility to others.

Evaluation of Small Group Homes for Nursing Home Residents

Goal: To investigate the operational, financial, and regulatory issues associated with the design of small group homes and assess their impact on nursing home residents and staff.

Award amount: $259,997

Timeframe: 8/1/03–7/31/06

Lead investigator: Rosalie Kane, Ph.D., Division of Health Policy and Management, University of Minnesota

For more information: See *Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program* or contact Rosalie Kane at kanex002@umn.edu.

"They came and asked me what kind of curtains I wanted. They asked what I wanted painted. I like the independence—I do anything I want to and have most anything I want."

—Green House resident, Tupelo, Miss.

With support from The Commonwealth Fund, Kane is exploring the impact on costs, operations, and residents' care and quality of life of Cedars Health Care Center's decision to convert to all Green House units. This analysis will inform the next wave of Green Houses being planned across the country.

Using Incentives to Reduce Hospitalizations and Enhance Quality for Nursing Home Residents in New York State

Goal: To study the relationship among hospitalizations, availability of clinical resources in nursing homes, and costs and then design a new payment model that rewards good management of at-risk or acutely ill residents.

Award amount: $395,848

Timeframe: 8/1/05–7/31/07

Lead investigator: Nancy R. Barhydt, Dr.P.H., R.N., director of clinical affairs, New York State Department of Health/Health Research

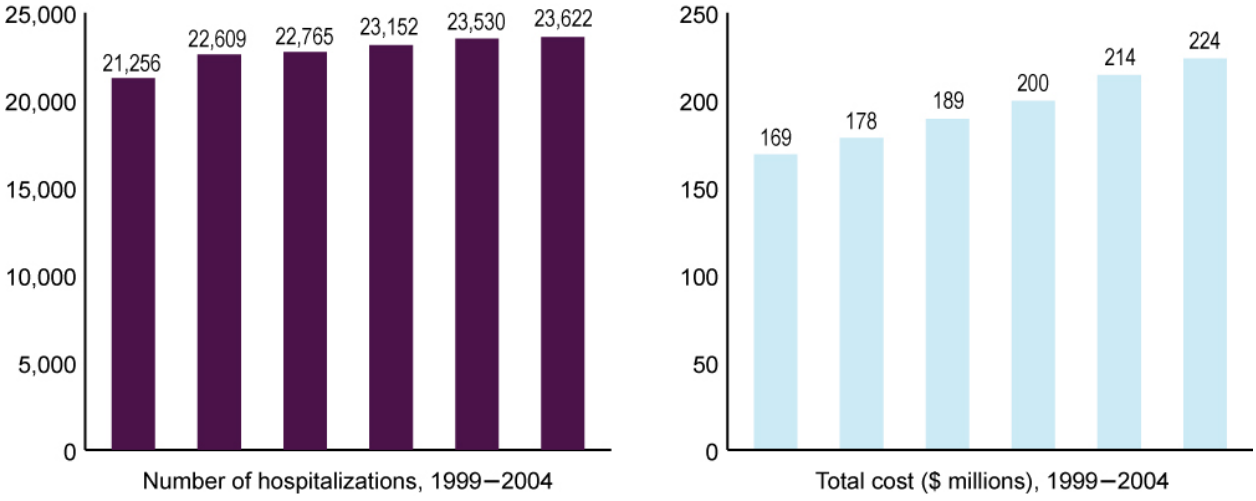
For more information: See *The Costs and Potential Savings Associated with Nursing Home Hospitalizations* or contact Dr. Barhydt at nrb01@health.states.ny.us.

Payment Reform for Better Performance

There is a well-worn path between nursing homes and hospitals and back to nursing homes. Within any given six-month period, 15 percent of nursing home residents are hospitalized. Research suggests that 40 percent of these hospitalizations could have been avoided if nursing homes were able to identify and treat incipient illnesses early and provide the necessary care for residents who become sick. Not only are hospitalizations expensive, but they also put elderly adults at risk of iatrogenic illness and dementia.

A Commonwealth Fund–supported study published in *Health Affairs* merged hospital and nursing home administrative files from New York State to show that spending on nursing home hospitalizations increased 29 percent from 1999 through 2004, reaching $972 million in 2004.[3] The researchers, from Harvard Medical School and the New York State Department of Health, concluded that a quarter of these costs were incurred for treatment of conditions such as pneumonia, kidney or urinary tract infections, and congestive heart failure that are considered to be amenable to medical care.

The number and cost of ambulatory–care sensitive nursing home hospitalizations in New York State have been increasing in recent years.



Source: D.G. Grabowski, A.J. O'Malley and N.R. Barhydt, "The Costs and Potential Savings Associated with Nursing Home Hospitalizations," Health Affairs, Nov./Dec. 2007 26(6): 1753-61.

The researchers are now designing a new reimbursement model that would reward nursing homes for managing at-risk or acutely ill patients. This could improve the quality and safety of nursing home care—and potentially yield substantial savings.

Although pay-for-performance strategies have taken hold in many areas of health care, they have yet to be embraced by the nursing home industry. The state of Minnesota has made an initial foray, with its legislature expressing interest in using financial incentives to promote high-quality, high-efficiency nursing home providers. The Fund supported Robert L. Kane, M.D., a University of Minnesota researcher, to explore the implications of the state's proposed payment system.

Exploring Performance-Based Payment Strategies for Nursing Home Care in Minnesota

Goal: The Minnesota legislature expressed interest in rewarding nursing home providers for high-quality, efficient care. This project developed models to help nursing homes and legislators estimate the financial benefits and costs of operating under a pay-for-performance system.

Award amount: $132,960

Timeframe: 12/1/04–11/30/05

Lead investigator: Robert L. Kane, M.D., University of Minnesota School of Public Health

For more information: See *Rewarding Quality in Nursing Homes* or contact Robert Kane at kanex001@umn.edu.

Writing in *The Gerontologist*, Kane and his colleagues note that quality-based payments must account for nursing homes' case mix—that is, the levels of acuity of their residents—while also providing financial incentives for them to deliver better, more efficient care.[4] His analysis explores the political and technical challenges that must be negotiated by stakeholders implementing this kind of pay-for-performance system for nursing homes.

Although Minnesota's nursing home industry has announced its support for the state's pay-for-performance approach, it has lobbied the legislature to delay its implementation until the technical details can be ironed out. For now, the state has enacted a simpler model involving a bonus payment of up to 3 percent of a nursing home's daily per-diem rate, depending on a facility's quality score.

Looking Forward

In the coming year, the Picker/Commonwealth Program on Quality of Care for Frail Elders will explore how use of health information technology in nursing homes could improve quality of care. A national survey will gauge the extent to which nursing homes currently use health information technology and explore whether providers are taking full advantage of such technology to improve care. Another project will examine the business case for health information technology in 15 nursing homes participating in a demonstration pilot program supported by New York State.

Over the next year, the Fund will continue to support initiatives to improve the experiences of nursing home residents—by helping to make nursing facilities better places to live, better places to receive care, and better places for caregivers to work. It is work the Fund believes is essential to creating a long-term care system of which America can be proud.

Notes

[1] D. B. Smith, Z. Feng, M. L. Fennell et al, "Separate and Unequal: Racial Segregation and Disparities in Quality Across U.S. Nursing Homes," *Health Affairs*, Sept./Oct. 2007 26(5):1448–58.

[2] R. A. Kane, T. Y. Lum, L. J. Cutler et al., "Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program," *Journal of the American Geriatric Society*, June 2007 55(6):832–39.

[3] D. C. Grabowski, A. J. O'Malley, and N. R. Barhydt, "The Costs and Potential Savings Associated with Nursing Home Hospitalizations," *Health Affairs*, Nov./Dec. 2007 26(6): 1753–61.

[4] R. L. Kane, G. Arling, C. Mueller et al., "A Quality-Based Payment Strategy for Nursing Home Care in Minnesota," *The Gerontologist*, Feb. 2007 47(1):108–15.

2007 Annual Report

International Program in Health Policy and Practice

Robin I. Osborn
Vice President

As the nation that spends more on health care than any other and yet receives proportionately less in return than most, the United States can learn a great deal from the experiences of other countries in providing their citizens with health insurance coverage and in delivering cost-effective, timely, quality health care.

Cross-national learning, sharing, and collaborating are the driving principles of The Commonwealth Fund's International Program in Health Policy and Practice. Specifically, the program's activities seek the following:

- to build an international network of health care researchers devoted to policy;
- to encourage comparative research and collaboration among industrialized nations; and
- to spark creative thinking about health policy through international exchanges.

In pursuit of these goals, the International Program highlights innovations in insurance coverage, health care delivery, and financing from which the U.S. might learn. Its most important activities include an annual international health care symposium, an annual multination survey on health policy issues, and the Harkness Fellowships program.

Health ministers, senior policy officials, and researchers shared ideas, strategies, and experiences at the Fund's 10th International Symposium on Health Care Policy. Flanked by Carolyn Clancy, director of the Agency for Healthcare Research and Quality, and Ab Klink, Dutch Minister of Health, Welfare and Sport, Canadian health minister Tony Clement comments on fundamental differences between the U.S. and Canadian health systems. To his left is founding *Health Affairs* editor John Iglehart, and in the background are Pete Hodgson and Ulla Schmidt, the New Zealand and German ministers of health.

2007 International Symposium

The Fund's 10th annual International Symposium on Health Care Policy, held in November 2007 in Washington D.C., brought together more than 70 policy experts to discuss topics around the theme, "Achieving a High Performance Health Care System: What Are the Policies and Practices to Get There?" Participants included health ministers, or their designates, from Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the U.S., as well as senior government officials and leading researchers from each country.

In his keynote address, New Zealand Minister of Health Pete Hodgson discussed in his keynote address the recent progress his country's health care system has made, highlighting reductions in health disparities, improvements in primary care access, and the implementation of quality measures. Lord Ara Darzi, Parliamentary Undersecretary of State for England's Department of Health, described in his remarks a vision for a high-performing National Health Service, stressing the importance of engaging patients and clinicians, investing in primary care services, and focusing on quality as the driving force behind the health system.

Other highlights from the 2007 symposium included:

- In the sixth John M. Eisenberg International Lecture Christine K. Cassel, M.D., president and CEO of the American Board of Internal Medicine, discussed the importance of redefining professionalism and physicians' roles in improving quality of care. Dr. Cassel singled out certification maintenance as a possible tool to engage physicians in quality improvement and to enhance public accountability.
- The assembled health ministers signed a letter of interest to collaborate on the "High Fives" Patient Safety Project, which aims to achieve measurable and sustained reduction in the occurrence of five patient safety problems over five years in seven countries.

- Karl Lauterbach, M.D., a member of the German Bundestag, shared new data from a three-year evaluation of the German Disease Management Programs that demonstrated striking improvements in the outcomes of care for patients with diabetes. Dr. Lauterbach attributed much of the improvements to his nation's emphasis on evidence-based clinical guidelines and targets.
- Researchers and policymakers from Canada, France, Germany, the U.K., and the U.S. shared innovative policies and practices to improve quality, access, cost-effectiveness

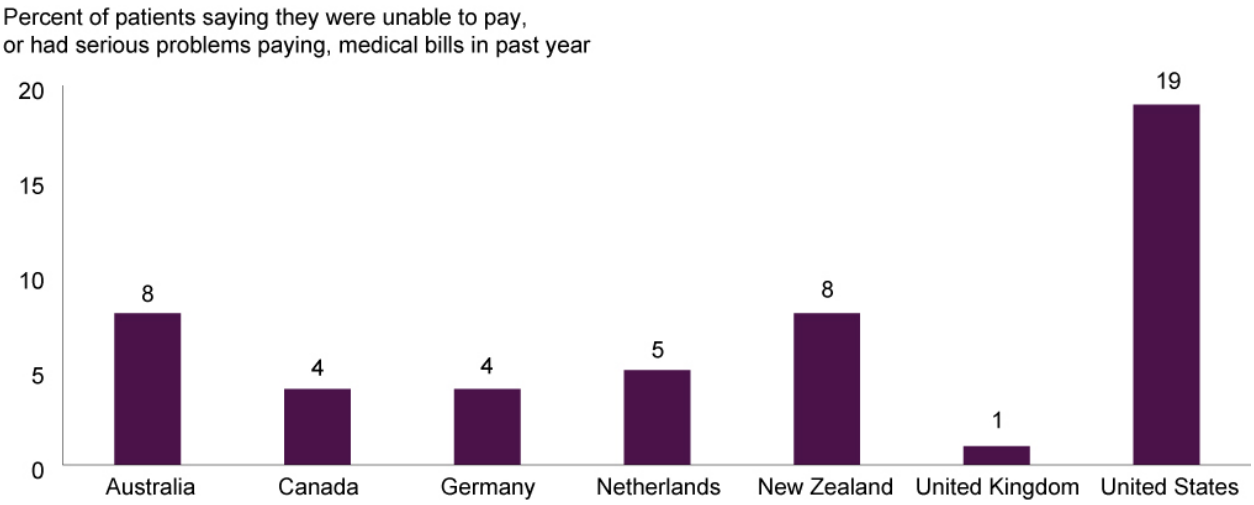
and patient experiences in cancer care, as well as the policy levers and drivers that improve cancer care performance.

International Health Policy Survey

According to the 2007 International Health Policy Survey, patients in the U.S. are more likely to experience medical errors, go without care because of costs, and believe that the health care system needs to be rebuilt completely than do their counterparts in Australia, Canada, Germany, the Netherlands, New Zealand, and the U.K. The 2007 survey results, which were published as a *Health Affairs* Web Exclusive, showed wide country differences in primary care access and affordability, care coordination, and patient safety.[1]

As in past surveys, the U.S. stood out for the cost-related barriers to care and the burden of medical bills reported by patients. Nineteen percent of U.S. adults said they had serious problems paying their medical bills, or were unable to pay them, in the past year, compared with 1 to 8 percent of adults in the other six countries.

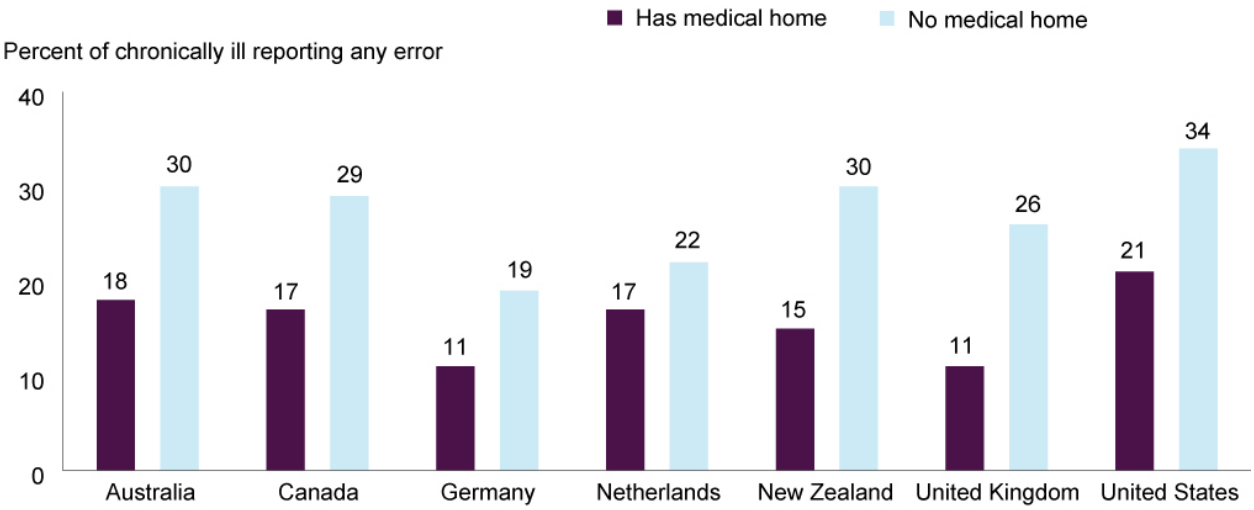
Adults in the U.S. are more likely than those in other countries to report difficulty paying their medical bills.



