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A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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Teaching Hospitals Must Adapt to Meet Challenges, Task Force Concludes

Offering a blueprint for the future of the nation's teaching hospitals and affiliated medical schools, the Commonwealth Fund Task Force on Academic Health Centers issued its final report at a February briefing in Washington, D.C., attended by policymakers, health care leaders, and journalists. The Task Force calls for a host of public policy and private management changes intended to strengthen the leadership role of academic health centers (AHCs) and preserve their research, education, and clinical care missions at a time when they are critical to the nation's well-being.

The Task Force, which has been studying the key issues confronting AHCs for seven years, cautions in its report, *Envisioning the Future of Academic Health Centers,* that future funding of these institutions is at risk. In addition to the pressures caused by spiraling health care costs and rising numbers of uninsured, recently proposed Medicare reforms could seriously hamper the ability of AHCs—which

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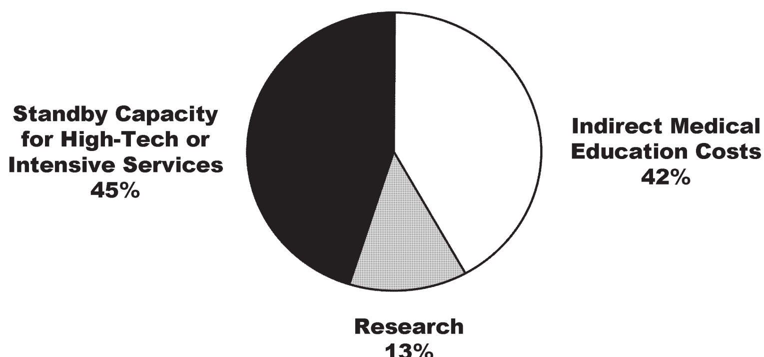
Breakdown of Academic Health Centers' Mission-Related Costs



Source: Commonwealth Fund Task Force on Academic Health Centers, *Envisioning the Future of Academic Health Centers,* The Commonwealth Fund, February 2003; based on Lewin Group analysis of 1998 data from the American Hospital Association.

Grantee Spotlight

Kate Lapane

Medication errors that cause injury, permanent impairment, and even death are especially prevalent in nursing homes.

Over the next few months, a new medication review process known as the Fleetwood Model will be tested and evaluated in 26 North Carolina nursing homes. Developed by the American Society of Consultant Pharmacists, the program aims to reduce errors by identifying at-risk patients and coordinating their pharmaceutical care. An economic evaluation and feasibility study have been completed; the North Carolina trials, which are being supported by The Commonwealth Fund and the Retirement Research Foundation, are part of studies to evaluate the effectiveness of prospective drug management in reducing drug-related problems and their costs. We spoke with Brown University's Kate Lapane, Ph.D., who is leading the evaluation, about the project.

Kate Lapane, Ph.D., is testing a new way to prevent medication errors in nursing homes by identifying risks and coordinating care.

Rates of adverse drug events in nursing homes are startlingly high. What are some of the factors contributing to the problem?

Kate Lapane: There are many reasons. First, the elderly, particularly frail elders, are often on many drugs at once. When they enter a nursing home, it may be the first time they're taking all their medications at the correct dose and time, so that side effects from overuse or from interactions between drugs would not appear until then. Often an acute episode brings an elderly person to a nursing home via a hospital, where physicians may change his or her drug regimen. Maybe the intention was not to be on this regimen forever, but the situation isn't carefully monitored. The elderly are also at risk due to changes associated with aging—the body begins to process and absorb drugs differently than before.

The federal Centers for Medicare and Medicaid Services mandates that consultant pharmacists perform monthly reviews of the drug regimens of all nursing home patients. What are some weaknesses of this system, in your view?

Lapane: The spirit behind the regulations is good, but there are problems. The regulations don't specifically say that drug regimen reviews should occur retrospectively, but in practice this is what seems to happen. Often residents go 30 days without having a review. They're at highest risk for adverse drug events during the first month of residence, so the review may be too late. Consultant pharmacists are responsible for up to 1,000 residents a month; considering that residents can be on eight to 10 drugs, they simply don't have time to do a comprehensive job.

