

**THE COMMONWEALTH FUND  
INTERNATIONAL PROGRAM IN HEALTH POLICY & PRACTICE**

**Suggested Project Themes for Harkness Fellowships in Health Care Policy, 2010-11**

The United States provides some of the best medical care in the world, yet a growing body of evidence indicates the system falls short. Although national health spending is significantly higher than the average rate of other industrialized countries, the U.S. is the only such country that fails to guarantee universal health insurance. In addition, the quality of care is highly variable and delivered by a system that too often is poorly coordinated, driving up costs, and putting patients at risk. With rising costs straining family, business, and public budgets, access to care deteriorating and variable quality, improving health care performance is a matter of national urgency.

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. The Fund also provides a leading voice for comprehensive health system reform through reports such as the [National Scorecard on U.S. Health System Performance](#) and [The Path to a High Performance U.S. Health System](#).

Below are descriptions of the core values that The Commonwealth Fund considers necessary for a high performance health care system. Also included are examples of recent Commonwealth Fund publications and Harkness Fellowship project topics done in these areas. (To view Harkness Fellowship publications related to the project topics, click on the project titles to link to the Harkness Fellow's page and list of project-related publications.)

Applicants are strongly encouraged to submit proposals based on original ideas that fall within the scope of the Commonwealth Fund's mission to support a high performance health care system. If data is readily available from their home country, applicants may also choose to undertake cross-national comparisons.

**Effective Care.** The ability of a health care system to provide effective care is an important facet of a high performance health care system. In the United States, a recent RAND corporation study documented that recommended care is delivered only 50 percent of the time. But how to measure quality in health care? One measure is the under-use of treatments that, according to evidence-based guidelines, are effective and appropriate for a given condition. Examples of topics centered on the evaluation of "effective care" in a health care system may include (but are not limited to): preventive care; mental health care; chronic disease management; and hospital care for common conditions. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of right care. For further information, see the [Commonwealth Fund website](#).

- [The Inverse Relationship Between Mortality Rates and Performance in the Hospital Quality Alliance Measures](#)
- [Rehospitalizations Among Patients in the Medicare Fee-for-Service Program](#)
- [Hospital Disclosure Practice: Results of a National Survey](#) (Harkness Fellowship project)

- [Impact of Health Care Delivery Systems on the Quality of Ambulatory Care for Patients After Myocardial Infarction](#) (Harkness Fellowship project)
- [Evaluation of Prescribing and Related Clinical Outcomes in U.S. Nursing Homes as a Basis for a U.K. Model](#) (Harkness Fellowship project)

**Coordinated Care.** Poor coordination of patient care throughout the course of treatment and across various sites of care is pervasive in the United States. Coordination of care is key to a high performance health care system because it helps to ensure appropriate appointment follow-up treatment, minimize the risk of error, prevent complications, and can reduce duplication and other inefficiencies. There are additional benefits to patients as well, including reduced stress and confusion surrounding their treatment and time saved in navigating a complex health care system. Examples of topics in the area of the coordination of patient care include (but are not limited to) regular source of primary care, coordination of care for hospital patients, and hospitalization of nursing home residents. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of coordinated care. For further information, see the [Commonwealth Fund website](#).

- [Coordination Between Formal Providers and Informal Caregivers](#)
- [Improving Transitions in the Care of Older, Hospitalized Patients: Testing Care Transitions Measures](#)
- [What Works in Chronic Care Management: The Case of Heart Failure](#)
- [Chronic Disease Self Management Programs: Scope of Programs and What Works for Whom in the U.S.?](#) (Harkness Fellowship project)
- [Economic Benefits of Health Information Exchange Interoperability](#) (Harkness Fellowship project)
- [Responding to the Burden of Chronic Disease: Development and Validation of an Integrative Framework for Coordination](#) (Harkness Fellowship project)

**Safe Care.** To achieve a high performance health care system, safe care must be a priority. Although some strides have been made in recent years towards improving patient safety in the United States, many possible and desirable changes remain unimplemented. For example, the U.S. still lacks a medical error reporting system to assess safety or to target areas for improvement at the national, state, and local levels. Examples of topics centered on safe care include (but are not limited to) drug safety, hospital mortality, and medical errors. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of safe care. For further information, see the [Commonwealth Fund website](#).

- [Committed to Safety: Ten Case Studies on Reducing Harm to Patients](#)
- [Nurse Staffing in Hospitals: Is There a Business Case for Quality?](#)
- [Patients' Roles in Patient Safety Initiatives: An Analysis of Current Practice](#) (Harkness Fellowship project)

- [A Trans-Atlantic Comparison of Medication Errors in Children and an Assessment of Strategies for their Prevention](#) (Harkness Fellowship project)
- [Inpatient Prospective Payment Systems to Improve Patient Safety](#) (Harkness Fellowship project)

**Patient-Centered Care.** Patient-centered care is care delivered with the patient’s needs and preferences in mind. Open and clear communication between doctor and patient is a key component. 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. Examples of topics in the area of patient-centered care include (but are not limited to): after hours care; physician communication including email access; hospital responsiveness to patients; and self-management for chronic conditions. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of patient-centered care. For further information, see the [Commonwealth Fund website](#).