Source: 2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.

The survey also introduced a new indicator of those patients who have a "medical home"—a regular source of care that has a patient's updated medical history, is accessible, and helps coordinate care from other providers. The findings showed that having a medical home is associated with lower rates of patient-reported medical errors, less difficulty getting care after-hours and on weekends, and better care coordination, patient-doctor communication, and overall ratings of quality of care. Although nearly all respondents placed a high value on having a medical home, only 45 to 61 percent of adults in the seven countries actually had such a place of care.

People with chronic illness who do not have a medical home are more likely to experience an error in their care



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care. Errors include medical mistake, wrong dose/medication or lab test error.
Source: 2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.

International Meeting on Quality of Health Care

In the world's most advanced nations, a growing proportion of older adults also means a growing prevalence of chronic illness. Improving care for people with chronic disease was the theme of the eighth International Meeting on Quality of Health Care, held jointly by The Commonwealth Fund and the U.K.'s Nuffield Trust. Senior policymakers and health care researchers from the U.S. and U.K. participated in a dynamic exchange of policy ideas for making better use of electronic medical records and other technology to improve care coordination, safety, and efficiency. The participants also discussed ways to improve transitional care for the chronically ill and design effective incentives to promote better care coordination.

The Fund's International Work Garners Wide Attention

Findings from the Commonwealth Fund report *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care* (May 2007) were reported in *The Economist*, *Newsweek*, the *New York Times*, and the *Los Angeles Times*; former U.K. Prime Minister Tony Blair referenced the report during a speech before Parliament. In addition, the Fund's 2007 International Health Policy Survey was covered by the *Washington Post*, *U.S. News & World Report,* and BBC News, and was the subject of a *New York Times* editorial.

Harkness Fellows in Health Care Policy and Practice

Aimed at developing promising health care policy researchers and practitioners in Australia, Germany, New Zealand, the U.K., and, beginning in 2008, the Netherlands, the Harkness Fellowships provide a unique opportunity for individuals to spend up to a year in the U.S.

conducting a policy-oriented research study, gaining firsthand exposure to different models of health care delivery, and working with leading policy experts.

This year brought two high-profile additions to the Harkness Fellowship program. In addition to two German Harkness Fellowships supported by the Fund and the Robert Bosch Foundation, the program announced a new partnership with the B. Braun Foundation to provide support for a third fellowship that aims to advance nursing science and encourage the next generation of leaders in nursing policy. The Commonwealth Fund also announced the launch of a Dutch Harkness Fellowship program, which will begin with the 2008-09 class.

The work undertaken by Harkness Fellows has been influential in the worlds of policy as well as practice. For example, a *New England of Journal Medicine* study coauthored by former fellows Russell L. Gruen, M.D., Ph.D., of the University of Melbourne, James Mountford, M.D., of the Institute for Health Policy at Massachusetts General Hospital, and others documented the often close links between physicians and the pharmaceutical, medical device, and other medically related industries. In fact, 94 percent of physicians in the U.S. were found to have some type of relationship with the pharmaceutical industry—from receiving drug samples or food in the workplace, to being reimbursed for professional meetings, to receiving consulting fees.[2]

Vidhya Alakeson, a 2006–07 Harkness Fellow, undertook an evaluation of the Medicaid cash-for-counseling program, which gives patients a budgetary allowance to purchase services that best meet their needs in long-term community care and mental health. At the invitation of her placement organization, the Office of the Assistant Secretary for Planning and Evaluation, Alakeson extended her fellowship stay to develop a cash-for-counseling toolkit for states based on her findings.

Fellows' Influence Abroad

Harkness Fellows' work also informs health policy outside the U.S. In a *Health Affairs* article, a group of former fellows led by Sharon Willcox, director of Health Policy Solutions in Victoria, Australia, compared patient waiting-time reduction strategies used in Australia, Canada, England, New Zealand, and Wales. All five countries have employed supply-side strategies, like funding increases in hospital capacity and staff. But overall, the study concluded that England achieved the most sustained improvement in reducing waiting times, due to "major funding boosts, ambitious wait-time targets, and a rigorous performance management system." Willcox's coauthors were Mary Seddon, Stephen Dunn, Ph.D., Rhiannon Tudor Edwards, James Pearse, and Jack V. Tu, M.D., Ph.D.

The 2007–08 Harkness Fellows in Health Care Policy and Practice are:

Kalipso Chalkidou, M.D., Ph.D. (United Kingdom)
Associate Director for Research and Development, National Institute for Health and Clinical Excellence
Project: *Paying for Value: Coverage of New Technologies in the Context of Prospective Evidence Collection*
Placement: Johns Hopkins University, Bloomberg School of Public Health and Center for Medical Technology Policy
Mentors: Gerard Anderson, Ph.D., and Sean Tunis, M.D.

Andreas Gerber, M.D., Ph.D. (Germany)
Assistant Professor, Institute of Health Economics and Clinical Epidemiology, University of Cologne Medical School
Project: *Measuring Quality of Care in Pediatric Oncology*
Placement: Children's Hospital of Philadelphia
Mentor: Christopher Forrest, M.D., Ph.D.

Richard Gleave, M.Sc. (United Kingdom)
Harkness/Health Foundation Fellow
Performance Director, Department of Health
Project: *Performance Improvement in Managed Care Organizations and Health Plans: Measuring and Delivering Added Value and Improved Care*
Placement: Kaiser Permanente
Mentors: Robert Crane and Louise Liang, M.D.

Peter Hockey, M.B.B.Ch, M.D., F.R.C.P. (United Kingdom)
Harkness/Health Foundation Fellow
Medical Director and Consultant Physician, Unscheduled Care Division, Lymington Hospital
Project: *The Effect of Organizational Culture on Patient Safety*
Placement: Harvard School of Public Health and Institute for Healthcare Improvement
Mentors: David Bates, M.D., and James Conway, M.S.

Geraint Lewis, M.A., M.B., B.Chir, M.Sc., M.R.C.P, M.F.P.H. (United Kingdom)
Policy Advisor, Cabinet Office
Project: *Predictive Risk Modeling for Vulnerable Populations: Implications for Improving Access, Quality, and Cost-Effectiveness*
Placement: New York University
Mentors: John Billings, J.D., and David Olds, Ph.D.

Neil McKinnon, Ph.D. (Canadian Associate)
Associate Professor and Associate Director for Research, College of Pharmacy, Dalhousie University
Project: *Impact of Canadian Drug Policies on Quality and Safety*

Ruth McDonald, Ph.D., M.Sc. (United Kingdom)
Research Fellow, National Primary Care Research and Development Centre, University of Manchester
Project: *Financial Incentives for Quality in Primary Health Care*
Placement: University of California, Berkeley
Mentor: Stephen Shortell, Ph.D.

Peter McNair, M.P.H. (Australia)
Senior Policy Analyst, Victoria Department of Human Services
Project: *Funding Incentives to Improve Patient Safety*
Placement: San Francisco General Hospital and University of California, San Francisco School of Medicine
Mentors: Andrew Bindman, M.D., and Harold S. Luft, Ph.D.

Shane Reti (Q.S.M.), M.B., Ch.B., M.Med.Sci. (New Zealand)
Senior Lecturer, Department of General Practice and Primary Health Care, University of Auckland
Project: *Patient Access to Personal Electronic Health Records*
Placement: Harvard Medical School
Mentors: Charles Safran, M.D., and Henry Feldman, M.D.

Claudia San Martin, Ph.D. (Canadian Associate)
Senior Researcher, Statistics Canada
Project: *Non-Need Determinants of Waiting Times*

Stephanie Stock, M.D., Ph.D. (Germany)
Harkness/Robert Bosch Foundation Fellow
Research Fellow, Institute of Health Economics and Clinical Epidemiology, University of Cologne Medical School
Project: *Impact of Organizational Characteristics on Selected Quality of Life Indicators in Long-Term Care Settings*
Placement: University of Pennsylvania School of Nursing
Mentor: Mary Naylor, Ph.D., FAAN, R.N.

Rhema Vaithianathan, Ph.D. (New Zealand)
Senior Lecturer, Department of Economics, University of Auckland
Project: *Designing a Value-Based Plan to Cover the Uninsured*
Placement: Harvard Medical School
Mentor: Michael Chernew, Ph.D.

Packer Policy Fellowships

The Packer Policy Fellowships, a "reverse Harkness Fellowship" program established in 2002, are designed to enable two mid-career U.S. policy researchers or practitioners to spend up to 10 months in Australia conducting research and gaining an understanding of Australian health policy issues relevant to the United States.

Chaired by Andrew Bindman, M.D., the selection committee met in November 2007 and selected the following two fellows:

Aaron M. Bishop, M.S.S.W., professional staff, U.S. Senate Committee on Health, Education, Labor, and Pensions (disability policy).
Project: *Comparative Analysis of Australia's and the Commonwealth of Massachusetts' Health Care Systems*
Placement: University of New South Wales, Sydney
Mentor: Ilan Katz, Ph.D.

Steven Counsell, M.D., director, Indiana University Geriatrics Program; scientist, Indiana University Center for Aging Research.
Project: *Innovative Models for Providing and Coordinating Care for Older Adults*
Placement: University of Queensland, Brisbane, Australia
Mentor: Len Gray, M.B., B.S., M.Med., Ph.D., FRACP

Partnerships with International Foundations

In 2007, the International Program established a new partnership with the Dutch Ministry of Health, Welfare and Sport and the Dutch Centre for Quality Care Research (WOK) at Radboud University Nijmegen Medical Centre that will enable the inclusion of the Netherlands in The Commonwealth Fund's international health surveys for three years. Also in 2007, the Health Council of Canada partnered with the Fund to expand the Canadian survey sample and to allow further country analyses of patients with chronic illnesses. As mentioned earlier, a new three-year partnership with the B. Braun Foundation will fund an expansion of the Harkness Fellowship to include an additional fellow in nursing from Germany.

The Fund is also pleased to recognize its ongoing partners. Since 2006, the Stuttgart-based Robert Bosch Foundation has collaborated with the Fund to provide support for a Harkness Fellow from Germany and, since 2004, the Fund's partnership with the U.K.-based Health Foundation has provided annual support for two U.K. Harkness/Health Foundation Fellows. Collaboration between the two foundations has also enabled the inclusion of an expanded U.K. sample in the Fund's international health policy surveys to allow comparisons of England, Scotland, Wales, and Northern Ireland.

Each year since 2001, two Canadian Harkness Associates have participated in the fellowship program as part of a collaboration between the Fund and the Canadian Health Services Research Foundation. The Canadian Harkness Associates participate in the fellowship seminars, including the Washington and Canadian briefings, adding a valuable perspective to the program. Also, the Fund continues to build on its longstanding partnership with the Nuffield Trust, with which the Fund has co-sponsored the International Meeting on Health Care Quality since 1999.

Looking Forward

The Fund's efforts to learn from other countries' experiences are bolstered by projects and commissioned papers that explore health care innovations and reforms abroad. Recently awarded grants that will produce valuable information in the near future include:

- A grant to Elias Mossialos**,** M.D., at the London School of Economics and the European Observatory to perform a comparative study of the health systems of Denmark, France, Germany, the Netherlands, Sweden, and the United Kingdom using the Fund's framework for a high-performing health care system.
- A project led by Victor Rodwin, Ph.D., of New York University to provide an in-depth case study of the French health care system and recent reforms.
- A grant to the Organization for Economic Cooperation and Development (OECD) to support expansion of its Health Care Quality Indicators project to include quality indicators for patient experiences. This project, led by Nick Klazinga, M.D., builds on the Fund's previous work with OECD to develop a set of routinely reported international quality indicators for inclusion in the OECD Health Data.

Notes

[1] C. Schoen, R. Osborn, M. M. Doty, M. Bishop et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive Oct. 31, 2007 26(6):w717–w734.

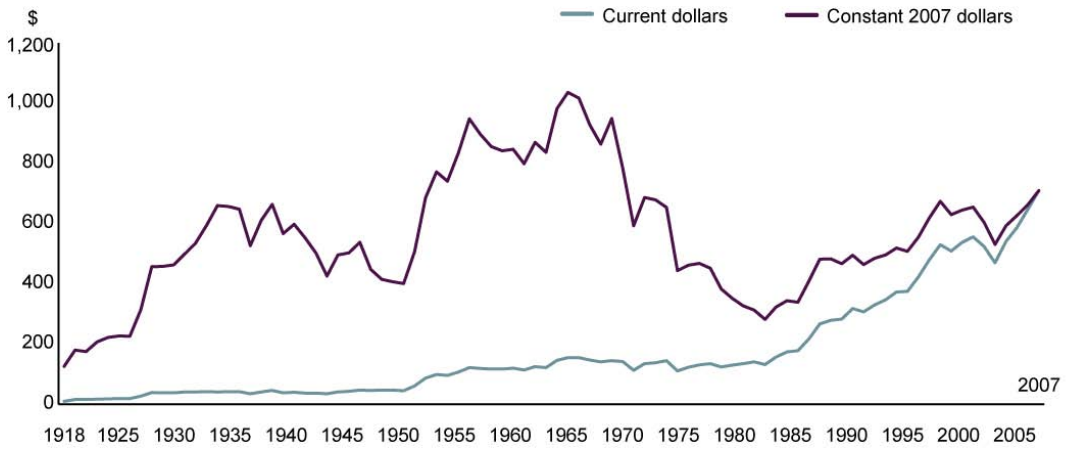
[2] E. G. Campbell, R. L. Gruen, J. Mountford et al., "National Survey of Physician-Industry Relationships," *New England Journal of Medicine*, Apr. 26, 2007 356(17):1742–50.

Treasurer's Report

The Investment Committee of The Commonwealth Fund's Board of Directors is responsible for the effective and prudent investment of the foundation's endowment—a task essential to ensuring a stable source of funds for programs and for the Fund's perpetuity. The committee determines the allocation of the endowment among asset classes and hires external managers, who do the actual investing. Day-to-day responsibility for the management of the endowment rests with the Fund's executive vice president and chief operating officer/treasurer, who, with the assistance of Cambridge Associates consultants, is also responsible for researching policy questions to be addressed by the committee.

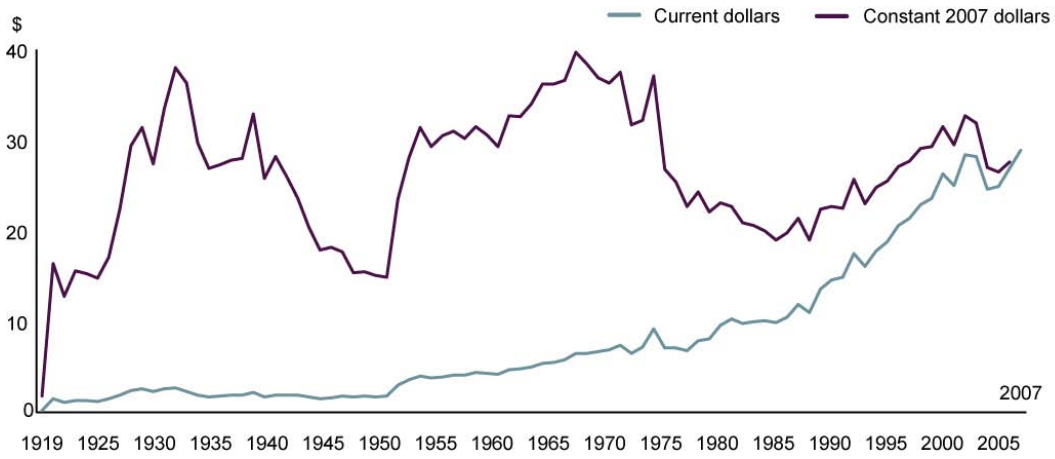
The committee meets at least three times a year to review the performance of the endowment and individual managers; reassess the allocation of the endowment among asset classes and managers, and make changes as appropriate; deliberate investment issues affecting the management of the endowment; and consider new undertakings.

