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Senior Vice President

2003 Annual Report

IMPROVING THE QUALITY OF HEALTH CARE SERVICES



As health care providers to more than one of five Medicaid-enrolled children under age 6, managed care plans offer great potential to enhance services for children in low-income households. With Fund support, the Center for Health Care Strategies is facilitating a collaboration among a group of Medicaid managed care plans, including HealthPlus in New York City, to improve screening, counseling, and referrals for young patients.

Americans are coming to understand that the quality of their health care is often compromised by gaps and shortcomings in the health care system. Indeed, a recent study by the RAND Corporation found that, over a two-year period, a sample of adults in 12 metropolitan areas received only about 55 percent of “recommended care,” or just over half the number of preventive, acute, and chronic care processes indicated for patients of their age and health status.¹

The problem of health care quality is multifaceted and serious. To help define its scope, the Fund last year issued a groundbreaking collection of information on quality, compiled by researchers Sheila Leatherman and Douglas McCarthy from more than 150 sources and presented in 54 charts. *Quality of Health Care in the United States: A Chartbook*² detailed specific shortcomings in the care provided to patients of all ages, in all types of care (preventive, acute, chronic, and end-of-life), and in six important dimensions of care (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity).

The Fund is addressing the challenge of improving health care quality through four programs:

- The Health Care Quality Improvement Program focuses on developing information about quality, aligning financial incentives to stimulate quality improvement, and building the capacity of the health care system to achieve and sustain quality improvements.
- The Quality of Care for Underserved Populations Program works to improve quality and reduce disparities in health care for low-income and minority patients by raising awareness of problems, identifying and developing methods to improve care, and evaluating the effectiveness of quality improvement programs
- Child Development and Prevention Care Program seeks to enhance young children's healthy development and receipt of preventive care.
- The Picker/Commonwealth Quality of Care for Frail Elders Program strives to improve care for nursing home residents.

Health Care Quality Improvement Program

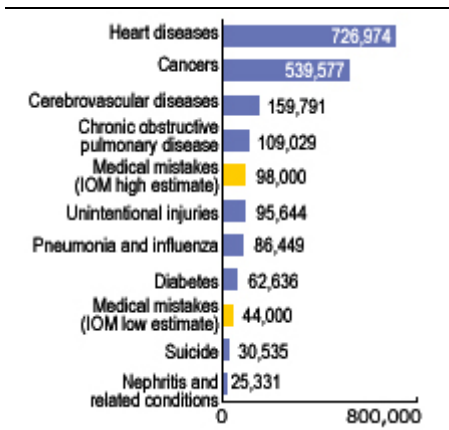
The Health Care Quality Improvement Program encourages change in the American health care system by sponsoring work to develop better information about health care quality that can guide improvement, accountability, and choice; identifying incentives that could lead to improvement; and evaluating and disseminating promising tools and models of care that will lead to improved quality.

In November 2002, the Fund published a call to action for quality improvement, *Escape Fire: Lessons for the Future of Health Care*, by Donald M. Berwick, M.D., of the Institute for Healthcare Improvement. The essay, which originated as a keynote address, outlined an array of pressing problems—



Anne-Marie J. Audet, M.D.
Assistant Vice President

Leading causes of death in the United States in 1997



Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook*, The Commonwealth Fund, 2002, based on data from the Institute of Medicine and other sources



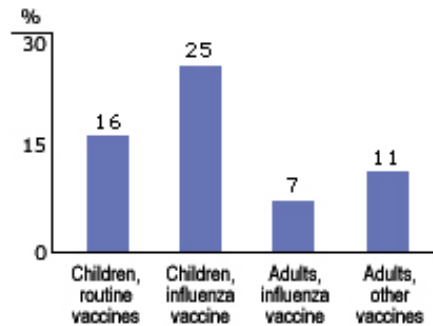
David Blumenthal, M.D.
 Director, Institute for Health Policy,
 Massachusetts General
 Hospital/Partners HealthCare
 System

medical errors, confusing and inconsistent information, and lack of personal attention and continuity of care—and sketched an ambitious program for reform.