Your trials aim to identify patients at high risk for medication complications. How does this process work?

Lapane: We worked with a software vendor to create a computer model focusing on preventable drug events. Take the example of a resident with a history of stroke who is taking the blood-thinning drug warfarin. If he develops an infection and is prescribed an antibiotic, the interaction of the two drugs could cause problems, like the blood becoming too thin. In this case, the software would automatically raise a flag to alert the dispensing pharmacists of the potential risk, who could then alert nurses, physicians, and consultant pharmacists to monitor the situation.

How does prospective drug management encourage a team approach to care?

Lapane: We're trying to use technology to enhance communication. Using this software, dispensing pharmacists can enter their recommendations into a patient's computer file, and those recommendations will be transferred to the field the next day so consultant pharmacists can view them. We also hope that pharmacists will be encouraged to go out onto the floor to meet residents and speak to nurses and family members about residents' care.

What do you hope to accomplish in the trials?

Lapane: We expect to see a reduction in hospitalizations due to adverse drug events. A lot of attention has been given to overmedication, with residents on multiple psychotropic drugs, for instance. But there are also sins of omission. Prospective drug management could be used to proactively look for situations where a drug could help a resident, such as aspirin therapy for those who have suffered a stroke.

rely heavily on Medicare for financial support—to continue fulfilling their vital medical and social missions.

One proposal advanced by the group to help pay for mission-related expenses is the creation of a public trust fund. The new public authority would provide financing explicitly for those activities that yield society-wide benefits—biomedical research, training for health professionals, the provision of rare and highly specialized services, clinical innovation, and care for indigent patients. Funding could be derived from a number of sources, including current Medicare payments for medical education, a tax on health care premiums, or contributions from private groups that benefit from AHCs, such as pharmaceutical and medical device manufacturers.

Looking beyond public policy, the Task Force says that AHCs must take steps themselves to further rationalize their financial management, integrate new technologies in education, and demonstrate greater accountability for what they do. "The missions of academic health centers are essential to maximizing public health in the United States," said David Blumenthal, M.D., executive director of the Task Force and director of the Institute for Health Policy at Massachusetts General Hospital/Partners HealthCare in Boston. "But AHCs must be able to meet the evolving needs of the American people. They will have to learn quickly, act expeditiously, and face change head-on."

Thinking Strategically

The blueprint outlined in the report encourages AHCs to think and act more strategically than in the past. In the future, most AHCs will specialize in certain missions, the Task Force predicts. Few will attempt proficiency in all areas of research, education, and clinical care. Interdisciplinary work, rather, will be the norm, especially in research. The report specifically recommends the following courses of action:

- **Bringing research into the mainstream.** University-based research and innovation should be brought into the mainstream of American health care delivery. AHCs could become centers of research innovation, the Task Force says, by giving higher priority and recognition to new and traditionally undersupported areas of biomedical science, including behavioral science and public health-related research. They should also work harder to translate research results into everyday practice.
- **Educating in new ways.** The Task Force recommends that AHCs incorporate into their basic education curricula training in leadership, team-building, continuous improvement, and measurement of clinical performance. Moreover, they should begin to educate students, residents, and clinicians online and expand the use of simulation in all levels of experience, from students' first encounters with clinical care to continuing education. Medical schools also need to provide leadership in training a culturally competent clinical and research workforce that can meet the needs of America's multiracial and multiethnic society.
- **Raising the bar on clinical care.** AHCs must work to improve the safety, quality, and efficiency of the services they provide as part of a continual performance improvement process, the report says. They must act decisively to improve outcomes that

AHCs must take further steps to rationalize their financial management, integrate new technologies in education, and demonstrate greater accountability for what they do.

fall below those obtained by peer institutions—or discontinue those clinical services. A key to quality improvement will be health systems' investment in information technology to enable automation of clinical care processes where appropriate, provide patients with secure access to their medical record, and help people with chronic conditions self-manage their day-to-day care.