The Commonwealth Fund's endowment, in millions, 1918—2007



The value of the endowment rose from $667.7 million on June 30, 2006, to $775.4 million on June 30, 2007, reflecting a return of 21.5 percent on the investment portfolio during the year combined with total spending (including programs, administration, investment management fees, and taxes) of $32.5 million. In that 12-month period, the return of the Wilshire 5000 index of U.S. stocks was 20.6 percent; the return of the Lehman Aggregate Bond index was 6.1 percent; and the return of a benchmark portfolio weighting these two broad market indexes according to the Fund's target allocations of stocks and bonds during the year was 17.6 percent. The Fund's overall investment performance exceeded not only that of the weighted market benchmarks, but also the 16.4 percent produced by the median U.S. balanced manager during the fiscal year.

The Commonwealth Fund's annual spending, in millions, 1919–2007: Total spending of $730 million over 88 years, or $2.34 billion in constant 2007 dollars.



The Fund's team of equity (U.S. and international) managers produced a combined 12-month return of 24.4 percent, well above the Wilshire 5000's 20.6 percent and the median U.S. equity manager's 19.2 percent. The foundation's emerging markets equities, nonmarketable alternative equities, developed international equities, and several U.S. equities managers produced very strong returns compared with their market benchmarks, and accounted for the overall superior equity team performance. The Fund's bond manager team (including a global fixed income manager) outperformed the Lehman Aggregate bond index (7.3% vs. 6.1%) in 2006–07.

The Fund's investment returns in 2006–07 continued to benefit from the significant restructuring of the endowment's management that the Investment Committee undertook in the early 2000s. The impetus for the restructuring was threefold: to reduce the risk of performance significantly divergent from that of the overall market or peer institutions; to streamline the management structure; and to ensure appropriate diversification of investments.

The salient features of the Fund's current investment strategy are summarized in the accompanying figure. Key among these are:

- an overall target commitment of 80 percent of the portfolio to equities (publicly traded and private) and 20 percent to fixed-income securities;
- a 22.5 percent commitment to publicly traded U.S. equities, paired with a 22.5 percent commitment to international equities, including a 5 percent allocation to emerging markets;
- active large and small capitalization value and growth stock managers, with mandates to outperform their respective market bogeys;

- assignment of responsibility for 10 percent of the endowment to marketable alternative equity (hedge fund) managers;
- a 10 percent commitment to nonmarketable alternative equities (venture capital and private equities); and
- a 15 percent allocation to inflation hedges, including real estate, oil and gas, commodities, and TIPS.

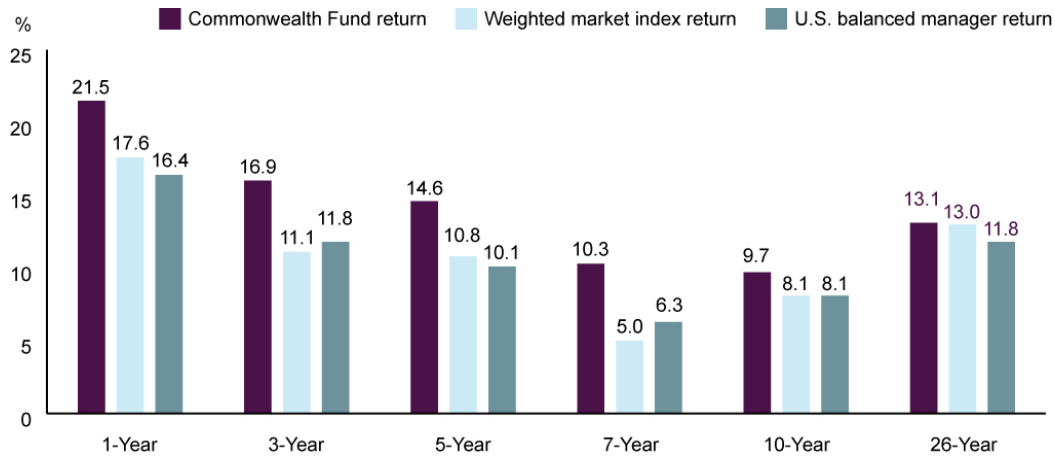
The Commonwealth Fund's endowment management strategy.

	Allocation on September 30, 2007	Long-term target	Permissible range
Total endowment	100%	100.0%	
Asset Class			
Total Equity	82%	80.0%	65%–85%
U.S. equity marketable securities	19%	22.5%	15%–40%
Non-U.S. equity marketable securities	25%	22.5%	15%–30%
Marketable alternative equity	13%	10.0%	0–20%
Non-marketable alternative equity	7%	10.0%	0–15%
Inflation Hedges	18%	15.0%	5%–20%
Fixed Income	18%	20.0%	15%–35%

The Commonwealth Fund's Investment Committee devoted particular attention during the year to building up the foundation's nonmarketable alternative equities—venture capital and private equities—and nonmarketable oil-and-gas and natural resources portfolios. New commitments to nine partnerships totaling $43 million, following $41 million in such commitments in the preceding year, have put the foundation well on the road to meeting the target allocations for these types of investments. The committee periodically reviews asset class allocation targets and the permissible ranges of variation around them; except in very unusual circumstances, the portfolio is rebalanced when market forces or manager performance cause an allocation to diverge substantially from its target.

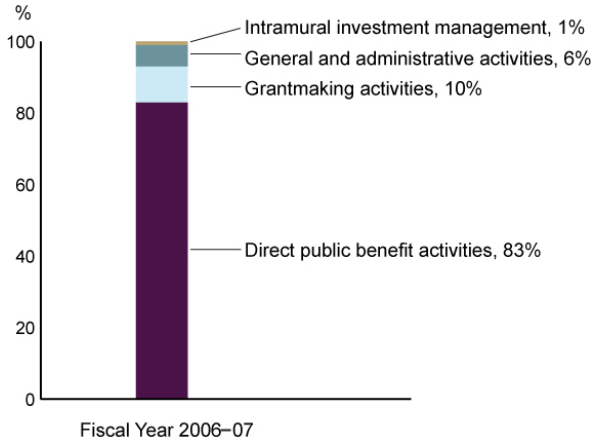
As shown in the figure, the Fund's investment managers as a group outperformed the overall portfolio market benchmark and the median balanced U.S. manager by wide margins over the three-, five-, seven-, and 10-year periods ending June 30, 2007. Over the nearly 26 years since the foundation adopted a multiple manager system, the portfolio's average annual return has significantly exceeded that of the median U.S. balanced manager and equaled that of the weighted benchmark index return.

The Commonwealth fund endowment's average annual investment returns, years ending June 30, 2007.



Three considerations determine the Fund's annual spending policy: the aim of providing a reliable flow of funds for programs and planning; the objective of preserving the real (inflation-adjusted) value of the endowment and funds for programs; and the need to meet the Internal Revenue Service requirement of distributing at least 5 percent of the endowment for charitable purposes each year. Like most other institutions whose sole source of income is their endowment, the Fund found it necessary to adjust spending plans to the realities of the severe bear equities market that began in early 2000—reducing its budget by 10 percent in 2003–04 and allowing only very modest increases through 2005–06. Heartened by the continuing recovery of the market value of the endowment and a comparatively strong average annual return since the bear market began, the Fund's Board has approved a 30 percent increase in annual spending for the 2007–08 fiscal year, with the hope that increases somewhat greater than inflation will be possible in coming years.

The Commonwealth Fund's total direct public benefit activities — including extramural grants and intramural research, communications, and programs conducted by the foundation — account for 83 percent of its annual expenditures. Value-adding oversight of grants takes up 10 percent of the Fund's budget.



As a value-adding foundation, The Commonwealth Fund seeks to achieve an optimal balance between its grantmaking and intramural research and program management activities, while minimizing purely administrative costs. Recognizing that data on expenditures reported in the IRS 990PF annual tax return inadequately reflect the purpose of many expenditures, the analysis in the figure sorts out the foundation's 2006–07 expenditures according to four categories recommended by the Foundation Financial Officers Group: direct public benefit activities (extramural grants and intramurally conducted programs such as research, communications, and fellowships); grantmaking activities, including grants management; general and administrative activities; and intramural investment management. In 2006–07, the Fund's total direct public benefits activities accounted for 83 percent of its annual expenditures. Value-adding oversight of grants took up 10 percent of the Fund's budget, and the intramural costs of managing the endowment, 1 percent. Appropriately defined, the Fund's administrative costs amounted to 6 percent of its budget.

The recent strong performance of the foundation's endowment enables it to take on new initiatives at a propitious moment in the continuing debate over how to solve this country's health care dilemma: costs far greater than any other industrialized country, combined with access gaps that other countries do not have and subpar performance on quality and efficiency of care. The Commonwealth Fund aims to use its increased resources to spur awareness of how the U.S. health care system falls short of its potential and to help develop a roadmap to higher performance.

The Commonwealth Fund

INDEPENDENT AUDITORS' REPORT

The Commonwealth Fund

We have audited the accompanying statements of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2007 and 2006 and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the Fund's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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, such financial statements present fairly, in all material respects, the financial position of the Fund at June 30, 2007 and 2006 and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

November 5, 2007

THE COMMONWEALTH FUND

STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2007 AND 2006

	2007	2006
ASSETS		
CASH	$ 374,518	$ 109,897
INVESTMENTS - At fair value (Notes 1 and 2)	771,312,919	666,665,521
INTEREST AND DIVIDENDS RECEIVABLE	163,748	180,295
PROCEEDS RECEIVABLE FROM SECURITY SALES - NET	484,863	972,432
PREPAID INSURANCE AND OTHER ASSETS	20,196	72,363
RECOVERABLE GRANTS	86,891	100,000
LANDMARK PROPERTY AT 1 EAST 75TH STREET - At appraised value during 1953, the date of donation	275,000	275,000
FURNITURE, EQUIPMENT AND BUILDING IMPROVEMENTS - At cost, net of accumulated depreciation of $1,134,297 at June 30, 2006 and $1,662,626 at June 30, 2005 (Note 1)	3,973,430	4,674,919
TOTAL ASSETS	$776,691,565	$673,050,427
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable and accrued expenses	$ 1,410,281	$ 963,458
Taxes payable - net	181,201	883,615
Program authorizations payable (Note 3)	17,216,632	15,862,626
Accrued postretirement benefits (Note 4)	2,194,182	2,194,182
Deferred tax liability (Note 5)	4,275,720	3,341,375
Total liabilities	25,278,016	23,245,256
NET ASSETS:		
Unrestricted	751,413,549	649,805,171
Total net assets	751,413,549	649,805,171
TOTAL LIABILITIES AND NET ASSETS	$776,691,565	$673,050,427

See notes to financial statements.

THE COMMONWEALTH FUND

STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2007 AND 2006

	2007	2006
REVENUES AND SUPPORT:		
Interest and dividends	$ 10,950,773	$ 9,323,639
Contribution and other revenue	73,779	1,611
Net assets released from restrictions (Note 7)	-	44,593
Total revenues and support	11,024,552	9,369,843
EXPENSES:		
Program authorizations and operating program	27,156,624	24,915,810
General administration	2,019,445	1,563,886
Investment management	3,986,702	3,868,871
Taxes (Note 5)	2,751,130	2,773,039
Unfunded retirement and other postretirement (Note 4)	241,803	185,974
Total expenses	36,155,704	33,307,580
EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS	(25,131,152)	(23,937,737)
NET INVESTMENT GAINS:		
Net realized gains on investments	80,022,275	34,908,663
Change in unrealized appreciation of investments	46,717,255	47,666,161
Total net investment gains	126,739,530	82,574,824
CHANGES IN UNRESTRICTED NET ASSETS	101,608,378	58,637,087
NET ASSETS RELEASED FROM RESTRICTIONS	-	(44,593)
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS	-	(44,593)
CHANGES IN NET ASSETS:	101,608,378	58,592,494
Net assets, beginning of year	649,805,171	591,212,677
Net assets, end of year	$751,413,549	$649,805,171

See notes to financial statements.

THE COMMONWEALTH FUND

STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2007 AND 2006

	2007	2006
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets:	$ 101,608,378	$ 58,592,494
Net investment gains	(126,739,530)	(82,574,824)
Depreciation expense and retirement of assets	928,643	269,777
Adjustments to reconcile change in net assets to net cash used in operating activities:		
(Increase) decrease in interest and dividends receivable	16,547	(50,014)
Decrease in prepaid taxes - net	-	377,905
(Increase) decrease in proceeds receivable from securities sales - net	487,569	(838,035)
Decrease (increase) in prepaid insurance and other assets	52,167	(41,022)
Decrease (increase) in recoverable grants	13,109	526
Increase (decrease) in accounts payable and accrued expenses	446,823	(205,654)
(Decrease) increase in taxes payable - net	(702,414)	883,615
Increase (decrease) in program authorizations payable	1,354,006	(1,576,872)
Increase in deferred tax liability	934,345	953,323
Net cash used in operating activities	(21,600,357)	(24,208,781)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of furniture, equipment, and building improvements - net	(227,154)	(428,548)
Purchase of investments	(380,100,469)	(281,338,990)
Proceeds from the sale of investments	402,192,601	305,589,305
Net cash provided by investing activities	21,864,978	23,821,767
NET INCREASE (DECREASE) IN CASH	264,621	(387,014)
CASH, BEGINNING OF YEAR	109,897	496,911
CASH, END OF YEAR	$ 374,518	$ 109,897
SUPPLEMENTAL INFORMATION -		
Taxes paid: excise and unrelated business income	$ 3,290,058	$ 1,511,519

See notes to financial statements.

THE COMMONWEALTH FUND

NOTES TO FINANCIAL STATEMENTS
YEARS ENDED JUNE 30, 2007 AND 2006

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The Commonwealth Fund (the "Fund") is a private foundation supporting independent research on health and social issues.

a. *Investments* – Investments in equity securities with readily determinable fair values and all investments in debt securities are carried at fair value, which approximates market value. Assets with limited marketability, such as alternative asset limited partnerships, are stated at the Fund's equity interest in the underlying net assets of the partnerships, which are stated at fair value as reported by the partnerships. Realized gains and losses on dispositions of investments are determined on the following bases: FIFO for actively managed equity and fixed income, average cost for commingled mutual funds, and specific identification basis for alternative assets.

In accordance with Financial Accounting Standards Board Statement No.133, *Accounting for Derivative Instruments and Hedging Activities*, the Fund records derivative instruments in the statements of financial position at their fair value, with changes in fair value being recorded in the statement of activities. The Fund does not hold or issue financial instruments, including derivatives, for trading purposes. Both realized and unrealized gains and losses are recognized in the statements of activities.

b. *Fixed Assets* – Furniture, equipment, and building improvements are capitalized at cost and depreciated using the straight-line method over their estimated useful lives.

c. *Contributions, Promises to Give, and Net Assets Classifications* – Contributions received and made, including unconditional promises to give, are recognized in the period incurred. The Fund reports contributions as restricted if received with a donor stipulation that limits the use of the donated assets. Unconditional promises to give for future periods are presented as program authorizations payable on the statement of financial position at fair values, which includes a discount for present value.

d. *Use of Estimates* – The preparation of financial statements in conformity with generally accepted accounting principles requires the Fund's management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of additions to and deductions from the statement of activities. The calculation of the present value of program authorizations payable, present value of accumulated postretirement benefits, deferred Federal excise taxes and the depreciable lives of fixed assets requires the significant use of estimates. Actual results could differ from those estimates.

e. *Cash* – Cash consists of all checking accounts and petty cash.

At times the Fund's cash exceeds federally insured limits. This risk is managed by using only large established financial institutions.