At the same time, the Fund launched a series of colloquia on quality improvement, beginning with an exploration of the prospects for establishing a compelling “business case” for health care quality improvement in the United States. Berwick was among a distinguished roster of presenters, while workgroups considered the issue from the perspectives of four major stakeholder groups: providers, insurers, private purchasers, and public payers. Proceedings, along with conclusions and recommendations, will be published by the Fund. A colloquium in May 2003 focused on information technologies and featured a presentation by David Blumenthal, M.D., and Jeff Goldsmith, subsequently published in *Health Affairs*.³ Participants discussed the weakness of the information technology infrastructure in American health care and considered solutions to foster broader and more rapid diffusion.

Berwick also collaborated with Sheila Leatherman to examine the financial implications of quality improvement initiatives for health care organizations. In an article⁴ published in *Health Affairs*, the coauthors presented four case studies of specific interventions—on management of high-cost pharmaceuticals, diabetes management, tobacco cessation, and wellness programs in the workplace—and explored long-term and short-term costs and benefits for health care providers, purchasers and employers, individual patients, and society. To complement the article, the Fund released detailed electronic versions of the case studies for use by researchers and practitioners. A report⁵ by the Institute of Medicine, supported in part by the Fund, recommended that public programs such as Medicare and Medicaid adjust financial incentives to reward high-quality care.

Median percentage point increase in immunization rate for patients who received reminders, compared with control group



Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook*, The Commonwealth Fund, 2002, based on data from Szilagyi et al., "Effect of Patient Reminder/Recall Interventions on Immunization Rates," *JAMA* 284 (2000)

Value-based purchasing (VBP) in health care refers to a range of activities by which employers and public programs attempt to foster quality improvement through the contracting process or by wielding their power as health care purchasers. David Nash, M.D., and Neil Goldfarb, of Jefferson University, conducted a project to gauge the current state of VBP in the United States. Findings from interviews with key health care leaders and an extensive review of the literature were released in the spring of 2003.^{6,7} The authors report that while there is little evidence that current VBP initiatives are having an impact, that will change once financial incentives are realigned with the goals of high-quality care and performance measures address the particular concerns of health care purchasers.

Important opportunities to use health care legislation to foster quality improvement are often missed. In a paper⁸ published in *Health Affairs* in 2002, David Lansky proposes legislative requirements that any new expenditure of federal funds for health benefits be accompanied by public disclosure of performance information regarding quality, effectiveness, and safety. He argues that such disclosure would yield public and institutional benefits.

Measuring and reporting on the performance of physicians is another area of national interest. In October 2002, the Fund cosponsored a discussion of recent developments in the field, convened by the National Committee for Quality Assurance (NCQA) and attended by experts in performance measurement, health services researchers and statisticians, health plan and corporate medical directors, federal administrators, and program staff from leading foundations. One paper presented at the meeting, incorporating recommendations for future research, was recently published,⁹ and others will be issued in the coming year. In a Fund-supported project that builds on the recommendations, Sheldon Greenfield, M.D., and Sherrie

Kaplan are constructing measures of physician performance and testing them with physicians, purchasers, and the public.

A recent project by NCQA engaged members of the public, physicians, employers, and health care organizations in determining what consumers want and need to know about physician quality and how the information might best be provided. As highlighted in a report¹⁰ by Donna Pillittere and colleagues, the research indicates that consumers, if given an appropriate frame of reference, are capable of comprehending data on physician performance—a finding that strengthens the case for making such information more broadly available to the public. The results will also inform NCQA’s plan to adapt Health Plan Employer Data and Information Set (HEDIS) measures to assess the performance of physicians and physician groups.

NCQA has also compiled a catalogue of available measures of physician performance for use by the Doctor’s Office Quality Project, a national demonstration initiative of the federal Centers for Medicare and Medicaid Services. Medicare will eventually build on the work to implement a performance-based reimbursement system.

A great deal of information about physicians’ training, affiliations, and quality is already publicly available through the Internet. Yet, as documented in a 2002 Fund report¹¹ by Elliot Stone and the Massachusetts Health Data Consortium, there are significant gaps in the accuracy and completeness of web-based physician directories. Expanding on that work, NCQA convened a national advisory group that developed a set of recommended standards for physician directories. The recommendations were published in the fall of 2003. The Fund is supporting demonstration projects to develop and evaluate the impact of community-level physician directories that follow the recommended standards.