- **Meeting the needs of underserved communities.** To maintain their strong commitment to the care of poor, uninsured, and medically underserved Americans, AHCs will need to take steps to ensure that the quality of care provided to these vulnerable populations is comparable to that available to others. This can be achieved in part, the report notes, by actively partnering with local community-based organizations and clinics within low-income, immigrant, and minority neighborhoods and by adopting programs to train medical staff at all levels to provide care that is culturally appropriate to the diverse populations they serve.

"It is essential that academic health centers—which are the leaders in educating our health professionals, providing patients with specialty care services, conducting research to bring us a healthier future, and providing care for the less affluent—continue to focus on these missions, and have the financial security to be able to fulfill them," said Stephen C. Schoenbaum, M.D., senior vice president at The Commonwealth Fund. "Since our nation's health and security depend on them, AHCs must be accountable to the American people for accomplishing these missions."❖

New Tools Available for Reducing Drug Errors

Evidence gathered from 1,400 hospitals from around the country shaped development of a new set of tools for reducing medication errors. *Pathways for Medication Safety,* jointly developed by the Health Research and Educational Trust (HRET), the American Hospital Association, and the Institute for Safe Medication Practices, with support from The Commonwealth Fund, is designed to encourage a process-driven, system-based approach to addressing a critical issue in health care: medication errors and the harm that can result from them.

"Many hospitals have increased energy and attention to preventing medical errors, but more structured and rigorous approaches are needed to establish systems that prevent them from occurring."

"Many hospitals have increased the energy and attention to preventing medical errors, but more structured and rigorous approaches are needed to establish systems that prevent errors from occurring," noted Mary Pittman, president of HRET. "These tools go a long way toward helping hospitals and their staff do that." Errors made in prescribing or administering medications cause approximately 7,000 deaths annually in the United States.

The tools, which can be customized to suit the individual needs of organizations, are intended to help hospital leaders incorporate medical safety into their strategic plans; identify specific error-prone processes and devise safe alternatives; and implement a bedside bar-coding system for administering medications. They are available at no cost at www.medpathways.info.

The tools are designed as hands-on worksheets for practical use. The first set lays out goals for creating a model plan for medication safety and then provides guidelines on assembling a team, assessing current conditions, and

developing projects to create change. The second set employs "Failure Mode and Effects Analysis," a process developed by product engineers to help hospitals identify and prevent medication problems. For example, nurses answer a series of questions about their drug administration routines and then take specific actions based on their responses, such as notifying the pharmacy about any new allergies or changes in a patient's status. The third set of tools includes questions that allow hospitals to assess their level of readiness to implement a bedside, bar-coded drug administration system, including the adequacy of their drug labeling, storage, and distribution. A national educational initiative, to be presented in March at the Fifth Annual National Patient Safety Congress in Washington, D.C., will disseminate *Pathways for Medication Safety* to hospitals across the United States.❖

Would Consumers Really Use Quality-of-Care Data? Study Says "Yes"

Beyond a good bedside manner, what do patients want from their physicians? Would they appreciate information about their doctor's on-the-job performance?

As part of a Commonwealth Fund grant to develop a set of physician performance indicators and inform future public reporting of quality-of-care data, the National Committee for Quality Assurance (NCQA) convened a series of focus groups with consumers to address these and other questions. The sessions showed not only that consumers can comprehend and evaluate information about the effectiveness and safety of health care, but that they would in fact value having such information when choosing a physician. Complete study results are described in a new Fund report, *Exploring Consumer Perspectives on Good Physician Care,* by Donna Pillittere, Mary Beth Bigley, Judith Hibbard, and Greg Pawlson.

The focus group findings confirmed prior research demonstrating that consumer preferences are strongly influenced by how questions are posed. When asked open-ended questions, participants focused on the quality of the patient–doctor relationship, citing the importance of personal attention, communication skills, and other aspects related to a physician's bedside manner.

The focus groups showed that consumers would value having information about the effectiveness and safety of health care when choosing a physician.

