Ensuring that all health care providers—from physician practices to nursing homes—are responsive to the needs and preferences of patients is one of the key components of high performance and a central goal of The Commonwealth Fund.

Photo: Roger Carr

THE COMMONWEALTH FUND

2006 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 2006 Annual Report offers highlights of the Fund's activities in the past year

- **The Best Health System in the World.** In her essay, Commonwealth Fund president Karen Davis discusses the results of the National Scorecard on U.S. Health System Performance and highlights innovations at home and abroad that offer useful roadmaps for change.

- **The Fund's Mission, Goals, and Strategy**
- **Commission on a High Performance Health System**
- **Program Highlights, 2006**
  - The Future of Health Insurance
  - State Innovations
  - Medicare's Future
  - Health Care Quality Improvement and Efficiency
  - Patient-Centered Primary Care Initiative
  - Special Populations
  - International Program in Health Policy and Practice
- **The Commonwealth Fund Performance Scorecard.** Executive vice president and chief operating officer John E. Craig, Jr., discusses the "balanced scorecard" adopted by the Fund to measure organizational effectiveness, clarify goals and strategies, and ensure continued high performance.
- **Treasurer's Report** and **Financial Statements**
- **The Fund's Founders and Benefactors**
- **Directors and Staff**
- **Grants Approved, 2005–2006**

Photo: Roger Carr

Karen Davis

President's Message

2006 ANNUAL REPORT

The Best Health System in the World

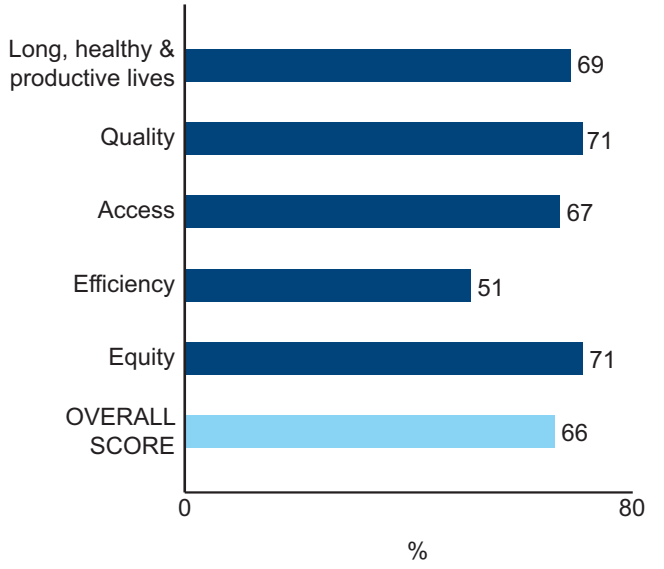
With some of the best-equipped hospitals and most highly specialized physicians in the world, it is no wonder that many people believe the U.S. health system is the best on earth. The evidence, however, suggests this confidence is misplaced.

According to the National Scorecard on U.S. Health System Performance, the United States scored just 66 out of 100 when comparing the nation's average performance on three dozen indicators against benchmarks set either within the U.S. or abroad. Given America's high standards—and high spending on health care—that is simply unacceptable.

The national scorecard is the creation of the Commonwealth Fund Commission on a High Performance Health System. Established in July 2005, the Commission seeks to move the nation toward a system of care affording better access, higher quality, and greater efficiency for all members of society, including the most vulnerable. With the release of the scorecard in September 2006, the Commission has made substantial progress in meeting a primary objective—setting realistic benchmarks and targets to track change over time. The coming year will be devoted to a fact-finding process to identify and analyze promising approaches being used across the country and around the world. Later in its tenure, the Commission will recommend immediate and long-term practical steps and policy measures.

In the sections that follow, I review the scorecard's main findings to highlight where our current health system falls short; discuss the central messages that emerge; and, aided by real examples of high-performance health care, outline a blueprint for change.

Scores: Dimensions of a high performance health system



Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

WHAT'S WRONG: A SNAPSHOT

The Commission's scorecard on U.S. health system performance focuses on five core goals:

- Long, healthy, and productive lives;
- High-quality care;
- Access for all;
- Efficient care; and
- Equitable care.

The scorecard's data highlight areas within each category where the U.S. health system currently falls short.

Long, Healthy, and Productive Lives

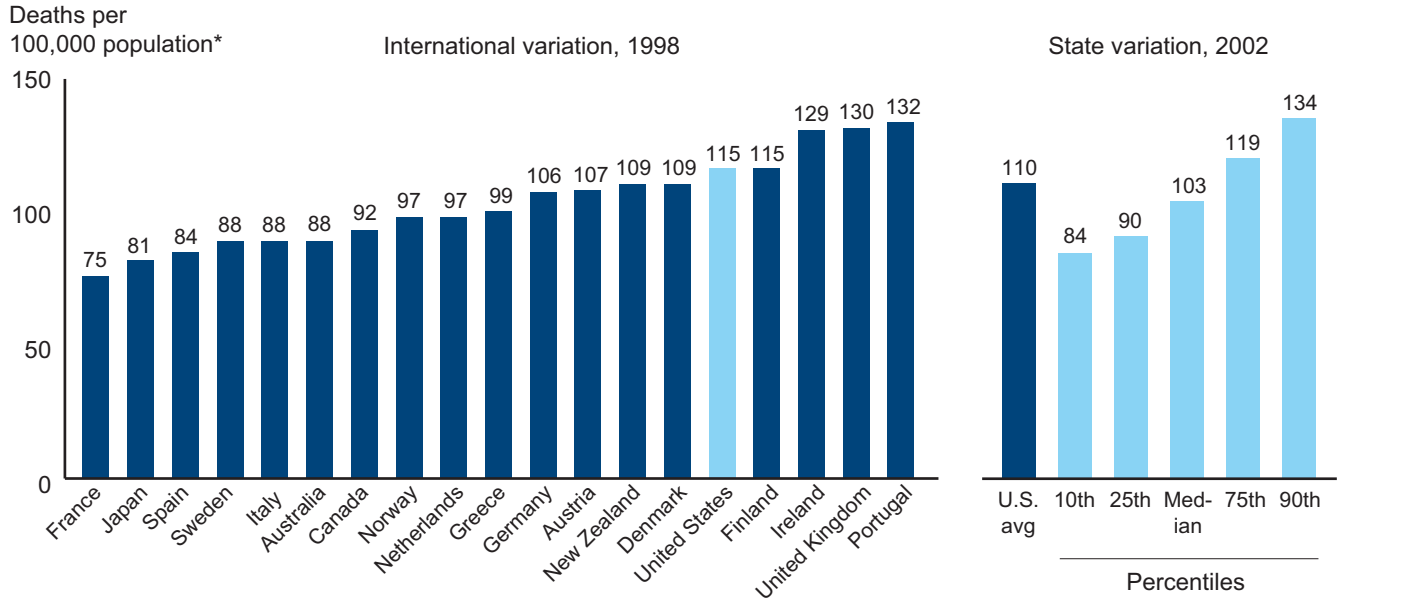
The overriding expectation for a health system is that it ensures the opportunity for a long, healthy, and productive life for everyone. The Commission scorecard includes indicators of mortality, healthy life expectancy, and health-related limitations faced by children and adults.

Poorer Health Outcomes, Higher Mortality. Across five indicators of health outcomes, the U.S. scores 69 compared with the benchmark performance of 100. On no indicator of health outcomes is the U.S. the best. The traditional excuse—that the U.S. population is "different"—is not convincing. The indicators were selected to focus on the effect of the health care system, not on health outcomes primarily related to socioeconomic determinants of health or health behaviors such as smoking or diet.

One indicator, for example, focuses on mortality from conditions "amenable to health care"—a measure of death rates before age 75 from diseases and conditions that are preventable or treatable with timely, effective medical care. The U.S. ranked 15th

Mortality amenable to health care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003); State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.
Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

out of 19 countries, with a death rate 30 percent higher than France, Japan, and Spain.

Yet hidden in these sobering findings is a glimmer of hope: if all U.S. states performed at the same level as the five best performing states, the U.S. would be on a par with the best countries. Spreading proven best practices from a few pockets of excellence to the entire U.S. health system will be a critical step in improving outcomes.

High-Quality Care

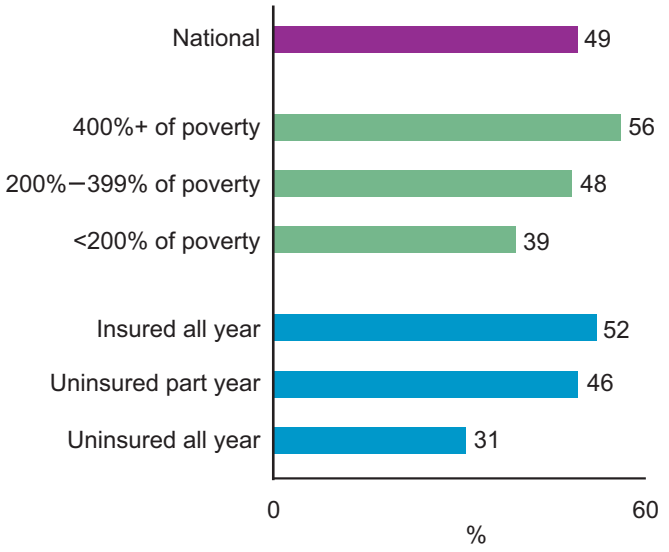
Ensuring that patients get the "right care" and that the care is safe, well-coordinated, and patient-centered is the essential foundation of high-quality care. On 19 indicators capturing these dimensions of care, the U.S. scored an average of 71 out of a possible 100.

Too Little Preventive Care. Slightly less than half of U.S. adults are up-to-date with preventive care recommended by the U.S. Preventive Services Task Force. Not surprisingly, the poor and uninsured figure prominently in this group, but even among adults earning four times the poverty rate, only 56 percent received appropriate preventive care.

Spotty Chronic Care Management. Proper management of chronic conditions is essential to good care, and is an especially important task as the population ages. The good news is that the proportion of the population with their diabetes adequately controlled has improved modestly in the last five years. The bad news is that this varies widely, ranging from 79 percent in the best privately insured plans, to 23 percent in the bottom 10 percent of Medicaid managed care plans.

Receipt of recommended screening and preventive care for adults, by family income and insurance status, 2002

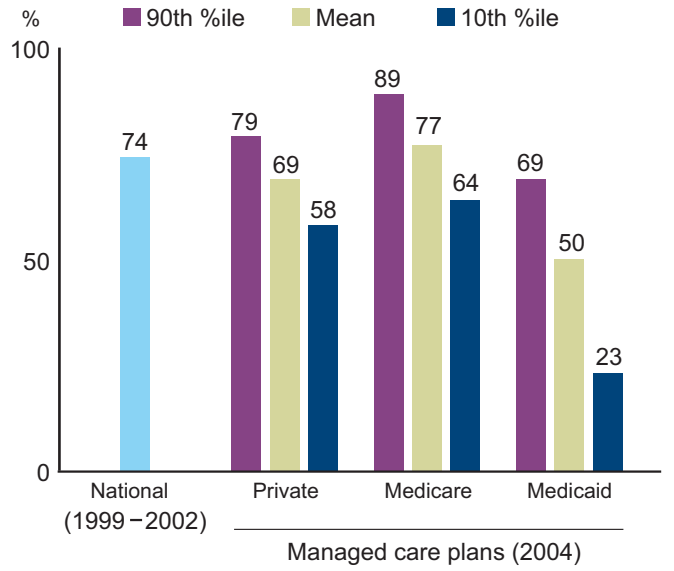
Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*



* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot.
Data: B. Mahato, Columbia University analysis of 2002 Medical Expenditure Panel Survey.
Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Diabetic adults who have blood glucose levels under fair control, national and managed care plan type

Percent of adults with diagnosed diabetes whose HbA1c level <9.0%



Note: National estimate includes ages 18+ and plan estimates include ages 18–75.
Data: National estimate—National Health and Nutrition Examination Survey (AHRQ 2005a); Plan estimates—Health Plan Employer Data and Information Set (NCQA 2005a, 2005b).
Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Inadequate Coordination. Coordination of patient care throughout the course of treatment and across various sites of care helps to ensure appropriate follow-up treatment, minimize the risk of error, and prevent complications. But about a third of adults and more than half of all children did not have a medical home with a physician who is easily accessible and a central source of care and referrals to specialists.

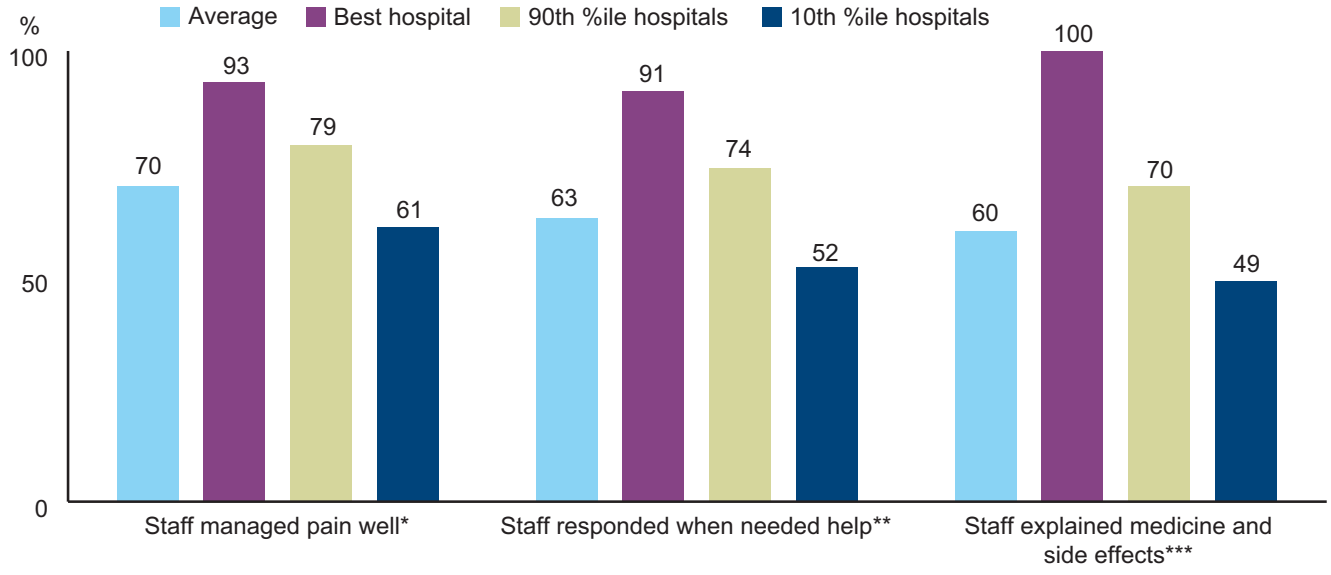
Ensuring coordination of care is especially critical at the time of discharge from a hospital. The Commission's scorecard found that patients with congestive heart failure received written care instructions when discharged only half the time—with a gap of 80 percentage points between the top and bottom 10 percent of hospitals. Failure to manage conditions after discharge can result in trips to the emergency room or rehospitalization, with associated human and financial costs.

Unreliable Care and Processes. More than six years ago, the Institute of Medicine published its landmark report, *To Err Is Human,* calling for implementation of systems to ensure patient safety.[1] Yet, one-third of American patients surveyed in the Fund's 2005 international survey said that in the last two years a medical mistake or a medication or lab test error was made during their care. In order to reach the levels of reliability achieved by the benchmark countries, Germany and the United Kingdom, the U.S. must reduce its error rate by one-third.

Insufficient Focus on Patients' Preferences. Patient-centered care is care delivered with the patient's needs and preferences in mind. When care is both patient-centered and delivered in a timely manner, patients are more likely to adhere to treatment plans, to be fully engaged in care decisions, and to receive better care overall.

Patient-centered hospital care: staff managed pain, responded when needed help, and explained medicines, by hospitals, 2005

Percent of patients reporting "always"



* Patient's pain was well controlled and hospital staff did everything to help with pain.
** Patient got help as soon as wanted after patient pressed call button and in getting to the bathroom/using bedpan.
*** Hospital staff told patient what medicine was for and described possible side effects in a way that patient could understand.
Data: CAHPS Hospital Survey results for 254 hospitals submitting data in 2005. National CAHPS Benchmarking Database. Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

In the mid-1980s, The Commonwealth Fund became one of the pioneers in the patient-centered care movement, calling for regular surveys of hospitalized patients to learn from their experiences with care. Among 254 hospitals voluntarily reporting results in 2005, there was a substantial differential between the top- and bottom-performing groups of hospitals on how well they manage pain, respond when patients press call buttons or need help, or explain medications and possible side effects. In the fall of 2007 the Medicare program will require all hospitals to report standardized patient-centered care survey results.

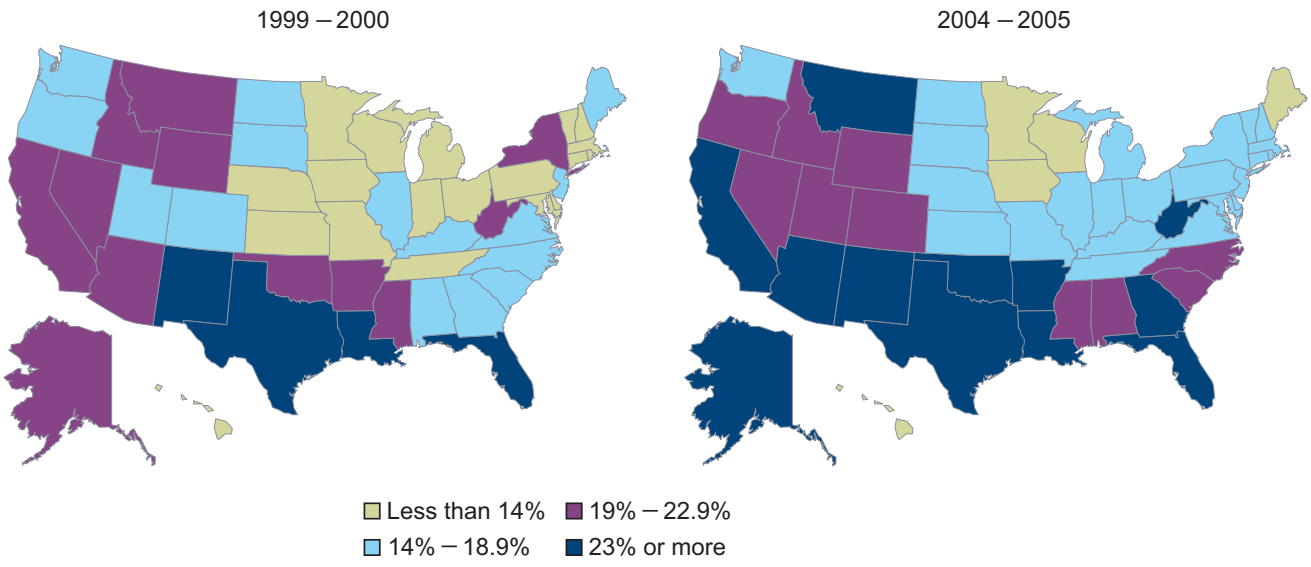
Access to Care

Access to care is a critical hallmark of health system performance. The single most important factor determining whether people can obtain essential health care is whether they have health insurance coverage. The scorecard looks at the percent of the population that is uninsured or underinsured, patient reports of difficulties obtaining needed care, and measures of affordability of insurance and care for families and employers. On these access indicators the U.S. scored 67 out of a possible 100.

Inadequate Insurance Coverage. In 2005, 46.6 million people were uninsured, 7 million more than in 2000. Because insurance coverage is very unstable and changes as people change jobs or life circumstances, 28 percent of working-age adults are uninsured at some point during the year. Cost pressures have also led employers to limit benefits and require higher deductibles and more cost-sharing by patients. As a result, at least 16 million insured adults are underinsured, and can experience financial difficulties obtaining care.

Rates of uninsured adults varied in 2004–2005 from 30 percent in Texas to 11 percent in Minnesota. By contrast nearly all major industrialized countries provide universal and comprehensive health insurance coverage.

Percent of adults ages 18–64 uninsured by state



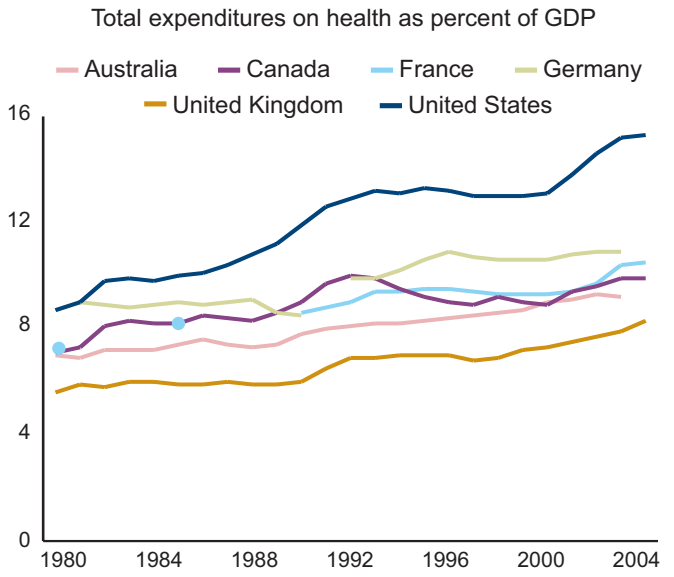
Data: Two-year averages 1999–2000 and 2004–2005 from the Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Surveys. Estimates by the Employee Benefit Research Institute.
Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Efficiency

The U.S. spends 16 percent of its gross domestic product on health care—twice as much as the typical industrialized nation, and growth in health spending in recent years has outpaced that of other major countries. On eight efficiency indicators, the Commission scorecard averages 51 out of 100—in other words, average U.S. performance would have to double to reach the best benchmarks.

Overuse, Misuse of Care. Duplication, overuse or inappropriate care—sometimes the result of our fragmented health system—contribute to high costs in the United States. U.S. adults are more likely to report that medical records and test results are not available when needed, and that tests are duplicated or unnecessary. Care that is not evidence-based, such as imaging tests for lower-back pain with no apparent risk factors or signs of serious pathology, adds unnecessarily to costs.

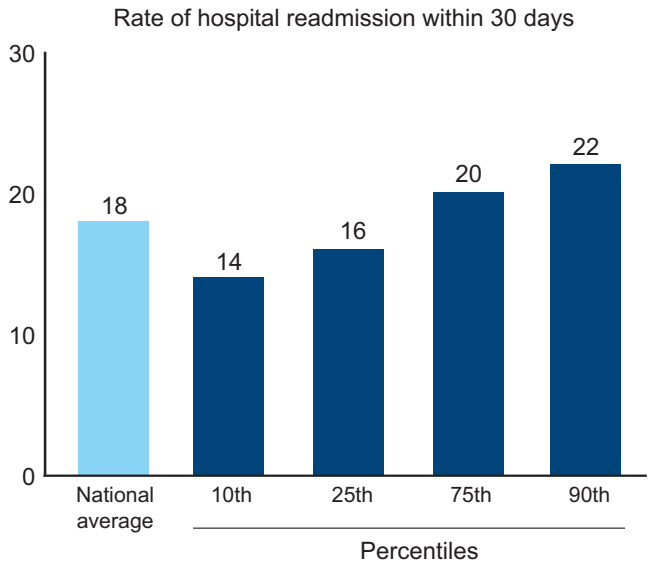
International comparison of spending on health, 1980–2004



Data: OECD Health Data 2005 and 2006.
Note: Data missing for France 1981–84 and 1986–89.
Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Too Many Admissions and Readmissions. Inadequate access to primary care, whether during regular office hours or after-hours, contributes to expensive visits to the emergency room or admission to the hospital. Americans are more likely to report use of emergency rooms for conditions that could have been treated by a primary care physician, if available. Hospitalization for potentially preventable conditions such as congestive heart failure, diabetes, and pediatric asthma vary two- to four-fold. Bringing national rates of preventable hospitalizations down by 10 percent to 20 percent could save $4 billion to $8 billion annually.

Medicare hospital 30-day readmission rates and associated costs, by hospital referral regions, 2003

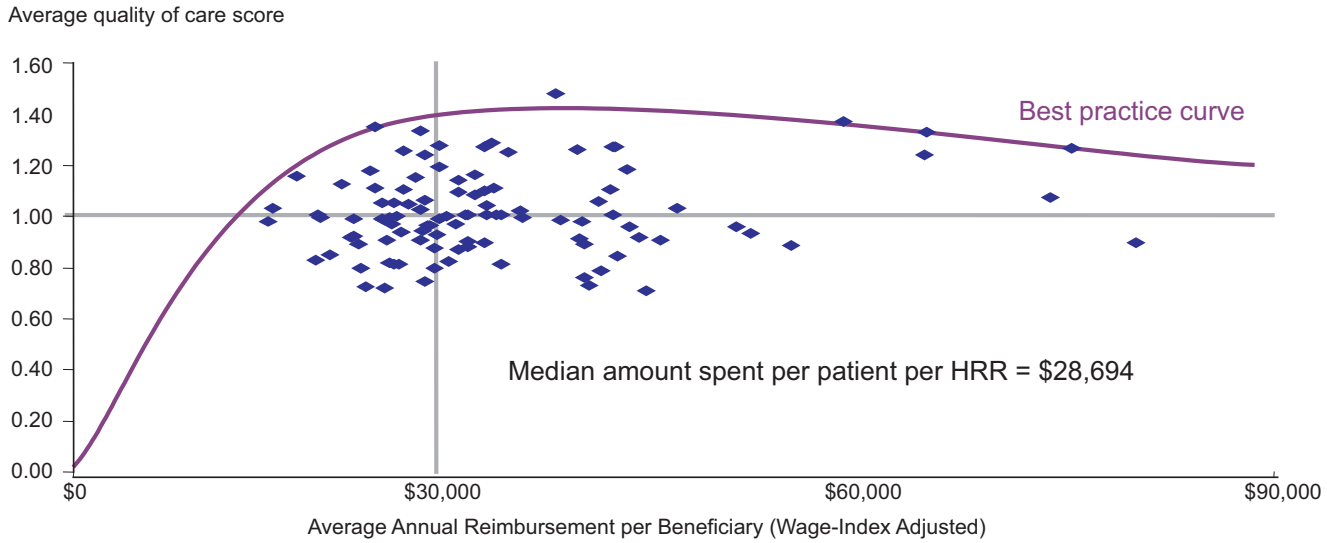


Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of 2003 Medicare Standard Analytical Files (SAF) 5% Inpatient Data. Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Wide Variations in Quality and Cost. Quality and cost vary widely across the U.S., but there is no evidence that higher spending produces higher quality, yielding the strong suggestion that it is possible—paramount, really—to improve quality and reduce cost.

Variation in annual total cost and quality for chronic disease patients

Quality of care* and Medicare spending for beneficiaries with three chronic conditions, by hospital referral region



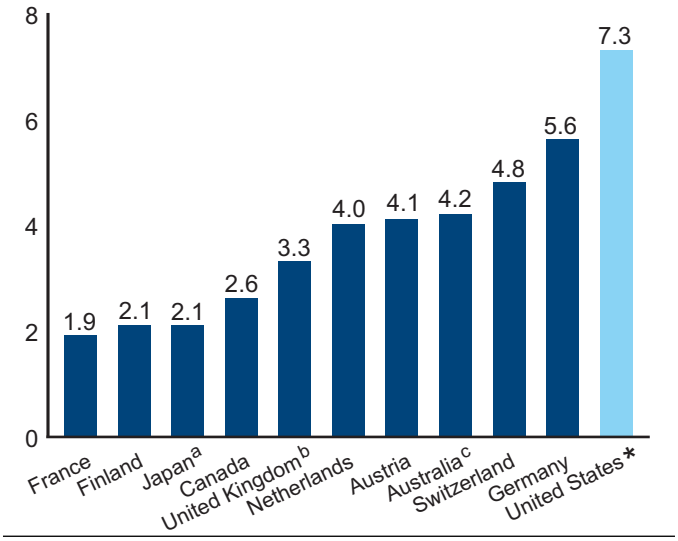
* Based on percent of beneficiaries with three conditions (diabetes, chronic obstructive pulmonary disease, and congestive heart failure) who had a doctor's visit four weeks after hospitalization, a doctor's visit every six months, annual cholesterol test, annual flu shot, annual eye exam, annual HbA1c test, and annual nephrology test.
Source: G. Anderson and R. Herbert for The Commonwealth Fund, Medicare SAF 5% 2001 data.

For example, data show that if all Medicare patients being treated for heart attacks, hip fractures, or colon cancer received the quality of care delivered by the benchmark regions, Medicare would save an estimated 8,400 lives and $900 million annually.

High Administrative Costs. Insurance administration costs contribute significantly to the high cost of care in the U.S., without contributing to commensurate gains in quality of care or health outcomes. As a percentage of national health expenditures, U.S. insurance administrative costs are more than three times the rates found in countries with the most integrated insurance systems (France, Finland, and Japan), and 20 to 30 percent higher than those in Germany and Switzerland, two countries where private insurance plays a substantial role. If U.S. administrative costs were on a par with the best countries, we would save $85 billion a year.

Percentage of national health expenditures spent on health administration and insurance, 2003

Net costs of health administration and health insurance as percent of national health expenditures



[a] 2002 [b] 1999 [c] 2001
* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.
Data: OECD Health Data 2005.
Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Not Enough Reliance on Information Technology. U.S. physicians lag well behind their counterparts abroad in use of electronic medical records—a key component of health information technology. Fewer than one of five U.S. doctors said they used electronic records, compared with nearly 90 percent in the top two countries.

EQUITY

Despite the fact that our country was founded on the principle of equal opportunity, and that eliminating disparities in health and health care has for years been a national policy priority, there remain significant differences in the care and health outcomes of Americans depending on their insurance coverage, income, and race or ethnicity.

Disparities Based on Income, Insurance, Race and Ethnicity. The average gap in health outcomes, quality, access, and efficiency between uninsured populations and the benchmark insured populations is 34 percent, while the gap between low-income and high-income groups is 38 percent. Additionally, risk rates are higher for Hispanics and African Americans for being uninsured and for having inadequate access to primary care and preventive care. Widely known is the fact that African American mortality rates are strikingly higher for heart disease, diabetes, and infant mortality.

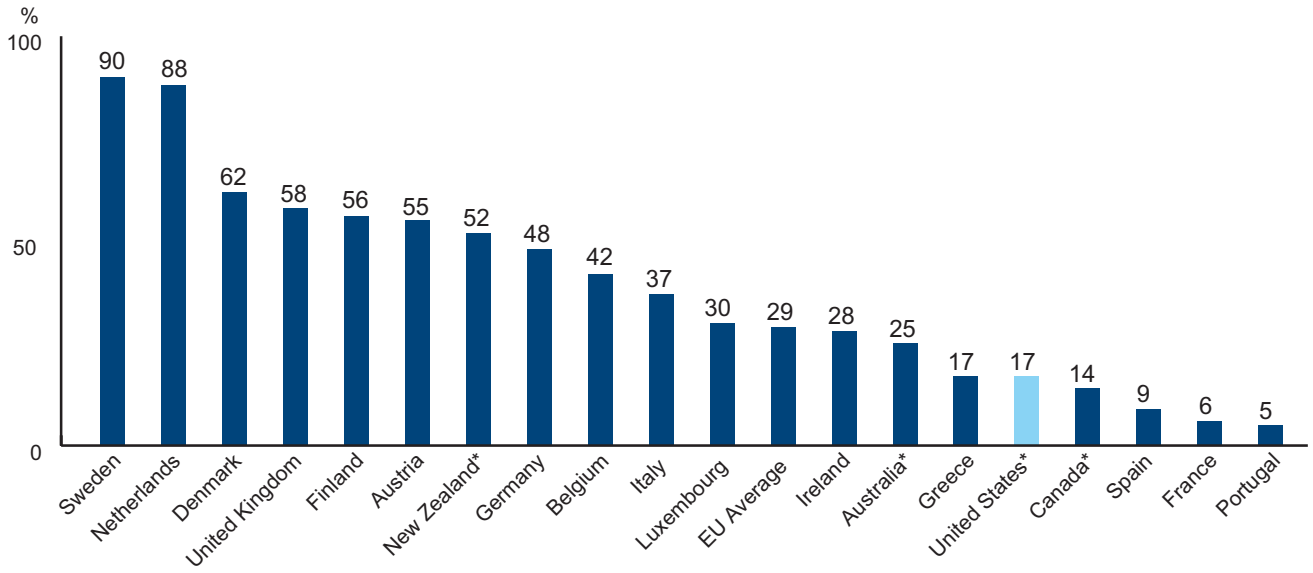
LESSONS FROM THE SCORECARD

The central messages emanating from the scorecard are clear. Whether measured in dollars or human terms, we are paying an unaffordable price for our health system's lackluster performance. In order to address the system's shortcomings, we must:

- *Simultaneously improve access, quality, and efficiency*. These elements are interrelated, and strategies focused on improving only one aspect of care are unlikely to achieve the central goal of long, healthy, productive lives for all Americans. All federal and state health policy proposals and private sector actions

Physicians' use of electronic medical records, U.S. compared with other countries, 2001

Percent of physicians



* 2000

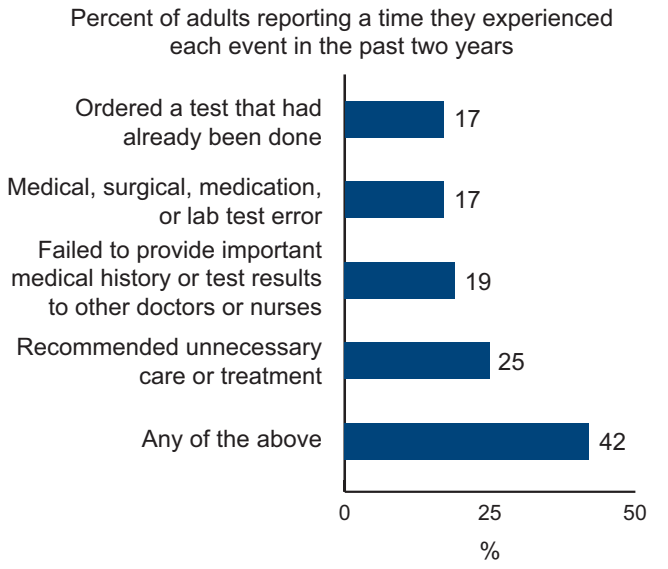
Data: 2001 European Union EuroBarometer and 2000 Commonwealth Fund International Health Policy Survey of Physicians (Harris Interactive 2002). Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

should be assessed to determine their likely impact on moving us forward as a nation on these core goals.

- *Ensure universal participation in health care and reduce disparities.* The percentage of working-age adults without insurance is up sharply since 2000 despite a growing economy. Loss of comprehensive health insurance coverage puts families and the nation at risk of losing ground on past gains in improved health and workforce productivity.
- *Reduce costs.* There is ample evidence that savings can be generated from improved efficiency in the health care system. Waste and duplication from our fragmented system of coverage and care abound. Widely varying hospital readmission rates from one hospital to another, one city or state to another, suggest that better transitional and follow-up care—and better support for self-care—after hospital discharge can improve quality and lower costs. The challenge is not just identifying and implementing best practices, but redirecting those savings into investments in improved coverage and system capacity to improve performance in the future.
- *Coordinate and integrate care.* Failure to coordinate care for patients over the course of treatment as they see multiple physicians, are hospitalized and rehospitalized, cared for at home by home health aides, or in nursing homes, takes an enormous toll on all fronts. Tests are repeated as records are lost or unavailable when needed. Patients with serious health problems receive conflicting advice and become increasingly frustrated and disaffected as their time and energy are expended finding their way through a complex and seemingly impersonal health system.

Inefficient, poorly coordinated, unsafe care

High rates of duplicate tests, medical errors, failures to share information, or times doctors recommended unnecessary care



C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, ***Public Views on Shaping the Future of the U.S. Health System*** (New York: The Commonwealth Fund, Aug. 2006).

Because our health care system has been slow to invest in the people, research, and infrastructure necessary to catalyze and implement the kind of sweeping change the scorecard calls for, we must also improve our capacity to improve. This will require:

- *A highly motivated health care workforce.* Particularly in the nation's hospitals and long-term care facilities, high turnover among "front-line" workers, such as nursing home aides—a result of low wages, a lack of benefits, and stressful working conditions—puts the health and quality of life of patients and residents at serious risk. Shortages of primary care physicians, nurses, and other key health personnel further undermine health system performance.

- *More research on evidence-based care and innovative delivery models.* While we spend nearly $2 trillion on health care, we devote just $1.5 billion to health systems research, less than $1 for every $1,000 in national health care spending.
- *Greater investment in information technology.* Electronic information systems show considerable promise for enhancing efficiency, eliminating duplication and waste, reducing medical errors, assisting physicians, nurses, pharmacists, and other health professionals in delivering the best care, and ensuring that patients are informed, active partners in their care. The U.S. lags behind leading nations in its use of such systems.
- *Improved capacity to measure quality.* Quality is unlikely to be improved if it cannot be measured. The current capacity of the U.S. system to measure and assess performance is fragmented and highly variable. Lack of more integrated data systems across the multiple private and public payers undermines national, state, or regional public or private efforts to assess access, quality, or efficiency of care.

Everyone has a stake and a role to play in transforming the health care system to achieve superior performance.

Armed with the right information and support, patients can take greater responsibility for their health. Physicians, hospitals, and other health care providers can work collaboratively to ensure that patients receive safe, effective, and coordinated care reliably. Insurers and employers can offer coverage that ensures access to essential services and enhances the health and productivity of the workforce, and mobilize their administrative records to provide information useful to patients and providers.

State governments can assess how well the health system performs within their own borders, and pursue the policies of best-performing states that are generating superior results. And the federal government can play a leadership role, ensuring that transparency and accountability in health care become commonplace, that coverage is affordable to all, and that care meets rigorous, evidence-based standards.

WHAT'S RIGHT: A BLUEPRINT FOR CHANGE

Although the task of overhauling our health care system is enormous, benchmark practices, organizations, or even nations offer useful and sometimes inspiring roadmaps to change. Some of the changes these examples suggest will require new policies at the federal or state level. Others rest in the hands of health care leaders who make decisions every day about the way health care is organized, delivered, and financed.

These seven key strategies show great promise for ensuring that the U.S. scorecard in the future will yield truly excellent results.

1. Expand Health Insurance to All

Case in Point: State of Maine

Surveys of health care opinion leaders and the public consistently show that ensuring that all Americans have adequate, reliable health insurance coverage should be the top health policy priority for Congress and the President.[2] Yet the gap between that ideal and today's reality remains huge.

Several states—including Maine, Massachusetts, Minnesota, Rhode Island, and Vermont—are leading the way by implementing creative and pragmatic approaches to achieving universal health insurance coverage.[3] Strategies that support these efforts include

Positive public views on the need for quality and cost information and payments that reward performance

How important is it to you that: (percent)	Total very or somewhat important	Very important	Somewhat important
You have information about the quality of care provided by different doctors or hospitals	95	77	18
You have information about the costs of care to you BEFORE you actually get the care	91	69	22
Insurance companies identify and reward doctors and hospitals who achieve excellence in the quality and efficiency of care	87	62	25

C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, ***Public Views on Shaping the Future of the U.S. Health System*** (New York: The Commonwealth Fund, Aug. 2006).

subsidies, mandates, taxes, public-private partnerships, and policy changes such as raising the age of dependence in parents' health insurance plans.

The State of Maine launched DirigoChoice in January 2005, an affordable insurance product that offers reduced monthly premium rates and deductibles based on income, using a sliding scale up to 300 percent of the poverty level.[4] Comprehensive benefits include 100 percent coverage of preventive benefits and cash-back incentives for participation in wellness programs. Currently the program insures nearly 13,000 people.

DirigoChoice is part of Dirigo Health, a comprehensive set of reforms enacted with the goal of providing all Maine residents with access to health care by 2009. (Dirigo is Maine's state motto, meaning "I lead.") Dirigo Health aims to do more than insure the poor and subsidize coverage for those who need it. It is designed to contain costs through efforts such as reducing bad debt and charity care, creating a capital investment fund, exercising tighter oversight on growth and expansion of health care facilities, and providing financial incentives for consumers to choose cost-effective providers. It also aims to improve quality by using information technology, including electronic health records, throughout the state. The new Maine Quality Forum, meanwhile, serves as a clearinghouse of best practices and related health information.

Dirigo Health has been controversial since its inception. It has claimed $43.7 million savings during its first two years. Under the program's financial structure there is a tax on insurance premiums equal to the savings offset. The Commonwealth Fund is supporting an evaluation of Maine's initiative.

The Fund is also supporting an evaluation of a newer initiative in Massachusetts. We hope to learn from these efforts to make financing coverage a shared responsibility of employers, state and federal government, and individuals. But public policy changes at the national level and increased federal financing are likely to be needed to extend these approaches to states with higher rates of uninsured and more limited ability to fund coverage from local sources. A forthcoming Commonwealth Fund analysis of national health legislative proposals introduced in Congress will lay out a wide range of ideas for consideration.[5]

2. Increase Transparency and Reporting on Quality and Costs

Case in Point: Massachusetts Health Quality Partners

Public reporting of information on the performance of health plans and providers can spur improvements in quality and efficiency by helping consumers make more informed decisions and by stimulating providers and health plans to be more accountable for their results.

It can also form the basis for new payment systems that reward providers for excellence and efficiency. Commonwealth Fund surveys indicate that most patients do not have access to the cost and quality information that would enable them to make informed choices, but they very much want access to such information.[6]

Strong public support for well-coordinated care

How important is it to you that: (percent)	Total very or somewhat important	Very important	Somewhat important
You have one place/doctor responsible for primary care and coordinating care	92	75	17
You have easy access to medical records	94	79	15
All your doctors have easy access to your medical records	93	77	16
Care from different doctors is well coordinated	96	79	17

C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, ***Public Views on Shaping the Future of the U.S. Health System*** (New York: The Commonwealth Fund, Aug. 2006).

A number of notable initiatives provide purchasers, consumers, and providers themselves with information about quality. The Pennsylvania Health Care Cost Containment Council, or PHC4, an independent state agency created in 1986, is a state-funded initiative to publish comparative data on hospital performance, including costs and complication rates. In 2005 PHC4 was the first organization in the nation to publish data on hospital-acquired infections.

Public reporting of hospital or medical group quality has also advanced in California under the leadership of the Pacific Business Group on Health and the Integrated Healthcare Association, as well as by state government quality reporting efforts in Minnesota, New Jersey, and New York.