The health care system's capacity to improve care can be enhanced with computer-based tools and other technical support. In 2000, a survey of hospitals by the Health Research and Educational Trust (HRET) produced striking evidence of the need for better medication practices. A follow-up Fund grant enabled HRET and the Institute for Safe Medication Practices (ISMP) to develop Pathways for Medication Safety,¹² a modular program that assists hospital leaders in identifying error-prone processes and implementing safer procedures. The tools are easy to use and can be put into action immediately. The Pathways program has generated intense interest among state hospital associations and health systems, and project director Lorri Zipperer and colleagues have presented the program at numerous professional meetings and workshops.

University of Colorado researchers Stephen Ross, M.D., and C. T. Lin, M.D., have been studying what happens when patients have access to their medical records. An initial survey of the medical literature revealed that, in the relatively small number of earlier studies involving patient access to traditional paper records, care was often positively affected. Ross and Lin published the results of the literature review in an article¹³ in the *Journal of the American Medical Informatics Association*. They are now completing work on a randomized trial involving patients with congestive heart failure, some of whom are given access to their electronic medical records and the ability to communicate with their physicians via email.

John Wasson, M.D., of Dartmouth Medical School has continued to disseminate an innovative online survey on health and health care, conducted through the website howsyourhealth.com. The How's Your Health survey was piloted in 2000 in Long Beach, California, where 2,000 respondents participated, and has since been used in Mobile, Alabama, and other communities. This year, the Fund's support enabled the Chicagoland Chamber of Commerce to

move forward with a plan to use the survey as the centerpiece of a health awareness campaign in the fall of 2003. Wasson has also published a book on the survey, *How's Your Health, America?*,¹⁴ with partial support by the Fund.

Finally, authors Sheila Leatherman and Douglas McCarthy, whose *Quality of Health Care in the United States: A Chartbook* has been the year's most frequently requested and downloaded Fund publication, are now developing specialized chartbooks on the quality of health care for children and the elderly.

Program on Quality of Care for Underserved Populations

The Program on Quality of Care for Underserved Populations focuses on improving health care for low-income and minority patients. Program strategies include improving communication and quality of care, enhancing clinical care, advancing data collection and analysis, and disseminating knowledge about quality and disparities that affect underserved patients.

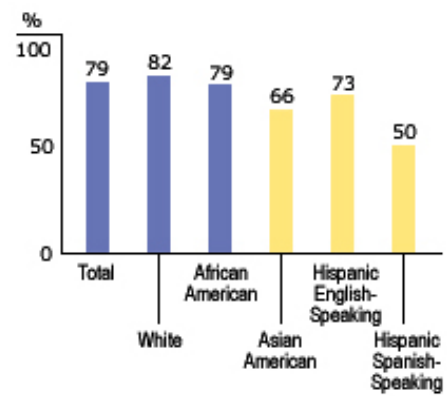
African American, Asian American, and Hispanic patients often experience problems in communicating with their physicians. As findings from the Fund's 2001 Health Care Quality Survey¹⁵ made clear, the difficulties are especially troubling for patients who do not speak English well or who have low levels of health literacy. With support from the Fund, the Institute of Medicine responded this year with a project to gather information on the challenges of caring for patients with low health literacy. In meetings across the country, project staff have heard from consumer and advocacy groups, as well as experts in literacy, communication, and chronic disease.

The Fund also provided partial support for a project by Mara Youdelman of the National Health Law Program to produce an action kit¹⁶ designed to help states finance language services for low-income patients by tapping available federal



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

Percent of adults who say it is "very easy" to understand a prescription bottle



Collins et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans*, The Commonwealth Fund, March 2002

funding. A project by Dana Mukamel of the University of California, Irvine, is studying whether African American patients are more likely to use high-quality cardiac surgeons if they have access to physician report cards on coronary artery bypass graft (CABG) survival rates. In the coming year, the Fund intends to expand its work in this area with support for several new projects to improve communication for patients with limited English proficiency and low health literacy.