- [Physician-Patient Communication About Prescription Medication Non-Adherence: A 50 State Study of America’s Seniors](#)
- [Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals](#)
- [Patient-Centered Care: What Does It Take?](#)
- [Enhancing Patient and Physician Email Contact: Survey Results](#) (Harkness Fellowship project)
- [How Does Internet Access to Medical Information Affect the Doctor-Patient Relationship?](#) (Harkness Fellowship project)
- [Barriers to Using Patient Survey Data in Quality Improvement](#) (Harkness Fellowship project)
- [Patient Access to Electronic Personal Health Records](#) (Harkness Fellowship project)

**Efficient Care.** An efficient health care system seeks to maximize the quality of care and outcomes given the resources committed, while ensuring that additional investments yield net value over time. Although the United States devotes far more of its economic resources to health care than other countries, its international ranking on quality-of-care indicators is remarkably low. Examples of topics in the area of efficient, high-value care include (but are not limited to): aligning incentives to achieve quality; supportive information systems; economics of health care; and overuse, inappropriate care, or waste. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of efficient, high value care. For further information, see the [Commonwealth Fund website](#).

- [Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs](#)
- [Medicare Physician Group Practices: Innovations in Quality and Efficiency](#)

- [Impact of Pharmaceutical Policies and Practice Guidelines on Costs and Quality](#) (Harkness Fellowship project)
- [Pay for Performance and Primary Health Care in England and California: A Qualitative Comparison](#) (Harkness Fellowship project)

**Health Insurance Participation.** Despite spending more on health care than any other nation, the U.S. is the only industrialized nation without universal health insurance coverage. Universal participation is essential for dramatic improvement in health care outcomes as well as overall performance of the U.S. health system. Examples of topics in the area of participation include (but are not limited to) coverage expansion and international lessons. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of universal participation. For further information, see the [Commonwealth Fund website](#).

- [Use of Health Services by Previously Uninsured Medicare Beneficiaries](#)
- [Improving the Medicare Part D Program for the Most Vulnerable Beneficiaries](#)
- [The Impact of Health Reform on Underinsurance in Massachusetts: Do the Insured Have Adequate Protection?](#)
- [Cost, Coverage and Access to Pharmaceuticals under Medicare Part D: Towards a Value-Based Drug Benefit](#) (Harkness Fellowship project)
- [Designing a Value-Based Plan to Cover the Uninsured](#) (Harkness Fellowship project)

**Affordable Care.** A high performance health care system is one that is affordable for the people it is supposed to serve. The high costs of health care and inadequate health insurance coverage are undermining the financial security of millions of Americans. Two of five adults—an estimated 77 million people age 19 or older—struggle with medical bills, have recent or accrued medical debt, or both. This is not just a problem for those who lack health insurance; three-fifths of working-age people who reported problems were insured at the time their medical bill or debt problem occurred. For employers, the high cost of premiums for health insurance coverage is leading many employers to cut back on or eliminate their health benefits altogether. In addition, the rising cost of health care means an ever-increasing proportion of the federal budget will need to be devoted to Medicare and Medicaid. Examples of topics in the area of affordable care include (but are not limited to): coverage and affordability; medical debt; and government programs. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of affordable care. For further information, see the Commonwealth Fund website.

- [Stretching State Health Care Dollars: Building on Employer-Based Coverage](#)
- [How High Is Too High? Implications of High-Deductible Health Plans](#)
- [Analysis of Health Care Policy Responses and Affordable Long Term Care Options for an Aging Population](#) (Harkness Fellowship project)
- [Reference Pricing for Drugs: Is it Compatible With U.S. Health Care?](#) (Harkness Fellowship project)

**Equitable Care.** In the United States, disparities in the opportunity to live a healthy life exist along many dimensions, but perhaps most striking are differences associated with insurance coverage, income, and race or ethnicity. Although the elimination of disparities in health and health care has for years been a national policy priority, gaps nonetheless remain pervasive, and they have even widened in some cases. Examples of topics in the area of equitable care include (but are not limited to): reducing disparities; and barriers to access. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of equitable care. For further information, see the [Commonwealth Fund website](#).