The Wisconsin Collaborative for Healthcare Quality (WCHQ), a voluntary collaborative, develops and publicly reports comparative performance information on physician practices, hospitals, and health plans through an interactive Web-based tool. WCHQ has earned credibility among health care providers because the measures are reported in ways that allow member groups to identify variation by physician practice and target areas for improvement.[7]

With Commonwealth Fund and Robert Wood Johnson Foundation support, Massachusetts Health Quality Partners (MHQP) has publicly released clinical quality data as well as patients' ratings of their experiences with doctors' offices throughout the state.[8] Data on the clinical performance of primary care physicians are now publicly available at the medical group level in Massachusetts. Formed in 1995, Massachusetts Health Quality Partners gathered information from the state's five largest private health plans on the quality of care provided by 150 medical groups. The coalition then posted these data on its Web site to encourage consumers to search for high-quality providers and guide physicians looking to improve their performance.

This information enables consumers to evaluate the performance of medical groups across 15 measures of clinical quality developed by the National Committee for Quality Assurance as part of the Health Plan Employer Data and Information Set, or HEDIS, as well as patient experiences with their care from physicians. Consumers can search for quality information by physician name and location.

The MHQP coalition, which has worked to engage physicians in the data release process,

recognizes that public disclosure is an essential step in the process of quality improvement. By providing data on physician groups—rather than limiting the release to state performance averages—it is possible to identify variations in care and begin to understand why some groups perform better than others. This year's report, for example, found significant variation in how well physicians care for patients with depression, those with asthma, and teenagers.

The Commonwealth Fund is also supporting projects to better understand variations in cost and quality across hospitals, medical groups, and geographic areas, and to assist providers and health plans in responding to the increasing availability of comparative data.

3. Implement Proven Quality and Safety Improvements

Case in Point: University of Colorado Health Sciences Center

Substantial gains in health system performance could be achieved if all providers were to adopt the "proven." These include use of evidence-based medicine, promoting effective chronic care management techniques, "reengineering" delivery within and among provider organizations to improve safety and reliability, and ensuring care coordination across sites of care, especially when transitioning from the hospital to other settings.

The Institute for Healthcare Improvement has been a leader in mobilizing hospitals and other providers to implement proven quality and safety improvements, saving lives and dollars.[9] Hospitals and health systems throughout the nation have achieved stunning improvements in clinical outcomes and cost reduction by standardizing care processes based on proven best practices.

Some efforts are institutional, and some are broader. The Pittsburgh Regional Health Initiative is an unusual collaborative of 44 hospitals in southwestern Pennsylvania that works together to improve together. The group shares data, information, ideas, successes, and failures openly, focusing on a wide range of clinical and safety issues. As a result, more than 30 of the region's hospitals have reduced the incidence of a lethal, hospital-acquired bloodstream infection by 68 percent.[10]

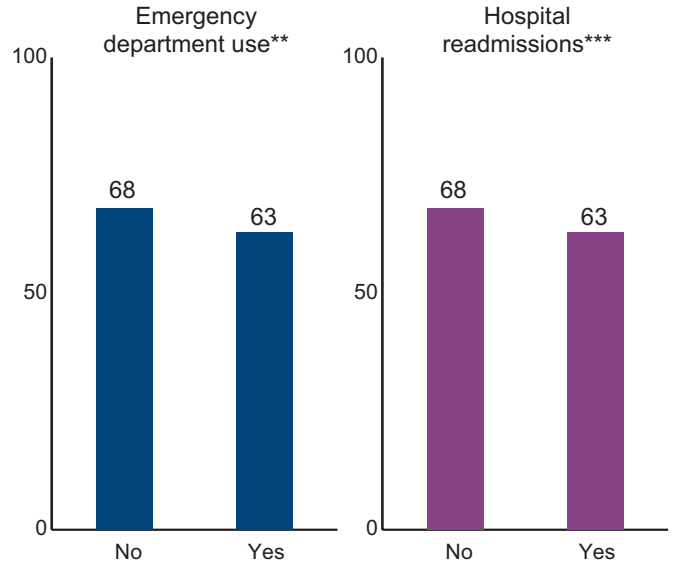
A Fund-supported effort by Eric Coleman, M.D., at the University of Colorado Health Sciences Center, is creating more effective forms of "transitional care" for patients returning home from the hospital. The goal is to ensure their care needs are met while avoiding preventable complications and costly rehospitalizations.

Dr. Coleman has worked to develop quality-of-care measures to help pinpoint problems that occur during the transition from one site of care to another. This led to the development of the Care Transitions Measure, which includes a discharge preparation checklist that asks patients to sign off on statements such as: "The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital"; and "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health"; and "When I left the hospital, I clearly understood the purpose for taking each of my medications." The Care Transitions Measure has been adopted by the National Quality Forum as the best measure of care coordination.

In an intervention to improve care coordination at Group Health Cooperative in Seattle, patients receive

Coordinated care across sites of care

Care transition measure scores*



* "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health"; "when I left the hospital, I clearly understood the purpose for taking each of my medications"; "the hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital".
** p = 0.01 *** p = 0.04
Source: Adapted from E. A. Coleman, "Windows of Opportunity for Improving Transitional Care," presentation to Commonwealth Fund Commission on a High Performance Health System, Mar. 30, 2006.

tools and are taught skills reinforced by a "transition coach" who follows patients across care settings for the first 30 days following their discharge from the hospital. Dr. Coleman has found that patients who participate are less likely to be readmitted during this time—and even in the six months following discharge.

4. Reorganize Health Delivery to Emphasize Patient-Centered Primary Care

Case in Point: Denmark

The U.S. is strikingly different from other industrialized countries in one important respect: its relative underinvestment in primary care. The U.S. has a much lower proportion of primary care physicians, and much better financial rewards for specialty care. A review of the literature indicates that better access to primary care lowers total cost and improves outcomes.[11]

Reorganizing the U.S. primary care system by moving to a "patient-centered medical home" model of primary care that employs teams of physicians, advanced practice nurses, and other professionals, and an organized system of off-hours care could improve the accessibility, effectiveness, and efficiency of care. A Commonwealth Fund survey of public views of the health system finds strong support for such a reorganization of care.

In Denmark, which has the highest public satisfaction with health care of any country in Europe, primary care is much more accessible than in the U.S.[12] Using a blend of capitation and fee-for-service payment, Denmark ensures that everyone has a primary care physician or "medical home," and generalist physicians typically provide services quickly, often in same-day appointments. An organized off-hours service assures accessible care from physicians 24 hours a day, seven days a week.

An interconnected health information system ensures that the patient's medical home has a complete and up-to-date record of filled prescriptions, lab and imaging results, specialist consultation reports, and hospital discharge information. Patients can e-mail their physician, book appointments, get prescription refills, and review their medication list online. Most importantly, patients are reminded about preventive services. As a result, 94 percent of women now have up-to-date Pap tests, and cervical cancer mortality dropped by 60 percent between 1988 and 2001.[13]

Most countries ensure that patients face no financial barriers to preventive and primary care, while the U.S. has been increasingly moving toward high-deductible health plans. Insurance should be designed to remove, not increase the financial barriers to early preventive and primary care. Public programs

and private insurers could also help improve care coordination by offering enrollees choices of patient-centered medical homes or advanced physician practices that take responsibility for ensuring patients receive accessible care, appropriate preventive care, and ongoing management of chronic conditions, while coordinating their care across different providers.

Payment reform to reward medical homes including a blended system that incorporates features of fee-for-service, monthly per-patient fees, and bonuses for excellence in clinical quality, patient-centered care, and efficiency could make primary care a more rewarding choice of practice.

5. Expand the Use of Information Technology

Case in Point: Rhode Island Information Exchange

Progress in improving health system performance will be difficult without widespread use of modern information technology. Electronic health records, decision support for physicians, computerized order entry systems, and patient access to their own medical information can help to reduce costs and improve safety and efficiency. Such systems are costly, and the benefits often accrue to insurers rather than providers who adopt such systems.

A Commonwealth Fund-supported set of case studies of smaller physician practices' adoption of electronic medical records found, however, that even in these settings providers can recover the capital costs of relatively simple systems in two to three years. Some health systems, such as Intermountain Health Care in Utah, Partners HealthCare in Boston, and Geisinger Health System in Pennsylvania, have used decision support systems to guide physicians in ordering expensive imaging tests or suggest lower-cost medications that might be suitable. Kaiser Permanente is rolling out a multi-billion-dollar integrated electronic medical and health information system that links clinical records with online patient information, the largest civilian EMR project in the U.S.

In order for the health system to maximize benefits from these individual systems, however, innovation must focus on more sophisticated applications and linking all pieces into an interoperable network. For example, if emergency room physicians have access to a patient's history, they may be able to avoid hospitalizing a patient or prescribing inappropriate medications.

A number of states, including New York and Rhode Island, are promoting an "interconnected" health information system. A Fund-supported evaluation of regional information systems in New York will evaluate the costs and benefits of such systems, as well as determine whether benefits accrue primarily to insurers and costs primarily to hospitals.

The Rhode Island Health Information Exchange (HIE) initiative is a public–private effort to allow providers, with their patients' permission, to electronically access important patient health information from a variety of sources. The sharing of data will be phased in, according to the following stages: 1) laboratory data; 2) medication histories; 3) emergency department and hospital discharge summaries, pathology reports, outpatient procedure records, and child health data; and 4) administrative data. The ultimate goals are to:

- Give consumers access to their health information, and enable them to decide when and with whom they want to share it.
- Use patient index functions to allow for unique identification of individual patients and locate where their health information is stored.

- Present data from a variety of sources in an integrated, patient-centered manner using a common interface, such as a portal or local platform.
- Integrate data into electronic health record applications and support the exchange of these data with others, as permitted.
- Provide decision-support capability.
- Aggregate and utilize data for public health purposes, such as population-based analysis, quality improvement, evaluation, biosurveillance, and research.[14]

6. Reward Quality and Efficiency

Case in Point: New York State

Aligning financial incentives so that health systems, hospitals, and physicians benefit financially from doing the right thing is essential. Our fee-for-service payment system rewards doing more, and rewards providing highly specialized services far more than preventive care or preventing an acute episode for patients with chronic conditions. Payment should be restructured so that providers are reimbursed based on the quality and efficiency of the care they provide.

In New York State, for example, the Department of Health began incorporating quality incentives into the computations of Medicaid managed care capitation rates in 2002. These incentives are tied to performance on 10 quality of care measures and five consumer satisfaction measures. By April 2005, the maximum incentive was 3 percent of the monthly premium. Incentive payments for 2005 totaled $40 million.

The Commonwealth Fund is supporting a qualitative and quantitative analysis of this incentive plan. Preliminary results indicate that rewarding performance does improve quality. For example, the percentage of women with Medicaid coverage who had appropriate postpartum care rose from 49 percent in 1996 through 1999—before the quality incentives were in place—to 68 percent in 2003 and 2004, after the incentives were implemented. When surveyed, 80 percent of senior Medicaid managed care plan executives, including CEOs, CMOs, CFOs, and quality improvement directors, said they believe the incentive program has a positive effect on health plan quality.

In September 2006, the Institute of Medicine issued a report evaluating the institution of a pay-for-performance program within Medicare. The report, *Rewarding Provider Performance: Aligning Incentives in Medicine,* recommends pay-for-performance incentives, which reward providers for delivering high-quality care efficiently, as a means of speeding the process of implementing best practices.

Purchasers, both public and private, can improve quality and efficiency by building performance standards into health plan contracts and developing "incentivized" payment systems that reward quality and efficiency in the provision of acute and chronic episodes of care. Fund-supported evaluations of such payment systems have documented at least modest gains in clinical quality when medical groups receive bonuses for higher quality.

The Fund has also assisted by convening participants in Medicare's physician group practice demonstration to learn from each other about effective practices to both improve quality and control costs.

7. Encourage Public–Private Collaboration

Case in Point: Puget Sound Health Alliance

Creating a "culture of high performance" requires a shared vision among all stakeholders. Public and private sectors must work together to achieve this vision. Good collaborative models for improvement can be found where each sector has taken the lead, and more such efforts should be

encouraged. A Fund project is studying collaborations among state or local government, providers, and insurers to improve both quality and efficiency in Minnesota, Washington, and Wisconsin.

In Washington, the Puget Sound Health Alliance is an independent, nonprofit organization composed of employers, physicians, hospitals, consumers, health plans, and other interested parties. The group's aim is to improve care and continuity by developing guidelines for providers, self-management and decision-making tools for patients and consumers, evaluations and reports on quality, and a collaborative approach to quality improvement.

The group seeks to build strong alliances among patients, doctors, hospitals, employers, and health plans to promote health and improve quality and affordability by reducing overuse, underuse, and misuse of health services. In line with this mission, the Alliance has outlined several initiatives:

- Develop evidence-based clinical guidelines for diabetes, heart disease, back pain, depression, and pharmaceutical prescribing;
- Produce publicly available reports measuring quality performance of providers in the Puget Sound area, and potentially across the state;
- Encourage greater adoption of health information technology and electronic health records and prescriptions;
- Recommend incentives to encourage improved health and treatment outcomes while simultaneously rewarding quality, affordability, and patient satisfaction; and
- Provide tools for employees on how to manage their health and health care and for employers and unions to support better health.[15]

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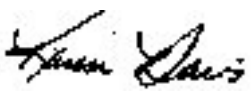
There is much to learn from these examples, and the need to do so is pressing. While they demonstrate that it is possible to make the kinds of changes required to improve our health care system significantly, they also highlight our greatest challenge: creating a system in which these capabilities and attributes are not isolated, but rather reside together throughout the entire system. The kind of system we desire and deserve will offer consistent and reliable excellence in all its features. This is a lofty but ultimately essential imperative.

The Commonwealth Fund Commission on a High Performance Health System intends to continue examining these and other solutions available to a nation with our exceptional resources and capacity. Learning from pioneers and early adopters is a critical step in the improvement process. Equally important is building the will and the commitment from all stakeholders—purchasers, payers, providers, regulators, government, and patients themselves—to undertake the hard work that major change requires.

It is our hope that the Commission's work will be pivotal in all these tasks. The Commission and The Commonwealth Fund seek not just to expose our system's shortcomings, but to highlight proven strategies to overcome them, and support innovations that may lead to additional solutions. Our ultimate goal is to hasten the day when we can all benefit from a high-performance health system that provides high-quality, accessible, patient-centered care to every patient, every day, everywhere.



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The Fund's Mission, Goals, and Strategy

Samuel O. Thier, M.D.
Chairman, Board of Directors

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.

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 Board of Directors has identified a set of goals to be pursued by the Fund over the next four years:

At the Fund's July 2006 Board of Directors meeting, Board member James J. Mongan, M.D., speaks with former Commonwealth Fund/Harvard University Minority Health Policy Fellows Shairi Turner, M.D., chief medical director of the Florida Department of Juvenile Justice, and Joseph Betancourt, M.D., senior scientist at the Institute for Health Policy and program director for multicultural education in the Multicultural Affairs Office at Massachusetts General Hospital–Harvard Medical School. Drs. Turner and Betancourt discussed ways to advance a minority health care policy agenda.

GOALS FOR 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, particularly focusing on populations that are most vulnerable due to income, insurance status, 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 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

- **Improve health insurance coverage and access to care for all Americans** by increasing the knowledge of the public and of policy leaders about the uninsured and underinsured and the consequences of inadequate coverage, and by stimulating new efforts in federal and state government and in the private sector to expand insurance coverage.
- **Enhance Medicare's capacity to be an innovative leader in coverage, quality improvement, and value** by evaluating policy options and practices for achieving better access, improved quality, and greater efficiency for Medicare beneficiaries—particularly those most vulnerable because of serious health conditions and/or low income—and for the health care system overall.
- **Improve the quality and promote the efficiency of health care services** by reporting on opportunities to increase the effectiveness, safety, and cost-effectiveness of health care at all levels of delivery; identifying, evaluating, and disseminating promising models of care, as well as the practices of high performing health care providers and systems; evaluating financial incentives and other payment innovations aimed at improving system performance; and exploring policy changes or opportunities to achieve higher quality and efficiency.
- **Identify, assess, replicate, and disseminate policies and practices that improve the ability of the health care system, particularly primary care practices, to deliver sensitive and appropriate care to all patients.** This includes creating more opportunities for patients and their families to provide physicians with feedback about their care experiences—information that can be used as a platform for improvements in care.
- **Identify and assess practices and programs in place at the state or local level that successfully address issues of access, quality, and efficiency.** Disseminating information about these efforts, it is hoped, will stimulate other state and local initiatives to improve health system performance. This goal includes supporting work in the Fund's own community, New York City.

GOALS FOR PROGRAMS ADDRESSING SPECIAL POPULATIONS

- **Enhance the possibility that children will develop normally and reach their full potential** by expanding the availability of developmental services and information about development to families with children age 3 and under; enhancing the accessibility, quality, and efficiency of preventive services for young children; adopting new standards of professional well-child care practice; and encouraging states to leverage their funding for child health care to improve developmental services and preventive care.
- **Foster growth of the knowledge, leadership, and capacity necessary 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 providers of care.
- **Transform institutional long-term care and the quality of life experienced by elderly Americans in nursing homes and other long-term care facilities** by identifying, evaluating, and promoting the adoption of resident-centered care and enhancing long-term care system performance; equipping the professional leaders of long-term care organizations to lead transformational change; and identifying state and federal policy, payment, and quality initiatives that will support the long-term care industry's adoption of resident-centered care.

GOALS FOR THE INTERNATIONAL PROGRAM:

- **Promote the international exchange of ideas and information on health care policy and practice** by preparing future leaders who are dedicated to learning from the experiences of other countries; sustaining a growing international network of policy-oriented health care researchers and practitioners; encouraging comparative research on international examples of high-performing health care systems and organizations; keeping U.S. policymakers informed of developments in, and transferable lessons from, other industrialized societies; and fostering the development of international collaborative programs to improve care.

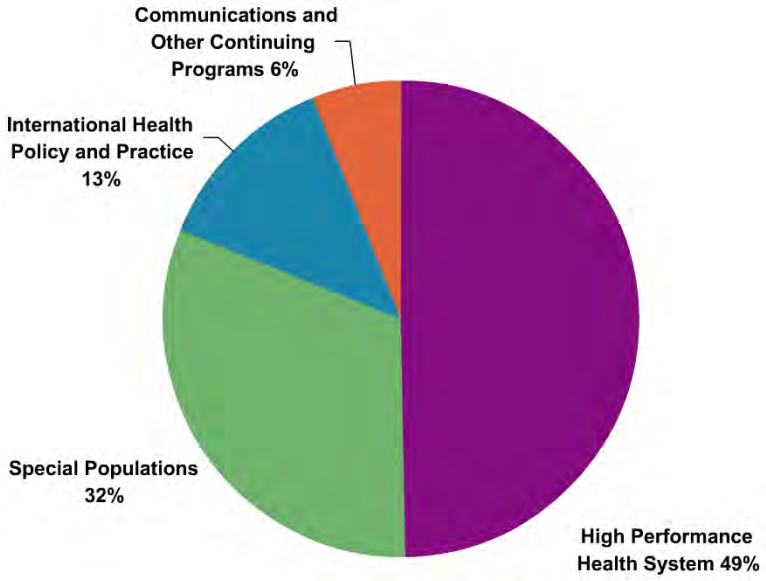
GOALS FOR COMMUNICATIONS/DISSEMINATION:

- **Augment the Fund's leadership in effectively and broadly disseminating credible, authoritative informatio**n, through the use of electronic publishing and other communications tools, about policy options and innovative approaches to moving the United States toward a high performing health care system.

The Fund's total programmatic spending over the five-year period 2006–10 is expected to be $158.8 million. Of that amount, it is anticipated that 65 percent, or $102.7 million, will be spent as grants, allocated across program areas as follows: 49 percent to promoting a high performance health system; 32 percent to addressing the health care needs of special populations; 13 percent to international health policy and practice; and 6 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, 35 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 $10.3 million to communicate the results of Fund-sponsored work and funds to operate programs directly managed by the foundation.

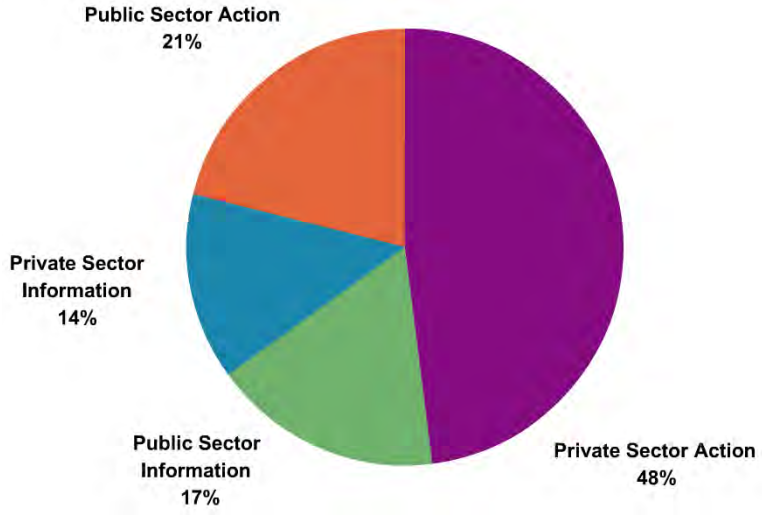
Planned extramural grants spending: $102.7 million for fiscal years 2006–07 through 2010–11.



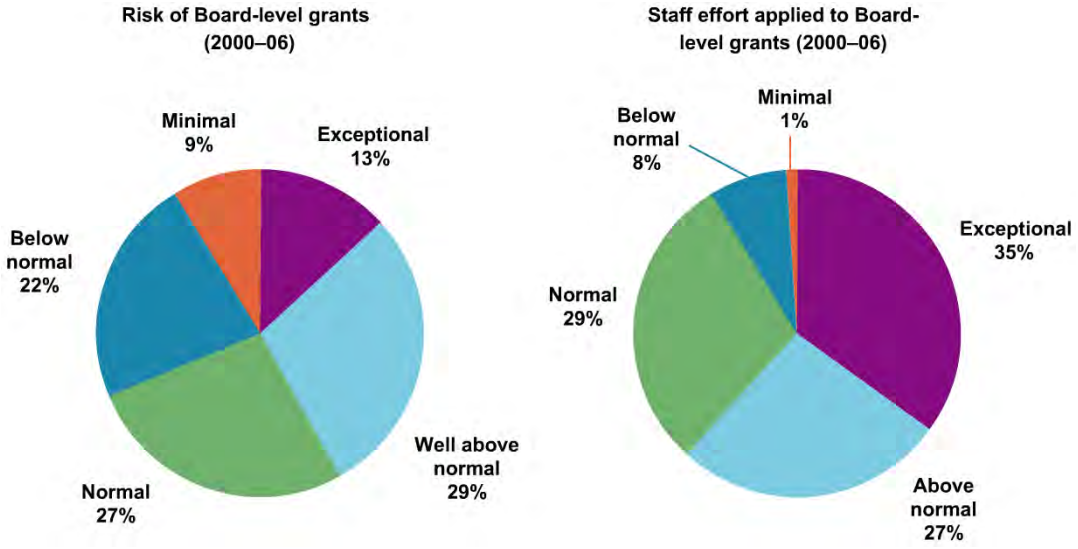
In all its work, the Fund seeks particularly to target issues that affect vulnerable populations. It also aims to achieve a balance between information-generating and action-oriented activities, and between public- and private-sector work. Other concrete objectives that help guide the foundation's grantmaking 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 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, 1995–2006



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

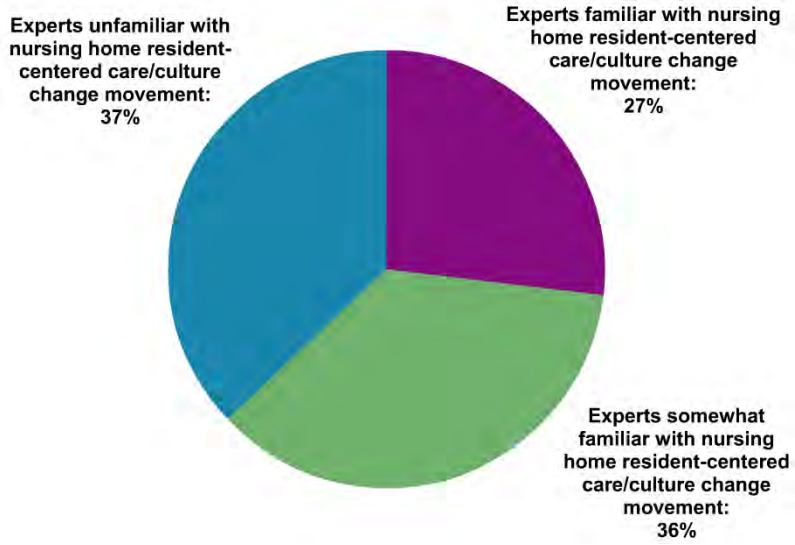


The Fund regularly reviews its major programs and activities to assess their effectiveness and reexamine their strategies. At its April 2006 Retreat, the Board of Directors closely examined the work of the Picker/Commonwealth Program on Quality of Care for Frail Elders, assisted by an external review by Health Policy Alternatives, Inc., led by Michael Hash. The external reviewers concluded that the program, through its support for action-oriented policies

and projects, is having a positive impact as it draws attention to practical approaches for improving nursing home quality and bringing about culture change in favor of resident-centered care. The reviewers reported that a consensus exists among experts that the Fund's investment in this area is critical and should be continued; furthermore, they noted that those most familiar with the field of nursing home quality and culture change stress the uniqueness of the foundation's contributions in this area.

The findings of the December 2005 Commonwealth Fund Health Care Opinion Leaders Survey on Long-Term Care Issues show both the promise and challenge of the program: of the 250 responding experts, 27 percent were familiar with the nursing home culture change/resident-centered care movement, and 36 percent were "somewhat" familiar with it, but 37 percent were not at all familiar with the movement. These findings, along with those of the external review, indicate that to make a real impact, a foundation must expect to remain engaged with knotty issues such as nursing home quality over an extended period.

The findings of the December 2005 Commonwealth Fund Health Care Opinion Leaders Survey on Long-Term Care Issues show both the promise and challenge of the Fund's Frail Elders Program.



As a result of the program review, the Fund's Board concluded to: 1) continue the Frail Elders program; 2) maintain the current focus on residential long-term care quality and efforts to further spur the culture change/resident-centered care movement; and 3) fund the program at approximately $1.3 million annually for the next five years. The Board further advised that program priorities should be as follows: 1) sponsor development of models, tools, and practices, 2) work on policy initiatives; and 3) increase communications and dissemination activities.

At the April 2006 Board of Directors retreat, the Board also examined a comprehensive "performance scorecard" for the foundation, details of which are discussed in the "Executive Vice President/COO's Report" in this *Annual Report*. An important feature of the scorecard is

the Fund goal of initiating development of at least four "institution stretching" products annually and of making the necessary investments for accomplishing them. In the 2005–06 fiscal year, the foundation's "stretch" goals and achievements were as follows: development of the "Medicare Extra" plan for a comprehensive Medicare benefit, which was published in *Health Affairs* and discussed with legislators;[1] the expansion of the Harkness Fellowship program to include Germany; partnership with the Netherlands to expand the International Health Policy Survey to that country; Web site redesign and inauguration of E-Forums on the Fund's Web site; and establishing a strong voice in the debate over whether health savings accounts are a solution to the nation's health care coverage and cost problems.[2,3,4]

Stretch initiatives for 2006–07 include the following: release of the National Scorecard on U.S. Health System Performance, discussed in the "President's Message" of this *Annual Report;* revamping of the Frail Elders program in accordance with the conclusions of the recent Board review; partnership with *Modern Healthcare* on the Fund's Health Care Opinion Leaders Survey, aimed at enrichment of the bimonthly survey and enhanced communication of findings; launch of a congressional health care legislative "policy watch" (analysis and modeling of the leading health care bills in Congress); development of the interactive ChartCart feature on the Fund's Web site, which aims to make available to users, at no cost, virtually all graphical data produced by the Fund and its grantees, and in a format that facilitates the use of research data for practical applications; and partnering with the Robert Bosch Foundation to fund the German Harkness Fellows in Health Care Policy.

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Commission on a High Performance Health System

The United States provides some of the best medical care in the world. We spend more on health care than anyone else. And our health system is in serious trouble. By now, most of us have heard about the problems: tens of millions of Americans without health insurance coverage; an employer-based coverage system in distress; spiraling insurance and health care costs; high variability in the quality and safety of care; disparities based on race, ethnicity, and income.

In establishing the Commission on a High Performance Health System in 2005, The Commonwealth Fund's board of directors recognized the need for national leadership to revamp, revitalize, and retool the U.S. health care system. The Commission's 19 members—a distinguished group of experts and leaders representing every sector of health care, as well as the state and federal policy arena, the business sector, professional societies, and academia—are charged with promoting 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. Of particular concern to the Commission are the most vulnerable groups in society, including low-income families, the uninsured, racial and ethnic minorities, the young and the aged, and people in poor health.

During its inaugural year, the Commission ignited considerable public interest and attention. Its greatest accomplishments so far have been to highlight for the public 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.

Laying the Groundwork for Change

In its first report, released in August 2006, the Commission traced the critical sources of health system failures and outlined a vision of a uniquely American, high performance system.[1] The Commission has identified concrete steps to make health care more effective, efficient, and equitable:

- Extend health insurance to all.

James J. Mongan, M.D.
Commission Chairman

Dr. Mongan, newly named to the Fund's Board of Directors, chairs the Fund's Commission on a High Performance Health System. He is the president and chief executive officer of Partners HealthCare, as well as a professor of health care policy and social medicine at Harvard Medical School.

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

Dr. Schoenbaum coordinates the development and management of the Fund's grants programs and those it operates directly, oversees the professional staff responsible for programs, and represents the Fund on programmatic issues in a wide range of settings.

- Pursue excellence in the provision of safe, effective, and efficient care.
- Organize the care system to ensure coordinated and accessible care for all.
- Increase transparency and reward quality and efficiency.
- Expand the use of information technology and exchange.
- Develop the workforce to foster patient-centered and primary care.
- Encourage leadership and collaboration among public and private stakeholders.

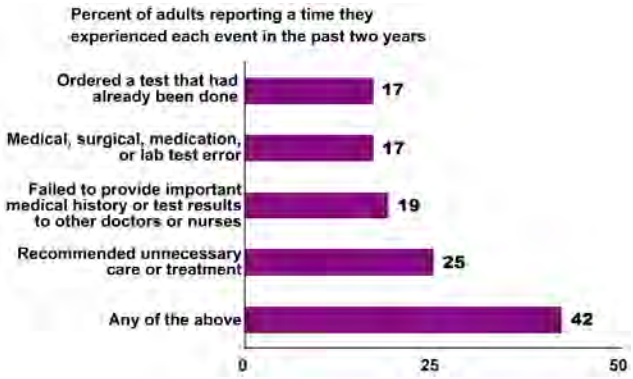
Anne K. Gauthier
Commission Senior Policy Director

Members of the Commission agree that such reforms will require the establishment of coordinated systems to enable health care providers to provide appropriate, high-quality health services for a range of acute and chronic care needs. At the same time, the Commission believes that providers must be held accountable for meeting benchmarks for effectiveness, safety, and efficiency.

Survey findings reveal that the Commission's priorities are in sync with public opinion. In the report, *Public Views on Shaping the Future of the U.S. Health Care System*, Fund senior vice president Cathy Schoen and colleagues described strong public support for efforts to improve care coordination, expand the use of information technology, and adopt a team approach to care delivery.[2] Survey respondents told of instances where they received duplicative or otherwise wasteful services, or had difficulty paying for insurance coverage or care—problems encountered not only by low-income families, but by middle-income ones as well.

Cathy Schoen
Commission Research Director
Fund Senior Vice President

High percentages of surveyed U.S. adults reported duplicate tests, medical errors, failures to share information, or times when doctors recommended unnecessary care.



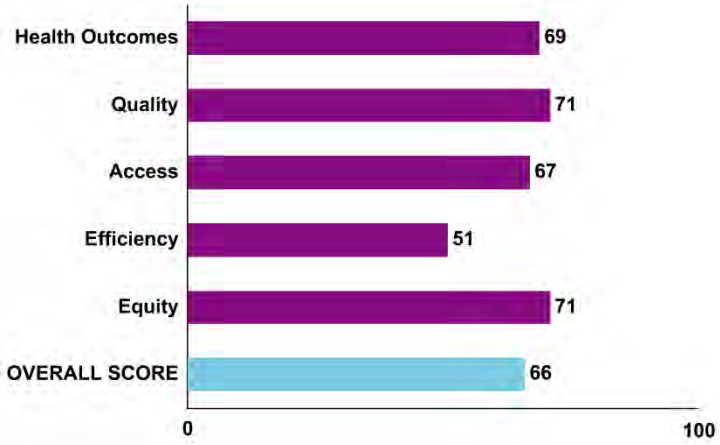
Source: C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health Care System* (New York: The Commonwealth Fund, Aug. 2006).

Three-quarters of those surveyed agree that the health system needs either fundamental change or complete rebuilding. Topping the list of priorities for federal action are expanding health coverage and controlling costs. Other favored reforms include ensuring that everyone has a "medical home"—a regular primary care provider who is responsible for coordinating all of a patient's care—as well as a personal health record, accessible to the patient and all of his or her health care providers, that contains all pertinent medical information.

A Scorecard for the Health System

Certainly the most significant contribution the Commission has made thus far is the National Scorecard on U.S. Health System Performance. Despite its name, the Scorecard is no game. The first-ever comprehensive, evidence-based means of measuring and monitoring health system performance, the Scorecard assesses how well the U.S. does across the key areas of health care relative to achievable benchmarks. It also points to deficient areas where public and private action is needed—and provides a yardstick against which to measure the success of new policies.

When comparing national performance to benchmarks, the U.S. health care system overall scored 66 out of 100.



Source: 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).

Published both as a *Health Affairs* Web Exclusive[3] and a Fund report,[4] the findings show that across 37 indicators of performance—from receipt of preventive care by children to hospital admission rates for nursing home residents—the U.S. attains an average score of just 66 out of a possible 100, based on ratios of national performance to the best-attained performance within the U.S. or abroad. Given our nation's wealth and high level of health spending, that is simply unacceptable. Following are some of U.S. health care's specific shortcomings:

- U.S. mortality rates from conditions "amenable to health care"—deaths that could have been prevented with timely and effective care—are 30 percent higher than in the three best-performing countries.

- Barely half of adults receive preventive and screening tests according to guidelines for their age and sex.
- If national average rates for control of diabetes and blood pressure matched rates achieved by the top 10 percent of U.S. health plans, an estimated 20,000 to 40,000 deaths and $1 billion to $2 billion in medical costs could be avoided.
- Only 17 percent of U.S. doctors have an electronic medical record system in place; in the top three countries, 80 percent of doctors have one.
- It would require a 20 percent decrease in Hispanic risk rates for such problems as being uninsured, lacking a regular source of primary care, and not receiving essential preventive care to reach the rates experienced by whites.

The Commission estimates that closing the gaps in performance described in the Scorecard could save at least $50 billion to $100 billion per year in health care spending and prevent 100,000 to 150,000 deaths. To do that, the nation first must have a coherent strategy for simultaneously achieving better access, quality, and efficiency. Covering the nation's 47 million uninsured is one component. But of equal importance is identifying and adopting successful programs and practices that have already been shown to improve patient care while keeping costs down.

Commission members and Fund staff presented the Scorecard results at a well-attended briefing in Washington, D.C., and findings were further disseminated through a Web Exclusive article in *Health Affairs*, the nation's leading health policy journal, and a Fund report. Just weeks following its release, the report, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*, was already the most-viewed publication ever posted on the Fund site. Moreover, organizations including the Institute of Medicine, the American Board of Internal Medicine, the New York City Department of Health and Mental Hygiene, and Blue Cross Blue Shield of Massachusetts have requested copies for their members and staff.

Informing Policy Leaders

The Commission will be updating the Scorecard on a periodic basis, allowing it to monitor changes in system performance—positive or negative—over time. Results from the Scorecard, as well as the public survey, will inform the work of the Commission as it formulates recommendations for policy options. In early 2007, the Commission is set to release a major Fund-authored analysis of health reform bills in Congress; its findings should be highly useful to policy officials as they deliberate and to the Commission as it formulates specific recommendations for legislative action.

The Commission on a High Performance Health System convenes three times a year. The March 2006 meeting, held in Denver, featured a site visit to Denver Health, an integrated health

Patricia Gabow, M.D.
Commission Member

As CEO and medical director of Denver Health and Hospital Authority—one of the nation's most highly regarded integrated health care systems—Dr. Gabow is nationally recognized for her work to increase access to basic health care for all Coloradoans.

system for which Commission member Patricia Gabow, M.D., serves as CEO and medical director. The visit allowed Commissioners to witness firsthand Denver Health's innovative approaches to health care delivery for a patient population with complex needs.

The Washington-based Alliance for Health Reform, co-chaired by U.S. Senators Jay Rockefeller (D–W. Va.) and Susan Collins (R–Maine), has received grants from the Fund to manage the Commission meetings and co-sponsor Washington policy briefings, roundtable discussions, and a bipartisan congressional retreat, which provides members from both parties a unique opportunity for off-the-record discussion of pressing health policy issues. In 2006, Commission members played a key role in developing the retreat agenda, and several served as panelists and moderators. Session topics included: characteristics of high performance health systems, health spending, Medicare, incentives to improve quality, health care polls, Medicaid, strategies for insuring workers, and lessons from abroad.[5]

The Alliance also helps coordinate Fund-sponsored briefings and roundtables on Capitol Hill. In 2006, these events focused on topics ranging from health services for children to implementation of the Medicare prescription drug benefit.

The Commission on a High Performance Health System is chaired by Fund board member James J. Mongan, M.D., president and CEO of Partners Healthcare System, Inc. A listing of Commission members and staff is available below.

The Commonwealth Fund
Commission on a High Performance Health System

Membership

James J. Mongan, M.D.
Chair of the Commission
President and CEO
Partners HealthCare System, Inc.

Maureen Bisognano
Executive Vice President and COO
Institute for Healthcare Improvement

Christine K. Cassel, M.D.
President and CEO
American Board of Internal Medicine
and ABIM Foundation

Michael Chernew, Ph.D.
Professor
Department of Health Policy
Harvard Medical School

Patricia Gabow, M.D.
CEO and Medical Director
Denver Health

Robert Galvin, M.D.
Director, Global Health
General Electric Company

Fernando A. Guerra, M.D.
Director of Health
San Antonio Metropolitan Health District

Glenn M. Hackbarth, J.D.
Chairman
MedPAC

George C. Halvorson
Chairman and CEO
Kaiser Foundation Health Plan, Inc.

Robert M. Hayes, J.D.
President
Medicare Rights Center

Cleve L. Killingsworth
President and CEO
Blue Cross Blue Shield of
Massachusetts

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Research Professor
School of Public Health
University of North Carolina
Judge Institute
University of Cambridge

Gregory P. Poulsen
Senior Vice President
Intermountain Health Care

Dallas L. Salisbury
President and CEO
Employee Benefit Research Institute

Sandra Shewry
Director
California Department of Health Services

Glenn D. Steele, Jr., M.D., Ph.D.
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Geisinger Health System

Mary K. Wakefield, Ph.D., R.N.
Associate Dean
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Health Sciences Director and Professor
Center for Rural Health
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Executive Director
Executive Vice President for Programs

Anne K. Gauthier
Senior Policy Director

Cathy Schoen
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Senior Vice President for Research and Evaluation

Allison Frey
Program Associate

Notes

[1] Commonwealth Fund Commission on a High Performance Health System, *Framework for a High Performance Health System for the United States* (New York: The Commonwealth Fund, Aug. 2006).

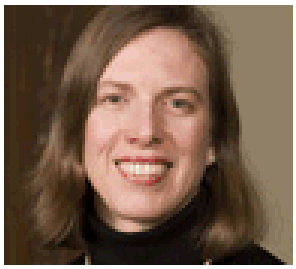
[2] C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health Care System*, The Commonwealth Fund, August 2006.

[3] 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.

[4] 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).

[5] Papers commissioned for the 2007 Bipartisan Congressional Health Policy Conference can be accessed at http://www.cmwf.org/grants/grants_show.htm?doc_id=382408.

The Future of Health Insurance



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

The Program on the Future of Health Insurance envisions an efficiently run health insurance system that makes available to all Americans comprehensive, affordable coverage. In support of that vision, the program seeks to:

- Analyze market- and policy-driven changes in employer-based insurance and public insurance programs for people under age 65, and determine how those changes may affect the numbers of people covered and the quality of coverage.
- Document the consequences of being uninsured and underinsured with regard to access to care, health, personal financial security, and economic productivity.
- Develop and evaluate strategies to expand and stabilize health coverage, make it more affordable, and enhance efficiency in its administration.

The Fund strives to keep the nation's leaders focused on the widening uninsured crisis while identifying strategies for expanding and improving health coverage. Researchers have tracked trends in coverage of young adults—the fastest-growing uninsured group—and exploring opportunities for getting them in a health plan. An option first presented by the Fund in 2004—requiring that policies cover dependents past age 19—has been enacted into law by five states.

Photo: Jared Leeds

Employers, both private and public, are the primary source of health insurance for people under age 65 (Medicare covers most of the elderly). Some 160 million U.S. workers and their dependents receive health benefits through the workplace. But in recent years, good, comprehensive coverage has been harder to come by. Although annual growth in national health

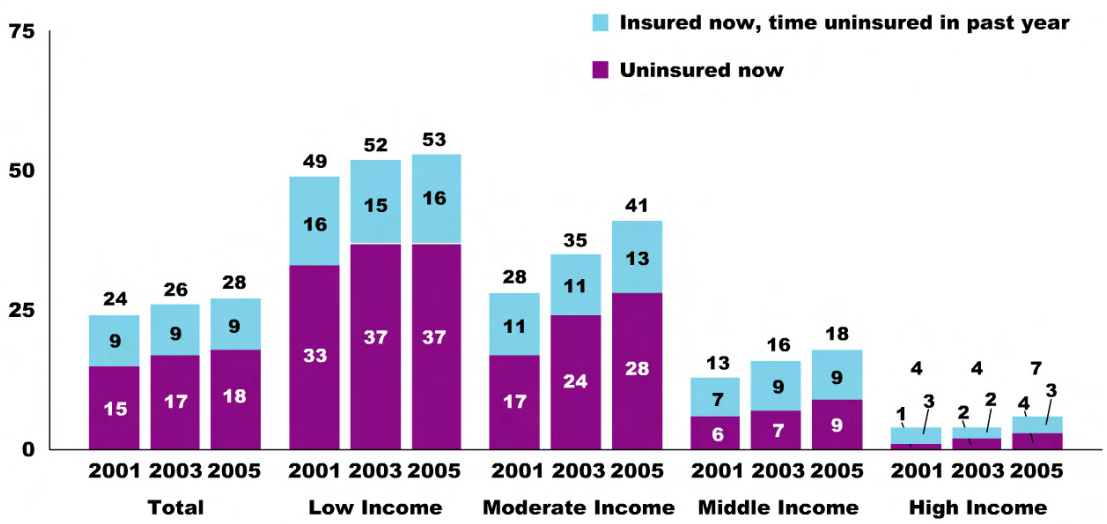
care expenditures and premiums has leveled off at around 7 percent, it continues to outpace economic and wage growth by a wide margin. As a result, employers that provide health benefits—especially small firms—are finding it difficult to maintain their level of generosity.[1,2,3] Businesses have tried to cope by sharing more of their expenses with employees, but some small companies have eliminated health benefits altogether.[4] Nearly the entire increase in the number of uninsured Americans between 2000 and 2005—from 40.2 million to 46.6 million—is attributable to the decline in employer coverage.