2. INVESTMENTS

Investments at June 30, 2007 and 2006 comprised the following:

	2007		2006	
	Fair Value	Cost	Fair Value	Cost
U.S. Equities	$178,200,640	$150,499,301	$160,463,317	$141,488,422
Non-U.S. Equities	186,180,119	109,367,300	152,712,540	85,501,421
Fixed income	114,529,147	105,097,342	101,950,359	98,856,492
Short-term	8,037,978	8,037,978	9,302,175	9,302,175
Marketable alternative equity	110,157,503	54,169,656	93,432,266	54,051,317
Nonmarketable alternative equity	46,905,079	38,349,529	27,305,663	25,996,468
Inflation hedge	127,302,453	92,005,808	121,499,201	84,400,476
	$771,312,919	$557,526,914	$666,665,521	$499,596,771

At June 30, 2007, the Fund had total unexpended commitments of approximately $77.6 million in various nonmarketable alternative equity investments.

The Fund's investment managers may use futures contracts to manage asset allocation and to adjust the duration of the fixed income portfolio. In addition, investment managers may use foreign exchange forward contracts to minimize the exposure of certain Fund investments to adverse fluctuations in the financial and currency markets. At June 30, 2007 and 2006, the Fund had no outstanding derivative positions.

3. PROGRAM AUTHORIZATIONS PAYABLE

At June 30, 2007, program authorizations scheduled for payment at later dates were as follows:

July 1, 2007 through June 30, 2008	$ 13,908,468
July 1, 2008 through June 30, 2009	3,303,261
Thereafter	173,856
Gross program authorizations scheduled for payment at a later date	17,385,585
Less adjustment to present value	168,953
Program authorizations payable	$ 17,216,632

A discount rate of 5.03 % was used to determine the present value of the program authorizations payable at June 30, 2007.

4. UNFUNDED RETIREMENT AND OTHER POSTRETIREMENT BENEFITS

The Fund has a noncontributory defined contribution retirement plan, covering all employees, under arrangements with Teachers Insurance and Annuity Association of America and College Retirement Equities Fund and Fidelity Investments. This plan provides for purchases of annuities and/or mutual funds for employees. The Fund's contributions approximated 18% of

the participants' compensation for the years ended June 30, 2007 and 2006. Pension expense under this plan was approximately $895,000 and $899,000 for the years ended June 30, 2007 and 2006, respectively. In addition, the plan allows employees to make voluntary tax-deferred purchases of these same annuities and/or mutual funds within the legal limits provided for under Federal law.

The Fund also has a group of former employees who retired prior to the inauguration of the above plan and certain other former employees to whom pension benefits have been approved, on an individual case basis, by the Board of Directors. Benefits under this program are paid directly by the Fund to these retirees. These pension payments approximated $71,000 and $67,000 for the years ended June 30, 2007 and 2006, respectively. In addition, the Fund provides health and life insurance to certain former employees.

Effective July 1, 2001, the Fund established a fully-funded Key Employee Stock Option Plan ("KEYSOP") for certain key executives which exchanges deferred compensation benefits for options to purchase mutual funds. In addition, the KEYSOP awarded options to purchase mutual funds to certain employees in exchange for certain pension benefits. The Fund no longer makes contributions to the KEYSOP.

Effective July 9, 2002, the Fund established a Section 457 Plan for certain employees that provides for unfunded benefits with employer contributions made within the legal limits provided for under Federal law.

The Fund provides postretirement medical insurance coverage for retirees who meet the eligibility criteria. The postretirement medical plan, which is measured as of the end of each fiscal year, is an unfunded plan, with 100% of the benefits paid by the Fund on a pay-as-you-go basis. Such payments approximated $121,000 and $119,000 for the years ended June 30, 2007 and 2006, respectively.

Expected contributions under the postretirement medical plan for the fiscal year ended June 30, 2008 are expected to be approximately $127,000. Additional required disclosure on the Fund's postretirement medical plan for the years ended June 30, 2007 and 2006 is as follows:

	2007	2006
Benefit obligation at June 30	$ 2,194,182	$ 2,194,182
Fair value of plan assets at June 30	-	-
Status - unfunded	2,194,182	2,194,182
Actuarial loss	-	-
Accrued benefit cost recognized	$ 2,194,182	$ 2,194,182
Net periodic expense	$ 120,480	$ 118,660
Employer contribution	$ 120,480	$ 118,660

Significant assumptions related to postretirement benefits as of June 30 were as follows:

	2007	2006
Discount rate	5.03%	4.28%
Health care cost trend rates – Initial	7.3%	7.3%
Health care cost trend rates – Ultimate	7.1%	7.1%

At June 30, 2007, benefits expected to be paid in future years are approximately as follows:

Year ended June 30, 2008	$ 127,000
Year ended June 30, 2009	$ 158,000
Year ended June 30, 2010	$ 184,000
Year ended June 30, 2011	$ 214,000
Year ended June 30, 2012	$ 217,000
Five years ended June 30, 2017	$ 1,049,000

5. TAX STATUS

The Fund is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code, but is subject to a 1% or 2% (depending if certain criteria are met) Federal excise tax on net investment income. For the years ended June 30, 2007 and 2006, that excise tax rate was 2%. The Fund is also subject to Federal and state taxes on unrelated business income. In addition, The Fund records deferred Federal excise taxes, based upon expected excise tax rates, on the unrealized appreciation or depreciation of investments being reported for financial reporting purposes in different periods than for tax purposes.

The Fund is required to make certain minimum distributions in accordance with a formula specified by the Internal Revenue Service. For the year ended June 30, 2007, distributions approximating $ 16.2 million are required to be made by June 30, 2008 to satisfy the minimum requirements of approximately $ 33.2 million for the year ended June 30, 2007.

In the Statements of Financial Position, the deferred tax liability of $ 4,275,720 and $3,341,375 at June 30, 2007 and 2006, respectively, resulted from expected Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2007 and 2006, the tax provision was as follows:

	2007	2006
Excise taxes - current	$ 1,686,925	$ 1,555,044
Excise taxes - deferred	934,345	953,324
Unrelated business income taxes - current	129,860	264,671
	$ 2,751,130	$ 2,773,039

6. FAIR VALUE OF FINANCIAL INSTRUMENTS

The estimated fair value amounts have been determined by the Fund, using available market information and appropriate valuation methodologies. However, considerable judgment is necessarily required in interpreting market data to develop the estimates of fair value. Accordingly, the estimates presented herein are not necessarily indicative of the amounts that the Fund could realize in a current market exchange. The use of different market assumptions and/or estimation methodologies may have a material effect on the estimated fair value amounts.

All Financial Instruments Other Than Investments – The carrying amounts of these items are a reasonable estimate of their fair value.

Investments – For marketable securities held as investments, fair value equals quoted market price, if available. If a quoted market price is not available, fair value is estimated using quoted market price for similar securities. For alternative asset limited partnerships held as investments, fair value is estimated using private valuations of the securities or properties held in these partnerships. The carrying amount of these items is a reasonable estimate of their fair value. For futures and foreign exchange forward contracts, the fair value equals the quoted market price.

7. CONTRIBUTIONS RECEIVED

In fiscal years 1987 and 1988, the Fund received a total of $15,415,804 as a grant from the James Picker Foundation, with an agreement that a designated portion of the Fund's grants be identified as "Picker Program Grants by the Commonwealth Fund." The Fund fulfills this obligation by making Picker Program Grants devoted to specific themes approved by the Fund's Board of Directors. For the years ended June 30, 2007 and 2006, Picker program grants totaled approximately $1,346,000 and $1,441,000, respectively.

In April 1996, the Fund received The Health Services Improvement Fund, Inc.'s ("HSIF") assets and liabilities, $1,721,016 and $57,198, respectively, resulting in a $1,663,818 increase in net assets. In accordance with the terms of an agreement with HSIF, this contribution enables the Fund to make Commonwealth Fund/HSIF grants to improve health care coverage, access, and quality in the New York City greater metropolitan region.

During the year ended June 30, 2002, the Fund received a bequest of $3,001,124 from the estate of Professor Frances Cooke Macgregor as a contribution to the general endowment, with the amount of annual grants generated by this addition to the endowment to be governed by the Fund's overall annual payout policies. An additional amount of $ 100,000 was received during the year ended June 30, 2004. This gift was made with the provisions that in at least the five-year period following its receipt, grants made possible by it will be used to address iatrogenic medicine issues, and that grants made possible by the gift be designated "Frances Cooke Macgregor" grants. During the years ended June 30, 2007 and 2006, the Frances Cooke Macgregor grants totaled approximately $314,000 and $326,000, respectively.

* * * * * *

Founders and Benefactors

Anna Harkness and Edward Stephen Harkness

The story of The Commonwealth Fund begins with the family of Stephen V. Harkness, an Ohio businessman who began his career as an apprentice harnessmaker at the age of 15. His instinct and vision led him to invest in the early refining of petroleum and to make a further investment at a critical moment in the history of the fledgling Standard Oil Company.

After her husband's death in 1888, Anna Harkness, Stephen's wife, moved her family to New York City, where she gave liberally to religious and welfare organizations and to the city's major cultural institutions. In 1918, she made an initial gift of nearly $10 million to establish a philanthropic enterprise with the mandate "to do something for the welfare of mankind," a broad and compelling challenge.

Anna Harkness placed the gift in the wise hands of her son Edward Stephen Harkness, who shared her commitment to building a responsive and socially concerned philanthropy. During his 22 years as president of the foundation, Edward Harkness added generously to the Fund's endowment and led a talented and experienced staff to rethink old ways, experiment with fresh ideas, and take chances, a path encouraged by successive generations of leadership.

Jean and Harvey Picker

In 1986, Jean and Harvey Picker joined the $15 million assets of the James Picker Foundation with those of The Commonwealth Fund. James Picker, a prime contributor to the development of the American radiologic profession, had founded the Picker X-ray Corporation, an industry leader in its field. Recognizing the challenges faced by a small foundation, the Pickers chose the Fund as an institution with a common interest in improving health care and a record of effective grantmaking, management, and leadership. The Commonwealth Fund strives to do justice to the philosophy and standards of the Picker family by shaping programs that further the cause of good care and healthy lives for all Americans.

Samuel O. Thier, M.D., retired from the Board of Directors of The Commonwealth Fund on November 13, 2007. He had served on the Board since November 11, 1997, and led it as chairman from November 12, 2002, until his retirement.

Samuel O. Thier, M.D.

Dr. Thier's distinguished career as a professor of medicine, health policy leader, university president, and academic health center and integrated health system chief executive made him ideally suited for guiding the Fund's efforts to improve health care coverage, quality, and efficiency. His broad and practical experience in health care and business, as well as his understanding of policymaking and communications, were important assets to the Fund working with the public and private sectors toward achieving a high performance health system.

Under Dr. Thier's leadership, the Fund launched the Commission on a High Performance Health System, which has produced landmark reports documenting the shortcomings of health care in the U.S. relative to benchmark standards and pointing to pathways for achieving high performance. On his watch, the Fund has become a recognized leader on the national stage and at the state level in addressing health insurance coverage and health care access issues; has provided crucial support to researchers and health care delivery organizations in their efforts to improve the quality of care and efficiency with which it is delivered; has advanced efforts to reform payment systems to promote quality and efficiency; has become a major resource on the problems facing underserved minority populations; has prompted pediatric practice to devote greater attention to the healthy development of children; and has instigated successful international collaborations and exchanges to improve the performance of health care systems abroad.

Dr. Thier led the work of the Fund's Board and staff with wisdom, humor, and good judgment, combining a thoughtful voice with great attention, diligence, and firm counsel. He will be missed.

James R. Tallon, Jr., succeeded Dr. Thier as chairman of The Commonwealth Fund Board of Directors on November 14, 2007. A member of the Fund's Board since April 1996, Mr. Tallon is president of the United Hospital Fund of New York and is recognized nationally for his policy leadership, his ardent concern for improving the performance of the health system, and his efforts to help make it accessible to all.

Mr. Tallon is chairman of the Kaiser Commission on Medicaid and the Uninsured, and secretary/treasurer of the Alliance for Health Reform. He is a member of the New York State Board of Regents and serves on the boards of the Institute on Medicine as a Profession, the New York eHealth Collaborative, and the advisory board for the Jonas Center for Nursing Excellence. Mr. Tallon headed Governor Eliot Spitzer's Health Care Policy Advisory Committee during the gubernatorial transition in 2006, and led the 1998–99 planning process that established the National Quality Forum. Prior to joining the United Hospital Fund, Mr. Tallon was majority leader of the New York State Assembly, where he served for 19 years.

With worries about health insurance and health care being a top issue for the U.S. population—and with presidential candidates, Congress, the states, and employers grappling for solutions—the Fund is extremely fortunate to be able to draw on Mr. Tallon's wealth of experience in the formulation and implementation of health policy at a time of great opportunity.

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*Term begins April 2008.

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Grants Approved, 2006 – 2007

Commission on a High Performance Health System

Commission on a High Performance Health System: Program Direction
Since July 2005, the Fund's Commission on a High Performance Health System has convened three times per year, produced a series of brief papers on key health system issues, prepared a framework statement laying out the attributes of high performance, and developed a national performance scorecard. The Commission will release the framework statement, the scorecard, and a second series of briefs, while continuing to develop other products and policy recommendations. Its work will also be reflected in current Fund-sponsored activities, including the Bipartisan Congressional Health Policy Conference, Congressional Staff Retreat, and Alliance for Health Reform briefings and roundtables. The Fund's grants to the Alliance and to AcademyHealth pay for basic staff support for important Commission activities. The Commission's senior policy director, based at AcademyHealth, works with the executive director to prepare for meetings and to develop all policy-related programs and products. The Alliance is responsible for the logistics for three annual meetings.

AcademyHealth
$521,311

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Alliance for Health Reform
$266,165
Meetings

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Alliance for Health Reform
$379,581
Commonwealth Fund Bipartisan Congressional Retreat, 2007
The Fund's annual Bipartisan Congressional Retreat gives members of Congress the opportunity to learn about timely health policy issues and engage in substantive discussion, all in an environment free from partisan politics and media pressures. With the formation of the Commission on a High Performance Health System in 2005, it became possible to link the Commission's policy agenda to the retreat. In 2007, the sessions will focus on issues surrounding Medicare, state coverage expansions, the Commission's scorecard findings, patient-centered care, health system redesign, international quality improvement activities, and financing and payment reform.

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Alliance for Health Reform
$232,736
Health Policy Seminars and Congressional Staff Retreat, 2007
Alliance for Health Reform briefings are a valuable resource for congressional staff and journalists seeking the latest health policy information and analysis. The Alliance will conduct eight briefings on such topics as: enhancing primary care capacity, results of the Commission on a High Performance Health System's national scorecard, findings from the Fund's 2006 Health Care Quality Survey and new minority health chartbook, long-term care and patient-centered care, state policies promoting high performance, comparative effectiveness of drugs and treatments, and international health policy perspectives. The Congressional Staff Retreat is a unique opportunity for up to 100 senior health staff from both political parties to engage in an informal, off-the-record exchange of ideas.

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The Commonwealth Fund
$90,000
Analytic Work in Support of the U.S. Health System Scorecard
The Commission's Scorecard on U.S. Health System Performance assesses system performance relative to benchmarks of excellence of health outcomes, access, quality, efficiency, and innovation. It also proposes attainable targets for the nation and highlights the potential for improved performance in each area. This authorization enables the Commission's research director to produce updated analyses of national data sources, Fund-supported surveys, and quality initiatives in support of the scorecard. Findings of this work will assist the Commission as it monitors system performance over time and assesses the impact of existing and proposed policies.