However, when consumers were asked how they felt about whether or not a doctor follows up with patients after a serious illness or has experience performing a certain procedure, they indicated that answers to such questions would be as important to them as the quality of the patient–doctor relationship. Consumers of different ages and with varying levels of education and income all said that they would desire such information, though there were differences regarding their levels of comprehension and the types of information they valued.

Most previous surveys of consumer preferences did not provide a framework for understanding the concepts of effectiveness and safety of care. A large majority of respondents to those surveys saw quality as related almost exclusively to the patient–doctor relationship—leading some researchers to conclude that consumers are interested in this aspect of physician quality only. The NCQA findings suggest, however, that consumers would use the more comprehensive measures of quality suggested by the Institute of Medicine and others.❖

Are Consumer-Driven Plans Simply Shifting Costs to Patients?

Health plans that allow consumers to customize their benefits and provider networks—in return for assuming a greater degree of financial risk—have become central to the business plans of major insurers. While total enrollment in "consumer-driven" plans is still modest, many health plans and benefit consultants predict they could account for 20 percent of the insurance market by 2005 and as much as half by 2007. To employers looking for ways to contain rising health care costs, there is the hope that such plans could lower costs by creating incentives for employees to reduce unnecessary use of services. Consumer advocates worry, however, that these plans may be a new vehicle for shifting costs from employers to employees.

Consumer advocates worry that consumer-driven health plans may be a new vehicle for shifting costs from employers to employees.

At its heart, consumer-driven health care is intended to provide people with a combination of incentives and information so they make informed choices about "non-life-threatening" health care, according to Jon R. Gabel, the lead author of "Consumer-Driven Health Plans: Are They More Than Talk Now?" (*Health Affairs* Web Exclusive, Nov. 20, 2002). Gabel was one of the speakers at a December 16 Alliance for Health Reform meeting on consumer-driven health care that was attended by business and labor leaders, health policy experts, and consumer advocates.

Although small start-up firms were the first to offer consumer-driven plans, all major insurers now offer their own version, and about 1.5 million Americans currently have this type of coverage. In one variation, enrolled employees draw from an employer-funded account until it is depleted, at which time health care costs are paid by the employee out-of-pocket until an annual deductible is reached. Other plans allow enrollees to design their own benefit package and choose from among provider networks with varying levels of costs. A key component of all plans is the provision of Web-based tools that allow enrollees to access information about costs and quality of care.

Some of those interviewed for the Commonwealth Fund-supported study believe that consumer-driven plans can control costs by making people much more aware of actual health care costs and thereby reducing their use of services. Others maintain, however, that the trend toward larger deductibles or health spending accounts could expand financial burdens for patients with chronic conditions requiring frequent care or for those who have expensive hospital stays.

Skeptics believe, moreover, that wider networks and fragmented patient pools will reduce the purchasing power of consumer-driven plans compared with HMOs and other managed care plans. This, they say, will impair their cost-control potential.

The study also raises questions about enrollees' ability to choose their provider networks on the basis of quality, since good information on plans and providers is not yet available, particularly for individual physicians.❖

"Small but Significant" Reforms Proposed to Help Uninsured

Even in the present economic and fiscal environment, a number of low-cost policies could ensure coverage for at least some Americans who currently lack access to affordable health insurance, a new

Commonwealth Fund report finds. While not a substitute for comprehensive health system reform, together these policies would, at a very modest cost, provide badly needed coverage to workers changing jobs, small business employees, and others for whom health insurance is unaffordable.

In the report, *Small but Significant Steps to Help the Uninsured,* George Washington University associate professor Jeanne M. Lambrew and University of Virginia Medical School dean Arthur Garson, Jr., M.D., outline a dozen policy options that, for less than roughly $1 billion each, would provide uninsured and "underinsured" Americans with access to private health coverage, public coverage, or both.

One of the key groups targeted by Lambrew and Garson is workers changing jobs, who are twice as likely to experience gaps in health coverage as those who remain in the same job all year. Under one of their proposals, COBRA continuation coverage would be offered to all workers who lose their job, including employees of small businesses (with fewer than 20 workers) that are not currently eligible under federal rules. Such an extension, which some states have already enacted, would allow people who are temporarily unemployed to buy into their former company's health plan for up to 18 months in most circumstances.