The Deepening Uninsured Crisis

Declining rates of health insurance coverage, combined with rising premium costs, have profound consequences for families, the health care system, and the economy overall. To explore these issues, the Program on the Future of Health Insurance partners with Princeton Survey Research Associates International every two years to ask Americans about their health coverage. Findings from the 2005 Commonwealth Fund Biennial Health Insurance Survey, as reported in *Gaps in Health Insurance: An All-American Problem*, indicated continued high uninsured rates among low-income families and a rapid deterioration in coverage among moderate-income households since 2000.[5]

Uninsured rates are high among adults with low and moderate incomes.

Percent of adults ages 19–64



Note: In 2001 and 2003, low income is <$20,000, moderate income is $20,000–$34,999, middle income is $35,000–$59,999, and high income is $60,000 or more. In 2005, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.

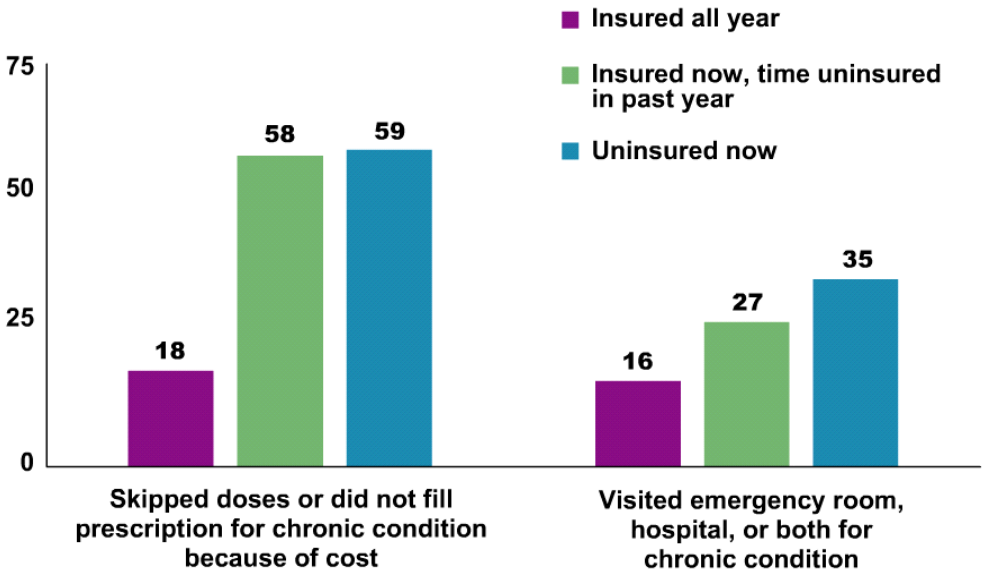
Source: S. R. Collins, K. Davis, M. M. Doty et al., *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

According to Fund assistant vice president Sara R. Collins, Ph.D., the report's lead author, uninsured adults are more likely than the insured to have problems getting needed care because of the costs, and more likely to be weighed down by medical bill debt. Among people with chronic health conditions, like diabetes and asthma, those lacking coverage are much more

likely than those covered all year to skip medications for their conditions, visit emergency rooms, or be admitted to the hospital. Media coverage of the report was widespread; an Associated Press article, for example, was picked up by some 200 news outlets.

Adults without insurance are less likely to be able to manage chronic conditions.

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 et al., *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

Adults in the 19-to-29 age group are the fastest-growing segment of the uninsured population. Every May since 2003, The Commonwealth Fund has published an issue brief documenting the crisis in young adults' health coverage and outlining potential policies that would give them access to meaningful and affordable coverage.[6] In the 2006 edition, the authors reported further deterioration of coverage for this age group: the number of uninsured young adults climbed by 2.5 million from 2000 to 2004, to nearly 14 million. Policy options presented in the Fund-authored brief formed the basis of bills introduced by Representative Vic Snyder (D-Ark.) and Senator Blanche Lincoln (D-Ark.) that propose to give states the option of raising the eligibility age for Medicaid and the State Children's Health Insurance Program (SCHIP) from 18 up to age 23.[7] Another option presented in the brief—that insurance policies cover dependent young adults past the age of 19—has been enacted into law by five states since 2005.

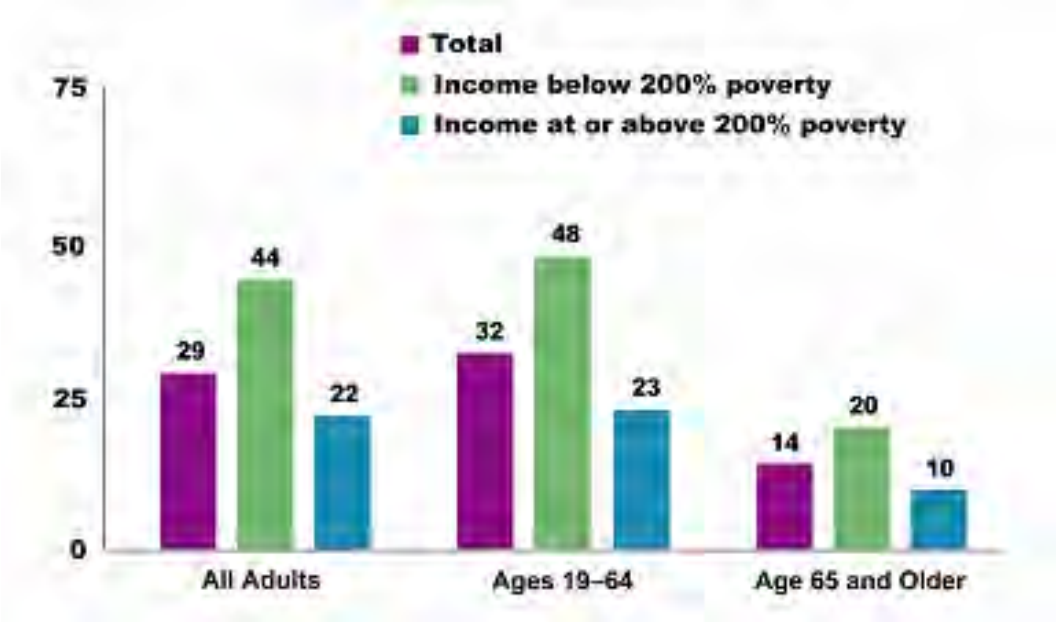
Fernando A. Guerra, M.D.
Member, Commission on a High Performance Health System

Dr. Guerra, a practicing pediatrician, serves as director of health for the San Antonio Metropolitan Health District. He also is a clinical professor of pediatrics at the University of Texas Health Science Center, San Antonio.

Minority Americans are also at high risk for being uninsured. Using data from the 2005 Biennial Health Insurance Survey, Fund staff Michelle M. Doty, Ph.D., and Alyssa L. Holmgren found that 62 percent of working-age Hispanics and 33 percent of African Americans were uninsured for some time during 2005, compared with 20 percent of their white counterparts.[8] The researchers found that Hispanic adults are particularly disconnected from the health system: compared with whites, they are substantially less likely to have a regular doctor, to have visited a doctor in the past year, or to feel confident about their ability to manage health problems.

Younger and poorer adults are at highest risk of medical bill problems.

Percent of adults who had medical bill problems



Data: The Commonwealth Fund Biennial Health Insurance Survey, 2003.
Source: M. M. Doty, J. N. Edwards, and A. L. Holmgren, *Seeing Red: Americans Driven into Debt by Medical Bills* (New York: The Commonwealth Fund, Aug. 2006).

Low-wage workers and their families, meanwhile, comprise the largest share of the uninsured. Uninsured, low-income workers and their spouses nearing retirement are particularly vulnerable, given the high rates of chronic illness in this group. In an analysis of the Commonwealth Fund Survey of Older Adults, Collins and colleagues found that many older adults in working families (ages 50 to 64) go through periods without coverage. More than half of those in families with incomes under $25,000, and one-third of those in families with incomes between $25,000 and $40,000, had been uninsured for at least some time since turning 50.[9] More than half of uninsured older adults in working families reported they were not able to get needed care because of the cost, had problems paying medical bills, or were paying off medical debt.

By the time they enroll in Medicare, many older adults who had previously been uninsured are hampered by health problems that have gone untreated and now require intensive and costly care. With Fund support, John Ayanian, M.D., and colleagues at Harvard

Medical School are assessing how this phenomenon affects costs and use of health services in Medicare. The project will inform policymakers about the potential gains of expanding Medicare coverage to adults under 65 and consider whether the cost of such an expansion would be offset by savings from having a healthier Medicare population.

Although families with income low enough are eligible for various publicly funded health insurance programs, research shows that more than three of five uninsured children are eligible for Medicaid or SCHIP but are not enrolled.[10] Many others, moreover, lose their public coverage before regaining it later on. Two Fund reports, as well as an Alliance for Health Reform briefing on Capitol Hill, spotlighted policy solutions to minimize this "churning" in enrollment. Stan Dorn, J.D., and Genevieve Kenney, Ph.D., of the Urban Institute assessed the potential of automatically enrolling children and their parents in SCHIP and Medicaid based on the eligibility determinations of other means-tested programs.[11] States are currently prohibited from doing this.

In another report, Laura Summer and Cindy Mann, J.D., of Georgetown University, analyzed the causes and consequences of churning in public insurance programs, and state strategies that can reduce it.[12] The researchers found that targeted policies substantially reduced coverage loss. In Washington State, enrollment declined sharply when families were required to renew their coverage every six months and rebounded when 12-month renewal periods were reinstituted. Premiums also can have a significant effect: in Virginia's public coverage program, 42 percent of children whose families were charged premiums would have lost coverage, due to their families' failure to pay premiums, if the state had followed through with planned sanctions for nonpayment.

With Fund support, Andrew Bindman, M.D., of the University of California, San Francisco, is investigating whether interruptions in Medicaid coverage for adults and children are associated with higher rates of hospital admissions, deaths, and costs for conditions that normally are treatable in primary care settings. Bindman's research will help policymakers determine whether short-term savings from restricting program eligibility and charging premiums might be offset by the costs of avoidable hospitalizations.

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

Health Coverage Without Protection

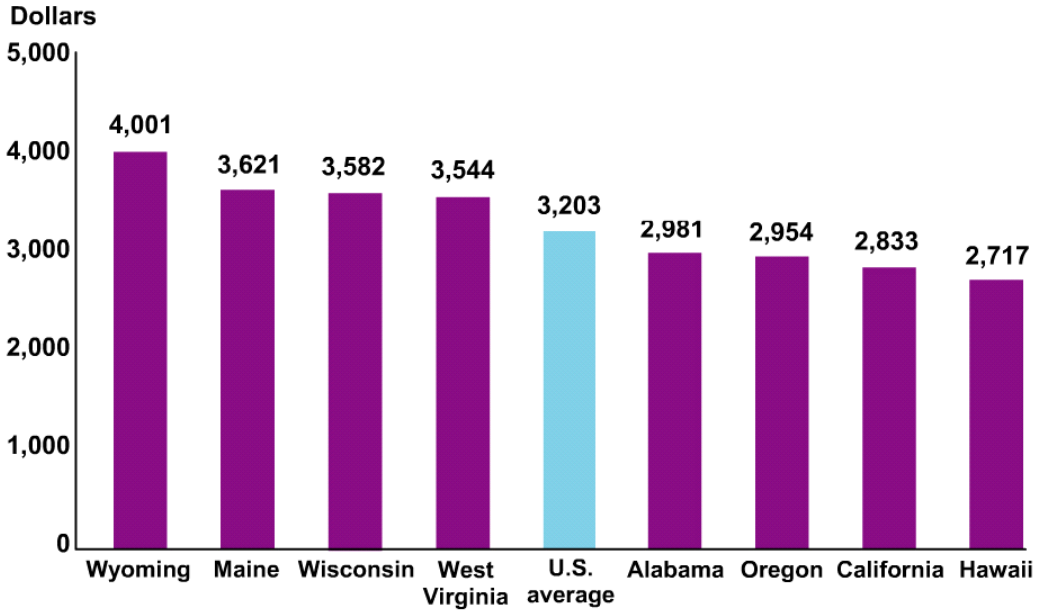
Workers of all ages who do not have access to job-based health benefits face a dearth of affordable health insurance options. While all 50 states have an individual, or non-group, insurance market, only a small percentage of Americans actually buys such coverage. Because individual insurers, through underwriting, try to cover their risk, premiums are often set too high to be affordable to many people. Individual insurers also sometimes exclude from coverage certain high-cost conditions, including pregnancy, or decline to enroll applicants with health problems.

In the Fund report *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, Collins and her Fund colleagues documented the growing crisis in out-of-pocket costs for lower-income—and now even middle-income—families. Based on national survey data, nearly nine of 10 people who sought coverage through the individual market in the past three years never actually purchased a health plan.[13] One-third of those who sought coverage said that it was very difficult or impossible to find a plan that met their needs, and 58 percent reported that it was very difficult or impossible to find one they could afford. One-fifth were turned down or would have been charged higher prices because of preexisting conditions.

Many employers, particularly small businesses, try to alleviate their health costs by sharing more expenses with workers in the form of higher deductibles, copayments, or increases in maximum employee costs. In an article published in *Health Affairs*, a Fund-supported team led by Jon Gabel found that workers in small firms are more likely than those in larger firms to have deductibles; their deductibles also tend to be higher. Employees in small firms pay an average of 18 percent more in premiums than those in large firms when taking into account actuarial value—the percentage of total medical expenses paid by health plans.[14] Employees in rural states, like Wyoming, also tend to pay more for health insurance—after accounting for the actual medical benefits covered—than do those in states with large urban populations, like California.

States with the highest and lowest adjusted health plan premiums.

Employee-only adjusted premiums (2002)



Adapted from J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs,* May/June 2006 25(3):832–43.

Higher health costs and sluggish growth in real incomes mean that families are spending more of their incomes on medical costs. A Fund report by Mark Merlis found that the percentage of households spending 10 percent or more of their income on out-of-pocket health costs rose from 8 percent in 1996–97 to 11 percent in 2001–02.[15] Including premiums, 18 percent of all families spent more than 10 percent of income on health care. With Fund support, Peter Cunningham, Ph.D., of the Center for Studying Health System Change is building on this analysis by examining geographic variation in out-of-pocket cost burdens and medical bill problems during the period 1996–2004, and how these affect access to care.

In related work, Fund grantee Jean Abraham, Ph.D., of the University of Minnesota is estimating the number of insured workers who have high out-of-pocket costs relative to their income—what Fund senior vice president Cathy Schoen has defined as being "underinsured." She will also document how being underinsured varies by size of employer. Both Abraham and Cunningham will develop policy options to make health coverage more affordable for workers and their families.

Health savings accounts (HSAs) combined with high-deductible health plans are part of a trend toward greater consumer cost-sharing. Created as part of the Medicare Modernization Act of 2003, HSAs are available to people who purchase health plans with at least a $1,100 deductible for individuals and $2,200 for families. Plan enrollees and their employers can contribute pre-tax dollars to the accounts and withdraw funds, tax-free, for medical expenses. Known as "consumer-driven" care, such arrangements are based on the theory that greater personal responsibility for health costs will lead to more prudent use of health services.

The EBRI/Commonwealth Fund Consumerism in Health Care Survey is one of just a few sources of national data on the experiences of those enrolled in high-deductible health plans (HDHPs). The survey report released by the Fund and the Employee Benefit Research Institute in December 2005 found that enrollees in such health plans, with or without HSAs, were less satisfied with their coverage than those with more comprehensive health insurance.[16] The report, co-authored by the Fund's Collins and EBRI's Paul Fronstin, Ph.D., found that plan members, particularly those who had health problems or lower incomes, were also more likely to report avoiding or delaying needed care because of cost and had high out-of-pocket costs relative to their income.

Numerous media outlets, including the *Washington Post, Wall Street Journal,* and *USA Today,* cited the survey report findings, and Fund president Karen Davis was invited to discuss consumer-driven health care on the "NewsHour with Jim Lehrer." The findings also informed congressional testimony on three occasions. In March 2006, the Fund's Collins testified before the House Energy and Commerce Committee, Subcommittee on Health, in a hearing on transparency in health care.[17] Collins also testified on HSAs before the House Ways and Means Committee in June, as well as before the Senate Finance Committee, Subcommittee on Health, in September.[18,19]

A follow-up survey and report by EBRI and The Commonwealth Fund, released in December 2006, found that enrollment in consumer-driven health plans is virtually unchanged since 2005.[20] Only 1 percent of the privately insured population ages 21 to 64 is currently enrolled in such a plan.

With Fund support, John Hsu, M.D., of Kaiser Permanente (KP) is assessing the impact of HDHPs on health service use, costs, and outcomes by examining KP health plan data and interviewing approximately 2,500 enrollees. This work will inform national policy as well as the design of health plan benefit packages within the private sector.

Upcoming Fund Work on Health Insurance

Health coverage and costs are likely to be key issues in the 2008 presidential election, and The Commonwealth Fund plans a series of reports to inform the policy debate. The next Biennial Health Insurance Survey, to be conducted in 2007, will include questions about the public's attitudes on policies to expand health insurance. The Fund is partnering with Health Policy R&D and the Lewin Group to conduct an analysis of health care bills introduced in Congress from 2005 to 2007.

The Fund is also supporting research on administrative costs stemming from the nation's fragmented system of health coverage. Because providers care for patients insured by various private and public plans, they must contend with multiple payment schedules, claims forms, credentialing requirements, and other regulations—a degree of complexity that creates excess costs as well as barriers to improving quality of care. The Fund and the Robert Wood Johnson Foundation have teamed up to sponsor an investigation into the scope of the problem, the sources of the highest costs, and possible public and private remedies. Fund-supported researchers at AcademyHealth, meanwhile, are conducting case studies of health care organizations' efforts to reduce administrative complexity.

Notes

[1] S. C. Schoenbaum, K. Davis, and A. L. Holmgren, *Health Care Spending: An Encouraging Sign?* (New York: The Commonwealth Fund, Jan. 2007).

[2] A. Catlin, C. Cowan, S. Heffler et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):142–53.

[3] C. Borgeret, S. Smith, C. Truffer et al., "U.S. Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web Exclusive, Feb. 22, 2006.

[4] G. Claxton, J. Gabel., I. Gil et al., "Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest," *Health Affairs* Web Exclusive, Sept. 26, 2006.

[5] S. R. Collins, K. Davis, and M. M. Doty, *Gaps in Health Insurance: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Apr. 2006).

[6] S. R. Collins, C. Schoen, J. L. Kriss et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated May 2006).

[7] H.R. 3040 and S. 1298, Health Care for Young Adults Act of 2005.

[8] M. M. Doty and A. L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults* (New York: The Commonwealth Fund, Aug. 2006).

[9] S .R. Collins, K. Davis, C. Schoen et al., *Health Coverage for Aging Baby Boomers: Findings from the Commonwealth Fund Survey of Older Adults* (New York: The Commonwealth Fund, Jan. 2006).

[10] S. Dorn and G. M. Kenney, *Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers* (New York: The Commonwealth Fund, June 2006).

[11] Ibid.

[12] L. Summer and C. Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies* (New York: The Commonwealth Fund, June 2006).

[13] S. R. Collins, J. Kriss, K. Davis et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[14] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Montana Is Down," *Health Affairs*, May/June 2006 25(3):832–43.

[15] M. Merlis, D. Gould, and B. Mahato, *Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets* (New York: The Commonwealth Fund, Feb. 2006).

[16] P. Fronstin and S. R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey* (EBRI/Commonwealth Fund, Dec. 2005).

[17] S. R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come*, Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," Mar. 15, 2006.

[18] S. R. Collins, *Health Savings Accounts: Why They Won't Cure What Ails U.S. Health Care*, Invited Testimony, Committee on Ways and Means, U.S. House of Representatives, Hearing on "Health Savings Accounts," June 28, 2006.

[19] S. R. Collins, *Health Savings Accounts and High-Deductible Health Plans: Why They Won't Cure What Ails U.S. Health Care*, Invited Testimony, Committee on Finance, Subcommittee on Health, U.S. Senate, Hearing on "Health Savings Accounts: The Experience So Far," Sept. 26, 2006.

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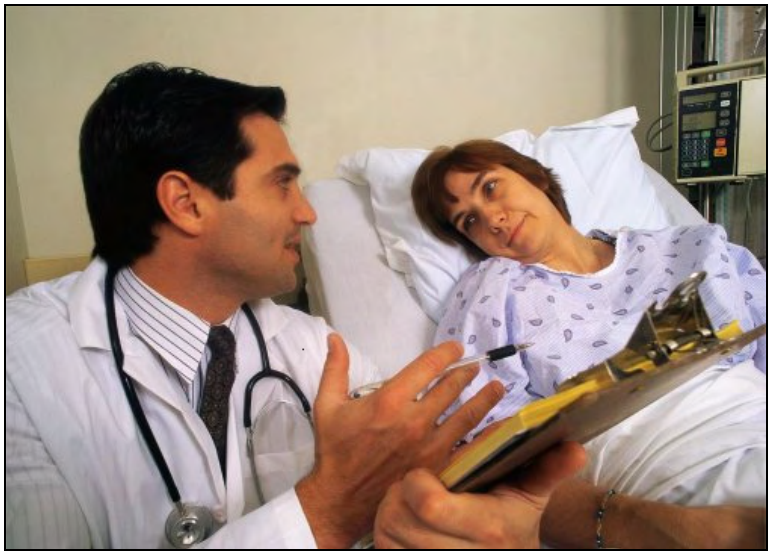
State Innovations

Rachel Nuzum
Program Officer

The Commonwealth Fund's State Innovations program, now in its second year, aims to improve state and national health system performance by supporting, stimulating, and spreading integrated, state-level strategies for expanding access to care and promoting high-quality, efficient care, particularly for vulnerable populations. The program pursues the following activities:

- Identifying and evaluating public and private sector policies that have the potential to improve health system performance, not just at the state level, but nationally as well.
- Stimulating new efforts to improve the performance of state health systems and spread promising approaches.
- Informing health care and policy leaders at the state and national levels about the ways in which states can take action to improve health system performance.



States are exploring health care reform from a number of angles, ranging from universal coverage efforts to incentive programs that foster improvements in health care quality and efficiency. With Fund support, the Massachusetts Health Quality Partners is creating quality and efficiency profiles of the state's physicians to help insurers select plan doctors and develop pay-for-performance programs, and help group practices improve the care they provide.

Faced with escalating costs, expanding uninsured populations, and uneven quality of care, a growing number of state policy leaders are taking matters into their own hands. The latest round of state reforms features a variety of approaches to improving health system

performance. Some are incremental and modest—providing universal health insurance coverage for children, for example, or promoting public–private partnerships to insure low-income workers. Others are comprehensive and bold, attempting to achieve near-universal coverage while simultaneously creating incentives for improving quality and containing costs—for example through better chronic care management.

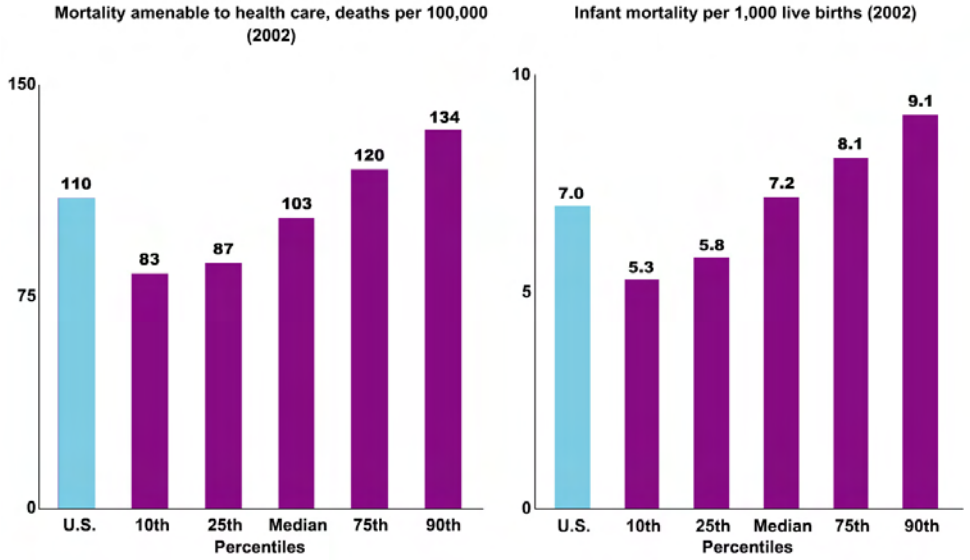
In its first year, the State Innovations program supported several efforts to identify innovative state initiatives and increase understanding of state performance in relation to benchmarks of high performance. For example, the National Academy for State Health Policy, under a Fund grant, is conducting a nationwide survey to identify states engaged in policies and practices that might lead to better health system performance. These include subsidy programs that enable the working poor to afford health insurance coverage; policies to promote the public reporting of information about the quality and safety of patient care; and policies encouraging physicians to implement electronic health record systems.

Alan R. Weil, J.D.
Member, Commission on a High Performance Health System

Mr. Weil is executive director of the National Academy for State Health Policy, a nonpartisan organization dedicated to helping states achieve excellence in health policy and practice. He has also served as executive director of Colorado's Department of Health Care Policy and Financing.

In a complementary effort, Joel C. Cantor, Sc.D., who directs the Center for State Health Policy at Rutgers University, is gathering state data on a comprehensive set of health system indicators to produce a state-level "performance scorecard," patterned after the national scorecard released by the Commonwealth Fund Commission on a High Performance Health System in September 2006.[1] As shown in the figure, two of the scorecard's key indicators—mortality for conditions "amenable to health care" and infant mortality—vary widely across states, with poor-performing states well below national averages. Data such as these will inform policymakers about areas ripe for improvement, and will also serve as a platform for promoting comprehensive, systemwide approaches to care delivery.

Death rates for health conditions considered "amenable to health care" vary widely across states, as do infant mortality rates.

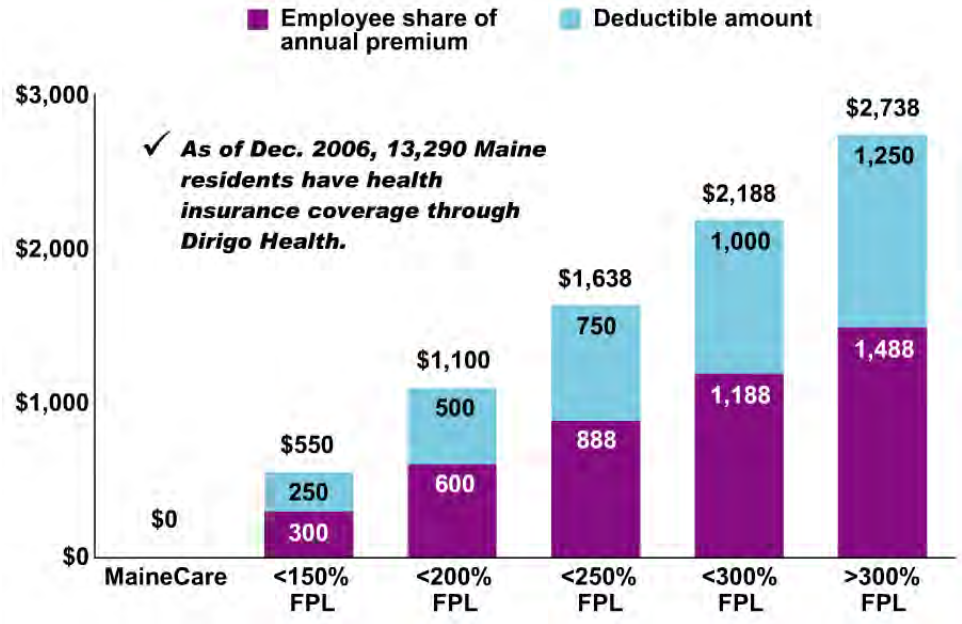


Data: Mortality amenable to health care—K. Hempstead, Rutgers University analysis using Nolte and McKee methodology; Infant mortality—National Vital Statistics System, Linked Birth and Infant Death Data (AHRQ, *National Healthcare Quality Report, 2005.* AHRQ Pub. No. 06-0018. Rockville, Md.: U.S. Department of Health and Human Services).
Source: The 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).

One of the first and most promising state reform efforts is Maine's Dirigo Health Reform Act, which aims to extend coverage to all uninsured state residents by 2009. With Fund support, national and state health policy experts assisted the Maine Governor's Office of Health Policy and Finance as it designed a low-cost insurance product, created marketing and outreach strategies targeting the uninsured, and weighed various political and market considerations. Maine is now one of only four states where less than 14 percent of working-age adults are uninsured, and one of the few states to markedly improve adult health coverage over the last five years.[2]

Retaining and expanding employer participation: Maine's Dirigo Health.

Annual expenditures on deductible and premium, by income (% federal poverty level)



Notes: FPL=federal poverty level. Employer contribution to premium not shown. MaineCare covers some individuals (e.g., children, pregnant women, and parents) under 150% of FPL.

Source: Dirigo Choice Health Plan 1 deductibles and Commonwealth Fund estimates of premiums.

A Fund-supported evaluation of DirigoChoice, the subsidized insurance plan that is the centerpiece of the Maine initiative, is currently under way. Led by James Verdier, J.D., of Mathematica Policy Research, Inc., the study is examining what impact DirigoChoice is having on health coverage and costs for low- to moderate-income individuals and small businesses—the groups for which the plan was designed—and on public and private payers. The evaluation team is also looking at sustainability and replicability of this model to inform other states considering similar coverage strategies. In partnership with the Blue Cross Blue Shield Foundation of Massachusetts, the Fund is also supporting an evaluation of the new Massachusetts Health Plan.

A 2006 keynote address given by Fund president Karen Davis at the annual meeting of the National Academy for State Health Policy sparked widespread interest in state innovations that are bringing about improved health care access, quality, and information technology capacity, as well as new payment systems that reward Medicaid providers for high quality and efficiency. Fund staff have responded to numerous requests to share this information at state forums.

Work undertaken by Commonwealth Fund staff has also spurred action in the states. For example, one of the policy options offered in the Fund's "commencement day" report on health insurance coverage among young adults—mandating that insurance policies cover dependent young adults past the age of 19—has been enacted into law by five states since 2005.[3] Other

reform options outlined in the report formed the basis of bills introduced by Representative Vic Snyder (D–Ark.) and Senator Blanche Lincoln (D–Ark.) that propose to give states the option of raising the eligibility age for Medicaid and the State Children's Health Insurance Program (SCHIP) from 18 to 23.[4]

Sharon Silow-Carroll
Principal
Health Management Associates

Fund grantees are also exploring how public and private purchasers of health care can collaborate to extract greater value from their health care dollars. With Fund support, Sharon Silow-Carroll of Health Management Associates is studying the experiences of states involved in joint public–private "value-based purchasing" initiatives. States have employed a variety of strategies: collecting quality-of-care data; contracting selectively with high-quality providers; partnering with health plans or providers to improve quality; and rewarding or penalizing plans or providers. The project investigators began field work in the fall of 2006, focusing on four initiatives—the Minnesota Smart Buy Alliance, Wisconsin Employee Trust Fund, Puget Sound Health Alliance, and Massachusetts Group Insurance Commission.

Another project in the quality arena, led by Stephen Somers, Ph.D., of the Center for Health Care Strategies, is assisting six state Medicaid programs in the design of pay-for-performance programs that lead to better care, at lower costs, for enrollees in public insurance. The Medicaid teams will take part in two intensive training sessions and receive follow-up assistance.

Since publication began in March 2005, the Fund e-newsletter *States in Action* has proven to be an effective vehicle for raising awareness of innovative state coverage expansions and quality improvement initiatives. Launched as a quarterly, and now published bimonthly, the newsletter reaches an audience of more than 9,000 state policymakers, administrators, researchers, and other who are working on ways to stretch health care dollars to meet the needs of their state's residents.

Notes

[1] 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).

[2] *Bangor Daily News* editorial, Oct. 21, 2006, p. 10.

[3] S. R. Collins, C. Schoen, J. L. Kriss et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated May 2006).

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Medicare's Future

Stuart Guterman
Senior Program Director

For more than 40 years, Medicare has helped the nation's elderly and disabled obtain the health care they need, while protecting the most vulnerable among them from financial hardship. Medicare faces many challenges as it begins its fifth decade, as program costs continue to rise and its beneficiaries' needs continue to evolve. Through its Program on Medicare's Future, The Commonwealth Fund works to:

- enhance Medicare's ability to carry out its traditional mission of ensuring access and affordability.
- 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.

The Fund' Program on Medicare's Future is exploring how Medicare can encourage better performance throughout the health care system. Recently, the Fund and the Centers for Medicare and Medicaid Services brought together participants in the Medicare Physician Group Practice Demonstration to share strategies and refine approaches. The three-year demonstration offers practices the opportunity to earn performance payments for improving their efficiency and quality of care.

The Medicare Modernization Act of 2003 made major changes to the Medicare program, adding a new Part D prescription drug benefit and expanding the role of private plans through the new Medicare Advantage option. Many Medicare beneficiaries who previously lacked drug coverage were able to obtain it under Part D. But low-income beneficiaries who previously were

covered under Medicaid have had to cope with an abrupt transition to a very different Medicare program; others who were without drug coverage, meanwhile, have not yet enrolled in Part D.

Medicare drug coverage is available only through private plans—either standalone prescription drug plans, available for those enrolled in traditional Medicare, or Medicare Advantage drug plans, available for those enrolled in Medicare managed care. Medicare Advantage added several new features to Medicare, including regional preferred provider organizations, special-needs plans, and a bidding process intended to generate lower plan premiums and program savings.

Apart from these legislated changes, Medicare faces increasing pressure to increase the quality, appropriateness, and efficiency of the care provided to beneficiaries. Currently, officials are seeking to develop approaches that encourage these improvements through the program's payment and regulatory mechanisms. Over the past year, the Fund has been monitoring the impact of these changes on Medicare beneficiaries, identifying areas of concern, and developing appropriate policy options.

The Prescription Drug Benefit: Year One

The prescription drug benefit, launched in January 2006, fills a serious gap in essential coverage for beneficiaries, particularly those with low incomes or chronic illnesses. As of the end of the first open enrollment period, 22.5 million beneficiaries were enrolled in standalone prescription drug plans or in Medicare Advantage drug plans. The U.S. Department of Health and Human Services has estimated that another 15.8 million beneficiaries have comparable coverage through an employer plan or alternative source.[1] Still, more than 4 million beneficiaries—approximately 10 percent of the Medicare population—lack prescription drug coverage. Moreover, some three-quarters of those uncovered beneficiaries have low incomes and so are particularly vulnerable to the financial burden of high drug costs.

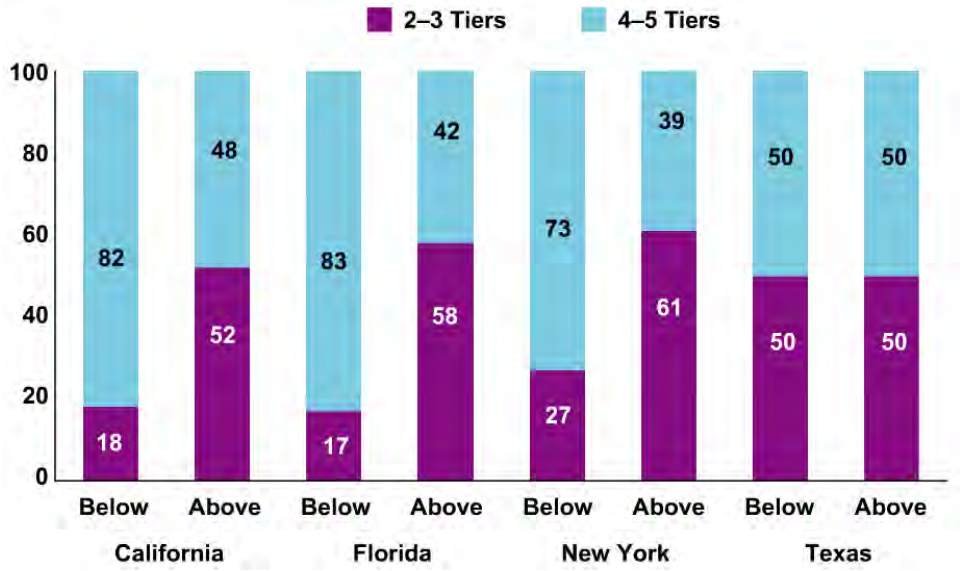
Several projects supported by The Commonwealth Fund have examined how the Part D benefit will affect beneficiaries' access to, and use of, medications prescribed by their doctors. A Fund-supported research team led by the University of Maryland's Bruce Stuart, Ph.D. examined prescription drug utilization and coverage prior to enactment of Part D among beneficiaries residing in nursing homes—a population with a high need for prescription medications. Of this group, 20 percent had no drug coverage, while another 60 percent had drug coverage through Medicaid (which no longer applies to Medicare beneficiaries beginning in 2006). These findings indicate that Part D will be extremely important to ensuring access to needed medications for this vulnerable group.[2]

An analysis of private drug plan benefit designs and formularies in the four most populous Medicare states, led by Tanisha Carino, Ph.D., of Avalere Health, revealed wide variation in rules requiring enrollees to obtain prior authorization for medications, as well as in the number of drugs covered. In particular, plans with lower premiums tended to have a greater number of formulary tiers. The researchers found that the high copayments in some of these tiers can hinder access to certain drugs—typically, those that are more expensive.

For plans with below-average premiums (into which Medicaid beneficiaries were automatically enrolled), average copayments in New York range from $6 for tier 1 to $69 for tier 4. Across the four states, 70 percent of plans with below-average premiums had more than three tiers, and 45 percent of plans with premiums above the benchmark had more than three tiers. The researchers recommend that indicators of beneficiary access to needed drugs be part of overall Part D performance measures.[3]

Private Medicare drug plans with more formulary tiers tend to charge lower premiums than plans with fewer tiers.

Percent of plans in state charging premiums below and above state benchmark



Source: N. Heaton, T. Carino, H. Dix, *Assessing Medicare Prescription Drug Plans in Four States: Balancing Cost and Access* (New York: The Commonwealth Fund, Aug. 2006).

Fund-supported researchers have been monitoring another trouble spot: the Part D subsidy designed to help low-income beneficiaries' meet their share of drug expenses. A review conducted by the Social Security Administration in January 2006 showed that more than half of applicants who qualified for the subsidy on the basis of their income were denied because their financial assets were above the maximum threshold allowed.[4] The most common sources of "excess" resources were modest bank accounts, in many cases opened in anticipation of health-related expenses later in life. But according to Fund-sponsored research conducted by Dennis Shea, Ph.D., of Pennsylvania State University, low-income beneficiaries who fail to meet the Part D's asset test have similar rates of chronic conditions and out-of-pocket spending to those beneficiaries who qualify for extra help.[5] Shea and colleagues noted that the similarities raise questions about the fairness of the means-testing and recommended that policymakers monitor these groups carefully.

Georgetown University's Laura Summer and colleagues have been gathering data from people who work with beneficiaries across the country to identify additional problem areas and potential solutions.[6] In addition to issues surrounding the low-income subsidy, Summer and her colleagues point out that Part D rules may make it too costly for many beneficiaries to continue

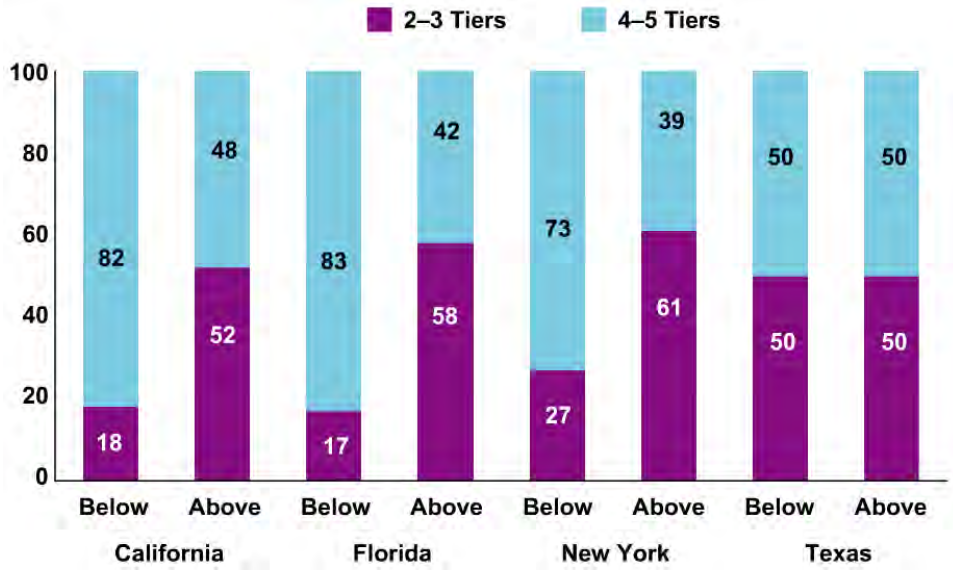
receiving long-term care in community settings rather than in nursing facilities, where residents are protected from copayments and other drug costs. Eliminating the copayment requirements for community-dwelling "dual eligibles" (low-income Medicare beneficiaries who were previously enrolled in Medicaid), as some in Congress have proposed, would be one way to allow such individuals to avoid institutionalization. Another serious issue—and one that affects all beneficiaries—is the general lack of assistance with using the new drug benefit, including accurate, easy-to-use information about private drug plan options, and help with applying for the low-income subsidy and enrolling in a plan.

Laura Summer
Georgetown University

Expanded Role of Private Plans

Through its grantmaking, The Commonwealth Fund has examined the impact of private plans on Medicare beneficiaries' access to care and out-of-pocket costs. Fund-supported researchers have documented the enormous variation in out-of-pocket costs for beneficiaries who choose various private Medicare plans—information that has been cited by members of Congress in their communications with the Secretary of Health and Human Services.[7] George Washington University's Brian Biles, M.D., and colleagues estimated that annual out-of-pocket spending for Medicare Advantage enrollees in poor health range from less than $1,400 to more than $7,500.[8] Speaking at a Fund-sponsored Alliance for Health Reform briefing, the study's authors recommended permitting beneficiaries to switch plans with 30 days' notice, making Medicare Advantage benefit packages more standardized, and better protecting enrollees from high out-of-pocket costs.