In 1998, the Bureau of Primary Health Care launched health disparities collaboratives¹⁷ in community health centers to address problems in the quality of care provided to minority, poor, and other medically underserved patients. Edward Guadagnoli of Harvard Medical School has recently begun a national evaluation of the impact of the collaboratives on diabetes, cardiovascular disease, and asthma care, with support from the Fund and the Agency for Healthcare Research and Quality (AHRQ). A project led by Mark Chassin, M.D., of Mount Sinai School of Medicine, also cofunded with AHRQ, is investigating underuse of medical services within minority populations and testing clinical interventions to improve care for stroke, hypertension, breast cancer, and premature birth. A project by Glenn Flores, M.D., of the Medical College of Wisconsin and cofunded with the Robert Wood Johnson Foundation, is piloting a program to train minority parents to coach other minority parents in managing their children's asthma.

Cultural competence is increasingly recognized as an important factor in health care quality, in part because of recent Fund-supported work. Last October, the Third National Conference on Quality Health Care for Culturally Diverse Populations, cosponsored by the Fund, featured presentations on innovative practices by several Fund grantees. A new Fund report by former Commonwealth/Harvard Minority Health Policy Fellow Joseph Betancourt, M.D., *Cultural Competence*

in Health Care: Emerging Frameworks and Practical Approaches,¹⁸ was unveiled at the conference. Filmmaker Maren Monsen, M.D., screened *Worlds Apart*, a documentary video dramatizing minority Americans' experiences with the health care system, which will soon be publicly available. Deborah Danoff, M.D., of the American Association of Medical Colleges, presented a framework for a curriculum on cultural competency to be incorporated into medical student education to fulfill a new accreditation standard. The initial work for the curriculum project was recently published in a series of articles in *Academic Medicine*.¹⁹

Improving the reporting of racial and ethnic data for quality assessment has been a major focus of the Fund's program. Work by David Nerenz, of Henry Ford Health System, revealed that health plans have the ability to obtain and assemble relevant data on race and ethnicity from various sources, as explained in his 2002 *Health Affairs* article.²⁰ Government and other funders now recognize that collecting such data is essential if disparities in care are to be detected and addressed. The federal government has produced recommended guidelines on race and ethnicity reporting in public programs, and other health care foundations, including the Robert Wood Johnson Foundation, have lent their support. The Fund's work also informed a new initiative by Aetna, which has established one of the first private sector projects to collect race and ethnicity data from health plan participants with a view toward addressing disparities in quality of care.

Raising public and professional awareness of the problems faced by vulnerable populations has also been a consistent theme of the Fund's work. Recent efforts include a series of well-attended briefings on Hispanic health issues, held in Los Angeles, Atlanta, and Washington, D.C., by Elena Rios, M.D., president of the National Hispanic Medical Association. Yvette Roubideaux, M.D., a former

Commonwealth/Harvard Minority Health Policy fellow, convened a conference of researchers, policymakers, and health advocates to develop an agenda for improving health care in American Indian and Alaskan Native communities. The program also provided support for the development of a new website,²¹ associated with Massachusetts General Hospital, featuring a search engine and links to useful sources on health disparities and cultural competency.

A particular highlight of the past year was the Women of Color as Leaders in Public Health and Health Policy Conference, held in January 2003 in Washington, D.C. Coordinated by Joan Reede, M.D., of Harvard Medical School, the conference was designed to enhance career and leadership development for women of color within the public health and health policy fields. Presenters included Marilyn Gaston, M.D., former Assistant Surgeon General; Yvonne Maddox, deputy director of the National Institute of Child Health and Human Development; and Clarice Reid, M.D., former director of the National Heart, Lung and Blood Institute.

Fellowship in Minority Health Policy

Improving the capacity of the health care system to address the health needs of minority and disadvantaged populations is the goal of the Commonwealth Fund/Harvard University Fellowship Program 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 program activities focused on minority health issues. Participants in the program



Nawal Nour, M.D.
1998-99 Minority
Health Policy Fellow

complete academic work for a master's degree in public health or public administration.