To assist uninsured employees working in small businesses, the report suggests allowing them to participate in the insurance program now open only to federal employees—at least on a limited basis to start. In a demonstration project, selected employers would buy into the Federal Employees Health Benefits Program by paying the same share of the premium paid by the federal government. The addition of a tax credit could make this coverage more affordable for lower-wage employees, the authors note. Among other incremental policies proposed are:

- providing Medicaid or CHIP coverage to low-income adults who sign up for unemployment insurance;
- testing a system of refundable tax credits for self-employed people and workers in small firms who lack access to group health coverage;
- phasing in Medicaid coverage of all adults living below the poverty level;
- requiring all private insurers that offer health coverage to dependents to insure children up to age 21;
- allowing workers age 60 and older who retire without health benefits to purchase COBRA continuation coverage until they are eligible for Medicare; and
- allowing Medicaid to act as a high-risk pool for adults with chronic health conditions who are priced out of the private market but are ineligible for public coverage. ❖

A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance.

(Near) Universal Coverage, the Minnesota Way

Among the many states that have worked to bring health insurance to more of their residents, Minnesota stands apart. In 2001, 95 percent of the state's nonelderly population had health insurance—one of the highest coverage rates in the nation. The state's secret, a new study reveals, is an effective combination of public programs and publicly sponsored private insurance that complements existing private coverage.

In their report, *Approaching Universal Coverage: Minnesota's Health Insurance Programs,* Deborah Chollet and Lori Achman of Mathematica Policy

Research, Inc., find that although widespread private coverage is partly responsible for Minnesota's achievement, also of central importance are five state-sponsored programs that work together to provide coverage for low-income children and adults, as well as for individuals who have trouble finding insurance in the private market because of health problems. Together, these programs cover about 11 percent of the state's nonelderly population.

"Minnesota is unusual in its overarching commitment to extending health coverage and its practice of seizing opportunities to do so," noted Chollet, the report's lead author. "Its lessons for success are simple: start programs modestly, expand them as they demonstrate value, and serve populations in need at all levels of income."

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Minnesota has three public health coverage programs: Medical Assistance targets low-income children and families, the elderly, and the disabled; General Assistance Medical Care aids adults without children; and MinnesotaCare, which requires premiums and some cost-sharing, assists families and adults with modest incomes. The state is now taking steps to integrate these three public programs—and reduce gaps in coverage—by automating eligibility determinations, making referrals among programs, and blending benefits and financing. Meanwhile, a single, simplified application form, available online and in eight languages other than English, has dramatically increased enrollment.

The state also operates the nation's largest high-risk pool for people who have trouble finding insurance because of health problems. In addition, the Public Employees Insurance Program, a small-group purchasing pool, is open to town and county governments as well as to school districts.❖

New York Survey: Seniors' Prescription Coverage Needs Not Being Met

While New York has one of the nation's largest and most effective prescription drug assistance programs for the elderly, nearly one of five of the state's seniors nonetheless had no drug coverage in 2001, according to a new study. Due to lack of coverage or inadequate benefits, one-fifth of all New York seniors reported they skipped medication doses or did not fill prescriptions because of cost concerns. Moreover, one-fifth of the 2.4 million seniors in New York paid more than $100 out-of-pocket for prescription drugs each month.

The study, *New York Seniors and Prescription Drugs: Seniors Remain at Risk Despite State Efforts,* is based on analysis of findings from the Henry J. Kaiser Family Foundation/Commonwealth Fund/Tufts–New England Medical Center 2001 Survey of Seniors in Eight States.

"New York's Medicaid and EPIC [Elderly Pharmaceutical Insurance Coverage] programs play a crucial role in providing coverage to the state's low-income seniors, but the state cannot bear the entire burden alone," said lead author David Sandman, a former analyst with The Commonwealth Fund now with Harris Interactive. "Even in New York, which has done an outstanding job of reaching out to low-income seniors who cannot afford needed drugs, there is an important role for the federal government to step in and fill the large gaps in the Medicare safety net."