Payments to Medicare Advantage plans in 2005 averaged 12.4 percent more than costs in traditional Medicare, an extra $922 per enrollee.



Source: B. Biles et al., *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised* (New York: The Commonwealth Fund, Nov. 2006).

Additional research by Biles and his team found that private Medicare Advantage plans received payments from the government in 2005 that exceeded expected fee-for-service payments for the same enrollees by an estimated $5.2 billion.[9] Armed with this evidence, both Democrats and Republicans have developed proposals to redirect some of this money to fund other policy initiatives, such as improvements in beneficiary coverage or deficit reduction. Already deep into the next phase of Fund-sponsored research, the research team is exploring geographic variations in Medicare Advantage benefit packages and their relationship to plan payment rates, with a focus on new special-needs plans, which target specific groups of enrollees (e.g., Medicare/Medicaid "dual eligibles" and beneficiaries with certain chronic conditions), and private fee-for-service plans, which provide the traditional Medicare benefit package through private plans.

Financial Aid for Low-Income Seniors

Through Medicare Savings Programs, states provide extra help to low-income beneficiaries by paying their Medicare premiums and, in one of the programs, cost-sharing. Fewer than one of three eligible individuals, however, is enrolled in them. Similarly, about three-quarters of Medicare beneficiaries without any drug coverage are believed to be eligible for the Part D low-income subsidy.[10]

Fund-supported researchers at the National Academy of Social Insurance examined ways to facilitate enrollment in these valuable programs. At an Alliance for Health Reform briefing, they presented a number of recommendations to congressional staffers—among them, simplifying and aligning programs for low-income beneficiaries, enhancing federal participation in the programs, and adopting uniform methods for counting income and resources.[11]

Fund support also helped the State Solutions National Program Office at Rutgers University assist Minnesota in its efforts to increase enrollment in its Medicare Savings Program. The Rutgers staff conducted more than 1,800 education and enrollment sessions at community venues, many located in minority communities. These efforts yielded tangible results: enrollment of eligible Native Americans in Minnesota, for example, rose 11 percent.

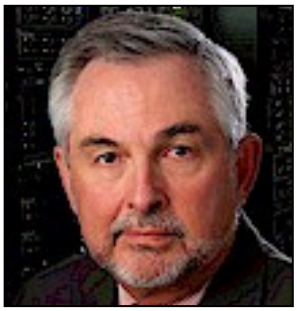
Increasing Value and Efficiency

A wide and potentially confusing array of health plan options confronts Medicare beneficiaries. With Fund support, Jack Hoadley, Ph.D. of Georgetown University is addressing the issue. In December 2005, Dr. Hoadley and colleagues convened an expert panel—comprising industry members, advocates, researchers, and insurance regulators—to discuss greater standardization in Medicare Advantage. This discussion, together with another meeting held in September 2006, will be used as a basis for developing options for achieving this objective.

Jack Hoadley, Ph.D.
Georgetown University

In an effort to reduce the fragmentation in seniors' health coverage, work on developing a comprehensive benefit option for Medicare—a new Part E—continues. As originally envisioned by Commonwealth Fund president Karen Davis and colleagues in an October 2005 *Health Affairs* article,[12] beneficiaries who would choose to enroll in the option—which they named "Medicare Extra"—would no longer need to purchase a private drug plan, in addition to Medigap supplemental coverage, to meet their coverage needs.

The Fund is also supporting efforts to improve the value Medicare gets for the money it spends. In April 2005, CMS launched the Physician Group Practice Demonstration, Medicare's first pay-for-performance initiative for physicians. Projected to run through March 2008, the program provides incentives for large, multi-specialty group practices to improve the coordination of care for their fee-for-service beneficiaries. Ten PGP sites serving upwards of 200,000 beneficiaries have projects under way to test improvements to data systems, care management programs, and coordination-of-care efforts, among other interventions that Medicare does not directly reimburse. In April 2006, leaders from each site met with CMS officials to share their experiences and strategies.[13] Participants will be able to use information learned about what works, and what does not, to refine their approaches during the demonstration's remaining two years.



Glenn Steele, Jr., M.D.
Member, Commission on a High Performance Health System

Dr. Steele is president and CEO of Geisinger Health System in Pennsylvania. Geisinger is one of 10 organizations participating in Medicare's Physician Group Practice Demonstration.

Fund grantees are also assessing the potential of value-based purchasing strategies to improve care and efficiency. For example, the Urban Institute's Robert Berenson, M.D., and his staff have been working with purchasers, providers, and federal and state regulators to see how the pay-for-performance approach might mesh with Medicare's system for compensating physicians. Many stakeholders agree that pay-for-performance should proceed in areas where there is underuse of recommended care, and where validated measures to profile and reward performance exist.

In invited testimony before the House Energy and Commerce Committee's Subcommittee on Health in July 2006, the Fund's Stuart Guterman emphasized that Medicare can use its role in financing health care to improve the performance of the Medicare program and the health care system as a whole.[14] "Determining how much to pay physicians certainly is an important issue," Guterman said, "but determining how to pay physicians so Medicare beneficiaries get the best care possible is of at least equal importance." Noting the marked deficiencies in quality and coordination of care throughout health care, he argued for paying greater attention to what the nation receives for the money it devotes to health care.

In addition to financial incentives to support quality improvement in Medicare, there is a need for objective, reliable evidence of the benefits, risks, and costs of new medical procedures and technologies to support decision-making on the part of patients, clinicians, payers, and

policymakers. In a Fund-supported *Health Affairs* Web Exclusive, Gail Wilensky, Ph.D., called for the creation of an entity to generate, collect, and disseminate comparative information about the effectiveness of health care treatments.[15] Wilensky will next examine the necessary policy conditions for realizing such a vision. The Fund will also support the development of a framework for identifying, disseminating, and applying better evidence for coverage, payment, and clinical decision-making.

Columbia University's William Sage, M.D., J.D., and Indiana University's Eleanor Kinney, J.D., M.P.H, meanwhile, argue for Medicare taking a leadership role in malpractice reform. In a Fund-supported article, they propose that malpractice disputes be adjudicated by Medicare's existing administrative appeals system, in conjunction with the program's quality improvement regulation and payment policy, to decrease errors and provide compensation for injured patients.[16] Congress has taken note of this issue; Sage testified on the subject before the Senate's Committee on Health, Education, Labor, and Pensions in June 2006.[17]

The Fund will continue to conduct analyses and develop policy recommendations to ensure that Medicare beneficiaries receive appropriate, effective, and efficient health care. With rising health care costs, concerns about the quality and appropriateness of care, and a population increasingly dealing with multiple chronic conditions, Medicare faces considerable challenges. In coming years, the Program on Medicare's Future will focus on strengthening the program's effectiveness for its beneficiaries and building Medicare's role in achieving a high performing health system.

Notes

[1] Department of Health and Human Services News Release, "Over 38 Million People with Medicare Now Receiving Prescription Drug Coverage," June 14, 2006.

[2] B. Stuart, L. Simoni-Wastila, F. Baysac et al., "Coverage and Use of Prescription Drugs in Nursing Homes: Implications for the Medicare Modernization Act," *Medical Care*, March 2006 44(3): 243–49.

[3] E. Heaton, T. Carino, and H. Dix, *Assessing Medicare Prescription Drug Plans in Four States: Balancing Cost and Access* (New York: The Commonwealth Fund, Aug. 2006).

[4] Henry J. Kaiser Family Foundation, *Prescription Drug Coverage Among Medicare Beneficiaries,* June 2006.

[5] D. Shea et al., "Close, But No Cigar. Medicare Beneficiaries Who Fail Asset and Income Testing for Subsidies in Medicare Part D," Presented at the Gerontological Society of America's 58th Scientific Meeting, Orlando, FL., November 2005.

[6] L. Summer, P. Nemore, J. Finberg, "The Effect of Program Complexity on Access to Part D Drugs for Vulnerable Medicare Beneficiaries," report forthcoming from The Commonwealth Fund.

[7] Letter to Health and Human Services Secretary Michael O. Leavitt from U.S. Senators Baucus and Rockefeller and U.S. Representatives Brown, Dingell, Rangel, and Stark, Oct. 25, 2006.

[8] B. Biles, L. H. Nicholas, and S. Guterman, *Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?* (New York: The Commonwealth Fund, May 2006).

[9] B. Biles, L. H. Nicholas, B. S. Cooper, E. Adrion, and S. Guterman, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised* (New York: The Commonwealth Fund, revised Nov. 2006).

[10] Henry J. Kaiser Family Foundation, *Prescription Drug Coverage Among Medicare Beneficiaries,* June 2006.

[11] J. Ebeler, P. N. Van de Water, and C. Demchak (eds.), "Improving the Medicare Savings Programs" (Washington, D.C.: National Academy of Social Insurance, 2006).

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[13] M. Trisolini, G. Pope, J. Kautter, and J. Aggarwal, *Medicare Physician Group Practices: Innovations in Quality and Efficiency* (New York: The Commonwealth Fund, Dec. 2006).

[14] S. Guterman, "Medicare Physician Payment: Are We Getting What We Pay For? Are We Paying for What We Want?" Invited Testimony, Energy and Commerce Committee, Subcommittee on Health Hearing, "Medicare Physician Payment: How to Build a Payment System That Provides Quality, Efficient Care for Medicare Beneficiaries," July 25, 2006.

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

[16] E. D. Kinney and W. M. Sage, "Resolving Medical Malpractice Claims in the Medicare Program: Can It Be Done?" *Connecticut Insurance Law Journal*, 2005–06 12(1):79–136.

[17] W. M. Sage, Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate, June 22, 2006.

Health Care Quality Improvement and Efficiency

Anthony Shih, M.D.
Senior Program Officer

The Commonwealth Fund is dedicated to improving the quality and efficiency of health care in the United States. Toward that goal, the Fund's Program on Health Care Quality Improvement and Efficiency supports projects that:

- promote the development and widespread use of health care performance measures, with a focus on efficiency, care coordination, and patient safety.
- enhance the capacity of health care organizations to provide better care more efficiently.
- encourage health care purchasers to adopt incentives that spur providers to improve quality and efficiency.

An important part of the Fund's work is studying what the innovators are doing and spreading the word. Recently, Fund-supported researchers examined the "culture of safety" created at OSF St. Joseph Medical Center in Illinois, which has realized a 90 percent reduction in adverse drug events. Playing a critical role are nurses, who conduct safety briefings at shift changes to review conditions that could have caused patient harm.

Evidence of shortcomings in the quality of our health care is substantial.[1,2,3] A 1999 Institute of Medicine report estimated that as many as 98,000 Americans die each year as a result of avoidable patient safety errors, while the Centers for Disease Control and Prevention has estimated that 90,000 die as a result of hospital-based infections.[4,5] According to the national health system scorecard released by the Commission on a High Performance Health System, anywhere from 100,000 to 150,000 deaths could be prevented each year if the U.S. were able to raise standards of care to benchmark performance levels achieved within this country and abroad. The Commission's scorecard also documented enormous variation in the delivery of care—nationally, regionally, and locally.

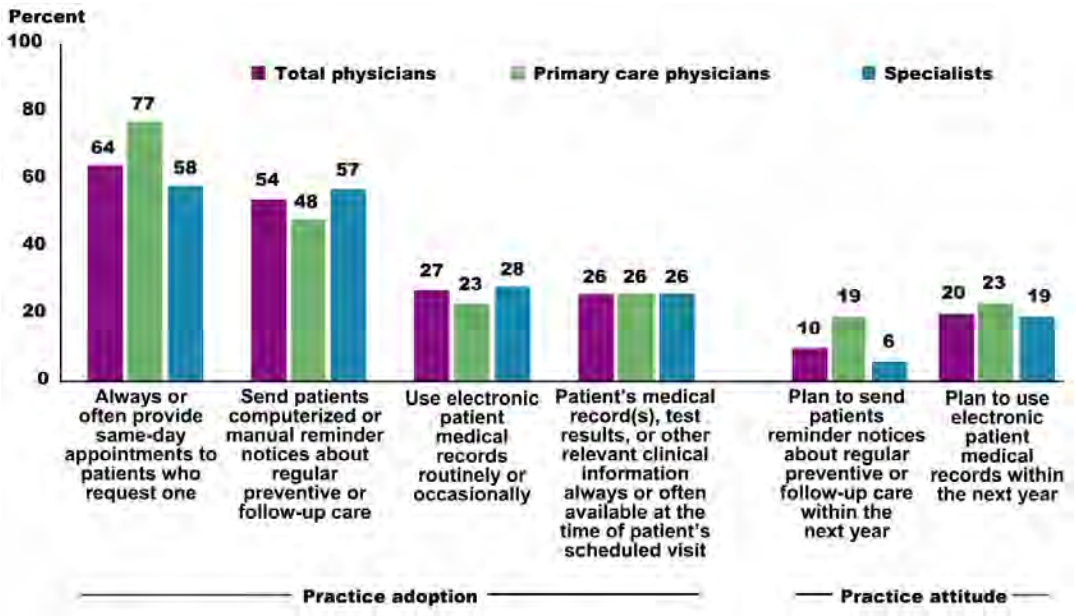
The Fund's Program on Health Care Quality Improvement and Efficiency is guided by the belief that improvements in health care quality are most likely to occur when the need for change is acknowledged and publicly recognized, when appropriate incentives are in place, and when those who deliver, purchase, and regulate care have the capacity to initiate and sustain change.

What Doctors Are Doing

Findings from the Fund's 2003 National Survey of Physicians and Quality of Care indicate that while many U.S. doctors have adopted some of the practices associated with high-quality care, there is plenty of room for improvement. As reported by former Fund vice president Anne-Marie J. Audet, M.D., and colleagues in the April 2006 issue of *Archives of Internal Medicine*,[6] a majority of the doctors surveyed were providing some degree of patient-centered care—one of the core components of quality identified by the Institute of Medicine. For example, about two-thirds of physicians said they were always or often able to provide same-day appointments to patients, and a similar proportion said they received timely information about patient referrals.

But in other important quality areas—use of information technology, practicing team-based care, collecting and using feedback from patients—physicians are not faring so well. Three-quarters of primary care physicians said they experienced problems having access to patients' medical records, test results, or other relevant information at the time of scheduled visits. Only about half sent patients reminder notices about regular preventive or follow-up care. Notably, physicians in larger practices appeared more likely to adopt patient-centered practices than solo physicians.

While a majority of physicians have implemented some patient-centered practices, there is much room for improvement.



Source: Adapted from A.-M. J. Audet, K. Davis, and S. C. Schoenbaum, "Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey," *Archives of Internal Medicine,* Apr. 10, 2006 166(7):754–59.

Another article by Fund staff, published in the May/June 2005 issue of *Health Affairs*, continues to have an impact in the field.[7] The study, which found that the majority of physicians are not actively engaged in quality improvement activities, was selected in June 2006 by the Thomson-Scientific Essential Science Indicators (ESI) as a "Fast Breaking Paper," one of the most frequently cited in the social sciences.[8] ESI covers more than 11,000 journals from around the world in 22 fields of research. The study also was among the 25 most frequently viewed articles in *Health Affairs* in 2005.

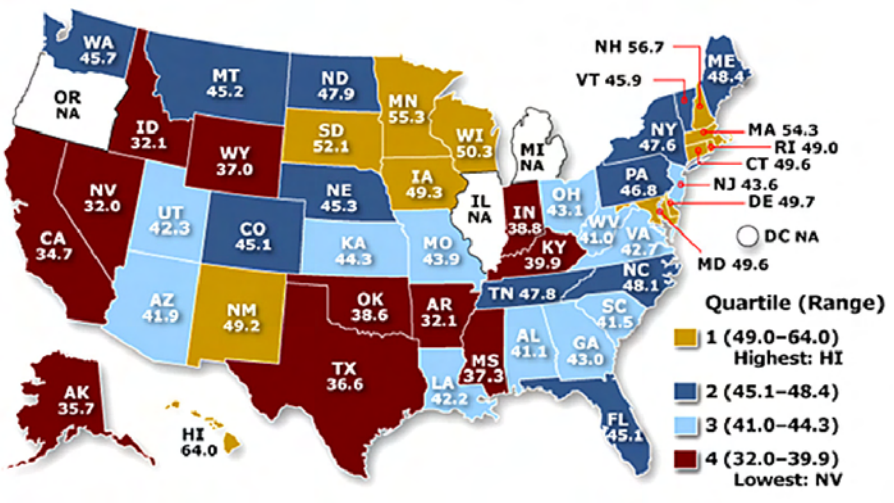
To engage physicians in quality measurement and improvement, particularly those working in smaller practices, the Fund and the American Board of Internal Medicine (ABIM) Foundation launched the "Putting Quality into Practice" initiative. Project investigators interviewed 39 physicians in solo and small group practices who have successfully introduced systematic improvements in their practices. Drawing on this wealth of firsthand experience, they developed a compendium of best practices for physician-led quality improvement. An accompanying DVD video profiles 10 physicians who have improved patient care and increased efficiency through relatively simple, easily implemented interventions.[9] Since March 2006, the ABIM foundation has fulfilled more than 2,000 requests for the video.

Disseminating Information About Quality and Performance

The Fund continues to support efforts to gather and disseminate information on the quality of care. Building on its series of chartbooks, the Fund published the first installment in a new series of "Performance Snapshots" on its Web site in December 2006. Performance Snapshots use graphs and narratives to demonstrate health care system challenges, successes, and opportunities to improve. Users can search this online resource by area of interest or quality domain. They can also create and save their own collections of charts for later reference or for use in their own presentations. Regular additions will provide up-to-date information on important quality indicators and trends, as well as new data on emerging issues.

One of the frequently downloaded charts from "Performance Snapshots."

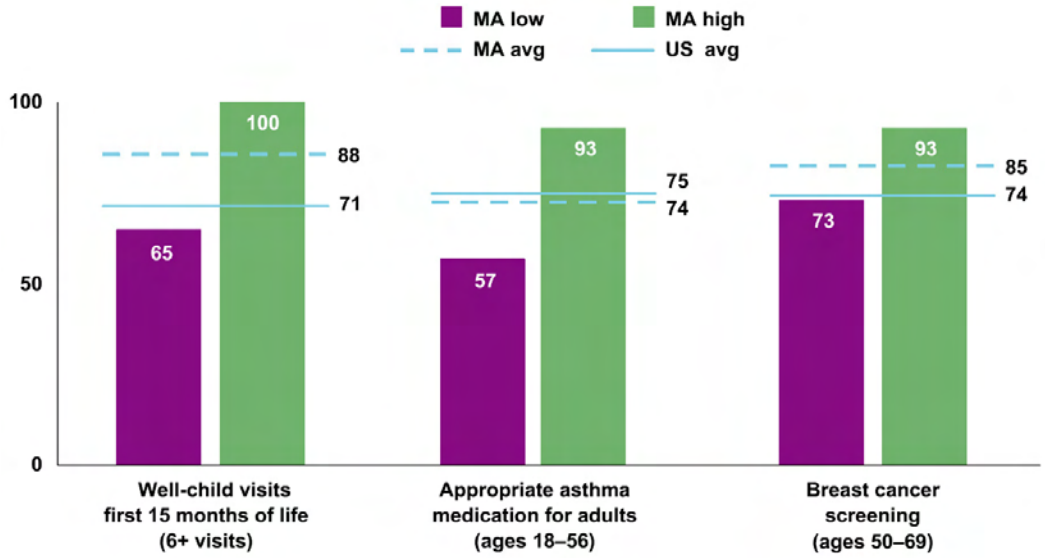
Percentage of Community-Dwelling Adults Ages 18 and Older With Diabetes Who Received Three Diabetes Care Services* in the Past Year, State Rates, 2002–2004



Data: Behavioral Risk Factor Surveillance System (Centers for Disease Control and Prevention 2005).
*Retinal exam, foot exam, and two or more hemoglobin A1c tests. Rates were age-adjusted to the 2000 U.S. standard population. NA = data not available.
Source: McCarthy and Leatherman, Performance Snapshots, 2006. The Commonwealth Fund. www.cmwf.org/snapshots

While there are ongoing efforts to assess the quality of care and costs in health plans and hospitals, there is little such information available for physician groups or practices. In February 2006, the Massachusetts Health Quality Partners (MHQP), a coalition of physicians, hospitals, health plans, purchasers, consumers, government agencies, and academics, publicly released a report on the performance of 150 medical groups on 15 measures of clinical quality.[10] Along with the Robert Wood Johnson Foundation, the Fund supported rigorous methodological work by Dana Safran, Sc.D., that laid the groundwork for the MHQP analysis—helping make the case for the feasibility, accuracy, and validity of public reporting of performance data.[11]

Quality variation among physician groups in Massachusetts: highest, lowest, and average.



Source: MHQP Quality Insights—Healthcare Performance in Massachusetts: Clinical Quality in Primary Care.

The MHQP data offer a unique opportunity to shed light on the factors that affect physician performance. With Fund support, Eric Schneider, M.D., and colleagues at the Harvard School of Public Health will survey physician leaders at each of the Massachusetts practices and visit selected practices to determine the organizational, cultural, and other characteristics associated with high performance. The results will inform policymakers and providers in other parts of the country.

In partnership with the Robert Wood Johnson Foundation, the Fund is supporting the 2006 National Survey of Physician Organizations, a project led by Stephen Shortell, Ph.D., at the University of California, Berkeley. The UC Berkeley team led a survey in 2000 to evaluate the extent to which large medical groups had implemented evidence-based care management processes for asthma, congestive heart failure, depression, and diabetes. Findings revealed that few medical groups used care management processes, and that external incentives and information technology capacity were associated with greater use. But much has changed since then: quality improvement methods are more common, more varied payment incentives have been adopted, and a national agenda for use of health information technology has been established. Shortell's team will re-survey large physician group practices to evaluate progress made in the management of chronic illness. These follow-up results will provide critical information on the effectiveness of ongoing incentive programs and will help guide future plans.

Glenn M. Hackbarth, J.D.
Member, Commission on a High Performance Health System

As chairman of MedPAC, Mr. Hackbarth advises Congress not only on payment policy regarding Medicare plans and providers, but also on quality-of-care issues affecting beneficiaries.

Maximizing Value and Efficiency

Efforts to align payments with the quality of care—so-called "pay for performance" programs—are growing in number. Most of these initiatives target effectiveness measures, but some are beginning to include other dimensions of performance, such as patients' experiences with care and indicators of efficiency. For example, Medicare and Premier Inc., a nationwide organization of nonprofit hospitals, are conducting the Hospital Quality Incentive Demonstration to test whether bonus payments and public reporting of performance data can foster quality. With Fund support, the Urban Institute's Robert Berenson, M.D., is studying whether New York State's incentive program for Medicaid managed care plans has encouraged quality improvement efforts and improved the quality of care for enrollees.

Robert Berenson, M.D.
Urban Institute

There is keen interest in developing indicators of efficiency for hospitals, physician groups, and other providers of care. Yet, the relationship between cost and quality is poorly understood, and health system characteristics associated with higher performance are not firmly established. With Fund support, Sharon Silow-Carroll, M.B.A., M.S.W., and her colleagues at the Health Management Associates are exploring the dynamics of high performance over time and the factors that contribute to its sustainability.

Using CareScience's national database of more than 3,000 hospitals, Silow-Carroll and her team have been tracking hospital quality as measured by such factors as mortality, complications, and resource use over three years. What interests them most are hospitals that are able to achieve high performance on a broad set of indicators, rather than just a few. As part of their work, the researchers are performing analyses of quarterly performance data from 200 hospitals and developing profiles of four of the highest-performing hospitals.[12]

Notes

[1] S. Leatherman and D. McCarthy, Quality of Health Care for Medicare Beneficiaries: A Chartbook (New York: The Commonwealth Fund, May 2005).

[2] S. Leatherman and D. McCarthy, Quality of Health Care for Children and Adolescents: A Chartbook (New York: The Commonwealth Fund, Apr. 2004).

[3] S. Leatherman and D. McCarthy, Quality of Health Care in the United States: A Chartbook (New York: The Commonwealth Fund, Apr. 2002).

[4] Institute of Medicine, *To Err Is Human: Building A Safer Health System* (Washington, D.C.: National Academies Press, 1999).

[5] Centers for Disease Control and Prevention, "Guidance on Public Reporting of Healthcare-Associated Infections. Recommendations of the Healthcare Infection Control Practices Advisory Committee" (Atlanta: CDC, Feb. 2005).

[6] A.M. Audet, K. Davis, and S. C. Schoenbaum, "Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey," *Archives of Internal Medicine*, April 10, 2006 166(7):754–59.

[7] A.M. Audet, M. M. Doty, J. Shamasdin, and S. C. Schoenbaum, "Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement," *Health Affairs,* May/June 2005 24(3):843–53.

[8] See http://www.esi-topics.com/fbp/2006/june06-AnneMarieAudet.html.

[9] To order a copy of "Putting Quality into Practice: Physicians in Their Own Voices," complete the order form at http://www.abimfoundation.org/pqip_video.htm or call Helen Egner at (215) 446-3530.

[10] Massachusetts Health Quality Partners, "Quality Insights—Healthcare Performance in Massachusetts: Clinical Quality in Primary Care," available at http://www.mhqp.org.

[11] D. G. Safran, M. Karp, K. Coltin et al., "Measuring Patients' Experiences with Individual Primary Care Physicians. Results of a Statewide Demonstration Project," *Journal of General Internal Medicine*, January 2006 21(1):13–21.

[12] E. Kroch, M. Duan, S. Silow-Carroll et al., "Hospital Performance Improvement: Trends in Quality and Efficiency," and S. Silow-Carroll, T. Alteras, and J. Meyer, "Hospital Performance Improvement: Process, Strategies, and Lessons from 'Top-Improving' U.S. Hospitals" (New York: The Commonwealth Fund, *forthcoming*).

Patient-Centered Primary Care Initiative

Melinda K. Abrams
Senior Program Officer

The Commonwealth Fund launched the Patient-Centered Primary Care Initiative in 2005 to spur the redesign of primary care practices and health care systems around the needs of the patient. Projects supported by the initiative seek to promote:

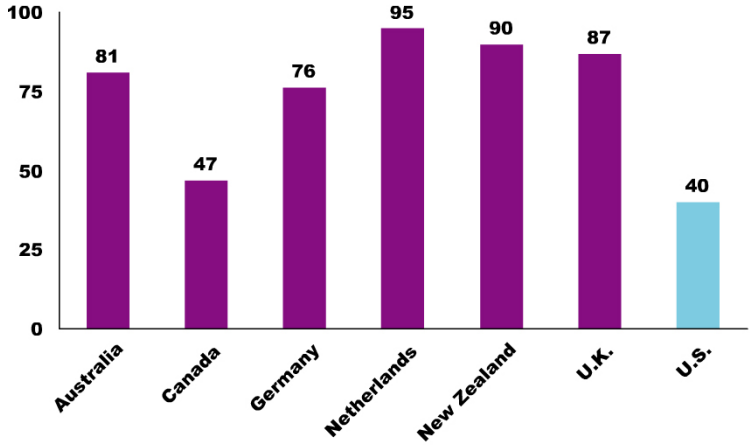
- The collection of information on patients' experiences with health care, and the public reporting of that information as a way to encourage quality improvement in primary care.
- The adoption of models, and tools to help primary care practices restructure and improve care to meet patients' preferences.
- Improvements in policy that support patient-centered care.

Increasingly, patients want and expect physicians to treat them as partners in care decisions, be responsive to their concerns, and provide the information and support needed to help them manage their own care.

Despite being named one of the key components of quality health care by the Institute of Medicine (IOM), "patient-centeredness" has yet to become the norm in primary care. One of five American adults has trouble communicating with doctors, and one of 10 feels they were treated disrespectfully during a recent health care visit.[1] The Commonwealth Fund 2006 International Survey of Primary Care Physicians shows that less than half of U.S. physicians receive feedback from patient surveys and just 9 percent always or often communicate with patients via e-mail.[2] A little over a quarter use electronic medical records in their practices.

Only two of five U.S. physician practices make arrangements for patients to see a nurse or doctor after hours.

Percent of primary care practices



Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

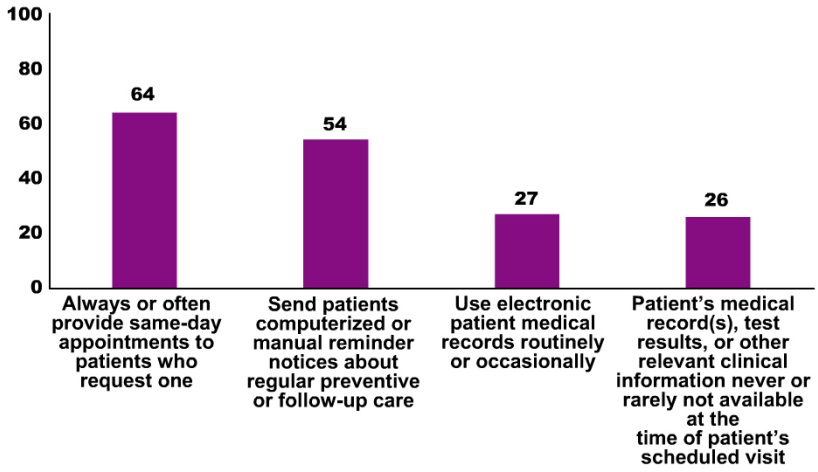
In the essay, "A 2020 Vision of Patient-Centered Primary Care," Karen Davis, Stephen Schoenbaum, M.D., and Anne-Marie Audet, M.D., outlined what it will take to orient physician practices around patients.[3] The authors define a patient-centered primary care practice through seven attributes:

- superb access to care
- patient engagement in care
- clinical information systems supporting high-quality care, practice-based learning, and quality improvement
- care coordination
- integrated and comprehensive team care
- routine patient feedback to doctors
- publicly available information on provider performance.

Ensuring that all Americans have a medical home is a first step toward creating a patient-centered health system, say Davis and colleagues. They argue that a package of patient-centered services—such as e-mail visits, automated patient reminders, access to electronic medical records, and same-day appointments or walk-in hours—could be supported through a fixed monthly fee. In addition, pay-for-performance contracts similar to those employed in the United Kingdom could encourage primary care practices to measure and improve the quality of care they deliver. Demonstration projects could test the viability of such models, helping to develop a "business case" for providing patient-centered care.

Patient-centered care practices have not yet been widely adopted by U.S. physicians.

Percent of physicians



Source: Adapted from A.-M. J. Audet, K. Davis, and S. C. Schoenbaum, "Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey," *Archives of Internal Medicine,* Apr. 10, 2006 166(7):754–59.

Fund-supported efforts are seeking to answer the challenge put forth in "A 2020 Vision." The National Committee for Quality Assurance (NCQA), for example, has been developing and testing a comprehensive set of measures to see how well patient-centered care has taken hold in physician practices. Of the patient survey instruments currently in use, most examine individual providers' performance, but quality improvement experts emphasize the importance of practice structure and environment in the quality of care patients receive. The NCQA measurement set expands and complements patient survey measures to assess a physician practice's systems, taking into account, for example, patients' access to medical records, their involvement in quality improvement activities, and systems to coordinate care between providers.

Sarah H. Scholle, Dr.P.H.
National Committee for Quality Assurance

So far, NCQA has incorporated 18 of these patient-centered care measures in the standards for its Physician Practice Connections program, which recognizes practices that use information systems to improve patient care. The program is part of Bridges to Excellence, a physician pay-for-performance program sponsored by several large corporations.

A project led by Dana Safran, Sc.D., of Tufts–New England Medical Center is examining the strength of the relationship between patient experience and clinical quality and outcomes at the individual physician and practice levels. The results from this work will provide much-needed information to motivate greater investment in and commitment to patient-centered care. In particular, it should encourage practices to routinely solicit feedback from patients about their health care experiences.

Successful models of patient-centered primary care can not only demonstrate for physicians the feasibility of delivering such care, but they can provide useful information for developing tools that improve patients' experiences. With Fund support, Susan Edgman-Levitan of Massachusetts General Hospital is documenting the experiences of 12 patient-centered primary care practices. After identifying top practices through patient survey data, Edgman-Levitan will assess how various aspects of each organization—from leadership style to use of technology to quality improvement methods—affect patients' experiences with physician care.

The Fund is supporting the Pacific Business Group on Health, meanwhile, to assess whether a Breakthrough Series Learning Collaborative of 13 practices in California is the type of intervention that can boost patient experience. Additional support for a Dartmouth College project led by John Wasson, M.D., will enable a Medicare quality improvement organization (QIO) to assist primary care practices in integrating Web-based patient surveys and other technologies that facilitate patient-centered care. The hope is that many other practices and QIOs will replicate this model if it is shown to improve patient-centeredness and increase office efficiency.

In the coming months, the Patient-Centered Primary Care Initiative will seek a better understanding of which features of a patient-centered practice are meaningful to patients and associated with high-quality care. Curricula, tools, and models under development will give physicians practical guidance on reorganizing their practices around patient-centered care. And policy analysis and demonstration projects will ensure that patients' experiences are taken into account in efforts to improve the quality and efficiency of primary care.

Notes

[1] 2001 Commonwealth Fund Survey of Health Care Quality.

[2] 2006 Commonwealth Fund International Survey of Primary Care Physicians.

[3] K. Davis, S. C. Schoenbaum, and A.-M. J. Audet, "A 2020 Vision of Patient-Centered Primary Care," *Journal of General Internal Medicine,* Oct. 2005 20(10):953–57.

Quality of Care for Underserved Populations

Anne C. Beal, M.D.
Senior Program Officer

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 low-income Americans and members of racial and ethnic minority groups, and to reduce racial and ethnic health disparities. The program builds on efforts to improve quality of care overall in the United States, focusing on health care settings that serve large numbers of low-income and minority patients. The strategies it pursues include:

- Finding and promoting models of high performance health systems for the underserved that provide accessible, effective, safe, and efficient health care.
- Promoting health care that is culturally competent and patient-centered.
- Supporting the development of public policy that will lead to improvement in health care systems serving minority and low-income populations.

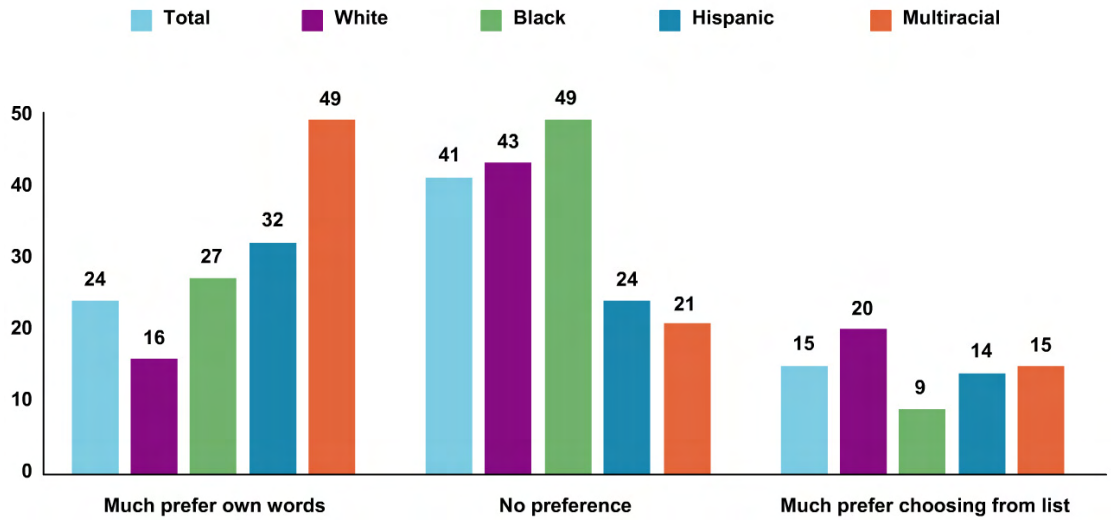
Raising the cultural competence of the health care workforce—so that the patient's needs and preferences are fully addressed during health care encounters—is one of the major goals of the Fund's Program on Quality of Care for Underserved Populations.

Uncovering disparities in health care provider performance begins with accurate data—including patient race, ethnicity, and income level. For several years, Fund grantees have sought to show how hospitals and health plans can obtain and analyze data on quality of care stratified by race and ethnicity. Early on, there were some concerns about the legality of collecting such information; these are now recognized to be unfounded and have by now largely dissipated.[1] Still, many parties remain uncertain of the best way to collect such information, knowing that patients may be uncomfortable disclosing their racial and ethnic backgrounds to their health care providers.

In a Fund-supported study published in March 2006, David W. Baker, M.D., and his colleagues at Northwestern Memorial Hospital in Chicago demonstrated that allowing patients to describe their racial or ethnic background in their own words can improve the accuracy of such data.[2]

Patients of multiracial background strongly prefer to use their own words to describe their race/ethnicity.

Percent



Source: D. W. Baker, K. A. Cameron, J. Feinglass et al., "A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity," *American Journal of Public Health,* Mar. 2006 96(3):532–37.

In another Fund-supported study, Baker and colleagues found that indeed there are right and wrong ways to ask patients about their race and ethnicity.[3] Fully 80 percent of the patients interviewed for the study agreed that hospitals and clinics should document the racial and ethnic makeup of their patient populations. Yet, the interviews revealed that blacks were more likely than whites to express concern that the information would be used to discriminate against patients. Such concerns, the researchers say, can be addressed by clearly explaining the reasons for gathering information and seeking patients' input about how best to do so.

Once race and ethnicity data have been collected, health care professionals can link this information with performance measures to pinpoint disparities in patient care. With support

from the Fund, the Center for Health Care Strategies has been working with 12 Medicaid managed care plans from across the country to develop strategies for identifying and addressing disparities.[4] These plans have sought to improve care in a range of areas, including teenage pregnancy, childhood asthma, diabetes care for Native Americans, prenatal care, and child immunizations. Preliminary results show improvements in both the processes and outcomes of health care, as well as some reduction in disparities.

In a Fund report exploring policy options to promote collection of race and ethnicity data, Sidney D. Watson, J.D., a professor at the Saint Louis University School of Law, argues that incorporating measures of equity into existing quality reporting does not require legislative action.[5] According to Watson, Medicaid and Medicare managed care plans, the Centers for Medicare and Medicaid Services (CMS), and states already have the necessary regulatory authority to mandate that health care organizations report performance data on measures of equity—to demonstrate that they provide the same quality of care to all patients, regardless of race or ethnicity. CMS could, for example, use financial incentives to encourage equity performance measurement, just as it now uses incentives to encourage hospitals to report overall performance data. Private accreditation bodies could include equity performance measurement as part of their voluntary accreditation processes.

Mark Chassin, M.D.
Mount Sinai School of Medicine

Although many studies have documented the underuse of appropriate care among minority populations, the underlying reasons are not well understood. An earlier Fund grant to the Mount Sinai School of Medicine, led by Mark Chassin, M.D., investigated this phenomenon by focusing on black and Hispanic hospital patients with chronic illness in New York's East and Central Harlem. By listening to patients and examining patterns of service use, the project investigators were able to measure underuse, pinpoint some of its causes, and develop a patient-centered approach to treatment emphasizing health promotion and patient self-management. Two of the hospitals involved with the project were able to reduce patients' hospitalizations and generate savings. As a result, they secured enhanced Medicaid payment rates from New York State for treating patients in the new program.

A front-page article in the *Wall Street Journal* in June 2006 documented the project's successes. The patient-centered care approach and payment model, the article's author suggested, "could offer a way to help ease the U.S.'s seemingly intractable health-care crisis."

As a result of work supported by the Fund and others, more health care organizations are monitoring the quality of care they provide to racial and ethnic minority patients. In the next year, the Fund's Program on Quality of Care for Underserved Populations will identify organizations that have demonstrated high performance in delivering care to low-income and minority patient populations. These organizations are likely to have transferable "best practices" and could serve as models for others.

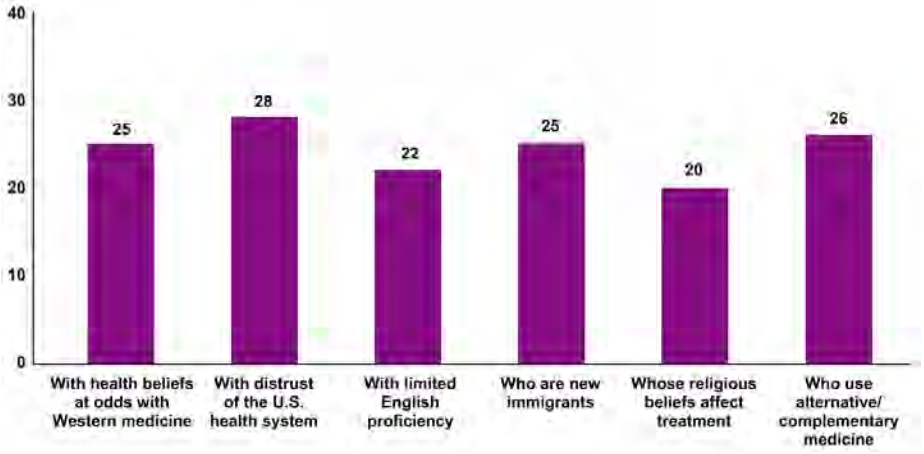
In recent years, "cultural competency" has been recognized as a key component of patient-centered care. Physicians and other health care professionals who are culturally competent show respect for and demonstrate understanding of patients' preferences and their cultural, social, and economic backgrounds, and engage patients in decision-making with regard to treatment plans. Data from the Commonwealth Fund 2004 International Health Policy Survey of Adults' Experiences with Primary Care show that minority patients often experience difficulties communicating with their providers. For example, black and Latino patients in the survey were less likely than white patients to report that their doctors listen carefully to them (69% and 76% vs. 87%). To improve patient–provider relationships, projects supported by the Fund focus on developing standards for cultural competency training and evaluating the effectiveness of culturally competent health care practices.

Through a Fund grant, the Association of American Medical Colleges (AAMC) created TACCT—the Tool for Assessing Cultural Competence Training—which enables medical educators to determine whether their curricula include key components of cultural competency education.[6] Fund support also allowed researchers to examine the degree to which cultural competency training has been incorporated into graduate medical education. As detailed in a September 2005 article in the *Journal of the American Medical Association,* Joel Weissman, Ph.D., Joseph Betancourt, M.D., and Eric Campbell, Ph.D., at Harvard Medical School found that there is substantial room for improvement in preparing physicians to care for diverse patient populations.[7] Overall, the three researchers found that medical residents think cross-cultural training is important to the delivery of high-quality care. Yet, residents lack the time and mentoring they would need to learn how to provide cross-cultural care, and hospitals do not evaluate residents on this aspect of performance.

Joseph Betancourt, M.D.
Harvard Medical School

At least one of five resident physicians are not prepared to deal with cross-cultural issues.