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Issues Research, Inc.
$72,071
Maintaining the U.S. Health System Scorecard, Performance Snapshots, and the Quality Matters Newsletter, 2007
The Fund seeks to stimulate higher performance within the U.S. health system, in part by educating stakeholders about the nature and scope of performance deficits, the implications for Americans' health and well-being, and promising approaches to address these shortfalls. The development of innovative information resources is important for this ongoing educational process. This contract engages the services of Issues Research, Inc., to provide research and writing in support of the Fund's U.S. Health System Scorecard, the Web-based Performance Snapshots, and Quality Matters newsletter.

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The Lewin Group, Inc.
$235,000
Achieving Savings and Investing to Improve Health System Performance
Opportunities exist for the nation to achieve savings in total health care expenditures. These include: more efficient insurance arrangements, better integration of health care delivery systems, broad diffusion of information technology, and expanded use of financial incentives for providing cost-effective, high-quality care. To inform development of national policies aimed at higher health system performance, the project team, working with Fund staff, will identify options for short- and long-term savings, model their

potential impact, and identify opportunities to improve health system performance. The Commission on a High Performance Health System will provide oversight for the study.

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Small Grants—Commission Activities

Kaiser Foundation Health Plan, Inc.
$15,000
Improving Health Care 'Systemness': A Look at the Evidence and Policy Implications

Laura Tollen
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New America Foundation
$45,500
Innovation Dissemination: Communicating Examples of High Performance

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Pittsburgh Regional Healthcare Initiative
$25,000
Network for Regional Healthcare Improvement (NHRI) Summit: Creating Payment Systems to Accelerate Value-Driven Health Care

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Program on the Future of Health Insurance

Analysis and Modeling of the Leading Health Care Reform Bills of the 110th Congress (2007-08) and Presidential Candidates' Health Care Proposals
In March 2007, the Fund released the first of two reports analyzing and comparing leading reform bills of the 109th and early 110th Congresses. The first paper focused on health insurance expansion bills and included estimates of cost and coverage as well as detailed, side-by-side analyses of the bills' provisions and potential for success. The second paper analyzes and compares bills to improve quality and efficiency and the Medicare Part D benefit, also providing side-by-side analyses. By presenting comprehensive, nonpartisan analysis of legislative proposals, the report fills a large gap in health reform debates. For this project, Fund staff and consultants will analyze a new set of bills introduced in the 110th Congress, including reforms designed to expand health coverage, improve public insurance programs, control costs

and maximize efficiency, enhance the quality and safety of care, and develop more rational payment policies. The project team will also develop comparative coverage and cost analyses of the 2008 presidential candidates' health plans. With health reform promising to be a key issue in the 2008 elections, this analysis will help policymakers and the public understand the practical impact of the proposals on the table.

Health Policy R&D
$100,000
Comparisons of Select Health Care Bills from the 110th Congress

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The Lewin Group, Inc.
$200,000
Estimating the Cost and Coverage Impacts of Health Reform Proposals from Congress and the Presidential Candidates

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Education & Research Fund of the Employee Benefit Research Institute
$132,900
EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006
The 2005 EBRI/Commonwealth Fund Consumerism in Health Care Survey found that enrollees in high-deductible and “consumer-driven” health plans were, in several respects, less satisfied with their coverage than people with comprehensive health insurance. Plan members were also more likely to avoid or delay needed care, had high out-of-pocket costs relative to income, and lacked necessary information about the price and quality of providers. Along with assessing trends in consumer-driven plan enrollment, the 2006 Consumerism in Health Care Survey will ask enrollees about their prior insurance coverage and reasons for joining, whether they have an employer-funded health savings account, whether preventive or chronic disease care is excluded from deductibles, and whether they receive plan information on provider quality and cost. The survey will also assess these plans’ impact on care utilization. Findings will inform not only federal and state policymakers but employers that are considering such plans for their benefit programs.

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The President and Directors of Georgetown College
$149,987
Strategies to Reduce Instability of Coverage in Public Insurance Programs, Phase 2
Although many families with low incomes are eligible for various health insurance programs, more than three of five eligible children are not enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP). 'Churning' in enrollment is also common: over half of low-income family members who repeatedly experience periods without coverage leave Medicaid and then re-enroll later. Focusing on eight states, this project will examine factors that affect program enrollment and coverage stability, including a new federal rule requiring people to document their citizenship when applying for or renewing Medicaid coverage. In Phase 1, state officials and others convened to discuss the implications of the new citizenship documentation requirements and how these effects might be measured. In Phase 2, the

researchers will analyze administrative data to determine the impact of the new Medicaid rule and other factors. Findings will inform debate over extending public coverage to a greater number of children.

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President and Fellows of Harvard College
$200,289
Assessing the Long-Term Implications of Uninsured Older Adults to Medicare, Phase 1
By the time they enter the Medicare program at age 65, uninsured older adults—particularly those with chronic conditions—often have health problems that require more intensive and costly care than if these individuals had been continuously insured. This two-phase project will inform policymakers about the potential health gains of expanding Medicare coverage to older adults under 65, and how the cost of such an expansion could be offset by savings to the Medicare program. Using Medicare claims data and findings from the longitudinal Health and Retirement Study, project staff in the first phase will assess the impact that gaining Medicare coverage has on health care use and out-of-pocket costs for previously uninsured adults and other disadvantaged, near-elderly adults, as well as the impact on Medicare program costs.

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Princeton Survey Research Associates International
$319,855
The Commonwealth Fund 2007 Biennial Health Insurance Survey
In five biennial surveys since 1999, the Fund has assessed the stability and quality of U.S. adults' health insurance coverage, cost-related difficulties in accessing care, and medical bill problems. Policymakers have learned about these important surveys through widely cited media reports and journal articles, as well as through testimony to Congress. A new survey will update information on coverage and access trends and explore emerging areas of concern, including the effect of high-deductible health plans on the out-of-pocket spending of those enrolled. The release of the survey findings in late 2007 will be timely, given that rising health care costs and declining coverage will likely be a major issue in the presidential election.

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Trustees of Columbia University in the City of New York
$163,871
Developing Policy Options to Expand and Stabilize Health Insurance Coverage: Support for Analysis and Technical Assistance
The Fund's Program on the Future of Health Insurance tracks changes in Americans' health insurance coverage, documents the consequences of being uninsured or underinsured, and investigates new policies to expand coverage for working families. This core grant to Columbia University supports the analytical basis for such activities and for other health coverage-related work undertaken by Fund staff, grantees, and the Commission on a High Performance Health System. Over the next year, the Columbia team will: 1) explore the association between coverage and regional variations in costs and medical practice patterns; and 2) develop more accurate cost estimates for coverage expansion proposals, by taking into account potential savings to government, business, and households. In addition, the Columbia researchers will

assist the Commission as it develops options for achieving savings and improving health system performance, for example by synthesizing research evidence pertinent to cost estimation and simulation modeling.

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Washington University
$121,320
Assessing the Impact of Employee Cost-Sharing on Health Care Costs and Outcomes
In an effort to alleviate their rising health care costs, employers have sought to share more of these expenses with their workers. To assess the impact of changes in employee cost-sharing on the use, cost, and quality of preventive and therapeutic care, the project investigators will examine medical claims and personnel data at two or three St. Louis firms for up to 70,000 employees and dependents. The analysis will include a special focus on workers earning low to moderate wages. Study findings will inform policymakers and employers about the personal health and financial implications of imposing higher levels of cost-sharing.

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Small Grants—Program on the Future of Health Insurance

The Century Foundation
$15,062
Conference on Employers and National Health Reform

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Education & Research Fund of the Employee Benefit Research Institute
$36,000
Sustaining Membership in the Employee Benefit Research Institute Education and Research Fund (EBRI-ERF) and Support for the Annual Health Confidence Survey

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The President and Directors of Georgetown College
$37,968
Strategies to Reduce Insurance Instability in Public Programs: Coping with New Medicaid Rules Regarding Citizenship Verification and Program Premiums

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Massachusetts General Hospital
$41,361
A Review of Commonwealth Fund Biennial Health Insurance Survey Policy Questions Involving Revenue-Spending Trade-offs

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National Opinion Research Center
$45,751
Capping the Deductibility of Employer-Sponsored Health Insurance: Characteristics of High-Cost Plans and Employers

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Medicare's Future

AcademyHealth
$492,263
Medicare's Future: Program Direction Grant
The Medicare Modernization Act of 2003 made prescription drug coverage available through private drug plans and expanded the role of private insurers, which enhanced the benefits available to beneficiaries but raised questions about how the most vulnerable among them will be affected. Medicare also is developing and testing ways to encourage quality improvement, foster greater coordination of care, promote the use of preventive services, and increase providers' efficiency. The Fund's Program on Medicare's Future provides independent analysis of these and other changes, identifies issues and directions that should be considered, and develops policy options for improving Medicare's ability to provide beneficiaries access to the most effective care. This grant will provide strategic direction for the program, develop new projects, coordinate ongoing work, and direct efforts to disseminate findings to policymakers and the public.

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Harvard Pilgrim Health Care
$211,332
Gauging the Affordability of Prescription Drugs for Medicare Enrollees and Older Adults
The patient's share of health care costs, particularly for prescription drugs, is on the rise. Especially vulnerable to high cost-sharing are older adults with significant health care needs. This project will

examine the relationship between the health care burden and the household's total financial resources, including assets, focusing on two groups: Medicare beneficiaries and people between the ages of 50 and 64. The analysis, which will be based on data from the National Institute on Aging's Health and Retirement Study, will establish a baseline against which the impact of the Medicare prescription drug benefit can be evaluated. Moreover, the findings will provide a foundation for systematically evaluating how changes in the health care market affect the affordability of prescription medicines and other health care.

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A Conceptual Framework for Understanding the Gaps in Evidence That Impair Medical Decision-Making

Critical to improving the performance of the U.S. health care system is better medical decision-making, and critical to improving medical decision-making is reliable information about the benefits, risks, and costs of new medical treatments, procedures, and technologies. Two experts will address this need from different directions. Sean Tunis, M.D., M.Sc., will develop a framework for understanding the gaps in evidence and for improving the identification, generation, dissemination, and application of better evidence for coverage, payment, and clinical decision-making. Meanwhile, Gail Wilensky, Ph.D., will examine the policy context in which the establishment of such a mechanism would be considered. The products—two policy papers—will guide the development of initiatives to improve the decisions made by health care payers and practitioners, while also providing a basis for further work.

Health Technology Center

$47,024

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Project HOPE/The People-to-People Health Foundation, Inc.

$49,965

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President and Fellows of Harvard College

$258,582

Analyzing the Relationship Between Quality and Efficiency of Hospital Care, Phase 1

In 2005, Congress began requiring hospitals to report their performance on quality-of-care measures in order to receive full payment from Medicare. These data present an opportunity to examine the various dimensions of hospital performance and determine how that performance can be improved. Building on its previous Fund-supported work, the research team will analyze the relationship between hospital characteristics, quality of care, and risk-adjusted costs, including the costs of patient readmissions up to 180 days post-discharge. If data on care coordination, patient-centered care, and patient satisfaction become available in the next year as expected, the investigators will develop a proposal for a second phase of work to incorporate these quality dimensions into the analysis. The project's findings will advance the identification of high- and low-performing hospitals, as well as help explain variation in quality, cost, and efficiency.

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Trustees of Dartmouth College
$274,304
Understanding the Quality and Performance of Medical Groups, Phase 1
Little is known about how the structural characteristics of U.S. physician practices affect the care they provide to their patients. Drawing upon unique data sets, the project team will examine: 1) the associations between group practice structure and the cost and quality of care for Medicare beneficiaries; and 2) how care management processes affect cost and quality over an episode of illness. Study findings will be useful for the development of new performance measures at the medical group level—measures that could encourage both better organization of care and new methods of payment.

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Tufts-New England Medical Center
$206,873
Improving Evidence-Based Decision-Making in Medicare Coverage
New medical procedures and treatments can improve health outcomes, but they also are a major factor in the rapid rise of health care costs. What makes this trade-off particularly problematic is the lack of data on which procedures and treatments work and in which situations they are effective, as well as the lack of a mechanism for making appropriate decisions even when such information is available. This project will seek to: 1) analyze the evidence and the process used by the Medicare program to determine which new medical technologies it will pay for; and 2) explore alternative decision-making mechanisms, including those used by private insurers and other countries, that Medicare might consider. The analysis will draw from a database that includes information on treatment coverage decisions made from 1999 through mid-2007.

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Small Grants—Medicare's Future

American Institutes for Research
$12,455
A New Look at Medicare Extra

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Center for Medicare Advocacy, Inc.
$47,364
Modeling a Medicare Beneficiary Complaint System for Quality of Care: A Consultation with the Experts

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Johns Hopkins University
$45,230
The Role of Pharmaceutical Data in Identifying Patients Who Could Benefit from Better Care Management

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Johns Hopkins University
$27,500
Variation in Cost and Outcomes for Preventable Admissions, Readmissions, and Chronic Care

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University of Maryland, Baltimore
$15,000
An Issue Brief: Critical Success Factors for Medicare Special Needs Plans Serving Dual Eligibles

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Research Triangle Institute
$49,848
Medicare's Physician Group Practice Demonstration: Exporting Lessons Learned

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Health Care Quality Improvement and Efficiency

Bridges to Excellence
$300,000
Advancing Payment for Health Care Quality and Efficiency Through An Evidence-Based Case Rate Approach
Prometheus is the name of a new model for paying health care providers based on evidence-based case rates (ECRs)-derived from the costs of resources required to deliver care according to clinical practice guidelines. With the addition of robust performance incentives, the model is designed to promote quality and efficiency. Clinical working groups have already been assembled to determine the 'base rate' for prototype ECRs for cancer care, chronic care, interventional cardiology, orthopedic care, and routine and preventive care. This project will complete the development of at least five prototype ECRs, specifically by adjusting the base rates to account for unexpected events (e.g., hospitalizations), which can occur even when appropriate care has been provided, as well as for differences in severity of disease. If subsequent pilot-testing is successful, this payment model would advance the goal of aligning financial incentives with the delivery of high-quality, efficient care.

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Health Research and Educational Trust
$314,453
Physician Practice Patient Safety Assessment, Phase 2: Tool Development
Frances Cook Macgregor Grant
Recognizing the need to improve the safety of patients receiving care in doctor's offices, the Fund supported the development and pilot implementation of the Physician Practice Patient Safety Assessment tool. This survey instrument is designed to enhance physicians' awareness of patient safety issues, including factors that make a practice safer. Building on the results of that project and other Fund-supported work on hospital safety, the research team will develop and pilot-test three evidence-based tools to help physicians prevent medical errors and improve overall patient safety. These tools will be disseminated to group practices around the country and made available free of charge through a dedicated Web site.

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Joan and Sanford I. Weill Medical College of Cornell University
$364,270
Evaluating the Impact on Quality and Costs of Regional Clinical Data Exchange Programs in New York State Health Services Improvement Grant
New York is currently awarding $53 million in grants to support health information technology initiatives across the state, including developing capacity for the exchange of clinical data among patients, providers, and payers. This project will evaluate six regional programs for clinical data exchange to determine their impact on the quality and cost of health care. The research team will also establish a framework and standardized methodology for financial assessment of regional health information programs and return-on-investment analyses from the perspectives of providers and payers. Findings will be of interest to the Office of the National Coordinator of Health Information Technology and to many organizations nationwide that are engaged in developing clinical data exchange programs.

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The Leapfrog Group for Patient Safety
$102,359
Advancing Efforts to Realign Incentives for Improving the Quality and Value of Health Care
Today, there are more than 100 pay-for-performance programs aimed at health plans, physician groups, and even patients. Not only is the number of quality measures targeted by these efforts increasing, but there is greater diversity and complexity in the design of payment incentives. Monitoring the evolution of pay-for-performance is important for understanding how it affects quality and costs. To date, one of the few trusted sources of information about pay-for-performance programs is the 2004 Leapfrog Incentives and Rewards Compendium, developed with support from the Fund and the Robert Wood Johnson Foundation. For this project, the Leapfrog Group will survey leaders of pay-for-performance programs nationally and catalogue these efforts in the Leapfrog Compendium according to such attributes as sponsor, types of incentives, and performance measures. The project team will also improve the usability of the compendium on the Web by incorporating new search functions and analytic capacities.