Since completing their fellowship, the 35 alumni physician fellows have become actively engaged in health policy, research, and service delivery to minority communities. Most fellows hold appointments at schools of public health or medicine, and many have assumed leadership roles in government agencies and health care delivery systems. Alumni fellows also serve on numerous local and national advisory committees related to minority health.

The program continues to develop future opportunities for fellows. For example, this year the program established connections with state and local health departments and sought post-fellowship support from several organizations. The program also created a national advisory committee that seeks to mentor fellows and to help identify employment opportunities.

2003 FELLOWS IN MINORITY HEALTH POLICY

The program appointed five fellows in 2003.

- ***Allison Bryant, M.D.***, is a first-year clinical fellow in maternal-fetal medicine at Brigham and Women's Hospital. Her interests include clinical perinatology research and public health policy.
- ***Nakela Cook, M.D.***, is a resident in internal medicine and primary care at the Massachusetts General Hospital. She is particularly interested in racial and gender differences in the incidence and progression of cardiovascular disease.
- ***Philip DeChavez, M.D.***, is a resident in family medicine at the South Side Hospital in New York. He hopes to become more involved in Latino health issues through research and community outreach.
- ***Nefertiti Harmon Durant, M.D.***, is a resident in

pediatrics at Duke University Medical Center, Department of Pediatrics. Her particular interests are adolescent medicine and community health, including disease prevention and health promotion among minority adolescents.

- ***Claudia Martorell, M.D.***, is a fellow in infectious diseases at Baystate Medical Center-Tufts University School of Medicine. Her interests include health disparities in the HIV population and developing culturally competent education programs for health care providers and organizations.



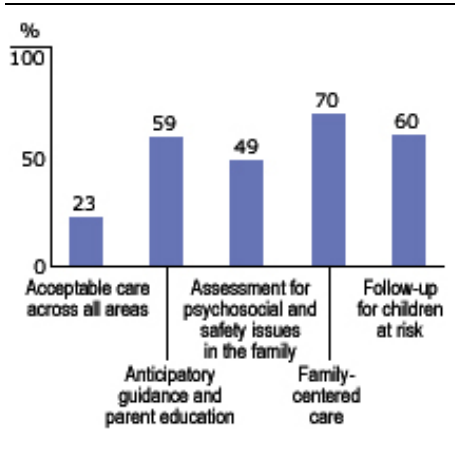
Edward L. Schor, M.D.
Assistant Vice President

Child Development and Preventive Care Program

In November 2002, the Fund established the Child Development and Preventive Care Program, with a mission to ensure that high-quality developmental and preventive pediatric services are available to all families, especially those with young children and low incomes. The program focuses on young children because the trajectory of children's health and development is strongly influenced by their early life experiences in families and communities. Through scheduled and incidental encounters with young children, child health care professionals have unique opportunities to identify children with developmental and behavioral disorders, or those who are at risk of developing such problems, and to initiate appropriate interventions and referrals. Many opportunities are missed, however, because of barriers that prevent the provision of appropriate services.

The new program builds on past and current Fund work to reduce those barriers and increase incentives for good care. For example, better standards are needed to measure quality and performance in pediatric care. A Fund-supported project by FACCT (the Foundation for Accountability) has produced a reliable instrument, the Promoting Healthy Development

Percentage of parents of young children reporting that they received pediatric care of acceptable quality in key areas



Bethell et al., *Partnering with Parents*, The Commonwealth Fund, September 2002



Paul H. Dworkin, M.D.
Chairman, Department of Pediatrics, University of Connecticut School of Medicine

Survey,²² to gather parents’ assessments of the quality of developmental services provided to their young children. The survey has attracted considerable federal and state interest, and a few states, including New York and Florida, have used parts of it in evaluations of their state Children’s Health Insurance Programs. Other states—Louisiana, Minnesota, Mississippi and Ohio—are using the survey as members of a multistate learning network. In addition, an American Academy of Pediatrics survey of pediatricians and the National Survey of Early Childhood Health have adopted some of its measures to gauge receipt of appropriate developmental assessments and follow-up care.