Percent of resident physicians very or somewhat unprepared to treat patients…

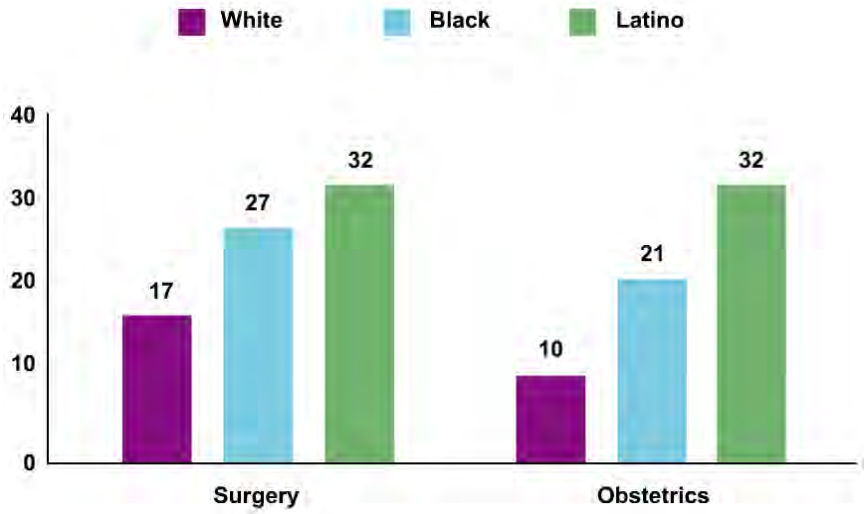


Source: J. S. Weissman et al., "Resident Physicians' Preparedness to Provide Cross-Cultural Care," *Journal of the American Medical Association,* Sept. 7, 2005 294(9):1058–67.

In another Fund-supported study, researchers led by LeRoi S. Hicks, M.D., M.P.H., of Brigham and Women's Hospital and Harvard Medical School, found significant differences in the degree to which white and minority hospital patients reported problems with their care.[8] Notably, a much lower proportion of black and Latino patients than of white patients said that hospital staff demonstrated respect for their preferences. In addition to uncovering disparities in hospital patients' experiences, the study demonstrated that data from generic patient surveys can be stratified by race and ethnicity to identify areas that might benefit from culturally competent care practices.

Black and Latino hospital patients are more likely to report that their preferences are not treated with respect.

Percent of hospital patients reporting more problems in dimensions of patient experiences



Source: Adapted from L. S. Hicks et al., "Is Hospital Service Associated with Racial and Ethnic Disparities in Experiences with Hospital Care?" *American Journal of Medicine,* May 2005 118(5):529–35.

Approximately 45 million U.S. residents—about 18 percent of the population—speak a language other than English at home. Working under a grant from the Fund, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) found that hospitalized patients whose first language is not English are more likely to be subject to medical errors caused by communication problems with their providers. Just recently, JCAHO adopted a new Information Management Standard (6.20) that requires documentation of patients' primary language in their medical record.

Fund-supported research has also found that use of medical interpreters can significantly improve patients' health care experiences. In a study of enrollees in California's State Children's Health Insurance Program, Leo S. Morales, M.D., Ph.D., of the University of California, Los Angeles, found that less than half (47%) of patients who required an interpreter during a medical visit said they were always provided with one.[9] When interpreters were available, patients were more satisfied with their care. In fact, non-English-speaking patients who always had an interpreter during medical visits reported greater satisfaction than English speakers who did not need interpreters.

This and other Fund work has demonstrated that culturally competent care, including the use of medical interpreters, can improve health care quality and satisfaction among minority patients. Still, there is little agreement about how to measure cultural competency or incorporate it into quality improvement efforts. Going forward, the Fund will turn to supporting efforts that set standards for culturally competent practice and develop measures of culturally competent processes and outcomes. These standards and measures can then be used to evaluate

health care organizations and monitor their progress in delivering higher-quality, patient-centered, culturally competent health care.

Notes

[1] R. T. Perot and M. Youdelman, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (New York: The Commonwealth Fund, Sept. 2001).

[2] D. W. Baker, K. A. Cameron, J. Feinglass et al., "A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity," *American Journal of Public Health,* Mar. 2006 96(3):532–37.

[3] D. W. Baker, K. A. Cameron, J. G. Feinglass et al., "Patients' Attitudes Toward Health Care Providers Collecting Information About Their Race and Ethnicity," *Journal of General Internal Medicine*, Oct. 2005 20(10):895–900.

[4] K. Llanos and L. Palmer, *Using Data on Race and Ethnicity to Improve Health Care Quality for Medicaid Beneficiaries* (Hamilton, N.J.: Center for Health Care Strategies, June 2006).

[5] S. D. Watson, *Equity Measures and Systems Reform as Tools for Reducing Racial and Ethnic Disparities in Health Care* (New York: The Commonwealth Fund, Aug. 2005).

[6] See AAMC Web site at http://www.aamc.org/meded/tacct/start.htm.

[7] J. S. Weissman, J. Betancourt, E. G. Campbell et al., "Resident Physicians' Preparedness to Provide Cross-Cultural Care," *Journal of the American Medical Association*, Sept. 7, 2005 294(9):1058–67.

[8] L. S. Hicks, J. Z. Ayanian, E. J. Orav et al., "Is Hospital Service Associated with Racial and Ethnic Disparities in Experiences with Hospital Care?" *American Journal of Medicine,* May 2005 118(5):529–35.

[9] L. S. Morales, M. Elliott, R. Weech-Maldonado et al., "The Impact of Interpreters on Parents' Experiences with Ambulatory Care for Their Children," *Medical Care Research and Review,* February 2006 63(1):110–28.

2006 Annual Report

Fellowship in Minority Health Policy

Enhancing the capacity of the health care system to address the needs of minority and disadvantaged populations is the goal of the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy. Established in 1996, the program offers a one-year, full-time program of study to future physician-leaders who intend to pursue careers in minority health and health policy. The program is directed by Joan Reede, M.D., dean for diversity and community partnership at Harvard Medical School. The fellowship combines an intensive year of training in health policy, public health, and management with special activities focused on minority health issues. Participants in the program complete academic work for a master's degree in public health or public administration. The program usually awards four to five fellowships per year.

A total of 67 physicians, dentists, and other health professionals, including 16 fellows funded by the California Endowment and Delta Dental, have completed the program. Alumni fellows are actively engaged in health policy, research, and service delivery to minority communities. More than half hold appointments at schools of public health or medicine, and many have assumed leadership roles in departments of public health and community health centers. Alumni fellows also hold important positions in federal, state, and local government, including health policy advisor to Senator Barack Obama (D–Ill.); chief medical officer for juvenile justice, state of Florida; commissioner of health in Austin, Texas; and deputy commissioner of health, Baltimore, Md.

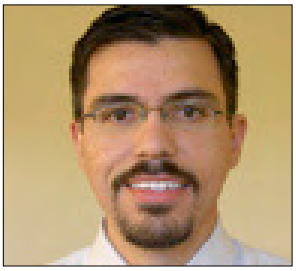
Dora L. Hughes, M.D., M.P.H.
Health and Education Advisor to U.S. Senator Barack Obama (D–Ill.)

Prior to her career on Capitol Hill, Dr. Hughes, a member of the 1999–2000 class of Commonwealth Fund/Harvard University Minority Health Policy Fellows, was a program officer for the Fund's Underserved Populations program.

This year, the fellowship program continued to develop relationships with state and local health departments and secured support for alumni fellows from HRSA, the Office of Minority Health, and the California Endowment. The program relies on a national advisory committee to provide ongoing mentorship to the fellows and help them identify career opportunities.

Over the past year, several former fellows have had their work published in the peer-reviewed literature. For example, in a study in the *New England Journal of Medicine,* Amal Trivedi, M.D., M.P.H., concluded that the quality of care for Medicare beneficiaries in managed care plans improved over a seven-year period, with racial disparities declining for some measures.[1] Trivedi also published a state-level minority health policy report card in *Health Affairs*.[2]

2006 Fellows in Minority Health Policy



Luis Castellanos, M.D., resident in internal medicine at University of California, San Diego Medical Center. Dr. Castellanos, who plans to practice academic medicine, is interested in studying ways to reduce cardiovascular risk factors in underserved populations, with special attention to the Latino community.

Joan Griffith, M.D., assistant professor of pediatrics at the University of Kentucky. Childhood obesity is Dr. Griffiths' chief concern. She conceived, developed, and implemented a pediatric weight-management clinic, the only one of its kind in Kentucky, and hopes to establish a nationwide network of such clinics. She is also interested in seeking political appointment as a medical authority in the area of childhood obesity and related illnesses.

Stephanie Hale, M.D., neurology fellow at Children's Hospital of Los Angeles/Los Angeles County UCLA Medical Center. Dr. Hale's major research interests are health and ethnic disparities related to infant mortality rates, and investigating causes of such disparities in order to target programs and policies for change.

Ann Kao, M.D., Durant Fellow in Refugee Medicine and clinical and research fellow at Massachusetts General Hospital. In 2005, Dr. Kao worked on behalf of the tsunami relief effort as part of Project HOPE. She has also worked at a Navajo reservation in Chinle, Ariz., and at an urgent-care clinic in Chelsea, Mass., serving a primarily Latin American immigrant population.

LaQuandra Nesbitt, M.D., chief resident in family medicine at the University of Maryland Medical System. Dr. Nesbitt's goal is to develop policies that will help improve access to medical resources and health education in minority communities.

Notes

[1] A. N. Trivedi, A. M. Zaslavsky, E. C. Schneider et al., "Trends in the Quality of Care and Racial Disparities in Medicare Managed Care. *New England Journal of Medicine,* Aug. 18, 2005 353(7):692–700.

[2] A. N. Trivedi, B. Gibbs, L. Nsiah-Jefferson et al., "Creating a State Minority Health Policy Report Card," *Health Affairs,* Mar./Apr. 2005 24(2):388–96.

Child Development and Preventive Care

Edward L. Schor, M.D.
Vice President

Melinda K. Abrams
Senior Program Officer

The Commonwealth Fund's Child Development and Preventive Care Program seeks to encourage, support, and sustain improvements in child development and preventive care for young children—particularly those services dealing with their cognitive, emotional, and social development. The program pursues three principal strategies:

- 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.
- encouraging reforms that remove barriers to quality care and align provider incentives with desired clinical practices.

State Medicaid programs remain the most important part of the health care safety net for low-income children. The Fund, through its Assuring Better Child Health and Development (ABCD) initiative, has partnered with states to improve and expand preventive care and developmental services for Medicaid children—and test innovative ways to change practice and provider behaviors. ABCD is currently working with states to promote children's healthy mental development.

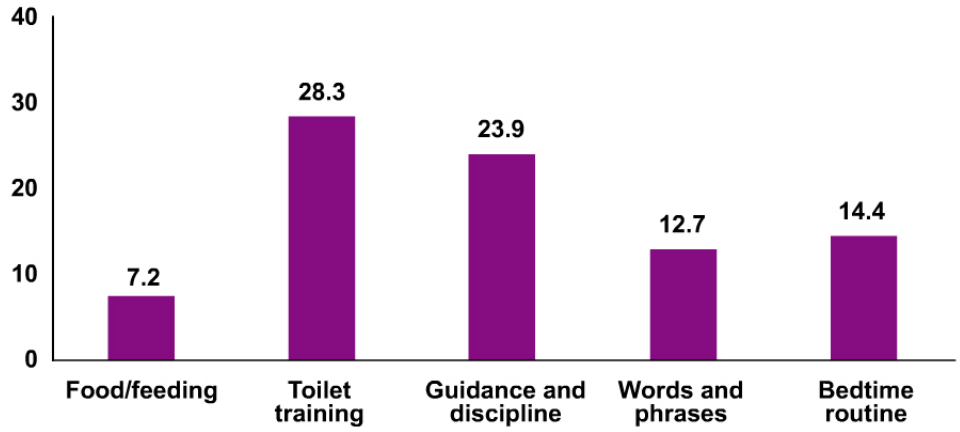
Children's success both in school and later in life depends on the quality of their early experiences and the ability of their parents and caretakers to anticipate and meet their developmental needs. Through regular contact with parents and young children, child health

care providers can foster positive parenting behaviors, help to promote optimal development, and initiate early intervention when problems appear imminent.

In the United States, the quality of preventive care—commonly referred to as well-child care—is highly variable. Despite the commitment of considerable time and resources by physicians and other child health professionals, too many children and their families do not get the care they need. Research studies find that fewer than half attend the well-child visits recommended by national guidelines, even when financial barriers are absent. Minority or economically disadvantaged parents are two to four times more likely than their white, insured, and more affluent counterparts to be dissatisfied with their children's care, especially that related to growth and development. And nearly all parents report having unmet needs for parenting guidance, education, or screening by a pediatric professional.[1]

Parents say they want more information on child-rearing from pediatric care providers.

Percent of parents of children age 19 to 35 months saying the following items were not covered by their pediatrician, but would have been helpful



L. M. Olson et al., "Overview of the Content of Health Supervision for Young Children: Reports from Parents and Pediatricians," *Pediatrics,* June 2004 113(6 Suppl):1907–16.

Pediatricians themselves report an array of obstacles to providing quality well-child care: time constraints, low levels of reimbursement for preventive pediatric care, lack of training in child development and limited access to community support services for patients, as well as few external incentives.[2]

Taken together, these findings form a compelling case for reexamining the structure, content, and processes of pediatric care.

States Lead the Way

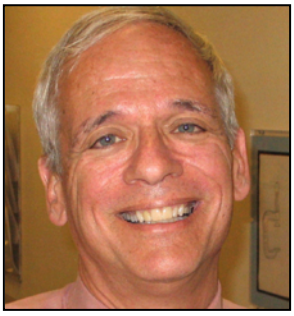
Creative reform of child health care policy and practice is likely to occur first among the states. And at the state level, partnerships among governmental bodies and between public and private entities are critical to formulating and implementing policies to encourage and sustain

improvements in child health care. The Fund has supported two projects that seek to cultivate such partnerships.

The Vermont Child Health Improvement Program (VCHIP)—an exciting model of statewide collaboration—supports clinicians in their efforts to improve care by providing a centralized resource for guidance on the techniques of quality improvement. With Fund support, VCHIP is helping five other regions develop improvement partnerships among state Medicaid programs, public health agencies, and local professional organizations. The improvement partnerships—in Kings County, Washington, Washington, D.C., and the states of Arizona, New York, and Rhode Island—will initially focus on strengthening developmental and preventive services for young children.

With Fund support, the American Academy of Pediatrics (AAP) is promoting cooperation among state government agencies, elected officials, child advocates, and state chapters of the AAP. Small grants have been awarded to eight AAP chapters (California, Iowa, Kansas, Maine, Maryland, Oregon, Puerto Rico, and Virginia) to launch a series of open forums focusing on early child development issues. The goal is to encourage ongoing, structured interactions among various stakeholders about ways to expand the availability and improve the quality of child health care.

The improvement partnerships and open forums seek to create environments in which primary care practice can become more effective and efficient. Two recent Fund projects provide guidance on how to redesign the structures and procedures of office practice. David Bergman, M.D., of Stanford University, undertook an extensive review of the literature and expert opinion to identify concepts that can contribute to the development of a high performing system of well-child care.



David Bergman, M.D.
Stanford University

In the Fund report, *A High Performing System for Well Child Care: A Vision for the Future*, Bergman describes some of the most innovative strategies for leveraging new technology and systems in order to improve quality and efficiency.[3] The report describes scenarios for improved practice in various settings, building on change concepts in the areas of information transfer, team-based care, family-centered care, cultural competency, financing, developmental screening, care coordination, and medical homes. Bergman is now creating a plan for implementing his framework for high performing pediatric care in an innovative health maintenance organization. If implementation is successful, an effort will be made to spread the model to other health plans.

In another Fund report, Amy Fine and Rochelle Mayer, Ed.D., of Georgetown University, describe the state-of-the-art in care coordination for children who have, or are at risk for, developmental problems.[4] The researchers expanded the concept of care coordination to include the links between child health care practices and other family service providers and community

resources. Based on their national search for best practices, Fine and Mayer conclude that successful strategies for connecting families to needed services depend on organizational changes within practices, partnerships among service providers, and system changes within communities.

Focusing on Medicaid: The ABCD Initiative

Medicaid remains the most important part of the public safety net of health services available to low-income children. In fact, more than a quarter of U.S. children receive health care through state-administered Medicaid programs. Because children from disadvantaged backgrounds are more susceptible to developmental problems, the Fund maintains a strong focus on improving the quality of developmental services and preventive care in Medicaid. Through its Assuring Better Child Health and Development (ABCD) initiative, the Fund has had success in working directly with state officials to adopt policies that support high-quality developmental services and to test innovations in the delivery and reimbursement of such care.

Now in its second phase, the ABCD initiative is working with Medicaid programs in California, Illinois, Iowa, Minnesota, and Utah to promote the healthy mental development of young children. The initiative is encouraging routine developmental and behavioral screening of young children and screening for parental depression and is partnering with private health care providers to improve care in this area.[5] The ABCD projects are managed by Neva Kaye at the National Academy for State Health Policy (NASHP), which conveys lessons learned in the participating states to public health leaders across the nation.

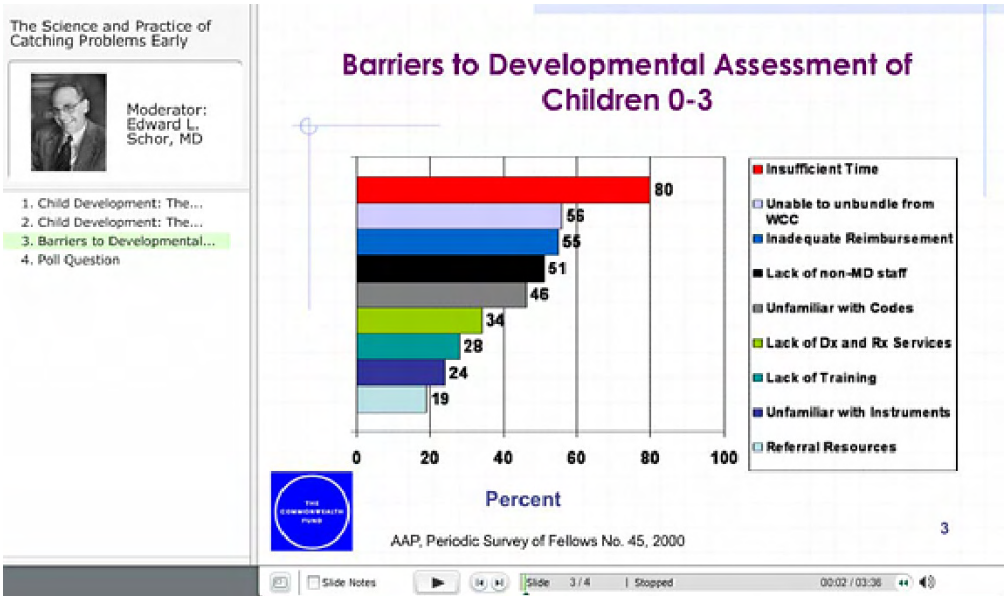
Neva Kaye
National Academy for State Health Policy

In Iowa's state budget for fiscal year 2006–07, $325,000 was set aside to spread the Iowa ABCD project statewide. In support of the measure, the Iowa Department of Public Health prepared a fact sheet for legislators detailing the importance of child development; the publication cited both the Fund and NASHP. In North Carolina, the proportion of children screened for developmental problems has been steadily increasing, thanks in large part to that state's successful ABCD initiative. North Carolina requires that all pediatric providers screen children for developmental disorders at periodic visits using a standardized instrument. In a study published in the journal *Pediatrics* in July, researchers led by Marian Earls, M.D., of the University of North Carolina School of Medicine noted that screening rates rose from 20 percent to 70 percent over a four-year period at one health center.[6]

Currently, NASHP is planning the launch of an ABCD Screening Academy to spread standardized developmental screening to even more states. This ambitious, Fund-supported project will encourage states to adopt policies that promote developmental screening, encourage pediatric practices to make such screening routine, and measure and report progress to statewide leadership committees.

Well-child care visits are important opportunities to monitor children's development and screen for developmental problems and risk factors. The Fund seeks to enhance the ability of parents and child health care providers to identify, as early as possible, young children who have cognitive, social, or emotional developmental delays or are at risk for such delays. Working with Medscape and national experts, the Fund has produced a series of webcasts that provide guidance to child health care professionals on why and how to perform structured, objective screening for developmental delays, behavioral problems, and maternal depression. The webcasts have reached tens of thousands of viewers. This training is supplemented and reinforced by the extensive information available to professionals and parents at the Fund-supported www.dbpeds.org, one of the most heavily trafficked online resources on developmental and behavioral pediatrics.

Webcasts produced by the Fund and Medscape provide child health care professionals with guidance on a variety of topics.



The Child Development and Preventive Care Program will continue to seek ways to address the persistent challenges of financing preventive care and enhancing linkages between health care providers and other family support and developmental service providers. Due to the lack of a substantial evidence base on the effectiveness of preventive pediatric care, the reluctance to make long-term investments in children, and the fragmented system of child health care, securing appropriate reimbursement for preventive care and for needed community-based services remains a continuing challenge.

Notes

[1] E. L. Schor, "Rethinking Well-Child Care," *Pediatrics,* July 2004 114(1):210–16.

[2] Ibid.

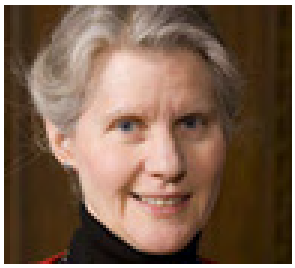
[3] D. Bergman, P. Plsek, and M. Saunders, *A High Performing System for Well-Child Care: A Vision for the Future* (New York: The Commonwealth Fund, Oct. 2006).

[4] A. Fine and R. Mayer, *Beyond Referral: Pediatric Care Linkages to Improve Developmental Health* (New York: The Commonwealth Fund, Dec. 2006).

[5] N. Kaye, *Improving the Delivery of Health Care that Supports Young Children's Healthy Mental Development: Early Accomplishments and Lessons Learned from a Five-State Consortium* (New York: The Commonwealth Fund, Apr. 2006).

[6] M. F. Earls and S. S. Hay, "Setting the Stage for Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice," *Pediatrics,* July 2006 118(1):e183–e188.

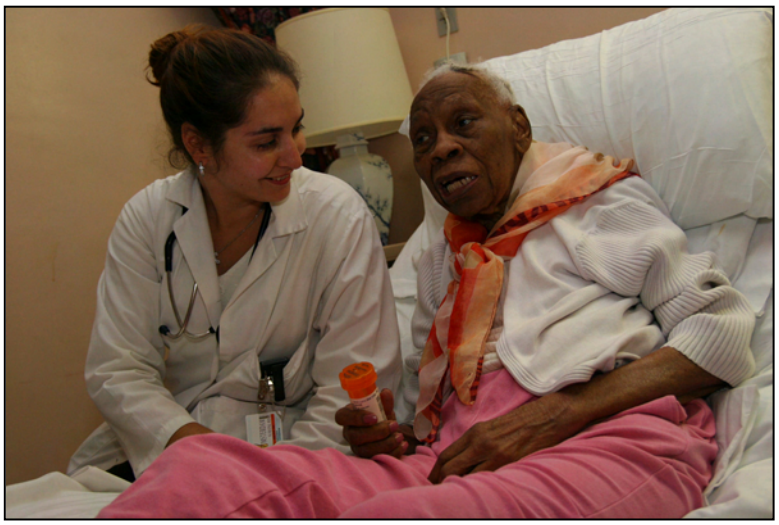
Picker/Commonwealth Program on Quality of Care for Frail Elders



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 the following:

- Identifying, evaluating, and spreading models of "resident-centered care," or care delivered in accordance with the needs and desires of the people who live in nursing homes.
- Equipping nursing home operators to lead transformation.
- Promoting policy options that support resident-centered care.



Many hospitalizations of nursing home residents are avoidable. But with the appropriate clinical resources—including registered nurses present around the clock—medical problems can be identified and addressed early on. The Commonwealth Fund is supporting an effort by the New York State Department of Health to develop a payment system that rewards facilities that improve their management of at-risk or acutely ill residents.

In hospitals, good care is paramount. But in nursing homes, offering good care is only half the picture; equally important is providing a good place to live. Despite passage of the Nursing Home Reform Act in 1987, which underscored the importance of quality of life and the preservation of residents' rights, there are still serious concerns about quality at the nation's 16,000 nursing homes. Staff shortages and high turnover rates exacerbate quality problems.

A grassroots movement proposes a radical departure from the traditional nursing home model—in effect a total "culture change"—that aims to improve the lives the frail older adults who live in such facilities. Proponents of culture change believe long-term care residents can and

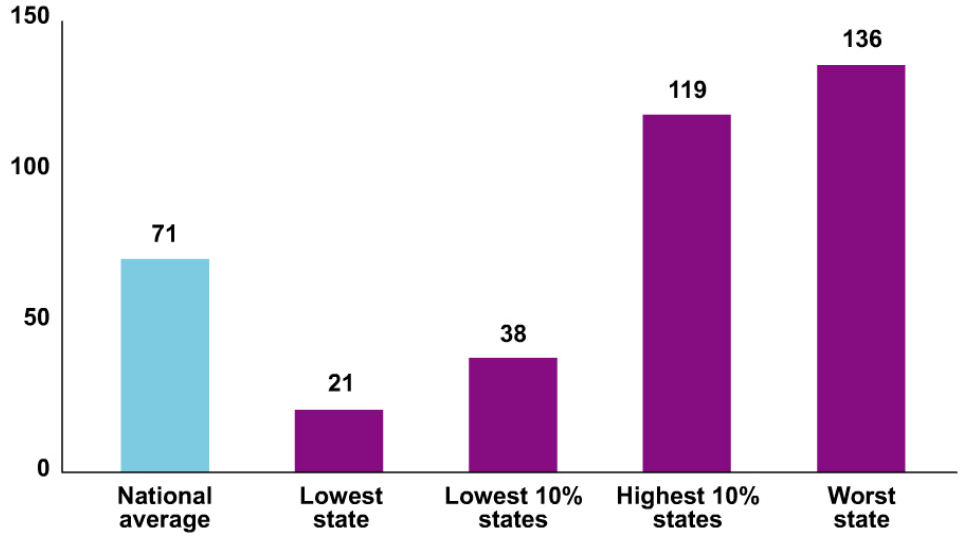
should direct their own lives. They recommend replacing institutional units with households of small groups of residents and staff.

Resident-centered care requires a fundamental shift from thinking of nursing homes as institutions where frail elders must live, to conceiving them as residences that also provide health services. A growing body of evidence is revealing that nursing homes that have undergone culture change—such as those following the Wellspring, Eden Alternative, or Green House models—are not only better for the people who live and work there, but they are also economically viable alternatives to more traditional facilities.[1]

With Fund support, Rosalie Kane, Ph.D., of the University of Minnesota evaluated the first operational Green House nursing home in Tupelo, Miss., where the residents are mainly Medicaid beneficiaries. The evaluation offered conclusive evidence that small group homes (for six to 10 residents) operated according to the principles of home care, rather than the acute care practices that have shaped the industry, can have positive outcomes for both residents and staff. In a Green House, each elder enjoys a private room or unit, which they decorate with their own belongings. There is easy access to all areas of the house, and residents are free from the limitations of an institutional schedule—sleeping, eating, and engaging in activities as they choose.

Turnover rates for certified nursing aides are high in U.S. nursing homes.

Termination rates for established positions (2002)



Data: 2002 American Health Care Association Survey of Nursing Staff Vacancy and Turnover in Nursing Homes (AHCA 2002).

Source: Commonwealth Fund Commission on a High Performance Health System.

Compared with residents of traditional nursing homes, those living in Green Houses reported a significantly better quality of life. Moreover, rates of turnover among nursing assistants have dropped to nearly zero—a tribute to the team-based approach to decision-making, which empowers frontline staff in Green Houses to manage their responsibilities as they see best. These homes' performance on federal inspections has also been outstanding.

This good news has generated considerable interest in the Green House model. More than 145 organizations attended a Fund-sponsored Green House workshop in 2006; more than 20 homes are in active development; and four Green House sites have recently opened. In addition, data from Kane's evaluation informed the decision by the Centers for Medicare and Medicaid Services (CMS) to include work related to organizational redesign in the agency's next contract with the Quality Improvement Organizations.[2]

Because of high real estate costs or other constraints, some nursing home providers may be unable to build Green Houses. But there are other structural improvements that providers can make to improve residents' quality of life. One such improvement is increasing the number of private rooms. Fund-supported research by Margaret Calkins, Ph.D., an architect and gerontologist with the IDEAS Institute, revealed that while construction costs may be higher for single rooms than for double-bedded rooms, enhanced revenue from private rooms quickly offsets these upfront costs.[3] More important, homes with a high proportion of private rooms are attractive to residents and their families, giving such facilities a competitive edge in the marketplace. Calkins also found unexpected efficiencies related to single-room housing.

Nursing home culture change can be accomplished through channels other than physical reconstruction. The Pioneer Network, an organization that has spearheaded the culture change movement since 1997, is reaching out to providers across the country to offer training, practical tools and resources, and a shared community for those trying to transform their facility. Last year, with Fund support, the group offered "Pioneer Institutes" in Chicago, Denver, New York, and Portland, Ore., to teach providers about resident-centered care.

The Pioneer Network also held a Fund-sponsored symposium in Orlando for frontline nursing home staff—nurse assistants and other staff who provide daily hands-on care. Participants talked about how they have been involved with culture change, shared lessons, and learned how to become agents of change in their own facilities. The Pioneer Network participates in a number of long-term care policymaking advisory groups and is working closely with the Medicare Quality Improvement Organizations.

Christine K. Cassel, M.D.
Member, Commission on a High Performance Health System

Dr. Cassel, the president and CEO of the American Board of Internal Medicine and the ABIM Foundation, is a leading expert in geriatric medicine, medical ethics, and quality of care.

As popular as the Pioneer Institutes have been, many nursing home administrators are unable to attend. Many, furthermore, desire step-by-step guidance on putting into practice culture change concepts, such as empowering staff, as well as on meeting federal regulations and passing annual inspections. Stephen Shields, president and CEO of the Meadowlark Hills retirement community in Manhattan, Kan., and LaVrene Norton, president of ActionPact, a culture change consultant group, created a comprehensive set of resources to help nursing home leaders enact culture change. Developed with support from the Fund, the Sunflower Foundation, and the Kansas Department of Health, this culture change

"toolkit" was released at the August 2006 Pioneer Network conference.[4] For the first time, all the elements of nursing home management have been tied to the concepts of resident-centered care. Included in the toolkit is a book on long-term care leadership, *Pursuing the Sunbeam*; a policy and procedures manual tied to federal nursing home requirements; a human resources system; and a quality improvement process. Approximately 150 toolkits were purchased in their first month of availability.

Consumers can be an important catalyst for quality improvement in the nursing home industry. But in order to exert their influence, consumers need reliable information about quality standards and the actual performance of individual nursing homes. A Fund-supported nursing home guide published in the September 2006 issue of *Consumer Reports* identifies the best and worst nursing homes in each state and offers tips for evaluating homes.[5] The "Nursing Home Quality Monitor," available online as an interactive state map, also indicates whether a home is state-owned, for-profit, or nonprofit, and whether it is part of a chain or independently owned. *Consumer Reports* found that nonprofit homes are more likely to provide good care than are for-profits, and independently run homes are more likely to provide good care than chains.

An accompanying investigative report, "Nursing Homes: Business As Usual," by Trudy Lieberman, director of the Center for Consumer Health Choices, was a wake-up call for the 12 nursing homes that were cited for poor care by *Consumer Reports* for five years in a row. It also captured the attention of the state agencies responsible for monitoring quality of care in these facilities.

Several other Fund-supported projects provide consumers with information needed to press for better care. Eric Carlson, J.D., of the National Senior Citizens Law Center, wrote the consumer guide, *20 Common Nursing Home Problems and How to Solve Them*, which several state ombudsman programs, including those in New York and Oregon, have ordered for their staff. Following the guide's publication, Carlson was interviewed for a *Wall Street Journal* article on long-term care.[6]

With Fund support, Charles Phillips, of the Texas A&M University System Health Science Center, and the National Citizen's Coalition for Nursing Home Reform surveyed consumer advocacy groups to gauge awareness of nursing home culture change. The survey revealed that consumer awareness of the movement has grown, though many people still have doubts about the industry's capacity to effect significant change, especially in the for-profit sector.

Charlene Harrington, Ph.D.
University of California, San Francisco

Culture change often requires seed money. Cynthia Rudder, Ph.D., executive director of the Long Term Care Community Coalition, and Charlene Harrington, Ph.D., of the University of California, San Francisco, investigated how states have been using the often sizable

funds that accumulate from federal and state civil monetary penalties and fines imposed on nursing homes for providing poor care.[7] The Fund-supported researchers found that several states are using the funds to sponsor culture change projects: for example, Maryland supported a Wellspring alliance, while Kansas helped fund development of the culture change toolkit described above. The majority of states, however are not using the penalty funds in such constructive ways, and some states have not collected any penalties at all.

Rudder and Harrington's study has led to several important changes. In New York, the findings helped convince policymakers to pass a bill authorizing the collection and release of civil penalties to support nursing home innovation. CMS, meanwhile, has begun to track penalty funds levied on behalf of the federal government.

From all of the evidence, it appears that the culture change movement is gaining momentum. Nursing home trade associations are realizing that their members can no longer do "business as usual." CMS and consumer advocacy groups are actively promoting resident-centered care. Researchers are becoming interested in measuring the impact of culture change.

But much work remains. Policymakers are, as yet, largely unaware of the movement, and the vast majority of nursing homes have yet to initiate systematic change. In the coming year, the Picker/Commonwealth Fund Program on Quality of Care for Frail Elders will work to raise the visibility of culture change among all those with a stake in long-term care. In the process, it will play an important role in making resident-centered care a reality in many more nursing homes.

Notes

[1] For further information on these models, see the Wellspring Web site, http://www.wellspringis.org/; and the Eden Alternative/Green House Web site, http://www.edenalt.com/.

[2] J. Rabig, W. Thomas, R. A. Kane et al., "Radical Redesign of Nursing Homes: Applying the Green House Concept in Tupelo, MS," *The Gerontologist,* Aug. 2006 46(4):533–39.

[3] M. Calkins, draft manuscript prepared for The Commonwealth Fund, Aug. 2006.

[4] Toolkits may be ordered either from the Pioneer Network at www.pioneernetwork.net or ActionPact at www.culturechangenow.com.

[5] http://www.consumerreports.org/cro/health-fitness/nursing-home-guide/0608_nursing-home-guide.htm.

[6] K. Greene, "New Resources Aim for Caregivers of Older Patients," *Wall Street Journal,* June 27, 2006, p. D2.

[7] T. Tsoukalas, C. Rudder, R. J. Mollot et al., "The Collection and Use of Funds From Civil Money Penalties and Fines From Nursing Homes," *The Gerontologist,* Dec. 2006 46(6):759–71.

International Program in Health Policy and Practice

Robin I. Osborn
Vice President

The goals of the Fund's International Program in Health Policy and Practice are threefold:

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

The program's key activities include high-level international policy forums, the Harkness Fellowships in Health Care Policy and Practice, and an annual international survey on health policy issues.

At a roundtable during the 2006 International Symposium, Germany's Minister of Health, Ulla Schmidt, discussed priorities for achieving a high performance health system, along with (left) Martin van Rijn, Director-General of the Netherlands' Ministry of Health, Welfare and Sport, and (right) Julian Le Grand of the London School of Economics and Political Science.

2006 International Symposium

For the past nine years, the Fund has hosted an annual international symposium focusing on a health policy topic of major concern to the United States and other industrialized nations. This year's symposium, held in November in Washington, D.C., brought together 65 policy experts around the theme, "What Makes a High Performance Health Care System and How Do We Get There?" Participants included health ministers or their designates from Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States as well as senior government officials and leading researchers from each country.

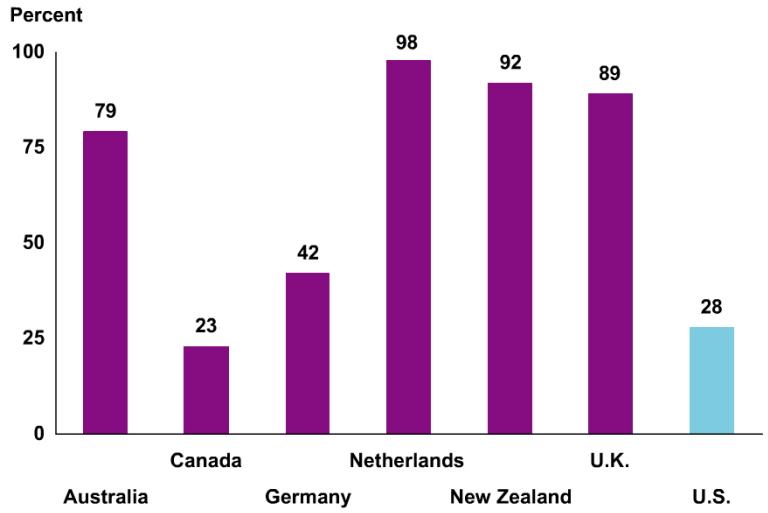
In his introductory remarks, U.S. Deputy Secretary of Health and Human Services Alex M. Azar II first underscored the value of international exchange and collaboration and then outlined the Administration's vision of a "value-driven health care system" guided by the principles of "transparency and consumer empowerment." The keynote address was given by U.K. Secretary of State for Health Patricia Hewitt, who spoke about her country's ambitious agenda for transforming its National Health Service into a quality-driven system, with greater consumer choice, competition, and transparency.

In the fifth John M. Eisenberg International Lecture, Hans F. Hoogervorst, Minister of Health, Welfare, and Sport for the Netherlands, described reforms undertaken in his nation to create a more efficient, patient-centered, and sustainable health care system. Under the Dutch system, insurance coverage is mandatory, insurers are obliged to accept everybody, and strong market incentives foster competition among insurers, which in turn pressure health care providers to deliver high-quality, high-value patient services.

Hans F. Hoogervorst
Minister of Health, Welfare, and Sport for the Netherlands

Another highlight of the symposium was the presentation of findings from the 2006 International Health Policy Survey by Cathy Schoen, Fund senior vice president, and Robin Osborn, vice president and International Program director. The survey captured the perspectives of primary care physicians in Australia, Canada, Germany, New Zealand, the U.K., the U.S., and, for the first time, the Netherlands. According to Schoen and Osborn, primary care doctors in the U.S. are less likely than those in most other countries surveyed to be able to offer patients access to care outside regular office hours, or to have systems alerting them to unintended drug interactions that could potentially harm their patients. U.S. primary care physicians are also less likely to receive financial incentives for improving patient care.

Primary care physicians in the U.S. lag behind those in several other industrialized nations in the use of electronic patient medical records.



Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

The 2006 survey findings, which were published as a *Health Affairs* Web Exclusive, also show that in all countries except Germany, a high proportion of primary care doctors said they are not well prepared to care for patients with multiple chronic conditions.[1] The use of clinician teams and systems known to improve outcomes for such patients varied widely across the countries, with particularly low usage found in the U.S, Canada, and Australia. Overall, the survey results suggest that system-wide approaches are a necessary foundation to well-coordinated, safe, and high-quality care.

A policy roundtable discussion among the health ministers at the symposium provided the opportunity for an exchange of views on what defines a high performance health care system and how to strike the right balance between health care quality, efficiency, innovation, and health system sustainability.

Sessions on the last day of the symposium were held on Capitol Hill in cooperation with the Alliance for Health Reform. These sessions for congressional staff and a broad Washington policy audience featured health care delivery and policy innovations in other countries that may translate to the U.S. The sessions showcased the role of national clinical guidelines in the Netherlands and the U.K. and Denmark's approach to developing, financing, and implementing electronic health records.

International Working Group on Quality Indicators

In 2004, the Fund's International Working Group on Quality Indicators produced the first-ever set of quality-of-care indicators—30 in all—for benchmarking and comparing health care system performance across countries. In collaboration with the Fund, the Organization for Economic Cooperation and Development (OECD) is building on this work through its International

Healthcare Quality Indicators Project. The project, which includes 23 countries, is chaired by Harvard School of Public Health's Arnold Epstein, M.D., who had previously chaired the Fund's Working Group.

The OECD project's first report, published in March 2006, included comparative data on 13 quality indicators in the 23 countries.[2] The OECD will continue to develop the scope and depth of the indicator set, with the aim of producing 50 internationally comparable quality measures to include in its database.

Harkness Fellows in Health Care Policy and Practice

Aimed at developing promising health care policy researchers and practitioners in the U.K., Australia, New Zealand, and, beginning in 2006, Germany, the Harkness fellowships provide a unique opportunity for individuals to spend up to 12 months in the U.S. conducting a policy-oriented research study, gaining firsthand exposure to managed care and other models of health care delivery, and working with leading health policy experts.

Harkness alumni continue to generate important research based on their fellowship work and move into high-profile positions in their home countries. For example:

- U.K. Fellow Martin N. Marshall, CBE, M.D. (1998–99) was appointed deputy chief medical officer for the U.K. Department of Health.
- Australian Fellow Jane Burns, Ph.D. (2004–05) received the Victorian Health Promotion Fellowship and was appointed director of the Sunshine Foundation and director of international health policy and research at the Inspire Foundation.
- In New Zealand, Elana Curtis, M.D. (2004–05) was appointed senior lecturer at the University of Auckland.
- Canadian Associate John N. Lavis (2001–02) was named Canada Research Chair in Knowledge Transfer and Exchange at McMaster University.

2006–07 Harkness Fellows in Health Care Policy and Practice

Vidhya Alakeson, M.Sc. (United Kingdom)
Senior Research Fellow, Social Market Foundation
Project Title: *Transforming Healthcare into a Patient-Led Service: The Potential of Individual Budgets in Mental Health to Support Patient Choice*
Placement: Office of the Assistant Secretary for Planning and Evaluation
Mentor: Pamela Doty, Ph.D.

Mark R. Booth, M.A., E.M.P.A. (New Zealand)
Manager, Strategic Funding, Therapeutic and Social Policy, Ministry of Health
Project Title: *Analysis of the Health Care Policy Responses to Population Ageing in New Zealand and the U.S.: A Comparison of Experts' Views*
Placement: Brown University
Mentor: Vincent Mor, Ph.D.

Robert Foy, Ph.D., M.B.Ch.B., M.Sc. (Harkness/Health Foundation Fellow; United Kingdom)
Clinical Senior Lecturer in Primary Care, University of Newcastle upon Tyne
Project Title: *Mapping Quality Improvement: A Comparative Study of Healthcare Organizational Strategies*
Placement: VA Los Angeles and the RAND Corporation
Mentors: Brian Mittman, Ph.D, and Lisa Rubinstein, M.D.