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Massachusetts General Hospital
$314,521
Developing Measures of Hospital Care Safety
Efforts to improve patient safety remain handicapped by the lack of clinically meaningful measures that enable institutions and regions to set goals, track improvement over time, and compare performance across health care facilities. This project will develop such safety measures in two areas of hospital care (e.g., intensive care and emergency department). Not only will these measures help hospitals assess and track safety in the targeted areas of care, they could provide a blueprint for the development of measure sets for other areas of hospital and ambulatory care. The project director has demonstrated there is broad stakeholder engagement and support for this project, which will help ensure that the new measures are widely disseminated and used.

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National Quality Forum
$199,999
Developing a Framework for Measuring Value Across Episodes of Care
Unlike most current measures of health care quality, which focus on services performed by individual providers, episode-based measures assess care over longer periods and across care settings. Ideally, they encompass multiple dimensions of quality, such as clinical processes and outcomes, patient satisfaction, and resource use—all critical for defining value. The National Quality Forum (NQF) recently established a steering committee charged with identifying priorities, goals, and measure sets for assessing value over episodes of care. This project will support the steering committee's work by developing a framework to help guide the development of measures of health care efficiency at the episode level. A workshop conducted by NQF will create the framework, with guidance provided by a technical advisory panel. This work will lay the groundwork for new measure sets that more accurately reflect health system performance and are more useful to improvement efforts.

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President and Fellows of Harvard College
$280,046
What Makes for High-Performing Physician Groups: Evidence from Massachusetts
In 2006, the Massachusetts Health Quality Partners issued two reports documenting significant variation in the quality of patient care in physician groups across the state. Why some practices are able to provide consistently high quality care, while others are not, is a question that remains largely unanswered. To determine the organizational, management, and patient demographic characteristics associated with higher performance, the project investigators will survey the leaders of approximately 500 physician practices in Massachusetts and visit four practices for in-depth study. Multivariate analyses will help determine the association between practices' quality scores and those characteristics. By identifying for policymakers and physician groups important determinants of quality, this project has the potential to stimulate targeted quality improvement efforts across the nation.

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Small Grants—Health Care Quality Improvement and Efficiency

Trustees of Boston University
$33,920
Health Information Technology and Quality of Care in U.S. Hospitals

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Bridges to Excellence
$30,000
Evidence-Based Case Rate Clinical Working Group Meeting

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President and Fellows of Harvard College
$35,905
A Comprehensive Approach to Promoting Health Policy and Health Systems Literacy Among Physicians

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National Academy of Sciences
$10,000
Engaging the Computer Science Research Community in Health Care Informatics
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National Committee for Quality Assurance
$49,855
Managed Care Organization Performance on Diabetes Resource Use and Care Effectiveness
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National Quality Forum
$20,000
Implementing Ambulatory Care Performance Measures Conference
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Regents of the University of California
$40,000
Clinical Information Systems and the Adoption of the Chronic Care Model: Use, Benefits and Barriers in Six Community Health Centers
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Rochester Individual Practice Association
$22,225
Evaluating and Improving Practitioner Cost Efficiency: Approaches and Recommendations
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The Urban Institute
$15,000
Impact of New York State Quality Incentive Program on Health Plan Performance
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Wisconsin Collaborative for Healthcare Quality
$49,940
Wisconsin Collaborative for Healthcare Quality: A Detailed Case Study
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Patient-Centered Primary Care Initiative

Massachusetts Health Quality Partners, Inc.
$232,179
Assessing How Health Plans and Providers Use Publicly Reported Information on Patients' Experiences
In March 2006, Massachusetts Health Quality Partners (MHQP) publicly released the results of performance assessments conducted for more than 400 physician group practices. The assessments measured patients' perceptions of the quality of care received. One year later, MHQP seeks to understand how health plans, medical groups, and individual physicians are using these data to stimulate quality improvement (e.g., through use of financial incentives) and implement changes in practice. The investigators will survey 120 physician practices in Massachusetts by telephone as part of the project. As more state and federal agencies, national organizations, and other entities contemplate publicly reporting data on patients' care experiences, a greater understanding of how such information is used could increase the effectiveness of reporting efforts.
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New England Medical Center Hospitals, Inc.
$56,994
Evaluating the Effect of a Physician Communication Skills Training Program on Patients' Care Experiences
How well physicians communicate is a fundamental measure of patients' care experiences. This project will evaluate the efficacy of the Four Habits Model, a patient communication training program for physicians. As part of their work, the investigative team will examine whether the training model has a positive impact on patients' perceptions of their doctors' communication skills, and whether there is greater improvement in some aspects of communication than in others. In addition, the team will explore whether the degree and pace of improvement depends on the timing of physicians' training and subsequent reinforcements provided after the training period ends.
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Pacific Business Group on Health
$80,737
Assessing the Effectiveness of a Collaborative Approach to Achieving Patient-Centered Care
California's pay-for-performance program, which incorporates feedback from patients when calculating financial rewards for physician groups, has thus far led to little improvement in patient experience scores.

Several physician practices have requested guidance on improving communication, access to care, and care coordination. In response, the Pacific Business Group on Health (PBGH) is launching a Breakthrough Series learning collaborative to help physicians provide patient-centered care and to assess whether such interventions can boost the effect of pay-for-performance incentives. This project will support an evaluation of the collaborative that will rely on frequent collection and reporting of patient feedback via telephone surveys. The findings will inform health system leaders, employers, health plans, and clinicians about what it takes to achieve patient-centered care given appropriate financial incentives.

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Pacific Business Group on Health
$123,161
Paying for Performance: Evaluating the Linkages Between Financial Incentives and Improvements in Patient Experiences
This project will analyze the impact of a pay-for-performance program on patients' health care experiences. A number of medical groups in California have been collecting data on patients' health care experiences and reporting this information to individual physicians since 2003, two years before the Integrated Healthcare Association's pay-for-performance program awarded its first financial reward. With Fund support, the Pacific Business Group on Health, along with experts at Tufts-New England Medical Center, will analyze five years of patient survey data regarding individual physicians to assess whether financial incentives promote patient-centered care. The results of the analysis will inform the design of pay-for-performance programs to foster patient-centered care.

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University of Texas Health Science Center
$238,822
Evaluating the Effect of Primary Care Practice Transformation on Patient-Centered Care
TransforMED, a nonprofit initiative established by the American Academy of Family Physicians (AAFP) to transform primary care practice, recently launched a two-year demonstration of this patient-centered care model in 36 U.S. primary care practices. The participating practices will be expected to implement a comprehensive set of innovations to improve health care quality, safety, efficiency, patient-centeredness, access to care, and information systems. Although the AAFP is funding a multimillion-dollar national evaluation, there is currently no plan to assess the impact of the model from the patient's perspective. This project will survey patients served by the intervention to determine if it is helping to make care more patient-centered. Both TransforMED and the AAFP will disseminate evaluation findings as they become available to family practitioners across the country.

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Small Grants—Patient-Centered Primary Care Initiative

Institute for Family-Centered Care
$11,924
Primary Care Programming for the 3rd Conference on Patient and Family Centered Care
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National Committee for Quality Assurance
$43,557
Planning for Implementation of the Patient-Centered Medical Home
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University of Texas Health Science Center
$24,836
The Effect of Primary Care Practice Transformation on Patient-Centered Care
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State Innovations

AcademyHealth
$164,908
State Innovations Program Direction Grant
States have the potential to develop and implement major improvements in the health system. Building on the attributes of high performance identified by the Fund's Commission on a High Performance Health System, over the next five years the State Innovations program aims to assess the status of all 50 states on the major dimensions of performance, identify and support promising ideas and local champions, and encourage replication of successful state efforts by other states and the nation. This grant will provide strategic direction for the program, develop new projects, coordinate ongoing work, and direct efforts to disseminate findings to policymakers and the public. The program director also will participate in the critical review of grantee reports and other Commission-related papers submitted for Fund publication, prepare issue briefs and other materials, represent the Fund in public forums, and contribute more generally to the activities of the Commission.
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Center for Health Care Strategies, Inc.
$179,689
Developing State Capacity to Forecast Return on Investment from Quality Improvement Initiatives
The Center for Health Care Strategies (CHCS) has developed the Return on Investment Forecasting Calculator to help state Medicaid agencies promote quality improvement interventions that have the potential to improve health outcomes while controlling expenditures. In this project, six to eight states will enter a one-year partnership with CHCS and its expert consultants to test the utility of this decision-support tool for projecting the benefits and costs of specific quality-enhancing initiatives. CHCS expects that participating states will implement at least one initiative from among the options they run through the calculator. In addition, CHCS will provide a forum—open to state officials, health plan leaders, and other stakeholders—for disseminating lessons learned and showcasing best practices.

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Center for Health Policy Development
$67,916
The Pennsylvania Learning Exchange: Helping States Improve and Integrate Patient Safety Initiatives
States have few opportunities to learn from one another about successful strategies for reducing medical errors and work together to improve patient safety. The National Academy for State Health Policy (NASHP) proposes to convene government officials from at least 12 states to learn about several promising patient safety initiatives that Pennsylvania has undertaken, among them: the Pennsylvania Patient Safety Authority, charged with identifying safety problems and recommending solutions; the Patient Safety Reporting System, nationally recognized for its quarterly patient safety advisories; and the Health Care Cost Containment Council, the first state agency to assess the human and financial impact of hospital-acquired infections. Informed by the experience of Pennsylvania, participating officials will work together to develop 'action plans' for improving patient safety in their home states. A session at NASHP's annual conference will present results from the project.

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Health Management Associates, Inc.
$86,460
States in Action Newsletter: Six Issues for 2007-08
Many states have developed innovative strategies for stretching their limited health care dollars to improve health system performance. A broad range of initiatives is under way, including collaborations between public and private stakeholders, programs that reward providers for quality and efficiency, and efforts to achieve insurance coverage. To keep track of noteworthy state efforts, the Fund launched an e-newsletter, States in Action: A Bimonthly Look at Innovations in Health Policy, in May 2005. With a circulation approaching 10,000 subscribers, States in Action updates local, state, and federal policymakers, researchers, program administrators, and grantmakers on ongoing activities in the states and promising new initiatives taking place across the nation.

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The Lewin Group, Inc.
$193,628
The State Public Employee Health Plan Forum
State public employee health plans (PEHPs) provide health care benefits for about 13 million state and local workers, retirees, and their families. Given their size and potential influence in the marketplace, these plans could make important contributions to efforts by state and private employers to improve the quality and efficiency of health care delivery. The proposed State Public Employee Health Plan Forum seeks to enhance state-to-state information exchange about the expanded role that PEHPs could play in improvement efforts. Project activities will include: three Web-based conferences; a face-to-face meeting designed for PEHP leaders and other stakeholders; and two papers focusing on state PEHP efforts to promote health care quality and transparency.

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The Urban Institute
$130,345
Monitoring the Impact of Health Care Reform in Massachusetts, Phase 1
The proposed study will evaluate the impact of Commonwealth Care, Massachusetts's recently enacted health care reform legislation, has had on the state's low-income and moderate-income adults in the state. The study will include annual surveys of Massachusetts residents conducted in the fall of 2006, 2007, and 2008. The fall 2006 survey—for which funding is being requested here—will collect baseline information on coverage, access, utilization, and out-of-pocket costs prior to implementation of the reform initiative on October 1, 2006. Subsequent follow-up surveys will gather similar information in 2007 and 2008 to support a pre-post analysis.

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Small Grants—State Innovations

AcademyHealth
$20,000
Support for AcademyHealth's State Health Research and Policy Interest Group Meetings

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University of Arkansas for Medical Sciences
$3,000
Quality Scorecard Forum Review

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Greater New York Hospital Association
$1,000
2007 Annual Symposium on Health Care Services in New York: Research and Practice
Tim Johnson
Executive Director
555 West 57th Street, 15th Floor
New York, NY 10019
(212) 506-5420
tjohnson@gnyha.org

Health Access Texas
$10,000
Health Access Texas Symposium
Patricia Nelson, Ph.D.
President and CEO
1111 Herman Dr., Suite 19A
Houston, TX 77004
(713) 522-8552
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Health Management Associates, Inc.
$50,000
Interoperable e-Health Information Exchange: Crucial Issues Facing States and How They Plan to Address Them - A Survey of All States and Territories
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Health Management Associates, Inc.
$35,700
Six Month Continuation of States In Action Newsletter
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Tides Center
$40,000
Assessing Equity Elements of Selected State Health Law and Proposed Legislation
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Special Populations

Quality of Care for Underserved Populations

Center for Studying Health System Change
$74,980
Analyzing the Special Problems of Providing Quality Care to Minority Patients
Few studies looking at the causes of racial and ethnic disparities in health care have examined the problem at the physician or practice level. Using the nationally representative Community Tracking Study Physician Survey, researchers will look at what physician- and practice-related factors are associated with lower- or higher-quality care for minority patients. The findings will not only inform policymakers about the best ways to allocate resources to reduce disparities, but also possibly influence the design of pay-for-performance programs in minority communities.

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Health Research and Educational Trust
$316,587
Examining the Quality and Efficiency of Care in U.S. Safety Net Hospitals
A large proportion of low-income, uninsured, and minority Americans receive their care in public hospitals and other safety net institutions. Very little is known, however, about the quality of care delivered in these facilities. Using national data provided by the Hospital Quality Alliance and the American Hospital Association, the project investigators will conduct the first national study of quality in safety net hospitals, focusing on the treatment provided to patients admitted with myocardial infarction, congestive heart failure, and community-acquired pneumonia. As part of the study, the project team will also survey safety net hospital leaders to determine the extent to which their institutions possess organizational systems and capacity, such as electronic health record systems, that facilitate engagement in quality improvement activities. Based on these findings, the investigators will recommend steps that safety net hospitals can take to achieve higher performance.

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Institute for Urban Family Health
$266,363
Using Electronic Health Records to Improve Quality and Reduce Disparities in Diabetes Care
Many studies have documented racial and ethnic disparities in the incidence of preventable complications of diabetes, such as loss of limb, blindness, and kidney disease. Such disparities can occur even in the care delivered by safety net providers at the forefront of treating underserved populations. Using clinical data obtained from electronic health records, one such safety net provider, the Institute for Urban Family Health, will identify factors that contribute to high-quality care and improved health outcomes for diabetes patients. The project will be conducted in New York City at the Institute's health centers in Manhattan and the Bronx. Findings from the study will be used to develop a set of "best practices" to be implemented by the Institute and disseminated to other providers to improve overall diabetes care and reduce disparities based on race or ethnicity.

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Massachusetts General Hospital
$72,936
Assessing the Current Role of Pay-for-Performance in Reducing Racial and Ethnic Disparities in Health Care
Although pay-for-performance programs are in place throughout the country, remarkably little is known about their ability to reduce racial and ethnic inequalities in health care. The project investigators will seek to fill this gap by interviewing 30 hospital and health plan executives who are involved in their organization's quality improvement efforts. The structured interviews will yield information about: the extent of provider and plan interest in using financial incentive programs to reduce racial/ethnic disparities in care and outcomes; whether existing pay-for-performance programs have had an impact on inequalities; and methodological and other barriers encountered in using such programs to address disparities. These findings will be of value to hospitals and health plans that are considering the addition of disparity-reduction measures to their pay-for-performance programs.