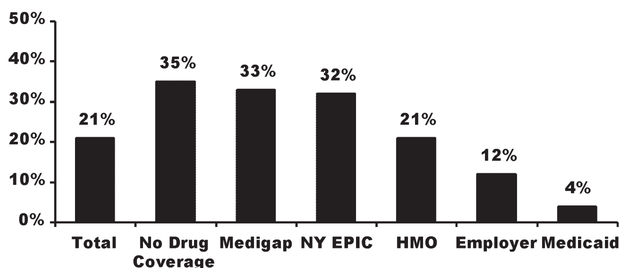
The Medicaid and EPIC programs in combination reached only one-third of the elderly with incomes below 200 percent of the federal poverty level, the report notes. One problem is that many seniors simply are

not aware of EPIC: only 60 percent of those with incomes that would potentially make them eligible for EPIC had heard of the program.

Medicaid drug benefits, meanwhile, covered fewer than half (45%) of seniors with incomes below the poverty level. One-third (34%) of poor seniors who indicated they were aware of Medicaid but not enrolled in it thought they had too much money to qualify. Improved outreach and simplified eligibility rules and application procedures, say the authors, could help these programs reach more of the elderly.

Additional findings showed that Medicaid provides the best protection against high drug costs, followed by employer-sponsored coverage (primarily retiree benefits). Just 4 percent of seniors with Medicaid and 12 percent with employer coverage spend $100 or more out-of-pocket monthly on drugs, versus 33 percent of those seniors who rely on Medigap supplemental coverage.❖

Even though New York has one of the nation's largest and most effective prescription drug assistance programs for the elderly, one of five of the state's seniors lacked drug coverage in 2001.



Note: Out-of-pocket costs exclude premiums.
Source: D. Sandman, C. Schoen, D. Downey, S. How, and D. Safran, *New York Seniors and Prescription Drugs: Seniors Remain at Risk Despite State Efforts,* The Commonwealth Fund, December 2002.

Options Weighed for Reforming Medicare Cost-Sharing

While surveys have shown that enrollees in Medicare are very satisfied with the program, the lack of a prescription drug benefit and adequate protections against catastrophic costs are serious drawbacks. Focusing on the issue of cost-sharing, experts at the Urban Institute have analyzed a range of modest policy options that would modernize Medicare's cost-sharing structure to reduce financial burdens on the sickest beneficiaries—without incurring significant new federal spending.

Medicare's current cost-sharing requirements are generally considered outmoded, particularly the absence of a stop-loss limit—a ceiling on beneficiaries' annual spending for copayments and coinsurance. The elderly spent an average of more than $3,700 out-of-pocket for Medicare and other health care services in 2002, representing 22 percent of a beneficiary's annual income. For people who often have multiple medical needs and live on limited, fixed incomes, such high expenses pose a serious financial burden.

In the Commonwealth Fund report, *Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditures,* analysts Stephanie Maxwell, Matthew Storeygard, and Marilyn Moon of the Urban Institute simulate the impact of 12 cost-sharing reforms on beneficiaries' out-of-pocket spending and on overall Medicare expenditures. The authors conducted their analysis after reviewing trends in stop-loss levels and the deductible requirements of private-sector benefit packages. The 12 options discussed involve various combinations of the following features:

- annual stop-loss levels of $3,000, $4,000, and $5,000;
- a decrease in the Part A deductible

Medicare beneficiaries spent an average of more than $3,700 out-of-pocket for Medicare and other health care services in 2002, or 22 percent of their annual income.

(for hospital services) from $812 per inpatient spell, which ends 60 days after a hospital's or skilled nursing facility's discharge, to $500 annually;

- an increase in the Part B deductible (for ambulatory care and related services) from $100 to $300 per year;
- elimination of hospital inpatient coinsurance requirements; or
- elimination of separate Part A and Part B deductibles and introduction of combined A/B deductibles set at $300, $400, and $500 annually.