Bruce Guthrie, M.B., B.Chir., M.R.C.P., M.R.C.G.P., M.Sc., Ph.D. (United Kingdom)
Health Foundation/Scottish Executive Chief Scientist Office Postdoctoral Research Fellow and Honorary Clinical Senior Lecturer, University of Dundee
Project Title: *Financial Incentives and Systematic Chronic Disease and Preventive Care in California Medicaid*
Placement: University of California, San Francisco
Mentors: Andrew Bindman, M.D.

Richard Hamblin (United Kingdom)
Head of Analytic Support, Healthcare Commission
Project Title: *Informing for Improvement: The Who, How and What of Using Information to Improve Healthcare*
Placement: Group Health Cooperative of Puget Sound Center for Health Studies
Mentor: Eric Larson, M.D., F.A.C.P.

Katharina Janus, Ph.D. (Germany)
Research Fellow, School of Public Health, Hannover Medical School
Project Title: *Decision-makers Across Medical Specialties: Assessing the Effects of Incentives at the Point of Care*
Placement: Columbia University
Mentors: Lawrence Brown, Ph.D., David Blumenthal, M.D., and Sherry Glied, Ph.D.

Ruth Lopert, B.S., B.M., M.Sc. (Australia)
Principal Adviser, Pharmaceutical Policy Taskforce, Commonwealth Department of Health and Ageing
Project Title: *Comparing Cost, Coverage, and Access to Pharmaceuticals Under Australian and U.S. Policy Frameworks*
Placement: George Washington University and the American Institutes for Research
Mentors: Sara Rosenbaum, J.D., and Marilyn Moon, Ph.D.

Anatole S. Menon-Johannson, B.Sc., Ph.D., M.B., B.Chir. (Harkness/Health Foundation Fellow; United Kingdom)
Specialist Registrar, Chelsea & Westminster Healthcare
Project Title: *Identifying Barriers to Effective Human Immunodeficiency Virus (HIV) Treatment and Policy Options*
Placement: Harvard Medical School
Mentors: Harvey Makadon, M.D., and Jean McGuire, Ph.D.

Carly Muller, M.P.H. (Australia)
Senior Policy Advisor and Health Program Evaluator, Victorian Department of Human Services and Whitehorse Community Health Service
Project Title: *An Evaluation of U.S. Proactive Telephone Disease Management Services for Patients with Chronic Illnesses*
Placement: University of California, San Francisco
Mentors: Dean Schillinger, M.D. and Andrew Bindman, M.D.

Mihi Ratima, Ph.D. (New Zealand)
Associate Professor Maori Health, Auckland University of Technology
Project Title: *The Characteristics of Obesity Prevention Strategies in Primary Care for Indigenous People and Ethnic Minorities*
Placement: Harvard Medical School
Mentor: Paula Johnson, M.D., Brigham and Women's Hospital

Jonas Schreyoegg, Ph.D. (Germany)
Senior Lecturer, Berlin University of Technology
Project Title: *Comparing the Costs of Health Service Delivery between the United States and Europe at the Micro Level*
Placement: Stanford University
Mentor: Alan M. Garber, M.D., Ph.D.

Laurel Taylor, M.B.A., Ph.D. (Canadian Associate)
Assistant Professor, Department of Medicine, McGill University
Project Title: *Enhancing Health Management for Patients and Providers: Understanding Physician Responses to Electronic Alerts*

Diane E. Watson, M.B.A., Ph.D. (Canadian Associate)
Director, Research and Analysis, Health Council of Canada
Project Title: *A Population-Based Telephone Survey of Canadians' Experiences with Primary Care*

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 U.S. Chaired by Andrew Bindman, M.D., the selection committee met in November 2006 and selected the fourth round of fellows.

- **Moira Inkelas, Ph.D., M.Phil., M.P.H.,** assistant professor, Department of Health Services, School of Public Health, University of California, Los Angeles.

- **Karl Lorenz, M.D., M.S.H.S.,** palliative consultant, V.A. Greater Los Angeles; assistant professor, University of California, Los Angeles; Adjunct Affiliate, RAND Health.

Partnerships with International Foundations

The Commonwealth Fund continues to seek and nurture partnerships with international foundations in order to expand and enrich its programs. In November 2006, the Fund announced a new partnership with the Stuttgart-based Robert Bosch Foundation, which has agreed to collaborate with the Fund to provide support for an additional Harkness Fellow from Germany, starting with the 2007–08 class. In addition, the German Institute for Quality and Efficiency in Health Care provided support for the inclusion of Germany in the Fund's 2005 and 2006 international health policy surveys, expanding the survey to six countries and helping to establish Germany as a core country in the Fund's international program.

Since 2004, the Fund's partnership with the U.K.-based Health Foundation has included annual support for two U.K. Harkness/Health Foundation Fellows. Collaboration between the

two foundations has enabled the inclusion of an expanded U.K. sample in the Fund's international health policy surveys and comparisons among England, Scotland, Wales, and Northern Ireland. In addition, the Australian Primary Health Care Research Institute at the Australian National University and the Dutch Centre for Quality of Care Research (WOK) at Radboud University Nijmegen Medical Centre partnered with the Fund in the 2006 International Health Policy Survey of Primary Care Physicians.

Each year since 2001, two Canadian Harkness Associates have participated in the fellowships 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 Washington and Canadian briefings, adding a valuable perspective to the program. The Fund continues to build on its longest-standing international partnership with the Nuffield Trust, with which the Fund has cosponsored the International Meeting on Health Care Quality since 1999.

Research Projects and Other Activities

Through its Small Grants Program, the Fund supports efforts to learn from other countries' experiences. Projects in 2005–06 included a grant to the Joint Commission on Accreditation of Healthcare Organizations for a seven-country patient safety collaboration. The project, led by Sir Liam Donaldson and the World Health Organization, with the Joint Commission, was launched at the Fund's 2006 International Symposium. A grant was provided to Linda L. Emanuel, M.D., at Northwestern University to support implementation of a National Patient Safety Curriculum, adapted from an Australian model.

In June, the Fund sponsored a policy briefing on Capitol Hill, in cooperation with the Alliance for Health Reform, entitled "Medicare Part D: What Can the United States Learn from Abroad?" The briefing, which was attended by more than 200 congressional staff, Washington policymakers, and journalists, highlighted innovative policy approaches being taken in the Australia, Canada, Germany, France, Italy, Spain, Sweden, and the U.K. to address pharmaceutical costs, coverage, and quality. Further Capitol Hill briefings on international health reforms, co-sponsored by the Fund and the Alliance, are planned.

Notes

[1] C. Schoen, R. Osborn, P. T. Huynh et al., "On the Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive, Nov. 2, 2006.

[2] E. Kelley and J. Hurst, *Health Care Quality Indicators Project Initial Indicators Report*, OECD Health Working Paper No. 22, Mar. 9, 2006.

The Commonwealth Fund's Board of Directors holds an annual retreat to consider external reviews of major programs, hear from expert panels on current health care issues, assess the foundation's overall performance, and deliberate long-term program strategy. Directors, including Jane Henney, M.D., senior vice president and provost for health affairs at the University of Cincinnati Medical Center, and Ben Chu, M.D., (foreground), regional president for Southern California of Kaiser Foundation Health Plan and Hospitals, carefully examine the Fund's grantmaking experience, operating practices, and performance scorecard for lessons useful in shaping the foundation's future work.

Photo: John Troha/Redux Plus

John E. Craig, Jr.

Executive Vice President—COO's Report

2006 ANNUAL REPORT

The Commonwealth Fund Performance Scorecard

Beginning with Tom Peters and Robert Waterman's *In Search of Excellence* in 1982, a large literature exists on businesses that have achieved iconic stature through high performance.[1] Numerous management experts have devoted careers to explaining why some businesses achieve long records of excellence on measures ranging from profits and return to shareholders, to innovation, to employee empowerment and satisfaction. The task of identifying high performing businesses is simplified by the fact that there is a bottom line: the market sorts out with sometimes startling speed those that are excelling and those that are resting on their laurels.

In the nonprofit sector, assessing organizational performance is more challenging. Financial success is but one measure of institutional success, and achievement toward nonfinancial, mission-related goals is both more important and more difficult to quantify. In some segments of the nonprofit sector—higher education, for example—methodologies for assessing performance have been developed and are accorded considerable attention, even if the metrics and the uses to which they are put are not universally applauded.[2]

Performance measurement of nonprofits may still be in its formative stages, but prominent management consultants like Jim Collins are nonetheless mapping out principles and approaches that show promise.[3] As observed by the late John Sawhill, in addition to financial metrics, every nonprofit organization needs performance metrics to measure its success in mobilizing resources, its staff's effectiveness, and progress in fulfilling its mission. "[G]iven the diversity of the organizations in the nonprofit sector," Sawhill cautioned, "no single measure of success and no generic set of indicators will work for all of them." He maintained, however, that "with creativity and perseverance, nonprofit organizations can measure their success in achieving their mission—by defining the mission to make it quantifiable, by investing in research to show that specific methods work, or by developing concrete micro-level goals that imply success on a larger scale."[4]

The health care sector has been a laggard in developing performance measures and using them to improve the quality, safety, accessibility, efficiency, and equity of care. Recent progress on a variety of

fronts suggests, though, that in a matter of years providers, payers, regulators, and consumers will have access to reliable performance measures for individual hospitals, health plans, nursing homes, and, ultimately, for physician groups and even individual physicians.[5] The Commonwealth Fund and other private foundations are contributing significantly to the development of individual measures and to testing their use along with incentivized payments to improve performance. The recently released National Scorecard on U.S. Health System Performance is itself an indicator of the progress made in this field; as a tool that enables the assessment and monitoring of a system encompassing 16 percent of the U.S. economy, the Scorecard is a product of years of research and testing by dozens of organizations.[6]

SCORING THE PERFORMANCE OF PRIVATE FOUNDATIONS

Assessing and comparing performance in private foundations is far more challenging than in other nonprofits. As noted by the Center for Effective Philanthropy's executive director, Phil Buchanan: "There is no universal measure of return for foundations. Some foundations fund efforts to promote literacy, and others fund efforts to promote peace and security. The impact of these efforts cannot possibly be measured in equivalent units."[7] For individual foundations, the challenge of performance measurement is hardly less difficult. First, the social objectives of most private foundations are broad and almost never easily quantifiable. Second, even when foundations are working toward quantifiable social improvements—for example, a reduction in the number of people lacking health insurance and access to health care—the size of the problem, the number of other players and forces at work, and the time required to achieve effect nearly always make performance attribution for any single institution impossible.

Yet the need for an overall performance assessment tool for private foundations is particularly acute. There are a number of reasons:

- The absence of market and electoral tests, the lack of continuing and widespread media scrutiny, the severe limitations of public regulation even with regard to preventing abuses, and the private and privileged nature of these institutions leave them peculiarly vulnerable to underperformance.
- The boards of private foundations require some form of institutional assessment if they are to fulfill their fiduciary responsibilities and justify the contribution of their time.
- As a result of abuses by some private foundations in recent years, the sector as a whole has come under heightened scrutiny by the Senate Finance Committee and state regulators—making it even more important that private foundations demonstrate they are worthy of the tax incentives available to them.
- In the absence of other measures, minimization of intramural expenses—loosely labeled as "administrative"—may become the "default universal measure of performance."[8] Yet, certainly for value-added foundations, intramural expenses on program development, research, and communication of results may be a defining difference between being "great" or just "good."

- Lack of appropriately constructed performance assessment tools can discourage the risk-taking that should be characteristic of foundations, given their unique privileges.
- Unexposed to market and other external forces, foundations especially need to be "learning organizations" if they are to be high performers, and much of that learning can be achieved by devising and implementing measures for assessing institutional performance.[9]

Foundations are therefore well advised—whatever their mission—"to assemble a set of indicators that, taken together, are suggestive of an answer to the larger question of 'how effective are we?'"[10] Fortunately, the "balanced scorecard" framework developed by Harvard management professor Robert S. Kaplan and consultant David P. Norton in the mid-1990s enables organizations to clarify their goals and strategy, measure performance, and use feedback mechanisms to improve performance.[11] Now used by a wide range of corporations, public agencies, nonprofits, and a small group of foundations, the balanced scorecard was adopted by The Commonwealth Fund during the year as a means of ensuring continued high performance.

DEVELOPMENT AND IMPLEMENTATION OF THE FUND'S PERFORMANCE SCORECARD

In their April 2005 review of the Fund's institutional growth and development over the preceding five years, management and board members agreed that while the Fund already had in place a variety of performance measures, a scorecard comprising a comprehensive set of measures would help frame the foundation's mission and strategy. Members agreed such an instrument could serve the institution well in the following respects: by further clarifying strategies and improving their articulation within the foundation; by providing performance feedback more regularly and more efficiently; by identifying any significant measurement gaps; by highlighting any weaknesses in operations and institutional capacities; and through the use of "stretch targets," by ensuring the foundation's continued creativity and vitality. Recognizing that the scorecard could be helpful in tracking the impact of shifts in the foundation's focus (such as the recent launch of the Commission on a High Performance Health System), the Fund's directors argued the measures should be dynamic, changing as the Fund's priorities changed.

In keeping with the Kaplan-Norton framework, the Fund's scorecard (Figure 1) measures the foundation's performance from four perspectives: finances, customers (the Fund's audience), internal business processes, and organizational learning and growth capacities. Central to the development of the performance scorecard are the following statements of the Fund's overall goal and its strategic objectives in each of these areas.

- Fund Overall Goal: To be a leading U.S. foundation helping to move the U.S. toward a high performance health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, minority Americans, young children, and elderly adults.

- Financial Strategic Objective: To maintain a stable (inflation-adjusted) endowment for advancing the Fund's mission and carrying out its value-added approach to grantmaking.
- Audience Strategic Objective: To be regarded by health care policymakers, influential health care leaders, researchers, and the major media as a reliable, unbiased, and useful source of information on health policy debates and an effective change agent for improving health system performance.
- Internal Processes Strategic Objective: To generate and communicate efficiently and innovatively new, timely, useful, and unique information for informing health policy debates and promoting a high performance health system.
- Organizational Capacities for Learning and Growth Strategic Objective: Under the oversight of a highly accountable board of directors, to recruit, retain, motivate, and empower professional staff uniquely qualified for adding value to the work of grantees and communicating results of the Fund's work to influential audiences.

The Fund's scorecard has a mix of outcome and "performance-driver" measures for each of the four perspectives. Outcome measures tend to be lagging indicators focused on the strategy's ultimate objectives and whether efforts are leading cumulatively to desirable results. Performance-driver measures are leading indicators that signal the extent to which the foundation has in place strategies and systems to achieve objectives over the long-term.

In selecting the initial 22 measures shown in Figure 1, due heed was paid to the advice of users of existing scorecards as well as consultants. In their view, the metrics should be:

- objective and unbiased;
- statistically reliable, with small margin of error;
- unobtrusive, and not disruptive of work or trust;
- inexpensive to collect;
- qualitative as well as quantitative in nature;
- robust, measuring the things that count most heavily in the foundation's performance;
- quantifiable, lending themselves to aggregation, calculation, and comparison;
- efficient, as a group enabling the drawing of many conclusions out of a small data set;
- comprehensive, addressing all the significant features of the foundation;
- discriminating, with the result that small changes in them are meaningful; and
- impervious to gaming by management or staff.[12]

For each measure we specified long-range goals and, whenever feasible, identified benchmark comparisons. When possible and appropriate, goals are based in considerable part on peer benchmarks. The proposed goals are geared to ensure that the Fund will at least sustain its current level of performance, and have a strong probability of exceeding it.

While Fund operations already routinely generated data for 10 of the performance scorecard

Figure 1. Commonwealth Fund Performance Scorecard

Fund Overall Objective: ***To be a leading U.S. foundation helping to move the U.S. toward a health care system that achieves better access, improved quality, and greater efficiency, with particular focus on the most vulnerable due to income, race/ethnicity, health, or age.***

STRATEGIC OBJECTIVES	STRATEGIC PERFORMANCE MEASURES	
	Core Outcomes (Lagging)	**Performance-Drivers (Leading)**
Financial		
To maintain a stable (inflation-adjusted), endowment for advancing the Fund's mission, and carrying out its value-added approach to grantmaking.	Constant real value of the endowment in 1980 dollars Extramural/intramural/administration spending allocation vs. 60%/32%/8% guideline	Endowment return compared with market benchmark over 1-, 3-, 5-year, and longer periods Spending rate vs. 5.5% target Percent of appropriations matched with cofunding vs. goal of 25%
Audience		
To be regarded by health care policymakers, influential health care leaders, researchers, and the major media as a reliable, unbiased, and useful source of information on health policy debates and an effective change agent for improving health system performance.	Percent of audience rating Fund effective/extremely effective in reaching change agents vs. goal of 90% and ratings for peer organizations Percent of audience rating Fund effective/extremely effective in improving health care access, quality, and efficiency vs. goal of 75% and ratings for peer organizations	Percent of audience rating Fund good/excellent as a source of credible, reliable, timely, and unique information on health care policy and health care service delivery issues vs. goal of 90% Percent of audience rating information on Fund's Web site very/extremely useful to their work vs. goal of 85% and ratings for competing Web sites Percent of audience rating Fund's major media visibility high/very high vs. goal of 50% and ratings for peer organizations Continually growing Fund audience as measured by Web site sessions and page views
Internal Processes		
To generate and communicate efficiently and innovatively new, timely, useful, and unique information for informing health policy debates and promoting a high performance health system.	Percent of completed Board-level grants meeting or exceeding expectations vs. goal of 80% Percent of grantees saying Fund staff contributes strongly to projects' design, execution, and communications of results vs. target of 75% Continuously growing communications output: annual Fund publications and Web content, journal articles, news releases, congressional testimony	Percent of Board-level projects completed within 12 months of original schedule vs. goal of 70% Average number of working days from manuscript acceptance to publication vs. goal of 60 At least four institution-stretching new product developments annually
Organizational Capacities for Learning and Growth		
Under oversight of a highly accountable board, to recruit, retain, motivate, and empower professional staff uniquely qualified for adding value to work of grantees and communicating results of Fund's work to influential audiences.	Staff job satisfaction rating, vs. goal of 75% and compared to staffs of peer foundations % key employee turnover, with 3-year rolling target of <12%	Board member accountability and service satisfaction level—vs. goal of 90% Staff satisfaction with resources to do their job, vs. goal of 85% Staff satisfaction with opportunities for learning and growth, vs. goal of 75%

metrics, and new internal tracking systems exist for another three measures, confidential audience, grantee, and staff surveys are necessary for the production of the remaining nine metrics on a regular basis. The 2002 Harris Interactive Commonwealth Fund Grantee Survey and the 2003 Harris Interactive Commonwealth Fund Audience Survey, along with the 2005 Center for Effective Philanthropy Foundation Staff Survey, provided baseline data for most of these measures. To generate 2006 data for all of the measures not generated internally, we commissioned Mathew Greenwald Associates, Inc., to survey Fund audiences and grantees confidentially in January 2006 and the Center for Effective Philanthropy to survey Fund staff confidentially again in February 2006.[13]

THE FUND'S PERFORMANCE SCORECARD

A "dashboard" view of how the Fund is measuring up on each of the four perspectives (finances, customers, internal business processes, and organizational learning and growth capacities) is presented in Figures 2 through 5.

Financial Metrics (Figure 2)

The Fund has been successful in maintaining the purchasing power of its endowment: in constant 1980 dollars, the fiscal year average value of the endowment rose from $135 million in 1980 to $275 million in 2006, thus restoring a significant portion of the purchasing power lost in the 1970s period of stagflation. This was achieved by realizing strong returns on the Fund's endowment and by spending at a rate to ensure sustained endowment purchasing power. The investment return objective is to outperform the weighted market benchmark over extended periods and to avoid substantial underperformance in one- to three-year periods. For the one-, three-, five-, seven-, and 10-year periods ending June 30, 2006, the endowment outperformed its market benchmark, and almost did so for the 25-year period.

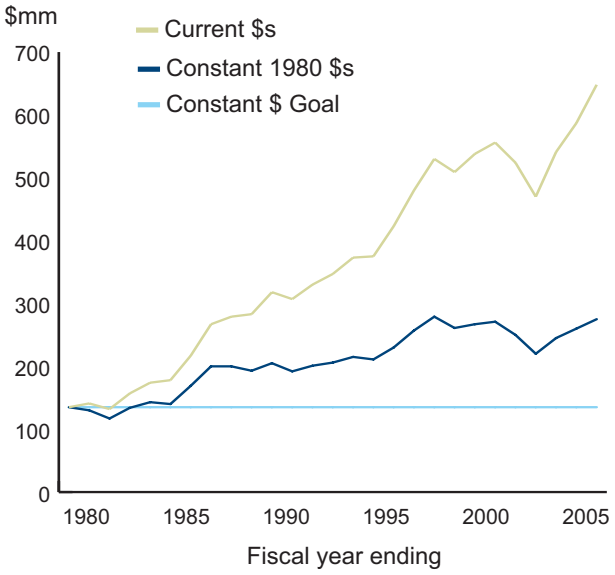
To ensure the foundation's perpetuity, spending as a percentage of the average value of the endowment should not exceed 5.5 percent over any five-year period.[14] With a substantial budget reduction in the 2003–04 fiscal year (in response to the 2000–03 bear stock market) and essentially flat budgets since, and with unexpectedly strong returns in the 2004 and 2005 calendar years, the Fund's five-year average spending rate is now below the target. To avoid any problems in meeting the long-term IRS spending requirement, the Fund accordingly increased its budget by 5.6 percent in 2006–07, and, given a favorable market environment, plans further increases for coming years.

The Fund helps secure the necessary resources for pursuing ambitious program goals by leveraging its resources. The foundation is exceeding its goal of having at least 25 percent of grant appropriations matched with cofunding by other organizations. In addition to seeking funding partners, the foundation aims to develop working partnerships with a wide variety of organizations (currently more than 175) able to augment its capacities and help disseminate the results of its work.

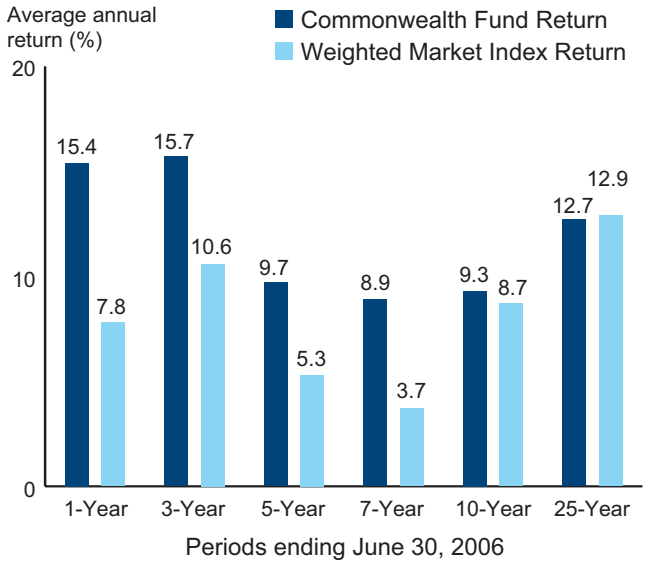
As a value-added foundation, the Fund must devote considerable resources intramurally to research, program development, and communications—representing, as with any other information-

Figure 2. Selected Commonwealth Fund Scorecard Metrics: Financial

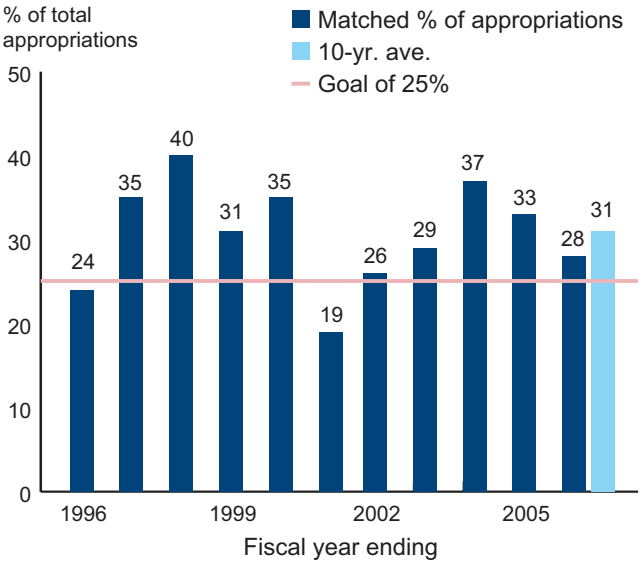
Maintaining the purchasing power of The Commonwealth Fund's endowment, 1980-2006



Achieving strong returns on the Fund's endowment



Leveraging the Fund's resources



generating business, production costs that are central to achieving a strong product line and being able to market it effectively. At the same time, ensuring effective balance between extramural grants and intramural research, program development, and communications is a key ingredient to long-term financial stability and to pursuing strategic objectives effectively. In 2003, the Board of Directors established a guideline that at least 60 percent of the Fund's spending should be in extramural grants—a useful marker for resource allocation decisions. Even in a tight overall budgetary environment, it has been possible to adhere to the ceilings on the intramural spending share of 32 percent and administrative spending share of 8 percent.

Audience Metrics (Figure 3)

Effectively reaching change agents (health policymakers, professional and health industry leaders, leading researchers, and key journalists), and thereby improving health care access, quality, and efficiency, is the aim of the Fund's work. The 2006 audience survey revealed that, with a 93 percent effectiveness rating, the foundation compares well with peer institutions in reaching policymakers and health care leaders, particularly given its comparatively small size.[15] Significantly, the Fund's audience rates the foundation higher on this metric than it did in 2003. At 75 percent, the audience effectiveness rating for the Fund's success in promoting improvements in health care access, quality, and efficiency is also very strong—again, especially given the foundation's small size and the numerous, powerful stakeholders populating this large sector—and is on a par with ratings for peer institutions with similar missions.

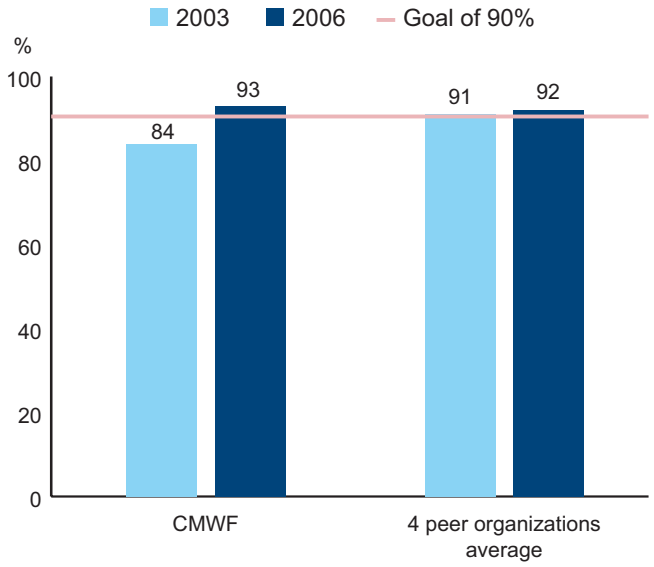
The core of the Fund's strategy for reaching influential audiences and bringing about improvements lies in providing credible, reliable, timely, and unique information meeting customers' needs. Audience surveys show that the foundation's work is highly regarded on all these dimensions, being accorded a 97 percent approval rating most recently. Following the 2003 Board review of the Fund's communications activities, the foundation set making the most of the Fund's Web site to communicate results of produced work as a major strategic objective. The Fund has regularly upgraded its site to address audience needs better, and it ranks highly in a very competitive market: the audience approval rating rose from 80 percent in 2003 to 92 percent in 2006, and within an audience that extensively overlaps those of peer institutions, the Fund's Web site is now rated comparatively more useful by customers.

Traffic on the Fund's Web site is a reliable measure of the foundation's progress in expanding its audience, and the Fund's statistics on annual site visits and page views reveal pronounced and continuing growth (e.g., from 1.3 million sessions in 2003 to approximately 3 million in 2006).

Achieving substantial major media visibility is part of the Fund's strategy for reaching influential audiences.[16] By its own audience's assessment, the foundation still lags peer institutions with more media-oriented strategies, but the Fund is achieving greater attention. Major media mentions rose from 31 in 2003, to 43 in 2004, and to 54 in 2005. As the work of the Fund's Commission on a High Performance Health System unfolds through such innovations as the National Scorecard on U.S. Health System Performance, the Fund will seek a higher profile in major media outlets.

Figure 3. Selected Commonwealth Fund Scorecard Metrics: Audiences

Reaching change agents effectively: audience views

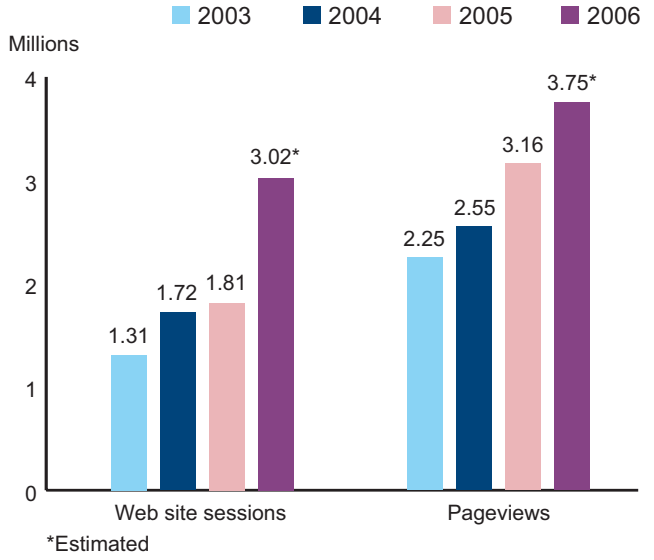


% Fund audience saying institution "effective"-"extremely effective" in reaching change agents: 2003 Harris Interactive & 2006 Mathew Greenwald CF Audience Surveys

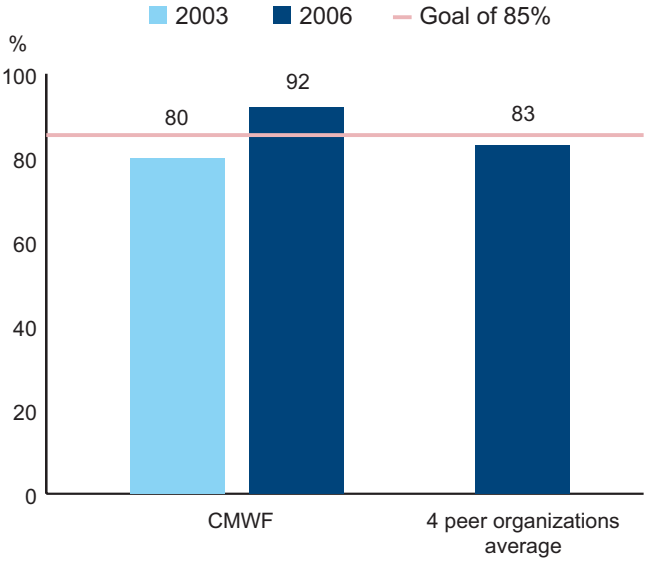
Improving health care access, quality, and efficiency: audience views

% Fund audience saying institution "effective"-"extremely effective" in improving health care access, quality and efficiency: 2003 Harris Interactive & 2006 Mathew Greenwald CF Audience Surveys

Expanding the Fund's Audience



Making the most of websites to communicate results of produced work: audience assessments



% Fund audience saying institution's Web site "useful"-"extremely useful" to their work: 2003 Harris Interactive & 2006 Mathew Greenwald CF Audience Surveys

INTERNAL PROCESS METRICS (FIGURE 4)

Effective grantmaking is key to producing the product line of unique and timely information that enables the foundation to stimulate efforts toward a high performance health system. Maintaining a high quality grants portfolio—selecting able grantees capable of carrying out complicated and often risky projects—is therefore the sine qua non for the foundation's strategy. Annual reviews of completed Board-level grants demonstrate the Fund's strong and consistent record of generating successful grants portfolios: cumulatively, 85 percent of Board-level projects have met or exceeded expectations, compared with the goal of 80 percent.[17]

Staff's function of adding value to the work of grantees is expected to have large payoffs, especially in ensuring effective project design and communication of results. Confidential surveys of grantees in 2002 and 2006 show that the Fund's staff is achieving its value-added function; with a significant boost in professional staff resources in the early 2000s and with these individuals' growing adeptness at the art of grantmaking, this should continue to be the case. Of recently surveyed grantees, 86 percent described Fund staff contributions to their work as "useful" to "extremely useful."

Almost as important as selecting able grantees and assisting them in producing high quality work accessible to policy audiences is ensuring timely completion of commissioned work. Fund program officers and grants management staff work with grantees to achieve ambitious schedules for project deliverables, but given the number of contingencies that can impinge on the execution of projects (e.g., data availability, Institutional Review Board approvals, the pace of study and control group enrollments, government cooperation, and unanticipated methodological hurdles), delays often occur. The project on-time completion metric indicates a need for continuing staff vigilance regarding the progress of many projects.

Effecting timely publication of the results of Fund-supported work involves working partnerships between grantees and Fund program and communications staff. As the volume of publications has increased, the Fund has implemented improved systems for setting priorities and organizing resources to achieve timely publication of commissioned papers and other research. As a result, there has been progress in reducing the time between acceptance of articles by the Fund's publications review committee and their posting on the Web site.

The Fund's strategy of harvesting the results of grants and intramural research to ensure a strong flow of accessible information for change agents sets it apart from most other foundations, which more often leave dissemination of results to their grantees. The Fund's communications product line has greatly expanded with the introduction of the Quality Improvement and Efficiency program and with the continuous upgrading of the foundation's Web site—rising from 215 products in 2003 to 515 in 2006.

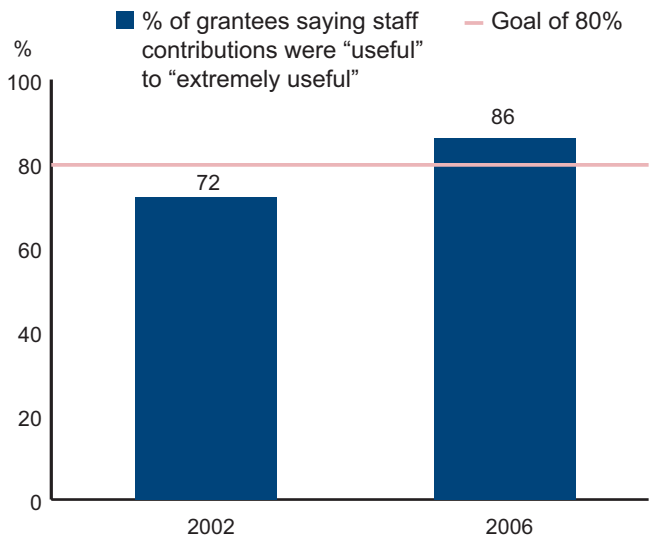
As already noted, the absence of the market, political, constituency, and media reality tests to which most other organizations are subject make private foundations particularly susceptible to losing momentum and strategic direction. Therefore, using strategic new initiatives to "stretch" the institution

Figure 4. Selected Commonwealth Fund Scorecard Metrics: Internal Processes

Maintaining a high quality grants portfolio: selecting capable grantees and assuring successful projects

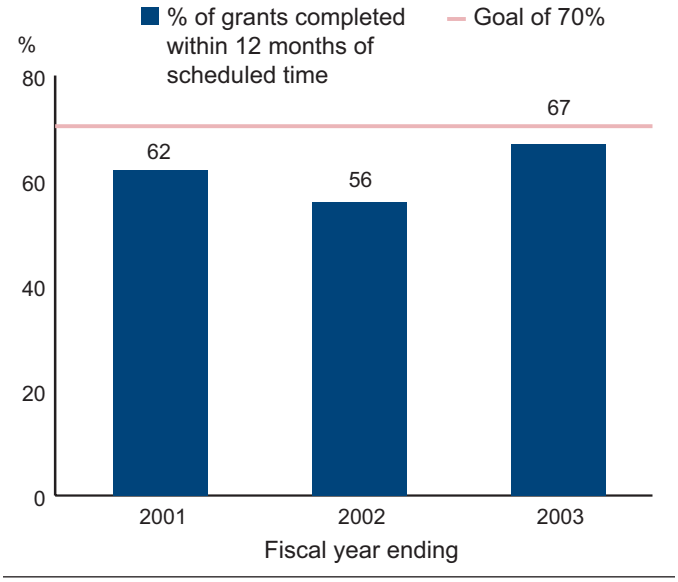
Annual Completed Grants Reports to the Board of Directors

Adding value to the work of Fund grantees

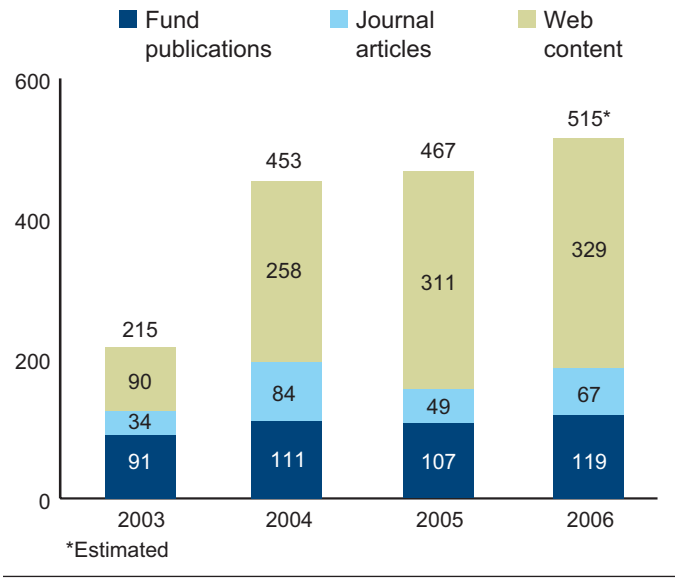


2002 Harris Interactive Survey of Fund Grantees and 2006 Mathew Greenwald Audience and Grantee Survey

Assuring timely completion of high quality commissioned work



Harvesting the results of Fund grants and research to assure a strong flow of accessible information for change agents



and maintain continued vitality is even more important than in business, government, and other nonprofits.

The Fund's goal of effecting at least four institution-stretching product developments annually spurs the foundation to take on even more ambitious goals and strategies and make investments for accomplishing them. Stretch initiatives for 2005–06 were as follows: development of the "Medicare Extra" option for a comprehensive Medicare benefit;[18] expansion of the Harkness Fellows in Health Care Policy program to Germany; partnership with the Netherlands to extend the International Health Policy Survey to that country; redesign of the Fund Web site and initiation of E-Forums on it; and establishment of a strong voice on the implications of the policy trend toward relying on health savings accounts to control health care costs.

Initiatives completed or under way for 2006–07 include the following: publication of the National Scorecard on U.S. Health System Performance; enrichment of the Frail Elders program to further promote culture change and resident-centered care in nursing homes; partnership with *Modern Healthcare* magazine on the Fund's Health Care Opinion Leaders Survey; introduction of a congressional health care legislative policy watch (analysis and modeling of the leading health care bills in Congress); partnership with the Bosch Foundation in the funding of German Harkness Fellows in Health Policy; and development of the Chart Cart feature on the Fund's Web site, which will eventually make available, at no charge, virtually all data produced by the Fund and its grantees, and in a format designed to speed the translation of research into policy action.

Organizational Capacities for Learning and Growth (Figure 5)

Along with their endowments, the most important assets of value-added private foundations are their human resources, and making the most of these resources is central to high performance.

In an era of intensified focus on the performance of corporate boards, increased attention is also being given to the boards of nonprofit organizations. The startling conclusion of one group of experts is that "only the most uncommon of nonprofit boards functions as it should by harnessing the collective efforts of accomplished individuals to advance the institution's mission and long-term welfare."[19] With the 2002 enactment of the Sarbanes-Oxley regulations respecting corporate governance, numerous foundations, including the Fund, have taken steps to ensure that their governance practices are up-to-date, and that Board members are positioned individually and as a group for using their talents and experience to add value to the foundation's work. A confidential annual development survey provides feedback on the Board's own judgment of its effectiveness, and the discussion of its findings creates a productive forum for addressing issues and discussing ways to continually improve the institution's governance.

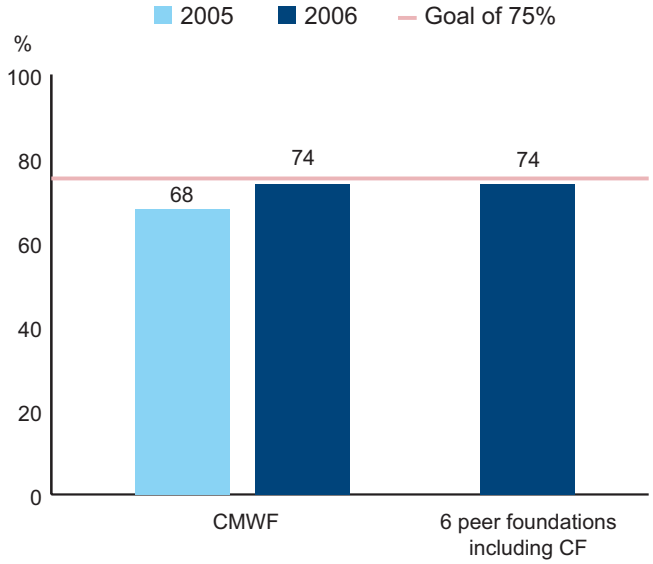
Foundations are enviably positioned for providing staff with the resources needed to do their jobs well, and the Fund's aim is to provide sufficient grant funds to meet program objectives, as well as the information technology and other resources needed for high productivity. The 2005 and 2006 confidential staff surveys conducted by the Center for Effective Philanthropy demonstrated high overall

Figure 5. Selected Commonwealth Fund Scorecard Metrics: Organizational Capacities for Learning and Growth

Assuring effective board governance

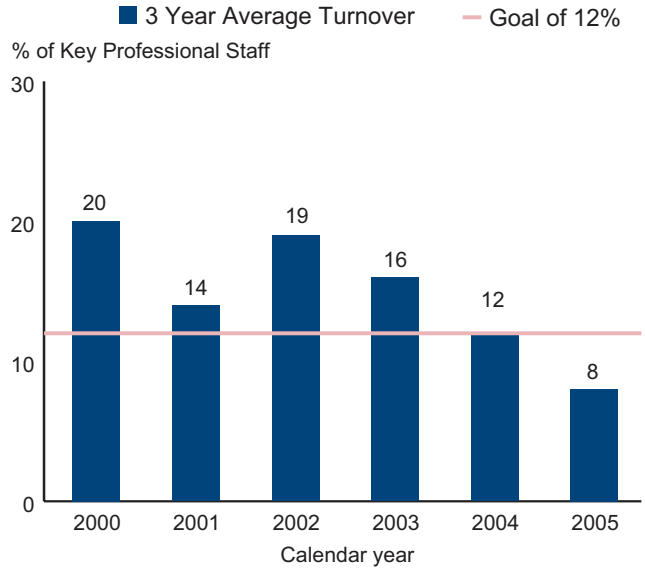
Average Board member accountability and service satisfaction - scale of 0-100%

Achieving staff job satisfaction: staff views



Average job satisfaction rating by foundation staff, scale of 0%-100%: Center for Effective Philanthropy 2005 and 2006 Foundation Staff Surveys

Retaining key professional staff who enable the Fund to carry out its value-added style of grantmaking



staff satisfaction with resources. However, it also revealed the need for continuing attention to the foundation's information technology services—particularly given the pace of technological improvements and the establishment of a Washington office.[20]

The Fund regards providing staff with opportunities for learning and growth as a means of enhancing recruitment, job satisfaction, retention, and the knowledge and skills base of its staff. The Fund's staff tuition assistance program, internal training courses, and on-the-job growth experiences help account for the strong marks staff accord this metric.