The Fund also seeks to assist health care practitioners in improving the quality of the developmental services they provide. A project by the National Initiative for Children’s Health Care Quality (NICHQ) is creating training modules and materials for doctors and other clinical staff on comprehensive developmental services for infants and toddlers. Through the New York City Department of Health, six pediatric practices serving low-income children have used the materials to improve developmental assessments. A follow-up project by NICHQ will evaluate the effect of the training materials on quality and cost of preventive care in a learning collaborative of approximately 40 pediatric practices in North Carolina and Vermont. The Fund is also supporting the evaluation of a statewide physician education program in Connecticut designed to improve recognition and referral of children at risk for developmental problems.

Federal and state health policies and reimbursement procedures should be structured to support improvements in the quality of developmental services. Previous work by Sara Rosenbaum at George Washington University highlighted the untapped potential of Medicaid to assist in children’s healthy development,²³ leading Medicaid to adopt an expanded

definition of medical necessity in 2002 that calls for age-appropriate preventive services that “enhance the growth and development” of young children. Rosenbaum will continue to analyze how state Medicaid and CHIP programs can adopt successful approaches to improve delivery of child development services.



Melinda K. Abrams
Senior Program Officer

The Fund actively engages states in improving the quality of care for children from lower-income families. Beginning in 1999, the Fund’s Assuring Better Child Health and Development initiative (ABCD) supported efforts by state Medicaid agencies in North Carolina, Utah, Vermont, and Washington to improve the delivery and financing of child development services for young children. As a result, services have increased for Medicaid-enrolled children in all four states.^{24, 25} In North Carolina, for example, Medicaid officials have worked with physicians to implement and replicate a developmental screening, referral, and case management model that produced a dramatic rise in the percentage of children screened and a threefold increase in rates of referral for developmental problems.²⁶ Vermont trained more than 900 physicians, public health providers, and government officials in Touchpoints, a curriculum designed by child development expert T. Berry Brazelton, M.D., to enhance communication with parents of young children.

The ABCD initiative aims to encourage all states to strengthen child development services for all low-income children. Working with the National Academy for State Health Policy (NASHP), the Fund has attracted national attention to the need for early childhood developmental services. A toolbox of ABCD publications and materials developed by states, such as Washington’s well-child examination form and North Carolina’s office resource guide, are available through NASHP.²⁷ Promising models created by the four consortium states demonstrate the value of working intensively with a few

states to improve the health and development of low-income children. To build on that success, the Commonwealth Fund and NASHP launched a second consortium in January 2004 with five new states—California, Illinois, Iowa, Minnesota, and Utah—to strengthen state Medicaid programs' capacity to enhance young children's healthy mental development.

The Healthy Steps Program,²⁸ a national demonstration of a new model of child health care practice initiated by the Fund and designed to promote the healthy development of young children, has achieved its aim. The Commonwealth Fund's core support for program administration, training, and evaluation has been augmented by several other national foundations, while nearly 80 local foundations provided support to local practice sites. In 15 sites studied as part of the formal evaluation, Healthy Steps families received significantly more developmental services and were more satisfied with their care than families in the control group.²⁹ In addition, the program was found to promote safe and effective parenting practices. For example, Healthy Steps mothers were more likely than mothers in the control group to place their babies on their backs to sleep, thus reducing the risk of sudden infant death syndrome. Intervention mothers spent more time playing with their children and reading books to them, and were nearly 30 percent less likely to use severe physical discipline. Healthy Steps mothers who had symptoms of depression or felt anxious were more likely than other mothers to report that they had discussed their feelings with someone in their physician's practice. Healthy Steps now operates in 35 pediatric practices in 15 states.



Mary Jane Koren, M.D.
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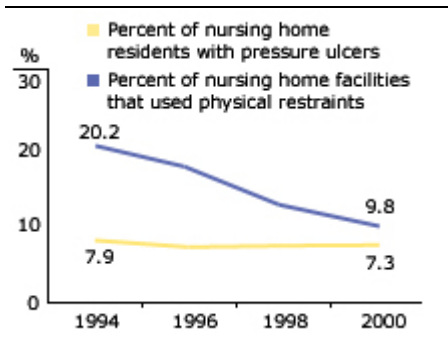
Quality of Care for Frail Elders Program

The Fund’s Picker/Commonwealth Program on Quality of Care for Frail Elders focuses on improving quality in nursing homes, where over 1.6 million frail older adults live. The program seeks out and helps to disseminate models of resident-centered care, promotes leadership, and enlists the help of consumers, regulators, industry trade associations, and others to improve nursing home quality. Through action-oriented projects, the program also helps to create nursing home environments that are good places to live and work.