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University of Texas Southwestern
$96,019
Using Parent Mentors to Improve Asthma Care for Urban Minority Children, Phase 3
This multiphase project is investigating whether parents trained as mentors can improve asthma care for inner-city minority children and lower morbidity for the condition. In Phase 1, project staff recruited parent mentors and began enrolling children and their families in the program. Recruitment continued in Phase 2, and a randomized, controlled trial was initiated. In the third and final phase, project staff will evaluate outcomes of the trial and summarize the experiences of children, parents, mentors, and physicians. Preliminary findings show that some mentored children had their emergency room visits and hospitalizations cut in half. If these results can be confirmed, this model for asthma management has the potential to help certain groups of patients reduce their need for emergency care and hospitalization and lower asthma morbidity, thereby also lowering costs related to asthma care. The model could also empower parents to manage their child's condition.

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University of Florida
$291,466
Development and Testing of the Patient Assessments of Cultural Competency Survey
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys have been used to assess racial, ethnic, and linguistic differences in patients' experiences with care. There are concerns, however, that the surveys do not fully capture aspects of the care experience that are particularly relevant to minority patients, such as access to language services and perceived discrimination. The goal of this project is to test, validate, and disseminate a new survey—the Patient Assessments of Cultural Competency (PACC)—that addresses issues of cultural competency. Once the project team has established the survey's reliability, it will create a short version of the survey to serve as a supplemental module for the CAHPS instruments. The Agency for Healthcare Research and Quality and the National Committee for Quality Assurance have both stated their intention to collaborate on dissemination of the PACC survey.

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Small Grants—Quality of Care for Underserved Populations

AcademyHealth
$3,000
2007 Disparities Interest Group Meeting
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Child Trends, Inc.
$50,000
Analytical Support for Staff in the Program for Quality of Care for Underserved Populations
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Drexel University
$25,000
The Fifth National Conference on Quality Health Care for Culturally Diverse Populations
Dennis P. Andrulis, Ph.D.
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1505 Race Street, MS 660
Philadelphia, PA 19102-1192
(215) 762-6957
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George Washington University
$50,000
Chartbook on Health Status and Healthcare Quality for Minorities in the United States
Bruce Siegel, M.D.
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Fellowship in Minority Health Care

President and Fellows of Harvard College
$800,000
The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: Support for Program Direction and Fellowships, 2007-08
Addressing pervasive racial and ethnic disparities in health and health care requires trained, dedicated physicians who can lead efforts to improve minority Americans' access to quality medical services. The Fellowship in Minority Health Policy has played an important role in addressing these needs. During the year-long program, physicians undertake intensive study in health policy, public health, and management, all with an emphasis on minority health issues, at Harvard University. Fellows also participate in special program activities. Since 1996, 51 fellows have successfully completed the program and received a master's degree in public health or public administration. In the coming year, program staff will select a 12th group of four fellows, provide current fellows with an enriched course of study and career development, and conduct ongoing evaluation activities.

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Child Development and Preventive Care

Center for Health Policy Development
$625,980
ABCD Screening Academy: Supporting Broad Adoption of Developmental Screening
The American Academy of Pediatrics and federal health agencies have called for the routine use of objective screening instruments to identify developmental problems during well-child visits. Since 2000, the Fund has successfully worked with eight states through its Assuring Better Child Health and Development (ABCD) initiative to promote broader use of standardized screening. The time is right to build on the ABCD experience and push for national adoption of developmental screening as a standard of pediatric care. As part of that push, this project will engage up to 20 states in a 15-month ABCD Screening Academy. Its goal will be to encourage states to adopt policies that promote developmental screening, spread screening to pediatric practices, and measure and report progress to statewide leadership committees, which will provide guidance on sustainability and policy development.

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Center for Health Policy Development
$223,927
ABCD II: Building State Medicaid Capacity to Support Children's Healthy Mental Development, 2006-07
In January 2004, the Fund launched the second phase of the Assuring Better Child Health and Development initiative (ABCD II) to help states promote the healthy mental development of low-income children under age 5. As Fund support of the states concludes this year, Medicaid agencies in California, Illinois, Iowa, Minnesota, and Utah are well on their way to ensuring that: young children at risk of developmental or behavioral delay are identified in primary pediatric settings and referred to specialists; parents at risk of depression are referred to mental health professionals; state Medicaid policies are designed to promote standardized screening and referral to follow-up services; and health care professionals are trained to provide higher-quality preventive pediatric care. In the year ahead, the National Academy for State Health Policy (NASHP) will: 1) provide technical assistance to the states to help them achieve success; 2) distill and synthesize lessons learned through publications, national meetings, and the NASHP Web site; and 3) disseminate project results and tools to state policymakers, health care leaders, and pediatric clinicians.

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Boston Medical Center
$106,206
Developing New Evidence Standards for Child Development and Health Promotion Services, Phase 2

A lack of standards for evaluating the effectiveness of preventive and developmental services for children has impeded pediatricians from obtaining adequate reimbursement for much preventive care—and it may jeopardize coverage of such care in the future. In the first phase of this project, the project team achieved consensus among key stakeholders around the need to create a new model for evaluating evidence in support of these generally low-cost, low-intensity services. The second phase of work will support a national consensus-generating process that should culminate in an agreement on new evidence standards and in the dissemination of those standards.

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Oregon Health & Science University
$324,768
Expanding Use of the Promoting Healthy Development Survey
With Fund support, the Child and Adolescent Health Measurement Initiative developed the Promoting Healthy Development Survey (PHDS), the first survey of parents to gauge the quality of preventive and developmental services provided to young children. The instrument has been validated and tested with nine state Medicaid agencies, four health plans, 46 pediatric practices, and a national survey. Those currently using the PHDS—state agencies, health plans, and pediatric providers—have reported that the information it provides is helpful in assessing, stimulating, and monitoring quality improvement activities. This project will develop tools to administer, complete, and score the survey on the Web. In addition, the team will implement a strategic plan for dissemination of the PHDS to national organizations, state health policy officials, health plans, and health care providers.

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Park Nicollet Institute
$150,981
Developing Electronic Health Record-Based Quality Measures for Child Development and Preventive Pediatric Care
Electronic health record (EHR) systems have great potential to facilitate the monitoring and assessment of developmental and preventive health services for young children. To help health care providers take full advantage of EHRs for quality improvement, this project will develop, test, and refine a set of EHR-based performance indicators for well-child care. Throughout the project, the investigative team will be working with a consortium of integrated health care delivery organizations that have well-established EHR systems, as well as with experts in quality measurement and EHR technology. The resulting indicators, together with information to help providers use them to improve children's care, will be disseminated through conference presentations, scholarly articles, reports, and technical support materials.

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Regents of the University of California
$142,522
Reaching Consensus on Quality Performance Measures for Developmental Services
Recent evidence shows that many children are not receiving the developmental and preventive health services they need. With states increasingly interested in improving the quality of well-child care, experts

in pediatric care need to reach a consensus on the best ways to measure and monitor the quality of these services. This project will create a framework for measuring the quality of developmental services and recommend a small set of key measures that states should use to assess and track quality. Results will also be presented to the National Committee for Quality Assurance, the National Quality Forum, and other measurement organizations able to promote use of the new measures by health plans and systems.

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Stanford University
$125,312
Planning the Implementation of an Innovative Model of Well-Child Care in a Health Maintenance Organization
Current pediatric office practice is inefficient and of variable quality, especially with regard to preventive care. Building on a framework for high performing well-child care developed by the project investigator with previous Fund support, this project will create a detailed implementation plan to transform pediatric practice in an innovative health maintenance organization. The planning process will be guided by the health plan's leaders as well as a national advisory board of child health experts. If implementation is successful, additional Fund support might be requested to help transform well-child care in other interested health plans.

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University of Vermont
$316,967
Fostering Partnerships Within States to Improve Children's Development and Preventive Services, Phase 2
In November 2004, the Fund provided a grant to the University of Vermont to support the development of state and local initiatives in Arizona, New York, Rhode Island, Washington, and the District of Columbia to bring together a wide range of stakeholders—from public health departments and Medicaid agencies to pediatric organizations and community organizations—to improve preventive and developmental services for young children. All five sites have successfully matched the Fund's support with local resources to launch the partnership, engaged physician practices in pilot projects to improve developmental services, and mapped out a strategy to sustain the nascent infrastructure for improving children's health care quality in their state or locality. In Phase 2, project staff will bring this quality improvement model to five new states, create a learning community of the new and existing partnerships, and disseminate results nationwide.

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Small Grants—Child Development and Preventive Care

American Academy of Pediatrics, Inc.
$35,585
Evaluating the Feasibility of Structured Developmental Screening and Surveillance in Pediatric Practice
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American Academy of Pediatrics, Inc.
$2,475
Training Residents in Developmental and Behavioral Pediatrics
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Child and Family Policy Center
$4,900
Identifying Policy Priorities Related to Child Development in the Context of SCHIP Reauthorization
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Executive Director
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Children's Hospital Medical Center
$29,843
Informing State and Federal Policy Choices that Affect Quality of Care in SCHIP
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The Commonwealth Fund
$10,090
Child Development and Preventive Care Leadership Meeting
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Connecticut Children's Medical Center
$49,210
Developing Care Coordination as a Critical Component of a High Performance Pediatric Health Care System
Richard Antonelli, M.D.
Director, Department of General Pediatrics

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Health Policy Alternatives, Inc.
$26,200
External Review of the Commonwealth Fund's Child Development and Preventive Care Program
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National Initiative for Children's Healthcare Quality
$15,000
6th Annual Forum for Improving Children's Health Care
Ann Marchetti
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Society for Developmental and Behavioral Pediatrics
$15,000
2007 Society for Developmental-Behavioral Pediatrics Education Workshop
Nancy E. Lanphear, M.D.
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Wayne State University
$23,175
The Science of Children's Development: a Curriculum for Pediatric Residency Education
Bonita Stanton, M.D.
Chair of Pediatrics
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Detroit, MI 48201
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Picker/Commonwealth Program on Quality of Care for Frail Elders

AcademyHealth
$169,505
The Commonwealth Fund/AcademyHealth Long-Term Care Colloquium, Year 4
Picker Program Grant
AcademyHealth's successful Long-Term Care Colloquium series brings together policymakers, providers, and researchers to forge a common agenda for addressing key issues in the field and to ensure that research findings reach those in a position to take action. The 2007 colloquium will again consist of a day-long meeting and a half-day policy seminar held in Washington, D.C. Possible colloquium topics include: establishing successful collaborations among practitioners, policymakers, and researchers; long-term care workforce issues; end-of-life care and disease management; and nursing home culture changes. In

addition, ongoing workgroups will help colloquium participants continue discussions begun during the meeting.

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American Association of Homes & Services for the Aging
$170,833
Assessing State Investments in Culture Change
Picker Program Grant
Resident-centered care will become the norm in the nation's nursing homes only if all major stakeholders use their influence to stimulate culture change. Because states finance nursing homes and monitor their quality, they are ideal catalysts for change. Several states have already embraced the idea of resident-centered care and are actively promoting culture change; this study will develop case studies of the approaches that six states are pursuing. The project team will disseminate findings through fact sheets, issue briefs, and the Web. Tools and materials will also be available through the Fund's Web site to assist other states seeking to transform their nursing homes.

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Brown University
$188,629
The Commonwealth Fund Long-Term Care Policy Survey: Assessing Experts' Views
Picker Program Grant
The development of a rational long-term care system is stymied by a disjointed array of federal and state policies that reimburse and regulate residential as well as home- and community-based long-term care services. At the same time, powerful market forces, responding to consumer demand, are causing providers and policymakers to rethink how the long-term care needs of the frail elderly might best be met. This project will undertake the first comprehensive survey of experts in the long-term care field to focus on what policy changes are the most important and viable, and what are most likely to make a difference in the type of services delivered to frail elders. Working closely with Fund staff, the investigators will identify the sample, construct the instrument with input from a project advisory committee, and conduct the Web-based survey. At the conclusion of the survey, project staff will convene three focus groups of critical stakeholders to discuss how the survey findings might inform policy action.

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Rhode Island Department of Health
$277,429
Improving the Nursing Home Regulatory Survey Process to Promote Resident-Centered Care
Picker Program Grant
Nursing homes are governed by a set of regulations intended to promote resident-centered care. Surveyors, however, often interpret these regulations as emphasizing clinical care. As a result, many providers perceive the regulatory survey process to be the biggest impediment to culture change. This project will analyze federal regulatory policies and guidelines to see how they might be used to promote resident-centered care. Working closely with the Centers for Medicare and Medicaid Services, the project team will seek input from providers, consumer advocates, and culture change experts on alternative ways

to interpret the regulations. The Rhode Island surveyors will pilot-test, evaluate, and disseminate their enhanced interpretive guidelines to state survey agencies nationwide.

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University of Maryland, Baltimore
$191,392
Improving Practices for Lifting Nursing Home Residents: Impact on Resident Outcomes and the Safety and Productivity of Nurse's Aides
Picker Program Grant
As part of the daily care they provide, nurse's aides must frequently lift and reposition frail residents. High rates of back and other injuries among aides have significant consequences not only for them, but for residents and for overall operational efficiency. By using mechanical lift devices, nursing homes can avoid at least some of these consequences. The research team, in collaboration with the National Commission of Compensation Insurers, will conduct a survey of 300 directors of nursing to assess facility lift practices. The team will analyze this data, along with measures of resident well-being, work-related injuries and costs, and caregiver productivity, to compare the impact of different lifting procedures. Study findings will inform state policymakers who are considering legislation regarding lift practices, as well as nursing homes and quality improvement organizations.

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University of Pittsburgh
$348,419
Improving Quality of Life in Nursing Homes Through Use of Structured Resident Interviews
Picker Program Grant
In nursing homes, good care is not just about good clinical care; at least as important is the quality of residents' daily lives. Quality-of-life issues, however, are rarely discussed at care planning meetings. The investigators for this project will draw upon research they conducted previously for the Centers for Medicare and Medicaid Services (CMS) to develop and test a structured interview guide that will enable nursing home staff to ask residents directly about problems they are experiencing and then design interventions to correct them. The project team will work with CMS to include items from the quality-of-life screen in the new Minimum Data Set—the federally mandated standardized assessment of resident care.

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Small Grants—
Picker/Commonwealth Program on Quality of Care for Frail Elders

American Association of Homes and Services for the Aging
$15,682
Organizational Readiness and Implementation Guide Revision

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Cornell University
$30,700
Linking Technology Implementation to Culture Change and Resident Centered Care
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President and Fellows of Harvard College
$31,662
Evaluating the Impact of Nursing Home Quality Improvement Organizations Under the 8th Scope of Work
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National Academy of Sciences
$5,000
Health Care Workforce for an Aging Society
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Southern Illinois University
$30,000
The Liability Environment for Physicians Providing Nursing Home Medical Care: Legal Apprehensions and Their Consequences for Residents' Quality of Care and Quality of Life
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Garwin Distinguished Professor of Law and Medicine
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University of Wisconsin Milwaukee
$24,287
DementiaDesignInfo.org: A Lexicon for the Planning and Design of Dementia Care Environments
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International Health Policy and Practice

The Commonwealth Fund
$285,000
International Symposium on Health Care Policy, Fall 2007
The Fund's 10th annual International Symposium on Health Care Policy will focus on major reforms in industrialized countries aimed at achieving a high performance health care system. Topics will include the changing public–private mix of financing and delivery, initiatives aimed at increasing market competition, and consumer choice as a lever for quality improvement. In bringing together leading policymakers and researchers from Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States—as well as other selected European countries—the symposium will highlight for U.S. policymakers the strategies followed by other health systems to ensure universal coverage, improve quality, and achieve greater efficiency. To reach broader policy audiences, the Fund will webcast a health ministers' roundtable discussion and hold the second day of the symposium on Capitol Hill. The international perspectives heard at the meeting will also inform the work of the Fund's Commission on a High Performance Health System.