Achieving staff job satisfaction is key to retaining highly qualified and productive staff. The 2006 Center for Effective Philanthropy confidential staff survey revealed overall job satisfaction to be reasonably high and equivalent to that at peer foundations. Gratifyingly, efforts to improve job satisfaction over the past year seem to be paying off and will continue.

As stated by management consultant Jim Collins, perhaps the defining characteristic of great nonprofits is hiring the right people, holding on to them, and enabling them to achieve the superior performance of which they are capable. Thus, a central concern of The Commonwealth Fund is retaining key professional staff, so that the institution can continue to excel at its value-added style of grantmaking. Operating in a highly competitive national labor market, from a high cost New York City base, the Fund seeks to contain average three-year annual turnover among professional staff to 12 percent or less. In recent years, the foundation has met that objective.

TOWARD GREATER USE OF PERFORMANCE SCORECARDS BY PRIVATE FOUNDATIONS

The Commonwealth Fund's Performance Scorecard is designed to help the Board achieve a reliable assessment of the foundation's overall effectiveness and spot weaknesses and opportunities to be addressed. It will be updated annually and revised as necessary, with particular attention to the need for new metrics in response to the foundation's evolving priorities and the emergence of new issues.

Surveys by the Center for Effective Philanthropy of a substantial group of private foundations reveal that the two top areas where foundation trustees seek more involvement in their foundation's activities are 1) assessing the foundation's social impact, and 2) assessing the foundation's overall performance.[21] Development of performance scorecards by a small group of foundations, including The Commonwealth Fund, along with the work of the Center for Effective Philanthropy, Grantmakers for Effective Organizations, and a few other organizations, indicates the potential of this and complementary approaches for meeting not only the needs of trustees, but also those of regulators, legislators, and the media.[22] Certainly, looking at a multifaceted set of performance indicators is preferable to the all-too-prevalent focus on poorly defined and often inappropriate measures of performance.

The challenge of developing a performance scorecard will vary greatly from one foundation to another, as will the appropriate features of any single scorecard. But it is difficult to imagine a situation, especially for mid-size to large foundations, where one is not feasible and where the institution and its stakeholders would not benefit from the process and findings.

NOTES

1 J. Kirby, "Toward a Theory of High Performance," *Harvard Business Review,* July-August 2005.

2 *U.S. News and World Report,* http://www.usnews.com.

3 J. Collins, *Good to Great and the Social Sectors: Why Business Thinking Is Not the Answer,* Nov. 2005.

4 J. Sawhill and D. Williamson, "Measuring What Matters in Nonprofits," *The McKinsey Quarterly,* (2) May 2001.

5 R. Sorian, *Measuring, Reporting, and Rewarding Performance in Health Care* (New York: The Commonwealth Fund Commission on a High Performance Health System, Mar. 2006).

6 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.

7 P. Buchanan, *Higher Impact: Improving Foundation Performance,* Center for Effective Philanthropy conference proceedings report, 2005.

8 Ibid.

9 D. A. Garvin, "Building a Learning Organization," *Harvard Business Review,* July 1, 1993.

10 Buchanan, *Higher Impact,* 2005.

11 R. S. Kaplan and D. P. Norton, *The Balanced Scorecard* (Boston: Harvard Business School Press, 1996).

12 The Balanced Scorecard Institute, *Designing Metrics,* http://www.balancedscorecard.org.

13 The confidential Mathew Greenwald 2006 Commonwealth Fund Audience and Grantee Survey had 2,654 respondents, 123 of whom were Fund grantees. The overall Fund audience response rate was 15 percent, and that for grantees, 29 percent. Survey experts regard such rates as high, and acceptable, for this type of survey, and the experience with the survey validates that it can be done regularly and inexpensively. The staff survey response rate was 88 percent. The cost of these surveys was quite low, as a result of using online survey technologies.

14 The Internal Revenue Service requires distributing, on average, five percent of the endowment annually for charitable purposes. Since the IRS calculation does not permit including investment costs and federal taxes, the effective required annual payout rate is 5 percent plus the investment costs/taxes expense ratio on the endowment.

15 Peer organizations surveyed were as follows: *Health Affairs,* the Institute of Medicine, the Robert Wood Johnson Foundation, and the Henry J. Kaiser Family Foundation.

16 "Major media mentions" are those in the *New York Times, Washington Post, Wall Street Journal, Boston Globe,* and *Los Angeles Times*.

17 John E. Craig, Jr., "Foundation Performance Measurement: A Tool for Institutional Learning and Improvement," *The Commonwealth Fund 2005 Annual Report* (New York: The Commonwealth Fund, Jan. 2006).

18 K. Davis, M. Moon, B. S. Cooper, and C. Schoen, "Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries," *Health Affairs* Web Exclusive (Oct. 4, 2005):w5-442–w5-454.

19 B. E. Taylor et al., "The New Work of the Nonprofit Board," *Harvard Business Review,* Sept.–Oct. 1996.

20 The Center for Effective Philanthropy's 2005 staff survey included six foundations; that for 2006 covered only Commonwealth Fund staff.

21 P. Buchanan et al., *Beyond Compliance: The Trustee Viewpoint on Effective Foundation Governance,* The Center for Effective Philanthropy, 2005.

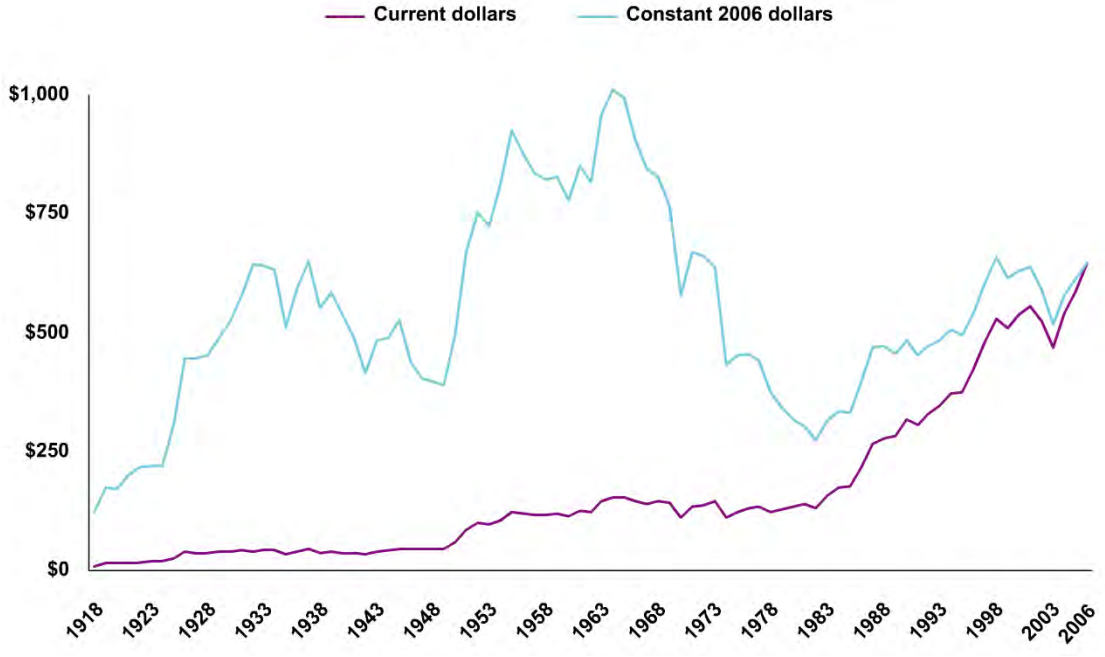
22 http://www.geofunders.org.

Treasurer's Report

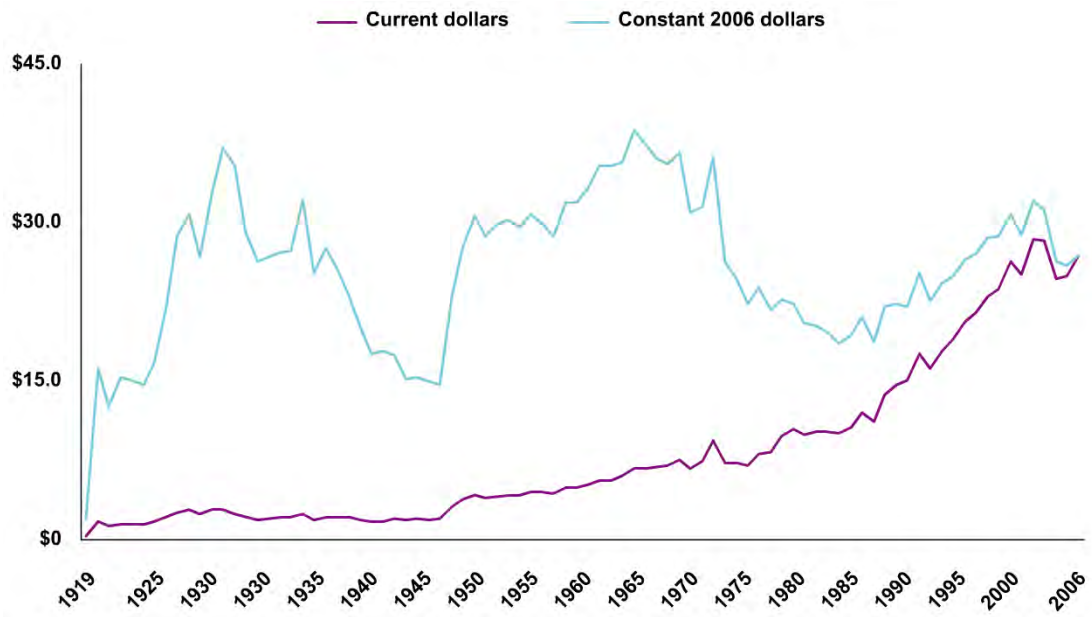
The investment committee of The Commonwealth Fund's board of directors is responsible for the effective and prudent investment of the endowment, a task essential to ensuring a stable source of funds for programs and the foundation's perpetuity. The committee determines the allocation of the endowment 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 COO/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 value of the endowment rose from $606.7 million on June 30, 2005, to $667.8 million on June 30, 2006, reflecting a return of 15.4 percent on the investment portfolio during the year combined with total spending (including programs, administration, investment management fees, and taxes) of $30.0 million. In that 12-month period, the return of the Wilshire 5000 index of U.S. stocks was 10.0 percent; the return of the Lehman Aggregate Bond index was –0.8 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 7.8 percent. The Fund's overall investment performance exceeded not only that of the weighted market benchmarks but also the 9.9 percent produced by the median U.S. balanced manager during the fiscal year.

The Commonwealth Fund's endowment, in millions, 1918–2006.



The Commonwealth Fund's annual spending, in millions, 1919–2006: Total spending of $701 million over 87 years, or $2.26 billion in constant 2006 dollars.



The Fund's team of marketable equity (U.S. and international) managers produced a combined 12-month return of 19.2 percent, well above the Wilshire 5000's 10.0 percent and the median U.S. equity manager's 9.3 percent. The foundation's energy, emerging markets equities, international equities, commodities, hedge fund, U.S. small capitalization growth stock, and venture capital/private equity 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 (1.6% vs. –0.8%) in 2005–06.

The Fund's investment returns in 2005–06 continued to benefit from the significant restructuring of the management of the endowment that the foundation's investment committee began in early 2000. The restructuring has been aimed at reducing the risk of performance significantly divergent from that of the overall market or peer institutions and at streamlining the management structure.

The salient features of the Fund's current investment strategy are summarized in the accompanying table. 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 25 percent commitment to publicly traded U.S. equities, paired with a 20 percent commitment to international equities, including a 5 percent allocation to emerging markets; allocation of approximately 7 percent of the endowment to a passive S&P 500 index fund, to help control investment costs and ensure adequate tracking of the market; satellite U.S. 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 non-marketable alternative equities (venture capital and private equities); and a 15 percent allocation to inflation hedges, including real estate, oil and gas, and TIPS.

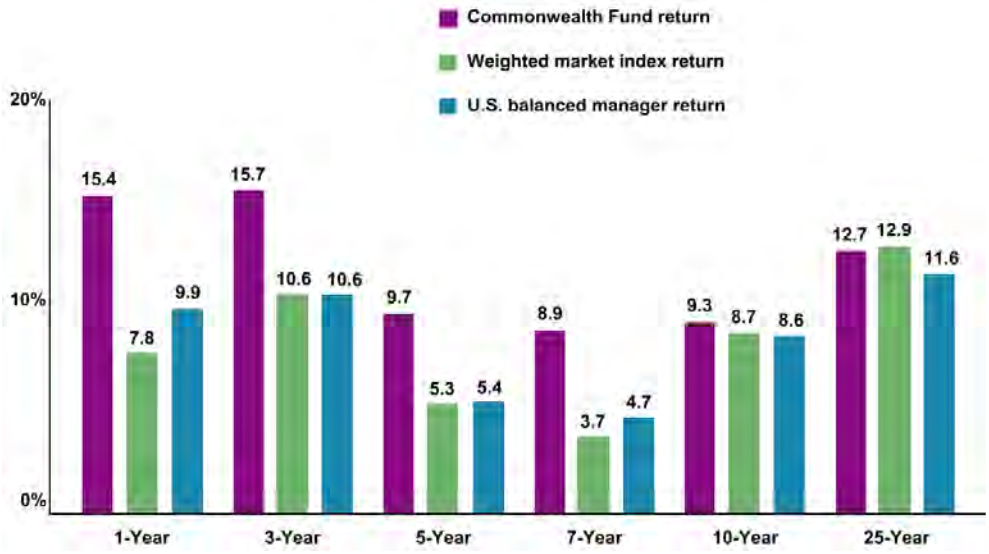
The Commonwealth Fund's endowment management strategy.

	Allocation on June 30, 2006	Long-term target	Permissible range
Total endowment	100%	100%	
Asset Class			
Total Equity	82%	80%	65%–85%
U.S. equity marketable securities	25%	25%	20%–45%
Non-U.S. equity marketable securities	24%	20%	10%–25%
Marketable alternative equity	11%	10%	0–20%
Non-marketable alternative equity	4%	10%	0–15%
Inflation Hedges	18%	15%	5%–20%
Fixed Income	18%	20%	15%–35%

The investment committee devoted particular attention during the year to building up the foundation's non-marketable alternative equities—venture capital and private equities—and non-marketable oil-and-gas and natural resources portfolios. New commitments to nine partnerships totaling $41 million, following $33 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-, and seven-year periods ending June 30, 2006, and by a respectable margin over the last 10 years. Over the almost 25 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.

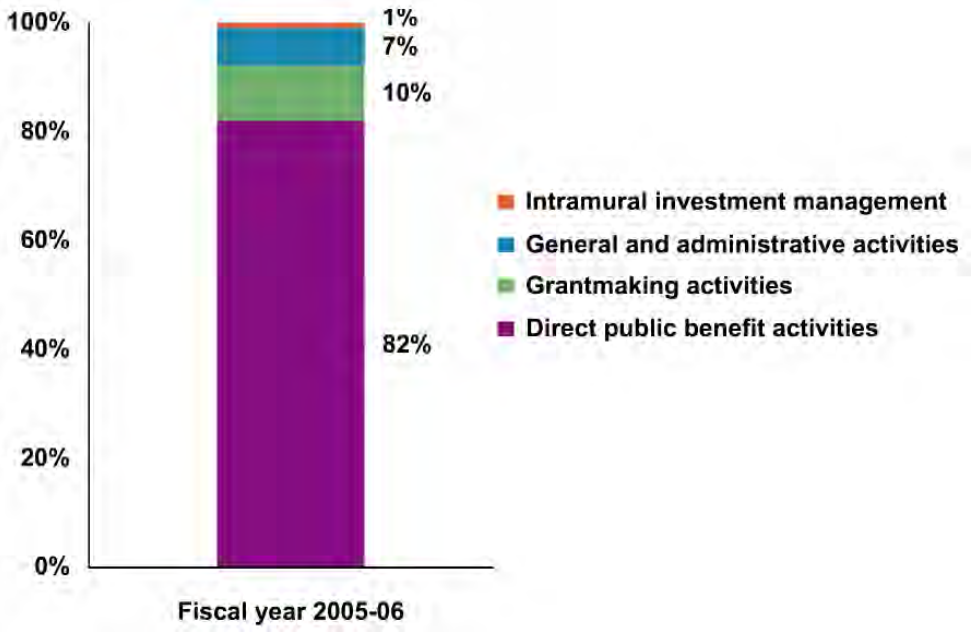
The Commonwealth Fund endowment's average annual investment returns, years ending June 30, 2006.



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 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 of 7.8 percent since the bear market began, the Fund's Board has approved a 5.6 percent increase in annual spending for the 2006–07 fiscal year, with the hope that comparable increases will be possible in coming years.

As a value-adding foundation, the 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 Internal Revenue Service 990PF annual tax return inadequately reflect the purpose of many expenditures, the analysis in the figure sorts out the foundation's 2005–06 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 2005–06, the Fund's total direct public benefits activities accounted for 82 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 7 percent of its budget.

The Fund's total direct public benefit activities—including extramural grants and intramural research, communications, and programs conducted by the foundation—account for 82 percent of its annual expenditures. Value-adding oversight of grants takes up 10 percent of the Fund's budget.



In a still-constrained fiscal environment, the Fund remained extraordinarily productive over the last year while achieving intramural cost savings that enabled staying well within the policy guideline set by the board of directors for the ratio of extramural to intramural spending. The Fund's earlier shift to electronic distribution of the results of its work and that of grantees, along with continuous upgrading of its Web site, accounted for much of the savings achieved on intramural costs. The foundation's ability to take on new initiatives while maintaining all grants programs and the intramural capacities that ensure their effectiveness will enable it to continue to fulfill a unique and highly productive role in American society.

The Commonwealth Fund

INDEPENDENT AUDITORS' REPORT

Financial Statements

Years Ended June 30, 2006 and 2005

We have audited the accompanying statements of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2006 and 2005 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, 2006 and 2005 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.

October 2, 2006

THE COMMONWEALTH FUND

STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2006 AND 2005

	2006	2005
ASSETS		
CASH	$ 109,897	$ 496,911
INVESTMENTS - At fair value (Notes 1 and 2)	666,665,521	608,341,012
INTEREST AND DIVIDENDS RECEIVABLE	180,295	130,281
PREPAID TAXES - Net (Note 5)	-	377,905
PROCEEDS RECEIVABLE FROM SECURITY SALES - NET	972,432	134,397
PREPAID INSURANCE AND OTHER ASSETS	72,363	31,341
RECOVERABLE GRANTS	100,000	100,526
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 $ 1,662,626 at June 30, 2006 and $1,562,270 at June 30, 2005 (Note 1)	4,674,919	4,516,149
TOTAL ASSETS	$673,050,427	$614,403,522
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable and accrued expenses	$ 963,458	$ 1,169,113
Taxes payable - net	883,615	-
Program authorizations payable (Note 3)	15,862,626	17,439,498
Accrued postretirement benefits (Note 4)	2,194,182	2,194,182
Deferred tax liability (Note 5)	3,341,375	2,388,052
Total liabilities	23,245,256	23,190,845
NET ASSETS:		
Unrestricted	649,805,171	591,168,084
Temporarily restricted (Note 7)	-	44,593
Total net assets	649,805,171	591,212,677
TOTAL LIABILITIES AND NET ASSETS	$673,050,427	$614,403,522

See notes to financial statements.

THE COMMONWEALTH FUND

STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2006 AND 2005

	2006	2005
REVENUES AND SUPPORT:		
Interest and dividends	$ 9,323,639	$ 9,054,636
Contribution and other revenue (Note 7)	1,611	3,073
Net assets released from restrictions (Note 7)	44,593	172,196
Total revenues and support	9,369,843	9,229,905
EXPENSES:		
Program authorizations and operating program	24,915,810	21,463,712
General administration	1,563,886	2,516,350
Investment management	3,868,871	3,270,239
Taxes (Note 5)	2,773,039	1,054,799
Unfunded retirement and other postretirement (Note 4)	185,974	593,834
Total expenses	33,307,580	28,898,934
EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS	(23,937,737)	(19,669,029)
NET INVESTMENT GAINS:		
Net realized gains on investments	34,908,663	13,345,794
Change in unrealized appreciation of investments	47,666,161	42,803,558
Total net investment gains	82,574,824	56,149,352
CHANGES IN UNRESTRICTED NET ASSETS	58,637,087	36,480,323
NET ASSETS RELEASED FROM RESTRICTIONS (Note 7)	(44,593)	(172,196)
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS	(44,593)	(172,196)
CHANGES IN NET ASSETS:	58,592,494	36,308,127
Net assets, beginning of year	591,212,677	554,904,550
Net assets, end of year	$649,805,171	$591,212,677

See notes to financial statements.

THE COMMONWEALTH FUND

STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2006 AND 2005

	2006	2005
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets:	$ 58,592,494	$ 36,308,127
Net investment gains	(82,574,824)	(56,149,352)
Depreciation expense	269,777	268,665
Adjustments to reconcile change in net assets to net cash used in operating activities:		
(Increase) decrease in interest and dividends receivable	(50,014)	26,750
(Increase) decrease in prepaid taxes - net	377,905	(377,905)
(Increase) in proceeds receivable from securities sales - net	(838,035)	(134,397)
(Increase) decrease in prepaid insurance and other assets	(41,022)	152,346
Decrease in recoverable grants	526	249,474
Increase (decrease) in accounts payable and accrued expenses	(205,654)	104,771
Increase (decrease) in taxes payable - net	883,615	(875,221)
Decrease in program authorizations payable	(1,576,872)	(133,790)
Increase in accrued postretirement benefits	-	269,180
Increase in deferred tax liability	953,323	856,476
Net cash used in operating activities	(24,208,781)	(19,640,319)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of furniture, equipment, and building improvements - net	(428,548)	(313,815)
Purchase of investments	(281,338,990)	(391,325,556)
Proceeds from the sale of investments	305,589,305	411,299,080
Net cash provided by investing activities	23,821,767	19,659,709
NET INCREASE (DECREASE) IN CASH	(387,014)	19,390
CASH, BEGINNING OF YEAR	496,911	477,521
CASH, END OF YEAR	$ 109,897	$ 496,911
SUPPLEMENTAL INFORMATION -		
Taxes paid: excise and unrelated business income	$ 1,511,519	$ 1,451,449

See notes to financial statements.

THE COMMONWEALTH FUND

NOTES TO FINANCIAL STATEMENTS
YEARS ENDED JUNE 30, 2006 AND 2005

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.

2. INVESTMENTS

Investments at June 30, 2006 and 2005 comprised the following:

	2006		2005	
	Fair Value	Cost	Fair Value	Cost
U.S. Equities	$160,463,317	$141,488,422	$183,218,869	$157,581,858
Non - U.S. Equities	152,712,540	85,501,421	139,418,015	86,726,067
Fixed income	101,950,359	98,856,492	89,458,155	92,583,406
Short-term	9,302,175	9,302,175	16,769,839	16,769,839
Marketable alternative equity	93,432,266	54,051,317	72,222,771	42,111,141
Nonmarketable alternative equity	27,305,663	25,996,468	15,451,026	17,443,048
Inflation hedge	121,499,201	84,400,476	91,802,337	75,723,063
	$666,665,521	$499,596,771	$608,341,012	$488,938,422

At June 30, 2006, the Fund had total unexpended commitments of approximately $77.1 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, 2006 and 2005, the Fund had no outstanding derivative positions.

3. PROGRAM AUTHORIZATIONS PAYABLE

At June 30, 2006, program authorizations scheduled for payment at later dates were as follows:

July 1, 2006 through June 30, 2007	$ 12,864,187
July 1, 2007 through June 30, 2008	2,550,984
Thereafter	616,409
Gross program authorizations scheduled for payment at a later date	16,031,580
Less adjustment to present value	168,954
Program authorizations payable	$ 15,862,626

A discount rate of 4.71 % was used to determine the present value of the program authorizations payable at June 30, 2006.

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% and 19% of the participants' compensation for the years ended June 30, 2006 and 2005, respectively. Pension expense under this plan was approximately $899,000 and $925,000 for the years ended June 30, 2006 and 2005, 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 $ 67,000 and $62,000 for the years ended June 30, 2006 and 2005, respectively. In addition, the Fund provides health and life insurance to certain former employees.

Effective July 1, 1998, the Fund entered into deferred compensation agreements with certain senior executives that provides for unfunded deferred compensation computed as a percentage of salary. Deferred compensation contributions were $ 22,175 for the year ended June 30, 2005; there were no contributions for the year ended June 30, 2006.

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 $119,000 and $110,000 for the years ended June 30, 2006 and 2005, respectively.

Expected contributions under the postretirement medical plan for the fiscal year ended June 30, 2006 are expected to be approximately $130,000. Additional required disclosure on the Fund's postretirement medical plan for the years ended June 30, 2006 and 2005 is as follows:

	2006	2005
Benefit obligation at June 30	$ 2,194,182	$ 2,133,837
Fair value of plan assets at June 30	-	-
Status - unfunded	2,194,182	2,133,837
Actuarial loss	-	60,345
Accrued benefit cost recognized	$ 2,194,182	$ 2,194,182
Net periodic expense	$ 118,660	$ 379,331
Employer contribution	$ 118,660	$ 110,151

Significant assumptions related to postretirement benefits as of June 30 were as follows:

	2006	2005
Discount rate	4.28%	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, 2006, benefits expected to be paid in future years are approximately as follows:

Year ended June 30, 2007	$ 125,000
Year ended June 30, 2008	$ 135,000
Year ended June 30, 2009	$ 149,000
Year ended June 30, 2010	$ 162,000
Year ended June 30, 2011	$ 194,000
Five years ended June 30, 2016	$ 871,000

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% Federal excise tax, if certain criteria are met, on net investment income. For the years ended June 30, 2006 and 2005, 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, 2006, distributions approximating $ 8.1 million are required to be made by June 30, 2007 to satisfy the minimum requirements of approximately $ 30.3 million for the year ended June 30, 2006.

In the Statements of Financial Position, the deferred tax liability of $ 3,341,375 and $2,338,052 at June 30, 2006 and 2005, respectively, resulted from expected Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2006 and 2005, the tax provision was as follows:

	2006	2005
Excise taxes - current	$ 1,555,044	$ 124,812
Excise taxes - deferred	953,324	856,476
Unrelated business income taxes - current	264,671	73,511
	$ 2,773,039	$ 1,054,799

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, 2004 and 2003, Picker program grants totaled approximately $1,350,000 and $1,370,000, 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. In keeping with this bequest, an initial amount of $552,000 was recorded as a temporarily restricted net asset as of and for the year ended June 30, 2002.

During the years ended June 30, 2006 and 2005, net assets released from donor restrictions were $ 44,593 and $172,196, respectively.

* * * * * *

Directors and Staff

James J. Mongan, M.D., was elected to be a member of The Commonwealth Fund Board of Directors in April 2006. The president and CEO of Partners HealthCare System in Boston and a professor of both health care policy and social medicine at Harvard Medical School, he has a long and distinguished career in health care policy, management, and education.

During his career, Dr. Mongan has served as president of Massachusetts General Hospital, the largest and oldest teaching affiliate of Harvard Medical School, as executive director of the Truman Medical Center in Kansas City, Mo., and as dean of the University of Missouri–Kansas City School of Medicine. Prior to that, he spent 11 years in Washington, D.C., serving for seven years as a staff member of the U.S. Senate Committee on Finance, for which he worked on Medicare and Medicaid legislation. During the Carter administration, he was deputy assistant secretary for health and then associate director of the domestic policy staff at the White House.

Dr. Mongan, a member of the Institute of Medicine of the National Academy of Sciences, chairs the Commonwealth Fund Commission on a High Performance Health System. He is a member of the board of directors of the Eastern Massachusetts Urban League and has served on the board of trustees of the American Hospital Association and on the Prospective Payment Assessment Commission of the U.S. Congress. He has also served as chairman of the Greater Boston Chamber of Commerce.

A native of San Francisco, Dr. Mongan received his undergraduate education at the University of California, Berkeley, and Stanford University, and his medical degree from Stanford University Medical School. He completed his medical internship at Kaiser Foundation Hospital in San Francisco and served two years in the public health service.

Upon naming him to the Fund's Board, Chairman Samuel O. Thier, M.D., said of Dr. Mongan: "His intimate knowledge of health care delivery gives him a clear understanding of the challenges and opportunities we face as we seek to achieve a high performance health care system."

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James R. Tallon, Jr.

Jane E. Henney, M.D.

William Y. Yun

* Current as of December 31, 2006.

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**Deceased, January 30, 2007.*

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Senior Program Officer, Patient-Centered Primary Care and Child Development and Preventive Care

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Senior Program Officer, Quality Improvement and Efficiency

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Grants Approved, 2005 – 2006

Commission on a High Performance Health System

AcademyHealth
$477,791
Commission on a High Performance Health System: Program Direction
In April 2005, the Board approved the establishment of The Commonwealth Fund Commission on a High Performance Health System, which is charged with identifying public and private policies and practices that would lead to higher performance, with a focus on those in society who are vulnerable due to income, minority status, health, or age. In addition to holding three meetings per year, the 18-member commission will produce an annual policy report and performance scorecard. Its work will also be reflected in existing Fund-sponsored activities, including the Bipartisan Congressional Retreat, Congressional Staff Retreat, and Alliance for Health Reform briefings and roundtables. The Fund will provide grants to the Washington, D.C.-based AcademyHealth and Alliance for Health Reform to provide basic staff support for key Commission activities. A senior policy director based at AcademyHealth will work with the executive director on Commission meetings and all policy-related programs and products. Staff at the Alliance will be responsible for logistical support of the three annual Commission meetings.

Anne K. Gauthier
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ag@cmwf.org
Alliance for Health Reform
$326,021

Alliance for Health Reform
$326,021
Commission on a High Performance Health System: Meetings
In April 2005, the Board approved the establishment of The Commonwealth Fund Commission on a High Performance Health System, which is charged with identifying public and private policies and practices that would lead to higher performance, with a focus on those in society who are vulnerable due to income, minority status, health, or age. In addition to holding three meetings per year, the 18-member commission will produce an annual policy report and performance scorecard. Its work will also be reflected in existing Fund-sponsored activities, including the Bipartisan Congressional Retreat, Congressional Staff Retreat, and Alliance for Health Reform briefings and roundtables. The Fund will provide grants to the Washington, D.C.-based AcademyHealth and Alliance for Health Reform to provide basic staff support for key Commission activities. A senior policy director based at AcademyHealth will work with the executive director on Commission meetings and all policy-related programs and products. Staff at the Alliance will be responsible for logistical support of the three annual Commission meetings.

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Alliance for Health Reform
$431,703
Commonwealth Fund Bipartisan Congressional Retreat, 2006
Since 1999, key members of Congress and other policy experts have met for three days in January under the auspices of The Commonwealth Fund and Harvard University's John F. Kennedy School of Government to discuss emerging issues in health care policy. With the formation of the Commission on a High Performance Health System, it becomes possible to tie the program for these retreats to the

Commission's policy work. The program for the retreat will be finalized each year at the Commission's summer meeting. As in the past, the retreats will provide an opportunity for lawmakers to spend time away from their day-to-day demands so they can openly discuss health policy issues in a private setting, obtain high-quality information and analysis on multiple facets of an issue, and enhance their ability to make the value and political judgments that lie ahead. In 2006, the sessions will most likely focus on issues around Medicare, health care spending trends, Medicaid, reinsurance and high-risk pools, pay-for-performance, and the efforts undertaken by other countries to improve health system performance.

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Alliance for Health Reform
$155,426
Health Policy Seminars and Congressional Staff Retreat, 2006
Alliance for Health Reform briefings are a valuable resource for congressional staff and journalists seeking the latest information on key health policy issues. In the coming year, the Alliance will conduct eight briefings and host a congressional staff retreat. Possible briefing topics include: implementation of the new Medicare drug benefit; pay-for-performance initiatives; medical errors and malpractice policy options; incremental steps toward broadening insurance coverage, including reinsurance; improving enrollment in public programs; and international issues.

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Small Grants — Commission Activities

Harris Interactive, Inc.
$30,000
Public Views on Health System Performance: A Public Opinion Survey

Jordon Peugh
Research Director
161 Sixth Avenue
New York, NY 10013
(212) 539-9706
jpeugh@harrisinteractive.com

Johns Hopkins University
$49,466
Analysis of Medicare Rates and Costs for the Commonwealth Fund Health System Scorecard

Gerard F. Anderson, Ph.D.
Professor and Director
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Bloomberg School of Public Health
624 North Broadway, Room 302 Hampton House
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ganderso@jhsph.edu

Trustees of Dartmouth College
$19,512
Benchmarks of Health System Excellence and Implication for Efficiency
Elliott S. Fisher, M.D.
Professor of Medicine and Community and Family Medicine
7251 Strasenburgh Hall, HB 7251
Hanover, NH 03755-3863
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elliott.s.fisher@dartmouth.edu

Program on the Future of Health Insurance

Center for Studying Health System Change
$184,981
Family Out-of-Pocket Medical Costs: Recent Trends and Implications for Health Care Access
Previous Fund-supported research has documented the growing burden of out-of-pocket medical expenditures and the resulting difficulties Americans face in accessing care and paying medical bills. This project will analyze Medical Expenditure Panel Survey data to measure the most recent changes in out-of-pocket spending and premium shares and to identify the factors causing these changes. In addition, project staff will analyze household and physician survey data from the Community Tracking Study to document variation in this cost burden across 60 U.S. communities and how it is affecting people's health care experiences. From these analyses, policymakers will learn how rising health care costs and cost-sharing are affecting families' financial stability and local health systems' capacity to care for the most vulnerable patients.
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Trustees of Columbia University in the City of New York
$195,362
Examining Health Insurance Issues and Developing Policy Options to Expand and Stabilize Coverage, 2005-06
The Fund's Program on the Future of Health Insurance tracks changes in insurance coverage, documents the consequences of being uninsured or underinsured, and explores new policies to expand coverage for working families. This core grant to Columbia University supports these activities by providing the analytical basis for reports authored by the Columbia team and for work undertaken by Fund staff, grantees, and the Commission on a High Performance Health System. Over the next year, the team will focus on such research topics as: the impact of health expenditures on people's savings; how sick leave and health benefits combine to affect access to care; new policies to expand coverage for low-wage workers; the latest trends in coverage among minorities and young adults; and components of the Commission's Health System Indicators Scorecard.
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Education & Research Fund of the Employee Benefit Research Institute
$126,157
Tracking the Evolution and Spread of Consumer-Driven Health Care Plans
Consumer-driven health plans (CDHPs), which include high-deductible health plans and tax-preferred

savings accounts for medical expenses, have gained currency among employers as a strategy to reduce premiums and promote cost-conscious health care behavior on the part of employees. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 helped stimulate interest in such plans by introducing Health Savings Accounts, which allow people with high-deductible plans to save pretax dollars to cover expenses that their health plans do not. Little, however, is known about the extent to which CDHPs have proliferated or their effect on the health behavior of employees. The Employee Benefit Research Institute (EBRI) proposes to fill this research gap through an annual Consumerism in Health Care Survey.

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fronstin@ebri.org

Regents of the University of Minnesota
$176,991
Uninsured and Underinsured Workers in Small Businesses: Policy Implications
The proportion of U.S. companies offering health insurance coverage has fallen in the last five years, a decline driven primarily by small firms. Among those small firms that still offer coverage, an increasing number are offering plans with higher deductibles. Using national Medical Expenditure Panel Survey (MEPS) data for 1997-2003, this project will analyze differences in the extent and quality of insurance coverage among firms of different sizes, focusing on the relationship of coverage to wages and other benefits, such as pensions, paid sick leave, and paid vacation. The researchers will also develop new estimates of 'underinsurance' based on health status, income, firm size, and comprehensiveness of health coverage. These findings will enable the project team to assess the potential impact of new legislative proposals for covering uninsured workers.

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Analysis and Modeling of the Leading Health Care Reform Bills of the 109th Congress (2005-2006)
Through various bills introduced in 2005-06, members of Congress have tried to address rapidly rising health care costs and insurance premiums, the erosion of comprehensive and affordable coverage, and problems with the safety and quality of care. Yet there has been little systematic analysis of these proposals to gauge their relative potential for success, estimate their costs to the federal budget, and assess their potential for long-term savings. This project will analyze and compare leading congressional bills that are designed to expand health coverage, improve public insurance programs like Medicare and Medicaid, control health care costs and improve efficiency, improve the quality and safety of care, and develop more rational payment policies. The findings will enable policymakers and the public to understand how various proposals will affect health care access, cost, and quality.

Health Policy R&D
$59,500
Comparisons of Select Health Care Bills

Katie B. Horton
President
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khorton@hprd.net

The Lewin Group, Inc.
$90,500
Estimating the Cost and Coverage Impacts of Selected Coverage Expansion Proposals

John F. Sheils
Vice President
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
(703) 269-5610
john.sheils@lewin.com

The Regents of the University of California
$176,698
The Health and Cost Consequences of Interruptions in Medicaid Enrollment
Relatively little is known about how instability in health insurance coverage affects people's health, or what the cost consequences are for public insurance programs and the health system overall. For this project, researchers will examine California hospital discharge data to investigate whether interruptions in Medicaid coverage are associated with a higher rate of hospital admissions, deaths, or costs for medical conditions that could have been prevented with early primary care. The findings will help federal and state policymakers who are currently weighing policy options—including changes in Medicaid enrollment policy and higher premiums—to control the program's escalating costs.

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bindman@medsfgh.ucsf.edu

Small Grants — Program on the Future of Health Insurance

Altarum Institute
$29,998
Retirees Under Age 65 at Risk of Losing Health Coverage: Scope of the Problem and Implications for the Health Care Sector

Paul Hughes-Cromwick
Senior Analyst
3520 Green Court, Suite 300
Ann Arbor, MI 48105-1579
(734) 302-4997

Education & Research Fund of the Employee Benefit Research Institute
$35,500
Sustaining Membership and Support of the EBRI Annual Health Confidence Survey

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Virginia Commonwealth University
$33,483
Trade-offs Between Treatment and Work: The Case of Unemployed Women with Breast Cancer

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Professor
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Medicare's Future

AcademyHealth
$419,316
Medicare's Future: Program Direction Grant
Medicare is poised to implement its first-ever outpatient prescription drug benefit along with a major restructuring of the role played by private health plans. These changes raise numerous concerns about their impact on beneficiaries, particularly the most vulnerable-the frail, the sick, and the poor. Medicare officials, moreover, are considering ways to encourage quality improvement, increase provider efficiency, and improve care coordination. 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 access to care. This grant will provide strategic direction for the program, develop new projects, coordinate ongoing work, and direct efforts to disseminate findings of work it supports to policymakers and the public. The program director also will participate in the critical review of Medicare-related reports submitted for Fund publication, prepare issue briefs and other materials, represent the Fund in public forums, and contribute to the activities of the new Commission on a High Performance Health System.

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National Opinion Research Center
$215,623
Assessing Trends in Retiree Health Benefits and the Impact of Medicare Part D
The Medicare prescription drug benefit (Part D) to be implemented in January 2006 may significantly affect employers' choices regarding the drug coverage they will offer to their retirees. To counteract the potential incentive for employers to drop retiree drug benefits altogether, the Medicare Modernization Act provides for a tax-free payment to employers or unions that provide retirees with a qualified drug coverage plan. Building on their previous experience in surveying employers about health insurance decisions and benefit offerings, the investigators will survey mid-size employers about their retiree health benefits in fall 2005, prior to implementation of Part D, and then re-survey employers in fall 2006, following implementation. The information collected in these surveys will provide policymakers with direct evidence of the effect of the Medicare drug benefit on employers' retiree coverage.

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George Washington University
$250,510
Expanding Medicare Plans: Issues for Beneficiaries
Through the Medicare Modernization Act of 2003, Congress has authorized major changes to the Medicare program, many of which take effect in 2006. It has expanded the role of private Medicare Advantage (MA) plans and increased plan payments; created a new prescription drug benefit available only though private plans; and introduced new types of plans. This project will examine these changes, particularly with regard to their impact on the benefits available to Medicare beneficiaries. One set of analyses will examine geographic variation in MA benefit packages, how benefits relate to traditional Medicare, and how they correspond to plan payment rates. A second set of analyses focusing on the new prescription drug plans, regional preferred provider organizations, special needs plans, and private fee-for-service plans will determine where these plans are operating, what they have to offer beneficiaries,

and what their impact might be. Findings will inform policymakers about the effects of these changes so they can develop refinements as needed.

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The President and Directors of Georgetown College
$222,626
Improving the Medicare Part D Benefit for the Most Vulnerable Beneficiaries
This project will identify difficulties that Medicare beneficiaries are encountering with the new Part D prescription drug benefit and the accompanying low-income subsidy. The investigators will identify the Part D issues that most affect vulnerable beneficiaries-including those with low incomes or multiple chronic conditions-as well as possible structural and operational improvements for policymakers to consider. They also will survey and interview members of legal services and consumer organizations that work with Medicare beneficiaries, summarizing their findings and policy recommendations in a report for policymakers.

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University of Maryland, Baltimore
$269,694
Benchmarking the Quality of Medication Use by Medicare Beneficiaries
As the January 2006 start date for Medicare outpatient drug coverage approaches, there is particular concern about how beneficiaries' access to the medications they currently use and need can be ensured under the complex Part D benefit structure. This concern stems in part from the lack of recognized benchmarks against which to evaluate patterns of drug utilization. For this project, the investigators will study the pharmacotherapeutic profiles of Medicare beneficiaries who have any of 10 priority health conditions singled out by federal officials for special attention. Data drawn from the Medicare Current Beneficiary Survey, including special Institutional Drug Administration files, will be used to examine drug utilization patterns of Medicare beneficiaries with the 10 priority conditions and assess the appropriateness of those patterns of use. The project will include a special focus on minority beneficiaries and beneficiaries in long-term care facilities, two groups that may be particularly vulnerable to the new changes.