Among the 12 reforms simulated, the two with the greatest potential cost savings from the beneficiary's perspective are the $3,000 stop-loss option and an option that reduces the Part A deductible for hospital services to $500 per spell of care and eliminates hospital inpatient coinsurance. The former option would help 5.4 percent of beneficiaries, while the latter would help 18 percent of beneficiaries. Both options would require comparable increases in aggregate additional federal funds ($4.6 billion and $3.8 billion, respectively).

In addition to protecting beneficiaries from high out-of-pocket costs, stop-losses, modestly higher ambulatory care deductibles, and lower inpatient cost-sharing requirements could also reduce beneficiaries' need to purchase private supplemental insurance.❖

Language Barriers Compound Problems for Hispanic Uninsured

As the Hispanic population grew over the last decade—more than doubling during the 1990s—so too did the ranks of its uninsured. Now a new study finds that problems resulting from lack of health coverage are exacerbated for Hispanics who also lack proficiency in English.

In *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English,* Commonwealth Fund senior analyst Michelle M. Doty finds that Hispanics with limited English skills are less likely than whites, African Americans, and English-speaking Hispanics to have health insurance or a regular doctor. Among those surveyed, 61 percent of Spanish-speaking Hispanic adults were uninsured during the year, compared with 36 percent of English-speaking Hispanics, 30 percent of African Americans, and 20 percent of whites. Two-thirds of the Spanish-speaking Hispanic population without insurance did not have a regular doctor. The analysis draws on findings from the Commonwealth Fund 2001 Health Care Quality Survey.

These results suggest that improvements in Hispanics' access to quality care may be best realized by focusing on this doubly burdened group. "The health needs of the burgeoning Hispanic population will continue to grow, and long-term negative health effects are likely if barriers to care—financial and language-related—persist," Doty cautioned. "Expanding health insurance coverage to working Hispanics and their families, as well as investing in programs that improve doctor–patient communication, are imperative for achieving better care for Hispanics and other minority Americans."

Compared with other groups, Spanish-speaking Hispanics also had more problems communicating with doctors, comprehending prescription bottle instructions, and understanding other written health information. Nearly half (45%) of Hispanics with limited English experienced a problem communicating with their doctor,

although English-speaking Hispanics with health insurance were no more likely than insured whites or African Americans to report communication problems. In spite of prevalent communication problems, only half (49%) of Hispanics who needed an interpreter reported they "always" or "usually" had access to one.❖

A new study finds that problems resulting from lack of health coverage are exacerbated for Hispanics who also lack proficiency in English.

2003–04 Harkness Fellows Appointed

The Commonwealth Fund recently announced the 2003–04 Harkness Fellows in Health Care Policy. Harkness Fellowships provide a unique opportunity for health policy researchers, clinicians, managers, public health officials, and journalists from Australia, New Zealand, and the United Kingdom to spend up to a year in the United States conducting research and working with leading U.S. policy experts. The new fellows and their research projects are:

Malcolm Battersby, M.B., B.S., Ph.D. (Australia), Senior Lecturer and Director, Flinders Human Behaviour & Health Research Unit, School of Medicine/Department of Psychiatry, Flinders University. *Chronic Disease Self-Management Education for Clinicians: What Works for Whom in the U.S. and Australia?*

Dale Bramley, B.H.B., M.B., Ch.B., M.P.H. (New Zealand), Public Health Physician and Lecturer/Senior Fellow, Funding and Planning Team, Waitemata District Health Board. *Healthcare Inequalities in Minority Groups: A Systematic Review of the Acceptability and Effectiveness of Interventions in the U.S.*

Elizabeth Davies, M.B., B.S., Ph.D. (U.K.), Honorary Lecturer and Specialist Registrar in Public Health, Department of Palliative Care and Policy, Guy's, King's and St. Thomas' School of Medicine. *Making Cancer and Palliative Care Services More Patient-Centered: A Comparison of U.S. and U.K. Survey Feedback Approaches to Quality Improvement and Their Impact.*

Stephen Dunn, Ph.D. (U.K.), Section Head and Policy Advisor, Foundation Trust Financial Regime, Policy and Planning Division, Department of Health. *Hospital Ownership: What Difference Does It Make?*