There is growing awareness among nursing home providers and consumers that pursuing a strategy of business as usual will not produce better outcomes. Services to residents, human resource practices, physical environments, and management strategies must all be reexamined. An emerging grassroots movement, known within the nursing home field as “culture change,” proposes radical transformation. A diverse group of nursing home providers, gerontologists, and researchers have banded together to form the Pioneer Network,³⁰ a resource clearinghouse for innovative practices and a peer support system for quality improvement. Last summer, with partial support from the Fund, the Pioneer Network convened a national meeting in Chicago that drew 600 attendees from 34 states; one outcome was the creation of a listserv of people interested in advancing a research agenda on resident-centered care. The Fund is also assisting the Pioneer Network with the development of its website and the completion of a book for providers called *Getting Started*.

The Fund continues to support dissemination of information about the Wellspring model of culture change.³¹ Originally an alliance of 11 independent nursing homes in eastern Wisconsin, Wellspring now includes about 50 homes in five separate alliances in Wisconsin and Illinois. Mary Ann Kehoe, a founder of Wellspring, has spoken widely about the

Reduction in quality-of-care problems in nursing homes



Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook*, The Commonwealth Fund, 2002, based on data from the On-line Survey, Certification, and Reporting (OSCAR) system



Steven Shields
Executive Director,
Meadowlark Hills nursing home

model to public and professional audiences. This year, continuing support from the Fund enabled strategic planning for the organization's future and spread of the Wellspring model.

Nursing homes routinely collect data about the clinical status of residents (including specific measures such as number of pressure ulcers, ability to walk independently, and cognitive status) for state regulatory agencies and the federal Centers for Medicare and Medicaid Services (CMS). Some information is fed back to facilities as quality indicators, but nursing home personnel have typically been uncertain about how to use the indicators to improve performance. A project led by David Zimmerman of the University of Wisconsin created a prototype curriculum for nursing home medical directors on how quality indicators can be used for quality improvement activities. The curriculum received an enthusiastic reception at the annual conference of the American Medical Directors Association and was featured in a recent issue of *Caring for the Ages*, the association's monthly membership publication. A project in Ohio is targeting the use of publicly available performance data, this time including information on resident and family satisfaction as well as clinical quality indicators, to assist providers in improving care and helping families make informed choices when selecting a nursing home for a relative.

Dehydration and unplanned weight loss because of inadequate food intake are common conditions among nursing home residents and can lead to costly adverse clinical outcomes. John Schnelle, Ph.D., studied the staff resources necessary to meet the dietary needs of residents and developed a package of materials, including risk assessment tools, feeding assistance protocols, and staffing models, to help nursing homes maximize available staff. Interest in the program is such that The Jewish Home for the Aging of Greater Los Angeles has

established a prototype unit on two floors, where staff from other nursing homes can observe the model in action. Plans for further dissemination of the package are being developed.

The new CMS Nursing Home Quality Improvement Initiative mandates public reporting of performance measures and requires that Quality Improvement Organizations (QIOs) work with facilities in their respective states to improve quality. A kickoff meeting for the new initiative was held in Baltimore during the summer of 2002. To ensure consumer representation, the Fund provided a grant that enabled the American Health Quality Association to offer reduced conference fees and travel expenses for state ombudsmen and resident advocates. Mary Ann Kehoe presented the Wellspring model at the meeting, and a number of QIOs have since discussed using Wellspring training modules in their work. In addition, CMS is planning another evaluation of Wellspring, this time to include all 50 homes in the five active Wellspring alliances.

Because long-term care is a “high-touch” rather than a high-tech field, there is a direct link between the number and quality of staff members and the quality of care. A congressional briefing held in December 2002 discussed the critical shortage of front-line workers from the perspectives of consumers, providers, and organized labor. Mary Ann Kehoe presented Wellspring’s strategy for staff retention through worker empowerment.