Robin Osborn
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(212) 606-3809
ro@cmwf.org

The Commonwealth Fund
$1,266,603
Harkness Fellowships in Health Care Policy and Practice, 2008-09
Support for an 11th class of Harkness Fellows in Health Care Policy and Practice will allow the Fund to continue to develop promising policy researchers and practitioners from Australia, Canada, Germany, New Zealand, and the United Kingdom. The inaugural class of German Harkness Fellows began their tenure in September 2006, and a new partnership with the Robert Bosch Foundation will provide support for a second German Harkness Fellow each year, beginning in 2007. To maintain the program's competitiveness and broaden its policy impact, program changes are planned beginning with the 2008-09 class: an increase in the value of a Harkness Fellowships award, the addition of a research and travel supplement for Canadian Associates, and the expansion of the fellowships to the Netherlands. As fellows return home, publish their findings, and move into leadership positions, they demonstrate their positive influence on health policy and practice.

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The Commonwealth Fund
$50,000
Enhancing International Program Communications and Publications Capacity
To strengthen the impact of the International Program in Health Policy and Practice (IHP), two external contractors will work with IHP and Communications staff to maximize publications produced from IHP-sponsored work and to develop a dissemination strategy that raises the Fund's profile as a source of cross-national analysis of health system performance for policymakers, researchers, and journalists. The contractors will author articles for Health Affairs submission, as well as Fund issue briefs and reports; prepare cross-national policy syntheses for the Fund Web site; and serve as editorial reviewers for papers commissioned for the International Symposium and international quality improvement meetings. In so doing, they will enhance the Fund's capacity to bring international innovations and lessons learned to the attention of U.S. audiences.

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Harris Interactive, Inc.
$347,800
International Health Policy Survey, 2007
The 2007 International Health Policy Survey will assess health care system performance and responsiveness from the perspective of patients and the general public. Conducted in Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States, the study will examine the public's views on access, cost, and quality of care experiences and assess confidence in the direction of change and government policy. The survey will also solicit consumers' views on policies that promote patient engagement in care decisions, availability of information on cost and quality, and provider performance incentives. Survey findings, which will be released at the Fund's 2007 International Symposium, should generate substantial interest among health ministers, policymakers, researchers, and the media, as well as inform the Commission on a High Performance Health System. Project staff will submit a paper discussing survey results to Health Affairs for Web publication.

Jordon Peugh
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161 Sixth Avenue, 6th Floor
New York, NY 10013
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jpeugh@harrisinteractive.com

Johns Hopkins University
$61,000
Cross-National Comparisons of Health Systems Quality Data, 2007
Comparisons of the U.S. health care system with those of other industrialized countries reveal striking differences in spending, availability and use of services, and health outcomes. This project will produce the 10th paper in an annual series of analyses of key health data for the 30 member-nations of the Organization for Economic Cooperation and Development (OECD). The authors will provide an update of overall trends in health systems' performance, with an emphasis on the core dimensions of high performance. A secondary theme will be national financing strategies and the impact of various approaches to the public/private mix. Findings will be presented at the Fund's October 2007 International Symposium and submitted to the journal Health Affairs for Web publication. The chartpack containing core OECD data that is currently available on the Fund's Web site will be updated as a resource for journalists, policymakers, and researchers.

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(410) 955-3241
ganderso@jhsph.edu

London School of Economics and Political Science
$109,340
Achieving a High Performance Health Care System: A Comparative Study of Six European Health Systems
This project will assemble a team of leading experts from the European Observatory on Health Systems and Policies to examine health system performance and policy approaches in six countries: Denmark, Germany, the Netherlands, Sweden, Switzerland, and the United Kingdom. The goal is to determine what U.S. policymakers can learn from the world's other advanced health care systems, many of which have undertaken ambitious reforms. Using the framework established by the Fund's Commission on a High Performance Health System, the project will address the following questions: Why do some countries perform better than others in certain areas? Can we identify policy trends and innovations? What policies have or have not been successful and why? The answers will not only inform the Commission's efforts to improve U.S. health system performance, but will guide the International Program as it expands its focus

to include additional countries. Project findings will be discussed in a manuscript submitted to Health Affairs and in a set of Fund issue briefs.

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The Nuffield Trust
$70,000
Commonwealth Fund/Nuffield Trust International Conference on Health Care Quality Improvement, 2007
Since 1999, the Fund and The Nuffield Trust have sponsored annual symposia that have brought together senior government officials, leading health researchers, and practitioners from the United States, the United Kingdom, and Australia for an exchange on quality improvement policies and strategies. These forums have provided a unique opportunity for building relationships among senior policymakers in participating countries, showcasing innovations in quality improvement, and facilitating an ongoing exchange on what works and what does not in the quality improvement arena. The eighth conference in this series will explore challenges in delivering high-quality, efficient acute care, with a focus on coordination of care among hospitals, primary care settings, and nursing homes. The conference will examine issues around: patient safety, communication and information technology, hospital readmissions, and transitional care needs of complex, chronically ill patients. Project staff will explore opportunities for cross-national collaboration to improve coordination of care for hospital patients.

Kim Beazor
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59 New Cavendish Street
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44 207 631 8450
kim.beazor@nuffieldtrust.org.uk

Small Grants—International Health Policy and Practice

Canadian Association for Health Services and Policy Research
$10,000
2007 Canadian Association for Health Services and Policy Research Conference

Kevin Barclay
Executive Director
292 Somerset Street West
Ottowa, Ontario K0A 2Z0
Canada
(613) 235-7180
kbarclay@cahspr.ca

Cancer Care Ontario
$38,000
Defining a High Performance Cancer Care System: A Five Country Comparison of Canada, France, Germany, the United Kingdom, and the United States

Terrence Sullivan, Ph.D.
President and Chief Executive Officer
620 University Avenue
Toronto, Ontario M5G 2L7
Canada

(416) 217-1244
terry.sullivan@cancercare.on.ca

Center for Quality of Care Research
$35,000
Expansion of 2007 Commonwealth Fund International Health Policy Survey to Include the Netherlands
Richard Grol
Professor and Director
P.O. Box 9101, 117
6500 HB Nijmegen
The Netherlands
31-24-361-5305
r.grol@wok.umcn.nl

The Commonwealth Fund
$10,000
International Session at AcademyHealth Annual Research Meeting: 'International Comparisons of Primary Care Policy and Practice: An Opportunity for Cross-National Learning'
Robin Osborn
Vice President & Director, IHP
One East 75th Street
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ro@cmwf.org

The Joint Commission
$25,000
Action on Patient Safety ('High 5s')
Karen Timmons
President & CEO
Joint Commission International
1515 W 22nd Street, Suite 1300W
Oak Brook, IL 60523
(630) 268-7430
ktimmons@jcrinc.com

New York University
$25,206
French Health System Performance
Victor Rodwin, Ph.D.
Professor of Health Policy and Management
Puck Building, 2nd Floor
295 Lafayette Street
New York, NY 10012
(212) 998-7459
victor.rodwin@nyu.edu

Organisation for Economic Cooperation and Development
$32,000
Experts Workshop on Responsiveness Indicators to Compare Health System Performance in Industrialized Countries
Niek S. Klazinga
Professor of Social Medicine
AMC - UVA
Department of Social Medicine
Room J - 215
PO Box 22660
Amsterdam NL-1100 DD
The Netherlands

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n.s.klazinga@amc.uva.nl

University of British Columbia
$34,325
Quality of Medicine Use in Seven Countries
Steven G. Morgan, Ph.D.
Assistant Professor, Health Care and Epidemiology
Centre for Health Services and Policy Research
429-2194 Health Sciences Mall
Vancouver, British Columbia V6T 1Z3Z
Canada
(604) 822-7012
morgan@chspr.ubc.ca

Communications

Harris Interactive, Inc.
$52,000
Health Care Opinion Leaders Survey, Year 3
The Fund recently strengthened its quarterly online surveys of health care opinion leaders through a partnership with Modern Healthcare magazine. The surveys, conducted by Harris Interactive, ask leaders for their views on a range of key health policy issues and options for addressing them. Survey results, along with commentaries written by top policy experts, are published in the print and online editions of Modern Healthcare and posted as well on the Fund's Web site. In addition, data briefs prepared by Fund staff examine the relevance of survey findings to the work of the Commission on a High Performance Health System. Building on the success of this project to date, the Fund will support an additional year of quarterly surveys covering major issues that are closely aligned with the Commission's work.
Jordon Peugh
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jpeugh@harrisinteractive.com

Project HOPE/The People-to-People Health Foundation, Inc.
$215,000
Web Publishing Alliance with Health Affairs
The Fund's online publishing partnership with the policy journal Health Affairs has provided opportunities to publish Fund-supported research faster and more frequently than traditional means allow, while also raising the Fund's professional and public profile. This grant will provide Health Affairs with an additional year of funding for general Web operations as well as development of papers on international policy issues.
John K. Iglehart
Founding Editor of Health Affairs
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814
(301) 656-7401 ext. 243
jiglehart@projecthope.org

Small Grants—Communications

American Public Media
$50,000

Marketplace's Health Desk: Support for Coverage of Health Care Economics and International Innovations

Jon K. Gossett
Senior Vice President for Development
480 Cedar Street
St. Paul, MN 55101
(651) 290-1212
jgossett@americanpublicmedia.org

American Society on Aging
$5,000
2007 Journalists Reception and Dinner/Joint Conference of the American Society on Aging

Paul Kleyman
Editor, Aging Today
833 Market Street, Suite 511
San Francisco, CA 94103-1824
(415) 974-9619
paulk@asaging.org

Association of Health Care Journalists
$10,000
Association of Health Care Journalists Annual Conference

Len Bruzzese
Executive Director
10 Neff Hall
Columbia, MO 65211
(573) 884-5606
len@healthjournalism.org

Association of Health Care Journalists
$10,000
Association of Health Care Journalists Urban Workshop

Len Bruzzese
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10 Neff Hall
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(573) 884-5606
len@healthjournalism.org

Society of American Business Editors and Writers, Inc.
$15,000
Spring and Fall Conference Journalist Training

Carrie Paden
Executive Director
University of Missouri-Columbia
385 McReynolds Hall
Columbia, MO 65211
(573) 882-8985
padenc@missouri.edu

Organizations Working with Foundations

AcademyHealth
$15,000
General Support

W. David Helms, Ph.D.
President and Chief Executive Officer

1150 17th Street, NW, Suite 600
Washington, DC 20036
(202) 292-6700
david.helms@academyhealth.org

Foundation Center
$15,000
General Support
Sara L. Engelhardt
President
79 Fifth Avenue
New York, NY 10003
(212) 620-4230
sle@fdncenter.org

Grantmakers for Children, Youth, and Families, Inc.
$2,500
General Support
Stephanie McGencey, Ph.D.
Executive Director
8757 Georgia Avenue, Suite 540
Silver Springs, MD 20910
(301) 589-4293
smcgencey@gcyf.org

Grantmakers in Aging, Inc.
$6,500
General Support
Carol A. Farquhar
Executive Director
7333 Paragon Rd., Ste. 220
Dayton, OH 45459-4157
(937) 435-3156
cfarquhar@giaging.org

Grantmakers In Health
$15,000
General Support
Lauren J. LeRoy, Ph.D.
President and Chief Executive Officer
1100 Connecticut Avenue, NW, Suite 1200
Washington, DC 20036
(202) 452-8331
lleroy@gih.org

Health Services Research Association of Australia & New Zealand
$1,300
General Support
Jane Hall
Professor and Director
C/- CHERE
Faculty of Business, UTS
P.O. Box 123 Broadway NSW 2007
Sydney, Australia
(612) 9351 0921
jane.hall@chere.uts.edu.au

Independent Sector
$12,500
General Support

Diana Aviv
President and Chief Executive Officer
1200 18th Street, NW, Suite 200
Washington, DC 20036
(202) 223-8100
diana@independentsector.org

International Society for Quality in Health Care, Inc.
$1,000
General Support
Lee Tregloan
Chief Executive Officer
212 Clarendon Street
East Melbourne, Victoria 3002
Australia
+613 9417 6971
tregloan@isqua.org

New York Regional Association of Grantmakers
$13,000
General Support
Ronna D. Brown
President
79 Fifth Avenue, Fourth Floor
New York, NY 10003-3076
(212) 714-0699
rbrown@nyrag.org

Nonprofit Coordinating Committee of New York
$35,000
General Support
Michael E. Clark
President
1350 Broadway, Suite 1801
New York, NY 10018-7802
(212) 502-4191
mclark@npccny.org

Rockefeller University
$90,000
Transfer and Maintenance of The Commonwealth Fund's Archives, Part 11
This grant will support the transfer, processing, and storage of additional Commonwealth Fund materials at the Rockefeller Archive Center, which has housed the Fund's archives since 1985.
Darwin H. Stapleton, Ph.D.
Director
Rockefeller Archive Center
15 Dayton Avenue
Sleepy Hollow, NY 10591-1598
(914) 631-4505
stapled@mail.rockefeller.edu

Small Grants—Special Opportunities

Academy for Educational Development
$5,000
Educational Equity Center Awards Dinner 2006
Keika Shimmyo

Special Events Assistant
100 Fifth Avenue, 8th Floor
New York, NY 10011
(212) 367-4603
kshimmyo@aed.org

National Medical Fellowships
$7,500
National Medical Fellowships 10th Annual Awards Dinner
Esther R. Dyer
President and CEO
5 Hanover Square, 15th Floor
New York, NY 10004
(212) 483-8880 ext. 302
erdyer@nmfonline.org

New York Academy of Medicine
$6,000
New York Academy of Medicine 2007 Gala
Jo Ivey Boufford, M.D.
Professor
1216 Fifth Avenue
New York, NY 10029-5293
(212) 822-7201
jboufford@nyam.org

Primary Care Development Corporation
$5,000
Primary Care Development Corporation 2007 Spring Gala
Ronda Kotelchuck
Executive Director
22 Cortlandt Street, 12th Floor
New York, NY 10007
(212) 437-3917
ronda@pcdcnyc.org

United Hospital Fund of New York
$8,500
2006 United Hospital Fund Gala
James R. Tallon, Jr.
President
350 Fifth Avenue, 23rd Floor
New York, NY 10118
(212) 494-0700
jtallon@uhf.org

Women's Prison Association and Home, Inc.
$4,000
Women's Prison Association Benefit Dinner: 2007 Spring Gala
Ann L. Jacobs
Executive Director
110 Second Avenue
New York, NY 10003
(212) 674-1163
ajacobs@wpaonline.org

Summation of Program Authorizations

Year Ended June 30, 2007	Major Program Grants	Picker Program Grants	Small Grants Fund Grants	Total
Program Grants Approved				
High Performance Health System	$8,268,158	—	$878,318	$9,146,476
Commission Activities	$1,848,864	—	$85,500	$1,934,364
Future of Health Insurance	$1,288,222	—	$134,781	$1,423,003
Medicare's Future	$1,458,651	—	$166,000	$1,624,651
Health Care Quality Improvement and Efficiency	$2,117,582	—	$252,020	$2,369,602
Patient-Centered Primary Care Initiative	$731,893	—	$80,317	$812,210
State Innovations	$822,946	—	$159,700	$982,646
Special Populations	$3,967,326	$1,261,455	$432,849	$5,661,630
Quality of Care for Underserved Populations	$1,226,153	—	$135,500	$1,361,653
Commonwealth Fund/Harvard University Fellowships in Minority Health Policy	$800,000	—		$800,000
Child Development and Preventive Care	$1,941,173	—	$172,385	$2,113,558
Picker/Commonwealth Program on Frail Elders		$1,261,455	$124,964	$1,386,419
International Health Care Policy and Practice	$2,189,743	—	$190,000	$2,379,743
Communications	$215,000	—	$90,000	$305,000
Other Continuing Programs	$206,800	—	$71,905	$278,705
Total Program Grants Approved	$14,847,027	$1,261,455	$1,663,072	$17,771,554
Grants Matching Gifts by Directors and Staff				$510,304
Program Authorizations Cancelled or Refunded and Royalties Received				($411,984)
Total Program Authorizations				**$17,869,874**

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