Vikki Entwistle, Ph.D. (U.K.), Reader and Programme Director for Delivery of Care Research, Health Services Research Unit, University of Aberdeen. *Patients' Roles in Patient Safety Initiatives: An Analysis of Current Practice and Exploration of Patients' Views.*

Martin Hefford, M.A. (New Zealand), General Manager, Planning and Funding, Hutt Valley District Health Board. *Case Studies in Evidence-Based Primary Care Practices in the U.S. and New Zealand.*

Tom Marshall, M.B., Ch.B., MRCGP (U.K.), Lecturer in Public Health, Department of Public Health and Epidemiology, University of Birmingham. *Potential Benefits of Patient-Focused Cardiovascular Disease Prevention Strategies in Primary Care.*

Gareth Parry, Ph.D. (U.K.), Senior Research Fellow, Medical Care Research Unit, School of Health and Related Research, University of Sheffield. *An Investigation into the Impact of the Uptake of New Interventions on the Volume Outcome Relationship over Time.*

Elizabeth Roughead, Ph.D. (U.K.), Senior Lecturer, School of Pharmaceutical, Molecular and Biomedical Sciences, University of South Australia. *Evaluating Medicines Policies: Australia, Canada, and the U.S.*❖

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Recent and Forthcoming Commonwealth Fund Publications, Winter 2003

Fund Reports

Deborah Chollet and Lori Achman, *Approaching Universal Coverage: Minnesota's Health Insurance Programs,* February 2003

Sara R. Collins, Stephanie B. Berkson, and Deirdre A. Downey, *Health Insurance Tax Credits: Will They Work for Women?* December 2002

Commonwealth Fund, *2002 Annual Report*

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

Michelle M. Doty, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English,* February 2003

Jeanne M. Lambrew and Arthur Garson, Jr., *Small but Significant Steps to Help the Uninsured,* January 2003

Stephanie Maxwell, Matthew Storeygard, and Marilyn Moon, *Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditures,* November 2002

Donna Pillittere, Mary Beth Bigley, Judith Hibbard, and Greg Pawlson, *Exploring Consumer Perspectives on Good Physician Care: A Summary of Focus Group Results,* January 2003 (Web publication)

David Sandman, Cathy Schoen, Deirdre Downey, Sabrina How, and Dana Gelb Safran, *New York Seniors and Prescription Drugs: Seniors Remain at Risk Despite State Efforts,* December 2002

Sharon Silow-Carroll, *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations,* January 2003

Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont,* February 2003 (Web publication)

Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, *Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times,* January 2003

Journal Articles and Publications

Randall R. Bovbjerg, Jack Hadley, Mary Beth Pohl, and Marc Rockmore, "Medicaid Coverage for the Working Uninsured: The Role of State Policy" *Health Affairs* 21 (November/December 2002): 231–43

Jon Gabel, Anthony Lo Sasso, and Thomas Rice, "Consumer-Driven Health Plans: Are They More Than Talk Now?" *Health Affairs* Web Exclusive (November 20, 2002): W395–W407

Michael K. Gusmano, Gerry Fairbrother, and Heidi Park, "Exploring The Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs* 21 (November/December 2002): 188–94

Dana B. Mukamel, David L. Weimer, Jack Zwanziger, and Alvin I. Mushlin, "Quality of Cardiac Surgeons and Managed Care Contracting Practices," *HSR: Health Services Research* 37 (October 2002): 1129–44

Tricia Neuman, Michelle Kitchman, Teresa McMeans, Dana Gelb Safran, Wenjun Li, and Andrea Bowen, *California Seniors and Prescription Drugs,* The Henry J. Kaiser Family Foundation and The Commonwealth Fund, November 2002

James M. Perrin, Karen A. Kuhlthau, Steven A. Gortmaker, Anne C. Beal, and Timothy G. Ferris, "Generalist and Subspecialist Care for Children with Chronic Conditions," *Ambulatory Pediatrics* 2 (November/December 2002): 462–69

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