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Massachusetts General Hospital
$169,879
Improving Medicare Hospital Performance Measures and Payment Methods
There is considerable interest in using quality indicators to assess the performance of hospitals and develop pay-for-performance initiatives. So far, however, hospital quality indicators are based solely on aggregate hospital-level data. This project will depict the quality of acute care hospitals using newly available patient-level data collected through the Hospital Quality Alliance. With these data, the investigators will not only learn what proportion of patients receives recommended care, they will also be able to create new measures of patient care and simulate the impact of different pay-for-performance

scoring methods on hospital rankings-information that will be useful to the Centers for Medicare and Medicaid Services. In addition, project staff will examine the extent to which care varies by race, ethnicity, or insurance status within and across hospitals.

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Small Grants — Medicare's Future

American Health Quality Foundation
$26,000
Improving Quality of Care in the New Medicare Drug Benefit

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Avalere Health LLC
$49,850
Defining and Measuring Performance of Medicare Prescription Drug Plans' Formularies

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George Washington University
$24,993
The Role of Palliative Care in Paying for Performance

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Research Foundation of the State University of New York
$49,275
A Comparative Approach to Examine the Association Between Cost and Quality of Coronary Revascularization Procedures: The Use of Administrative Versus Clinical Data

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Research Triangle Institute
$49,921
Physician Group Practice Demonstration Site Roundtable

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University of Maryland, Baltimore
$47,141
Chartbook on Medication Use by Aged and Disabled Medicare Beneficiaries Across the Spectrum of Morbidity

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Health Care Quality Improvement and Efficiency

Health Management Associates (grant originally awarded to the Economic and Social Research Institute)
$233,863
U.S. Hospitals' Quality and Efficiency Profiles Over the Past Five Years
Although data on hospital quality and efficiency are now available, most of the information consists of a limited number of care measures taken at one point in time. The next challenge is to identify hospitals that demonstrate high performance consistently over time for a broad spectrum of measures-those that can 'guarantee' high quality to all patients and high efficiency to payors. This project will explore the dynamics of hospital performance and the factors that contribute to its sustainability. In addition, the investigators will assess the factors and interventions that have enabled four hospitals to attain a high level of performance.

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Johns Hopkins University
$266,731
Assessing the Functional Capabilities, Quality and Costs of Clinical Information Systems in Texas Hospitals
While use of clinical information technology (CIT) to improve quality and efficiency is on the rise, achieving the full promise of these tools remains a challenge. For this project, the investigators will survey about 6,000 physicians in 156 Texas hospitals to assess the structural and functional capabilities of their CIT systems and determine whether these capabilities translate into improved quality and lower costs. Project staff will examine the relationship between the performance of hospitals' information systems and their clinical and financial outcomes. Project results will be presented to executives of the hospitals involved in the study to help guide their decisions about investment in CIT infrastructure.

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Massachusetts Health Quality Partners, Inc.
$322,832
Measuring and Reporting on the Quality and Resource Use of Physicians in Massachusetts
For this demonstration project in Massachusetts, a research team will create profiles of the state's physicians in order to assess the quality of the care they provide and their use of resources. The team will then test the utility of the profiles with focus groups and explore how the profiles might be used by health insurers to select plan doctors; by purchasers to develop pay-for-performance programs; and by physician practices and other health care providers to improve physician performance. The investigators will also establish a process for creating a statewide, all-payer data registry of all physician claims from commercial plans, Medicare, and Medicaid.

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Park Nicollet Institute
$153,378
Developing, Evaluating, and Pilot-Testing Electronic Health Record-Based Quality Indicators for Ambulatory Care
By significantly enhancing the measurement and evaluation of medical care, electronic health records (EHRs) have the potential to improve care processes and patient outcomes. This project will address the need for standard methods of assessing performance through EHR-based data by developing a framework for EHR-based measures of quality. Through review of the professional literature and interviews with key informants, the investigators will identify a set of core quality indicators. A compendium of these measures will result, along with case examples comparing the utility of typical HEDIS quality indicators with that of the new EHR-based indicators. Throughout the project, investigators will work closely with national organizations engaged in quality measurement to disseminate project results to the public and private sectors.

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President and Fellows of Harvard College
$253,719
Strategies to Improve the Value of Health Benefit Spending for Low-Wage Workers
Performance-based payment is attracting attention within both Medicare and the private health care sector as a means of improving the quality of physician care. At its April retreat, the Board recommended that the Fund devote resources to evaluating promising pay-for-performance models and disseminating findings to health care providers, purchasers, policymakers, and others. The proposed study will examine how a set of financial incentives targeting both physicians and patients affects cost and quality in a Preferred Provider Organization (PPO) model plan that insures low-wage workers in a single metropolitan area. The findings will be useful in developing policies to improve the quality and cost-efficiency of care in PPO arrangements and for low-income populations.

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The Regents of the University of California
$249,936
Analysis of Physician Group Practices' Management of Chronic Illness
Results from the first National Survey of Physician Organizations in 2000 indicated that medical groups' use of care processes to manage chronic illness-although known to improve quality-was fairly low. They also showed that external incentives and information technology (IT) were associated with greater use of such processes. This project will resurvey large physician group practices to evaluate progress made toward improving the management of chronic illness, as well as the effectiveness of interventions and tools, such as payment incentives and IT. Data from this follow-up survey will be critical in evaluating incentive programs currently under way and in guiding future plans.

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The Urban Institute
$245,564
Evaluating the New York State Medicaid Managed Care Quality Improvement Incentive Program
In 1997, the New York State Department of Health began enrolling an estimated 1.7 million Medicaid beneficiaries into fully capitated managed care plans. That initiative was linked to the Quality Improvement Incentive program, a pay-for-performance approach. The proposed project will evaluate the impact of two interventions within that program: 1) the automatic assignment of Medicaid beneficiaries to managed care plans, whereby plans with better performance receive a higher percentage of auto-assignees; and 2) the adjustment of capitation rates based on plans' performance on 10 quality-of-care measures and five consumer satisfaction measures. As the first study of its kind to evaluate the impact of pay-for-performance in the public sector, it will help guide the evolution of performance-based payment programs in the state, while also providing information to other states about the value of this approach.

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Trustees of Boston University
$326,195
Survey to Assess the Current State and Impact of Quality Improvement Activities in U.S. Hospitals
Frances Cooke Macgregor Grant
In a seminal 2001 report, the Institute of Medicine called for redesigning the U.S. health care system to make it better able to deliver care that is safe, effective, timely, patient-centered, efficient, and equitable to all. Numerous public and private organizations heeded this call by developing and supporting broad-based quality improvement and patient safety initiatives. Not much information is available, however, about the activities hospitals are undertaking. This project will survey 500 hospital CEOs and 3,000 physicians and nurses to determine the progression and breadth of change. Using quality-of-care data from the Centers for Medicare and Medicaid Services and the Joint Commission on Accreditation of Healthcare Organizations, project staff will analyze the relationship between quality improvement activities and quality of care.

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Small Grants — Health Care Quality Improvement and Efficiency

Harris Interactive, Inc.
$15,000
Strategic Health Perspectives 2006
Jordon Peugh
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New York, NY 10013
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Health Systems Research, Inc.
$34,996
Colloquium on Aligning Payment Incentives with Quality: A Review of Current Programs and Evidence of Impact
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National Committee for Quality Assurance
$25,650
Developing Measures of Ambulatory Care Efficiency: An Expert Working Group
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Society of General Internal Medicine
$31,269
Initiative to Advance the State of the Art on Assessing Quality of Care for Patients with Multiple Complex Comorbidities
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The Regents of the University of California
$44,350
Using Electronic Health Records to Improve Care for Underserved Populations: A Case-Study of the Institute for Urban Family Health
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Patient-Centered Primary Care Initiative

Trustees of Dartmouth College
$249,937
Improving Primary Care in Response to Patient Feedback
How's Your Health is an Internet-based survey of patients' health and health care. Past Fund support enabled the creators of How's Your Health to validate the survey and diffuse it among communities and businesses, which have taken to it with enthusiasm. Physician practices, however, have been reluctant to integrate the technology into everyday practice. This project will seek to package the survey with other patient-centered technologies and, in collaboration with a Medicare Quality Improvement Organization, integrate them in up to two dozen primary care practices. The practices will be coached on how to use the patient feedback obtained from these tools to provide patient-centered care. In addition, the project team will conduct an evaluation of the dissemination model to gauge its impact on participating practices and patients.

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President and Fellows of Harvard College
$285,963
Developing and Testing a Pediatric Patient-Centered Care Survey for Ambulatory Care
This project will help fill a gap in data on the quality of well-child care provided in ambulatory care settings. A team led by Harvard Medical School's Paul Cleary will enhance the ambulatory care version of the Consumer Assessment of Health Plans Survey (CAHPS)-the nation's most widely used and well-respected family of surveys measuring patients' experience with care-to include questions on the preventive and developmental services delivered to children and parents by group practices and individual clinicians. The Harvard team, which will work with the American Board of Pediatrics, the American Academy of Pediatrics, and other leading organizations, will develop and field the instrument in English and Spanish.

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Massachusetts General Hospital
$151,106
Case Studies of Patient-Centered Care Physician Practices
Primary care practices and administrators are searching for ways to deliver primary care that meets the needs of patients, families, and clinicians. Successful models of patient-centered primary care not only can demonstrate for physicians the feasibility of delivering such care, but can provide information that is useful in developing tools that improve patients' experiences. Moreover, they can also help purchasers establish pay-for-performance standards. This project will identify and document the experiences of 12 patient-centered primary care practices through in-depth case studies. After identifying top practices through patient survey data, the investigative team will assess how various aspects of each organization-from leadership style to use of technology to quality improvement methods-affect patients' experiences with physician care.

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New England Medical Center Hospitals, Inc.
$101,378
Linking Patients' Experience with Health Care to Clinical Quality and Outcomes
To encourage widespread adoption of quality measurement and improvement activities designed to meet the needs of patients, health care leaders must learn more about the relationship between patient-centered care and improved clinical outcomes. This project will analyze the association between patient care experiences and clinical performance at both the individual physician and practice levels. As part of their work, the investigators will 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. Results from these analyses could generate a greater commitment among health systems, purchasers, and policymakers to patient-centered care.

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State Innovations

AcademyHealth
$223,450
State Innovations: Program Direction Grant
States have the potential for developing and implementing major improvements in health system performance over the next five years. Building on the attributes of a high performance health system identified by the Fund's Commission, the State Innovations program aims to assess the status of all 50 states on the major dimensions of a high performance health system, identify and support promising ideas and local champions, and encourage replication of successful state efforts in other states and nationally. 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 State Innovations and other Commission-related reports 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.
National Academy for State Health Policy
$189,860
Assisting States in the Design of Medicaid Pay-for-Performance Programs
Many states are eager to learn how they can adapt the pay-for-performance programs prevalent in the private sector to meet the specific needs and goals of their Medicaid programs. This project will help up to six states develop incentives for Medicaid providers to deliver high-quality care to their disproportionately minority, low-income, and chronically ill enrollees. In so doing, the project will help Medicaid become a leader in promoting high-performance health systems.

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Center for Health Policy Development
$235,715
Promoting Promising State Initiatives in Pursuit of a High Performance Health System
State innovations in health policy and practice are often overlooked by other states and the federal government, due in large part to a lack of comparative information available on these initiatives. For this project, the investigators will collect and present information on initiatives each state is undertaking relative to the Commission on a High Performance Health System's goals. The team will produce a report and a Web-based tool allowing easy access to this information by topic and by state. These resources should help to encourage and facilitate adoption of promising state and federal policies that could improve health system performance.

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Health Management Associates (grant originally awarded to the Economic and Social Research Institute)
$177,258
Value-Based Purchasing to Improve Health System Performance: Case Studies and Analysis
Years of escalating health care costs, mounting evidence of substandard care, and a rising number of uninsured Americans are pressuring states to seek efficiencies and improved quality within Medicaid and other public insurance programs, state employee coverage programs, and public and private health systems. Many states are adopting components of 'value-based' health care purchasing, but only a few appear to be taking a broad, comprehensive approach. Through four state case studies, this project will provide an objective source of information about state and public-private purchasing activities designed to improve effectiveness and efficiency in health care. The series of reports developed from this work will help state planners, administrators, and policymakers sort through a complex set of options for improving health system performance.

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Mathematica Policy Research, Inc.
$234,529
Evaluation of Maine's Dirigo Health Reform Plan
Through its Dirigo health reform plan, Maine seeks to make quality, affordable health coverage available to every resident by 2009, while at the same time slowing growth in health costs. The plan's centerpiece is an insurance subsidy program, DirigoChoice, which offers affordable health insurance to small businesses and to families with low to moderate income. This project will measure the effects of the insurance subsidy on three groups: low- to moderate-income individuals, small employers, and public and private payers. The evaluation, which will cover the program's first two years, will provide state and federal policymakers with information on the impact and replicability of Maine's unique approach to broadening insurance coverage.

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Rutgers, The State University of New Jersey
$160,007
Commonwealth Fund State Scorecard on Health Care System Performance, Part 2
The Fund's Commission on a High Performance Health System is developing a national scorecard that

highlights and tracks how well the U.S. health system is performing overall, relative to best achieved performance in the United States or in other nations. This project will expand on the national scorecard by developing a companion scorecard that assesses health system performance at the state level. With a small planning grant, the Rutgers Center for State Health Policy adapted national indicators for use at the state level, identified appropriate data sources, and explored opportunities to acquire the information needed for the scorecard. The proposed grant covers all data collection and analysis, writing, and graphic production necessary to assemble the state-level scorecard. Findings will be targeted to state and local governments to assist them in setting policy priorities.

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Small Grants — State Innovations

AcademyHealth
$15,000
State Health Research and Policy Interest Group Meeting

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AcademyHealth
$16,265
State Health Research and Policy Interest Group Breakfast Meeting at the 2006 National Health Policy Conference

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Center for Health Policy Development
$24,585
Technical Assistance to Maine's Governor's Office of Health Policy and Finance in Implementing the Dirigo Health Reform

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Center for Health Policy Development
$17,295
Assisting in the Implementation of Dirigo Health Plans

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DMA Health Strategies
$24,365
Behavioral Health Purchasing and Quality Improvement Practices: Disseminating Promising Innovations
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Economic and Social Research Institute
$45,986
Six-Month Continuation and Expansion of the States in Action Newsletter
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New England Healthcare Institute
$19,620
Computerized Physician Order Entry: Blueprints for Success
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President and Fellows of Harvard College
$25,016
Eastern Massachusetts Healthcare Initiative
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Rutgers, The State University of New Jersey
$48,953
Analytic Support for the Commonwealth Fund State Scorecard on Health Care System Performance
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Special Populations

Quality of Care for Underserved Populations

Health Research and Educational Trust
$150,000
Adding Race/Ethnicity Data to Chicago Community Health Center Clinical Performance Information System
Evidence shows that quality improvement efforts are more likely to reduce disparities in health care for minority populations when providers keep track of patients' race and ethnicity. For this project-a partnership among the Health Research and Educational Trust, American Medical Association (AMA), and Alliance of Community Health Services in Chicago-the investigators will collect patient demographic data, including race and ethnicity, from a consortium of community health centers and then integrate that data into electronic health record systems. Doing so will enable the researchers to link AMA-developed clinical performance measures with key patient characteristics to identify disparities in performance and inform quality improvement efforts.

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Johns Hopkins University
$249,983
Disparities in the Quality of Hospital Care: Does Where You Go Matter?
Minority and low-income patients are more likely to use 'safety net' hospitals-primarily public hospitals and major teaching hospitals-than white and more affluent patients. Safety net hospital executives assert that because their staff have expertise in caring for these patients, they are able to provide them higher-quality care than other hospitals. For this project, researchers will use inpatient discharge data for 15 states to determine which hospitals provide the best care to minority and low-income patients, and which characteristics and best practices are associated with high-performing hospitals serving these populations. Findings will inform the development of policy options for improving hospital care in underserved communities.

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Mount Sinai School of Medicine
$125,000
Improving the Delivery of Effective Care to Minorities
Commonwealth/Health Services Improvement Fund
This is the third and final phase of a project to investigate the underuse of effective medical services in minority communities and test interventions to improve the delivery of care. The investigators are targeting four major conditions: breast cancer, recurrent stroke, hypertension, and prematurity of newborns. In the first phase, project staff, working with experts in clinical medicine, developed evidence-based, consensus guidelines defining how effective treatments should be used and what constitutes underuse of care. Focusing on northern Manhattan, the project team in the second phase assessed the magnitude and causes of underuse for each condition and designed interventions to improve the delivery of appropriate care. In the third phase, the investigators will evaluate the impact their interventions have had in Harlem.

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Princeton Survey Research Associates International
$404,250
Survey on Health System Performance: The Patient Perspective
The Fund's 2001 Health Care Quality Survey found that Americans face challenges in accessing high-quality, patient-centered care, and that obstacles are particularly problematic for minorities. A follow-up survey in 2006 will explore system performance from the patient's perspective, with a focus on care coordination, communication, safety, and the extent to which patients have timely access to primary and preventive care. The survey, which will over-sample minority and low-income adults, will explore how quality of care is affected by having, or not having, a 'medical home' and access to patient-centered care. In addition to informing leaders in health care and policy, findings will assist the Fund in its grantmaking and the Commission on a High Performance Health System in developing the Health System Indicators Scorecard.

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University of Florida
$236,225
Impact of Cultural and Linguistic Standards on Patients' Experience with Inpatient Hospital Care
In an effort to reduce racial and ethnic disparities in patients' health care experiences, the U.S. Office of Minority Health has developed national standards of culturally and linguistically appropriate services (CLAS) for health care providers. No one has yet examined whether such standards have any beneficial impact. Using five data sources, including the Cultural Competency Assessment Tool of Hospitals developed by the grantee, project staff will examine whether patients in hospitals that adhere to CLAS standards have better experiences in terms of communication with doctors and nurses, staff responsiveness, pain control, and other measures. Information about best practices will assist other hospitals in delivering more appropriate care to all of their patients.

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Small Grants

Association of Clinicians for the Underserved
$49,998
Assessment of Health Literacy Practices

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National Academy of Sciences
$25,000
Roundtable on Health Disparities

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National Committee for Quality Assurance
$49,654
Cultural Competence in Patient-Centered Care

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The Commonwealth Fund
$14,000
Cultural Competency Expert Roundtable

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The National Association of Community Health Centers
$10,000
Health Centers and the Medically Underserved: Building a Research Agenda

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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, 2006-07
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, young physicians undertake intensive study in health policy, public health, and management, all with an emphasis on minority health issues, at the Harvard School of Public Health or John F. Kennedy School of Government. Fellows also participate in special program activities. Since 1996, 46 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 an 11th 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

All Children's Research Institute, Inc.
$124,336
Sustaining and Promoting Developmental and Behavioral Pediatrics Online, Phase 2
Two years ago, the Fund supported the expansion of an existing Web site to provide children's primary care providers with ready access to screening tools, educational materials, and interactive support for adopting best screening practices in developmental and behavioral pediatrics. That expansion has been very successful; last year, www.dbpeds.org was ranked first for 'developmental screening' on both the Google and Yahoo search engines. This project will enhance the site, publicize it more extensively, and more closely engage the American Academy of Pediatrics in the site's long-term administration and governance. These activities will promote even greater use of the site and help ensure that it becomes self-sustaining.

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Case Western Reserve University
$97,480
Rating Developmental Screening Instruments
Realizing that early identification of developmental delay in children requires reliable screening methods, child health care providers and policymakers are seeking help in selecting appropriate instruments. For this project, the investigators, in collaboration with leading authorities in developmental-behavioral pediatrics, will review existing screening tools for children age 3 and younger and develop recommendations for pediatric practices. Their work will include a comprehensive review of journal articles on developmental screening, discussions with key experts in the field to uncover unpublished data, and evaluation of each identified instrument's strengths and weaknesses. This research should promote the adoption of standardized approaches to providing developmental services in primary care.

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Center for Health Policy Development
$341,212
ABCD II: Building State Medicaid Capacity to to Support Children's Healthy Mental Development, 2005-06
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, young children under age 5. Medicaid agencies in California, Illinois, Iowa, Minnesota, and Utah are working to ensure 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; billing and reimbursement policies facilitate use of these services; health care professionals have the training to provide developmental services; and new care models are tested in primary pediatric practice. The National Academy for State Health Policy continues to manage the collaborative to foster innovation, coordinate technical expertise, and disseminate results to all 50 states. This is the last year of funding for the four states supported by the Fund.

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Children's Hospital of Philadelphia (grant originally awarded to the Johns Hopkins University)
$155,723
Matching Preventive Services to Child and Family Needs
To be most effective, preventive pediatric care should be tailored to meet the particular needs of individual children and their families. One method for providing more individualized care is to offer a limited number of different service packages based on an assessment of each child's and family's risk factors and strengths. This project will develop an instrument that can help guide primary care physicians in the delivery of such care. Project staff will develop the instrument by reviewing the literature to identify items for the assessment, testing these items, and conducting a preliminary assessment of the instrument's validity.

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Trustees of Columbia University in the City of New York
$217,147
Intervention Services in Early Childhood: A State by State Picture
To be worthwhile, the screening of young children for developmental problems must be linked to follow-up assessments and early intervention services. States vary greatly in how well they identify and treat children with developmental problems, presumably because eligibility and service delivery differ. This project will catalogue for all 50 states existing policies, programs, services, and collaborations related to developmental services and early intervention for children from birth to age 5. The research team will highlight differences and promising approaches. Results will be directed toward policymakers to stimulate policy action that can improve children's developmental outcomes.

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Guilford Child Health, Inc
$143,413
Diffusion of the North Carolina ABCD Developmental Screening and Services Model
As a result of its Fund-supported Assuring Better Child Health and Development (ABCD) project, North Carolina Medicaid has produced a successful model for integrating standardized developmental screening into well-child care visits. In July 2004, the agency decided to expand the model statewide. Officials from around the country have requested guidance from North Carolina in replicating the model in their own states. This grant will enable the North Carolina ABCD team to assist pediatric practices and state health policy officials in five states and to revise resource materials for a national audience.

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Mathematica Policy Research, Inc.
$136,648
Enhance Preventive and Developmental Services for Public/Action Low-Income Children, Phase 2
State Medicaid agencies, by law, must contract with external quality review organizations (EQROs) to monitor the quality of care provided to beneficiaries enrolled in managed care plans. But in a study released in June of this year, the investigators found that only a few states use EQROs to assess and improve children's preventive and developmental services delivered by Medicaid plans. To help them expand the role of EQROs in improving well-child care, states need guidance and practical tools. In the project's second phase, the investigative team will develop these resources, including model requests for proposals, detailed specifications for contracts with EQROs, and companion materials that explain how these tools can be used. An advisory committee will review the materials and provide guidance for their dissemination.

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Medscape, LLC
$100,000
Continuing Medical Education Webcasts to Promote Better Developmental Services for Young Children
Checking for developmental problems in young children through use of standardized screening instruments is an integral part of comprehensive and efficient preventive care. But using these instruments, and acting on the information they provide, is a new skill for many clinicians. An effective way to reach large numbers of clinicians at minimal cost is through webcasts. This project will produce two new webcasts, one on behavioral screening and another on screening for maternal depression, that will be available to child health care providers at no cost. Viewers will also be eligible to receive continuing education credit. If past experience is any guide, substantial numbers of clinicians watching the webcasts are likely to introduce the depicted screening procedures into their practices.

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President and Fellows of Harvard College
$285,963
Developing and Testing a Pediatric Patient-Centered Care Survey for Ambulatory Care
This project will help fill a gap in data on the quality of well-child care provided in ambulatory care settings. A team led by Harvard Medical School's Paul Cleary will enhance the ambulatory care version of the Consumer Assessment of Health Plans Survey (CAHPS)-the nation's most widely used and well-respected family of surveys measuring patients' experience with care-to include questions on the preventive and developmental services delivered to children and parents by group practices and individual clinicians. The Harvard team, which will work with the American Board of Pediatrics, the American Academy of Pediatrics, and other leading organizations, will develop and field the instrument in English and Spanish.

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The Commonwealth Fund
Authorization to Support the ABCD II Initiative for up to Four States
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, young children under age 5. Medicaid agencies in California, Illinois, Iowa, Minnesota, and Utah are working to ensure 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; billing and reimbursement policies facilitate use of these services; health care professionals have the training to provide developmental services; and new care models are tested in primary pediatric practice. The National Academy for State Health Policy continues to manage the collaborative to foster innovation, coordinate technical expertise, and disseminate results to all 50 states. This is the last year of funding for the four states supported by the Fund. In the coming year, a subsequent ABCD III initiative will be explored. Federal Medicaid matching grants are being provided for each of the ABCD II projects.

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State of California Department of Health Services
$50,000
California's Behavioral, Developmental, and Emotional Screening and Treatment by Primary Care Providers in Medi-Cal Managed Care

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Iowa Department of Human Services
$55,000
Iowa's Care for Kids Health Mental Development Initiative, Phase 3

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Minnesota Department of Human Services
$55,000
Great Start Minnesota, Phase 3

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Utah Department of Health
$52,979
Enhancing Utah's Capacity to Support Children's Health Mental Development, Phase 3

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Small Grants — Child Development and Preventive Care

Association of Maternal and Child Health Programs
$16,924
Improving Early Childhood Systems in States
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Case Western Reserve University
$7,990
Establishing the Case for Screening Young Children for Developmental Problems
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Johns Hopkins University
$14,977
Enhancing Preventive Care for Children by Addressing Family Psychological Problems
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Johns Hopkins University
$26,317
Healthy Steps at Ages 8-10: Cohort Maintenance
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National Initiative for Children's Healthcare Quality
$25,000
Fifth Annual Forum for Improving Children's Health Care
Jennifer Powell
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New England Medical Center Hospitals, Inc.
$39,795
Evidence Standards for Child Health: Setting the Table for Discussion
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Oregon Health & Science University
$34,475
Developing a Measure to Assess if Children Were Screened for Developmental Delays
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Society for Developmental and Behavioral Pediatrics
$11,000
Society for Developmental and Behavioral Pediatrics Workshops
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Picker/Commonwealth Program on Quality of Care for Frail Elders

AcademyHealth
$149,619
The Commonwealth Fund/AcademyHealth Long-Term Care Colloquium, Year 3
Picker Program Grant
The first Commonwealth Fund Long-Term Care Colloquium, held in 2004, explored ways to measure the quality of long-term care in the United States as well as issues surrounding care for people who are dually eligible for Medicare and Medicaid. The 2005 colloquium focused attention on consumer-directed care and on ways to link housing with long-term care services. Between meetings, follow-up workgroups helped to ensure that participants collaborated on actions to address the issues raised during the colloquia. The third colloquium, to be held in June 2006, will address two new topics to be determined, with workgroups following the meeting. In addition, project staff will convene a half-day, follow-through session on consumer-directed care for policymakers in February 2006.
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Harris Interactive, Inc.
$334,000
The Commonwealth Fund 2006 National Survey of Culture Change in Nursing Homes
Picker Program Grant
Awareness of the culture change movement in nursing home care has been growing, but the number of facilities that have implemented resident-centered practices is unknown. This project will prepare national estimates of the prevalence of resident-centered practices and indicators of culture change by surveying nursing home administrators and nursing directors. The findings will provide a first look at the reach of culture change in the United States and will enable researchers and policy experts to track changes in resident-centered nursing home care. In addition, survey results will inform the Fund's national health care performance scorecard; elucidate areas for further work by providers, researchers, and others; and help assess the effectiveness of dissemination activities under way by the Quality Improvement Organizations.

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Health Research, Inc.
$395,848
Using Incentives to Reduce Hospitalizations and Enhance Quality for Nursing Home Residents in New York State
Picker Program Grant
Preliminary research suggests that the uneven availability and quality of clinical services in many nursing facilities is a primary reason for high rates of hospitalization among residents. Many costly hospital stays could be avoided if appropriate clinical resources were in place. For this project, the New York State Department of Health proposes to: 1) further study the relationship among hospitalizations, availability of clinical resources in nursing homes, and costs; and 2) design a new payment model that rewards better management of at-risk or acutely ill patients. The study team will seek agreement by the Centers for Medicare and Medicaid Services (CMS) to test the payment model. Project results will be of interest not only to New York and CMS officials, but to the many other states struggling with hospitalization costs and poor medical care in nursing homes.

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League 1199 SEIU Training and Upgrading Fund
$179,763
Engaging Workers in Improving Nursing Home Care: A Case Study
Picker Program Grant
In 2003, Local 1199 of the Service Employees International Union forged a partnership with senior management at 40 New York City nursing homes to promote resident-centered care. Through data review, field work, and interviews with union and nursing home officials, the project investigators will study the impetus for this initiative, how the usual barriers to cooperation were addressed, and how the nursing homes implemented the plan for culture change. These findings will inform efforts to recruit other New York nursing homes to the partnership and will be disseminated nationally to other unions, associations representing direct-care workers, quality improvement organizations, and the Pioneer Network.

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Pioneer Network
$159,784
Supporting the Nursing Home Culture Change Movement
Picker Program Grant
Since its inception a decade ago, the Pioneer Network has spearheaded a grass-roots movement to bring "culture change" and resident-centered care to the nursing home industry. This grant will enable the organization to keep pace with the demand for resources and information on culture change from the Quality Improvement Organizations, Centers for Medicare and Medicaid Services, providers, researchers, and others. In the coming year, project staff will host a second summit meeting of key leaders; conduct a survey of past trainees to assess its effectiveness; develop a speakers' bureau; and continue to upgrade the Pioneer Network Web site, an important resource and "home base" for far-flung practitioners.

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University of South Florida
$222,343
Assessing Florida's Innovations to Improve Nurse Staffing and Quality of Care in Nursing Homes
Picker Program Grant
Nursing home residents and their families know that the quality of care a home provides depends greatly on the number and type of staff employed. Indeed, a report by the Centers for Medicare and Medicaid Services provided strong evidence of the link between very low staffing and poor quality outcomes, with Florida cited as a state where staffing inadequacies were particularly evident. This study will examine how nursing home providers in Florida responded to financial incentives and legislative mandates to increase nurse staffing. It will also assess the impact that these changes have had on quality outcomes. Not only will the findings give Florida legislators important feedback about the effectiveness of their intervention, they will help policymakers in other states considering similar reforms.

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Small Grants — Quality of Care for Frail Elders

Health Policy Alternatives, Inc.
$16,400
Evaluation of the Picker/Commonwealth Program on Quality of Care for Frail Elders

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New York University
Health Care Professional Training in Nursing Homes
$10,000

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Northwestern University
$18,803
Patient-Centered Safety in Long-Term Care Facilities
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Quality Partners of Rhode Island
$27,674
Assessing the Impact of 'Improving Nursing Home Culture' Pilot
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Regents of the University of Minnesota
$29,985
Full-Scale Implementation and Sustainability of Small Group Nursing Homes in Tupelo, MS: Lessons for Replication
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The Regents of the University of California
$36,592
Identifying Culture Change Nursing Homes

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International Health Care Policy and Practice

The Commonwealth Fund
$1,286,768
Harkness Fellowships in Health Care Policy, 2007-08
As Harkness Fellows emerge as policy leaders and change agents in their home countries, the Fund can see the longer-term payoff from its investment. Seven classes of Harkness Fellows came together in July 2005 for the first Harkness Alumni Reunion, a two-day policy retreat cosponsored by the Fund and the U.K.-based Nuffield Trust and Health Foundation. Meanwhile, the Fund's announcement of the new German Harkness Fellowships elicited an outstanding pool of applicants, and two German Harkness

Fellows were chosen in January 2006. Support for a 10th fellowship class, to be selected by early 2007, will allow the Fund to continue to develop promising junior policy researchers and practitioners from Australia, New Zealand, the United Kingdom, and Germany.

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The Commonwealth Fund
$273,700
International Symposium on Health Care Policy, Fall 2006
The Fund's ninth annual International Symposium on Health Care Policy will focus on the efforts of industrialized countries to achieve a high performance health care system. 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 ways in which health systems are ensuring coverage, improving quality, and achieving greater efficiency. To reach a broad policy audience, the Fund will webcast a health ministers' roundtable discussion; in addition, the second day of the symposium will be held on Capitol Hill. Insights gained from these other nations will be valuable to the work of the Fund's Commission on a High Performance Health System. Commissioned papers from the symposium will be submitted for publication as Health Affairs Web Exclusives.

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Harris Interactive, Inc.
$407,000
International Health Policy Survey, 2006
The 2006 International Health Policy Survey, the ninth in an annual series of surveys commissioned by the Fund, will assess health care system performance from the physician's perspective. Conducted in Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States, the survey will explore how doctors perceive the quality of care in their countries and what factors they view as impeding or supporting high-quality, efficient, patient-centered care. The survey's findings, which will be released at the Fund's 2006 International Symposium, should generate substantial interest among health ministers, policymakers, researchers, and the media; they will also inform the work of the Commission on a High Performance Health System. Project staff will submit an analysis of survey results to Health Affairs for Web publication.

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Johns Hopkins University
$60,000
Cross-National Comparisons of Health Systems Quality Data, 2006
Comparisons of the U.S. health care system and those of other industrialized countries reveal striking differences in spending, availability and use of services, and health outcomes. This project will produce the ninth 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 health spending, coverage, hospital capacity and utilization, pharmaceutical costs, availability and use of technology, trends in health manpower supply and demand, and quality of care. Findings from the analysis will be submitted to the journal Health Affairs for Web publication and used by the Fund's Commission on a High Performance

Health System. In addition, a chartpack featuring key data from the OECD database will be updated as a resource for journalists, policymakers, and researchers.

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Small Grants — International Health Care Policy and Practice

Brigham and Women's Hospital
$35,000
The Adoption of Clinical Information Technology in Five Countries

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Center for Quality of Care Research
$32,600
Expansion of the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians to Include the Netherlands

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Harris Interactive, Inc.
$25,000
Commonwealth Fund International Health Policy Survey of Primary Care Physicians, Expansion to Include the Netherlands: Data Processing Supplement

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Northwestern University
$22,015
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The King's Fund
$38,000
King's Fund-Commonwealth Fund Meeting on Strategies to Improve Quality and Cost Effectiveness of Care for Patients with Chronic Conditions

Jennifer Dixon
Director of Policy
11-13 Cavendish Square
London W1M OAN
England
020 7307 2480
j.dixon@kingsfund.org.uk

The Office of the New Zealand Health and Disability Commissioner
$12,275
Patient Motives for Medico-legal Action

Ronald J. Paterson
Level 10, Tower Centre
45 Queen Street
P.O. 1791
Auckland, New Zealand
011-64-9-373-1071
rpaterson@hdc.org.nz

The Regents of the University of California
$50,000
Second International Meeting on Developing Early Childhood Comprehensive Systems

Neal Halfon, M.D.
Professor, Pediatrics
10845 Le Conte Avenue
Box 956939
Los Angeles, CA 90095-6939
(310) 206-1898
nhalfon@ucla.edu

Communications

Harris Interactive, Inc.
$65,500
Health Care Opinion Leaders Survey, Year 2
The Fund recently completed the first year of a bimonthly series of online surveys of health care opinion leaders. The surveys, conducted by Harris Interactive, ask about a range of key health policy issues and options for addressing them. Results are posted on the Fund's Web site, along with original commentaries written by top policy experts. Building on the success of the first year, the Fund will support an additional year of surveys, shifting to a quarterly schedule to allow more in-depth analysis of major issues, closer alignment of the initiative with the work of the Fund's Commission on a High Performance Health System, and likely collaboration with Modern Healthcare, a publishing partnership that should help the Fund reach a broader audience.

Jordon Peugh
Research Director
161 Sixth Avenue
New York, NY 10013
(212) 539-9706
jpeugh@harrisinteractive.com

Project HOPE/The People-to-People Health Foundation
$209,000
A Web Publishing Alliance with Health Affairs
The Fund has had an online publishing partnership with the policy journal Health Affairs since 2003, a collaboration that has provided opportunities to publish Fund-supported research more often and faster than traditional means allow, while raising the Fund's professional and public profile. This grant will provide Health Affairs with an additional year's funding for both general Web operations and for 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 Society on Aging
$5,000
Journalists Reception and Dinner

Paul Kleyman
Editor, Aging Today
833 Market Street, Suite 511
San Francisco, CA 94103-1824
(415) 974-9619
paulk@asaging.org

Center for Excellence In Health Care Journalism
$10,000
Association of Healthcare Journalists Annual Conference 2005

Len Bruzzese
Executive Director
10 Neff Hall
Columbia, MO 65211
(573) 884-5606
len@healthjournalism.org

Harris Interactive, Inc.
$26,000
Health Care Opinion Leaders Project

Jordon Peugh
Research Director
161 Sixth Avenue
New York, NY 10013
(212) 539-9706
jpeugh@harrisinteractive.com

Teachers College of Columbia University
$25,000
The Open Mind Online Digital Archive

Joseph Brosnan, Ed.D.
Vice President for Strategic Initiatives and External Affairs
525 West 120 Street, Box 306
New York, NY 10027-9998
(212) 678-3755
jsb57@columbia.edu

Organizations Working with Foundations

AcademyHealth
$33,000
General Support
W. David Helms, Ph.D.
President and Chief Executive Officer
1801 K Street, Suite 701-L
Washington, DC 20006-1301
(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
Executive Director
8757 Georgia Avenue, Suite 540
Silver Springs, MD 20910
(202) 962-3940
smcgencey@gcyf.org

Grantmakers in Aging, Inc.
$6,000
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, N.W., Suite 1200
Washington, DC 20036
(202) 452-8331
lleroy@gih.org

Health Services Research Association of Australia & New Zealand
$1,000
General Support
Jane Hall
Professor and Director
C/-CHERE

University of Technology, Sydney
PO 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, N.W., Suite 200
Washington, DC 20036
(202) 223-8100
diana@independentsector.org

New York Regional Association of Grantmakers
$13,000
General Support
Michael Seltzer
President
79 Fifth Avenue, Fourth Floor
New York, NY 10003-3076
(212) 714-0699
mseltzer@nyrag.org

Nonprofit Coordinating Committee of New York
$35,000
General Support
Michael E. Clark
Executive Director
1350 Broadway, Suite 1801
New York, NY 10018-7802
(212) 989-0909
mclark@npccny.org

Rockefeller University
$90,000
Transfer and Maintenance of The Commonwealth Fund's Archives, Part 10
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. One of the finest archival institutions in the country, the Rockefeller Archive Center houses the archives of the Rockefeller family, The Rockefeller University, the Rockefeller Brothers Fund, the Russell Sage Foundation, the John and Mary Markle Foundation, the Culpeper Foundation (now merged with Rockefeller Brothers Fund), as well as other organizations whose programs are related to Rockefeller philanthropic interests. In addition to processing and storing documents, the archive center provides research facilities and small research grants for scholars and conducts conferences designed to encourage use of the archives.
Darwin H. Stapleton, Ph.D.
Director
Rockefeller Archive Center
15 Dayton Avenue
Sleepy Hollow, NY 10591-1598
(914) 631-4505
stapled@mail.rockefeller.edu

Other Continuing Grants

Greater New York Hospital Association
$1,000
2006 Annual Health Services Research Symposium
Tim Johnson
Executive Director
555 West 57th Street, 15th Floor
New York, NY 10019
(212) 506-5420
tjohnson@gnyha.org

National Academy of Social Insurance
$5,000
National Academy of Social Insurance Forum Event
Pamela J. Larson
Executive Vice President
1776 Massachusetts Avenue, N.W., Suite 615
Washington, DC 20036
(202) 452-8097
plarson@nasi.org

National Medical Fellowships
$7,000
National Medical Fellwships Gala 2006
Vivian Manning Fox
President and CEO
5 Hanover Square, 15th Floor
New York, NY 10004
(212) 483-8880
natmed@worldnet.ett.net

New York Academy of Medicine
$6,000
New York Academy of Medicine Annual Gala 2006
Jeremiah A. Barondess, M.D.
President
1216 5th Avenue Room 602
New York, NY 10029-5293
(212) 822-7201
jbarondess@nyam.org

Research America
$500
Research America Advocacy Awards 2006
Mary Woolley
President
1101 King Street, Suite 520
Alexandria, VA 22314
(703) 739-2577
mwolley@researchamerica.org

Research Foundation of the City University of New York
$1,800
New York Health Policy Group Meetings
Christa Altenstetter, Ph.D.
Professor of Political Science.
Political Science PhD/MA Program

CUNY Graduate Center
The City University of New York
365 Fifth Avenue
New York NY 10016-4309
(212) 817-8670
caltenstetter@gc.cuny.edu

United Hospital Fund of New York
$8,500
United Hospital Fund Gala 2005

James R. Tallon, Jr.
President
350 Fifth Avenue, 23rd Floor
New York, NY 10118
(212) 494-0700
jtallon@uhf.org

United Methodist Senior Services of Mississippi, Inc.
$30,000
Hurricane Katrina Disaster Relief
Stephen L. McAlilly
President and CEO
109 South Broadway
Post Office Box 2514
Tupelo, MS 38803
(662) 844-8977
info@mississippimethodist.org

Women's Prison Association and Home, Inc.
$4,000
Women's Prison Association 2006 Benefit Dinner
Ann L. Jacobs
Executive Director
110 Second Avenue
New York, NY 10003
(212) 674-1163
ajacobs@wpaonline.org

2006 Annual Report
SUMMATION OF PROGRAM AUTHORIZATIONS

Year Ended June 30, 2006	Major Program Grants	Picker Program Grants	Small Grants Fund Grants	Total
Program Grants Approved				
High Performance Health System	$8,010,199		$745,436	$8,755,635
Commission Activities	$1,390,941		$98,978	$1,489,919
Future of Health Insurance	$1,010,189		$106,481	$1,116,670
Medicare's Future	$1,547,648		$208,080	$1,755,728
Health Care Quality Improvement and Efficiency	$2,052,218		$143,765	$2,195,983
Patient-Centered Primary Care Initiative	$788,384			$788,384
State Innovations	$1,220,819		$188,132	$1,408,951
Special Populations	$3,787,380	$1,441,257	$489,584	$5,718,221
Quality of Care for Underserved Populations	$1,165,458		$148,652	$1,314,110
Commonwealth Fund / Harvard University Fellowships in Minority Health Policy	$800,000			$800,000
Child Development and Preventive Care	$1,821,922		$201,478	$2,023,400
Picker / Commonwealth Program on Frail Elders		$1,441,257	139454	1580711
International Health Care Policy and Practice	$2,027,468		$189,890	$2,217,358
Communications	$274,500		$66,000	$340,500
Other Continuing Programs	$223,000		$63,800	$286,800
Total Program Grants Approved	**$14,322,547**	**$1,441,257**	**$1,554,710**	**$17,318,514**
Grants Matching Gifts by Directors and Staff				$535,106
Program Authorizations Cancelled or Refunded and Royalties Received				($1,253,731)
Total Program Authorizations				**$16,599,889**