For the most part, the Quality of Care for Frail Elders Program has focused its work on not-for-profit nursing homes. To make an impact on quality improvement throughout the industry, however, the Fund has also engaged the for-profit sector, which accounts for roughly two-thirds of all American nursing homes.

Beverly Enterprises, the largest for-profit chain of nursing homes in the United States, has begun a “culture change” initiative to implement resident-centered care in nine facilities; if successful, the model will be adopted in additional homes. Leslie Grant, at the University of Minnesota’s Carlson School of Management, received a planning grant from the Fund to design an evaluation of the initiative’s outcomes, including financial impact. He also created an instrument to measure the degree of change in the culture of participating homes—the first tool of its kind to be developed and a breakthrough for the field of long-term care. Grant’s full-scale evaluation, now underway, should make a major contribution to the growth of resident-centered nursing home care, especially in the for-profit sector.

Task Force on Academic Health Centers

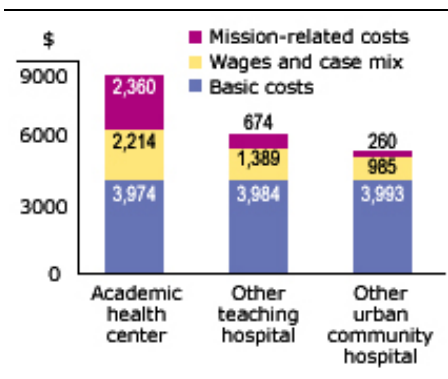
The Task Force on Academic Health Centers, which completed its final year in 2003, addressed the impact of a changing health care financing system on the traditional missions of academic health centers (AHCs): educating future doctors, conducting medical research, pioneering new treatments, providing specialized and cutting-edge services, and caring for indigent patients who have nowhere else to turn. Samuel O. Thier, M.D., president and chief executive of Partners HealthCare System in Boston, chaired the task force; the Honorable Bill Gradison, former congressman from Ohio and current senior public policy counselor at Patton Boggs LLP, served as vice chair. David Blumenthal, M.D., professor of medicine at Harvard Medical School and director of the Institute for Health Policy at Massachusetts General Hospital, was the program director of the task force during its tenure, from 1995 to 2003.

In its final report, *Envisioning the Future of Academic Health Centers*,³² the task force presented a blueprint for the future of the nation's teaching hospitals and medical schools. Released in February 2003, the report cautions that future funding of AHCs is at risk. In addition to the pressures caused by spiraling health care costs and rising numbers of uninsured, reductions in Medicare payments to teaching hospitals could seriously affect future funding for AHCs. A recent analysis by the Lewin Group indicates that total mission-related costs, including medical education, in the United States are estimated to be \$27.2 billion for all teaching hospitals. After accounting for differences in wages, case mix, and other factors, mission-related activities are approximately 28 percent of total costs (\$2,360 per case) for AHC hospitals, compared with 11 percent of total cost (\$674 per case) in other teaching hospitals.

The task force report contains more than two dozen public policy and private management recommendations intended to strengthen AHCs' leadership role and preserve their key missions. It discusses steps to help AHCs pay for mission-related expenses, rationalize financial management, take advantage of new technologies in education, and demonstrate greater accountability. In addition, the task force proposed creation of a public trust fund to support vital AHC missions and make their financing more accountable, predictable, and transparent.

Drawing heavily on the work of the task force and with support from the Fund, the Institute of Medicine established a committee to study the current role and status of AHCs. The committee's report, *Academic Health Centers: Leading Change in the 21st Century*, affirms many task force recommendations—calling, for example, for AHCs to take a leading role in transforming the education of health professionals, designing and assessing new structures of care,

Average cost per inpatient case, by hospital type, 1998



Task Force on Academic Health Centers, *Envisioning the Future of Academic Health Centers*, The Commonwealth Fund, February 2003

and adopting advanced information systems on performance, quality, and financial accountability. The Institute of Medicine further recommends that Congress establish an education fund to support innovation in clinical education through a competitive grant process.

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