- [In Search of Actionable Models of Culturally Competent Care](#)
- [Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey](#)
- [Disparities in Health Care Are Driven by Where Minority Patients Seek Care](#)
- [Tackling Health Disparities in the U.S.: A Study of Health Care Organizational Strategies](#) (Harkness Fellowship project)
- [Indigenous Disparities in Health Status: A Cross-Country Comparison Between New Zealand, Australia, Canada, and the United States](#) (Harkness Fellowship project)
- [An Analysis of Ethnic Disparities in Breast Cancer Mortality and Survival: Understanding the Role of Access and Quality in Breast Cancer Screening and Treatment](#) (Harkness Fellowship project)

**Knowledge and Capacity to Improve.** The capacity to innovate and improve to achieve excellence is fundamental to a high-performing health care system. It includes: a care system that supports a skilled and motivated health care workforce, with an emphasis on primary care and population health; a culture of quality improvement and continuous learning that promotes and rewards recognition of opportunities to reduce errors and improve outcomes; and investment in public health initiatives, research, and information necessary to inform, guide, and drive health care decision-making and improvement. On all three aspects, the U.S. currently under-invests in the system capacity to improve. Below are some recent Commonwealth Fund publications and Harkness Fellow project topics in the area of knowledge and capacity to improve. For further information, see the [Commonwealth Fund website](#).

- [A Quality-Based Payment Strategy for Nursing Home Care in Minnesota](#)
- [Translating Research into Practice: Speeding the Adoption of Innovative Health Care Programs](#)
- [Medicare as Incubator for Innovation in Payment Policy](#) (Harkness Fellowship project)
- [Facilitators and Barriers to IT Implementation and its Effects on Clinical Care Design](#) (Harkness Fellowship project)
- [Analysis of Centralized Drug Review Processes in Four Countries](#) (Harkness Fellowship project)

- [Integrating the Quality Tools: A Methodological Approach to Developing Guideline-Derived Quality Indicators](#) (Harkness Fellowship project)

### **Surveys**

Applicants may also choose to propose a project that builds on new information sources from recent surveys and data. Some areas to consider in structuring such a proposal include relevant findings and country comparisons. See Appendix for examples of surveys and their descriptions.

#### *Past Harkness Fellowship Survey-Based Projects:*

- [Reflection on Canada's Performance in the 2007 Commonwealth Fund International Health Policy Survey](#)
- [Non-need Determinants of Waiting Times](#)
- [Primary Health and Chronic Illness Care: Canadians Report on Quality and Outcomes](#)

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**Examples of Surveys**

Examples of relevant surveys in the U.S. include (see attached for survey descriptions):

**I. Surveys Sponsored by the Commonwealth Fund:**

- 1998-2008 International Health Policy Surveys
- 1999, 2004 Health Care Survey of Older Adults
- 2001 and 2006 Health Care Quality Survey
- 2003 National Survey of Physicians and Quality of Care
- 2001, 2003, 2005 and 2007 Biennial Health Insurance Survey
- 2007 National Survey of Nursing Homes
- 2006 and 2008 Survey of Public Views of the U.S. Health Care System

**II. Agency for Healthcare Research and Quality (AHRQ):**

- Medical Expenditure Panel Survey (MEPS)
- Consumer Assessment of Health Plans (CAHPS)
- Health Care Cost and Utilization Project (HCUP)

**III. Other:**

- Community Tracking Study (Robert Wood Johnson Foundation)
- Assessing the New Federalism (The Urban Institute)
- Health Risk Behavior Surveillance System (Center for Disease Control and Prevention)
- National Survey of Enrollees in Consumer-Directed Health Plans (Kaiser Family Foundation)

## **I. Surveys Sponsored by The Commonwealth Fund**

<http://www.commonwealthfund.org/surveys/>

### **1998 - 2008 International Health Policy Surveys**

The International Health Policy Surveys conducted annually in the U.S., U.K., Canada, Australia, New Zealand, Germany (beginning in 2005), and the Netherlands (beginning in 2006) provide new information on public attitudes about health care systems in each of the surveyed countries and patient experiences in obtaining, paying for and using health services.

In 1998, approximately 1,000 randomly selected residents, aged 18 and over, from each country responded to a series of questions via telephone (Australia, Canada, New Zealand, U.S.) or household (U.K.) interviews. The 1998 survey focused on access, cost and quality, comparing experiences of adults in the U.S. to their counterparts in the other countries.

The Fund's 1999 International Health Policy Survey surveyed 750 adults age 65 and over in each of the five countries (Australia, Canada, New Zealand, U.K., U.S.), focusing on elderly people's experiences with the health care system, long-term care, out-of-pocket expenses and financial barriers to care, roles as informal caregivers, and concerns about needing and paying for long-term care in the future.

In the 2000 survey, 500 primary care doctors and specialists in all five countries (Australia, Canada, New Zealand, U.K., U.S.) were asked about their views of and concerns about their health care system; the extent to which access to specialists, drug therapies, and advanced technologies influence the quality of care they deliver, their attitudes toward use of clinical guidelines, health care performance data, and feedback regarding patient and family satisfaction with care; and their perceptions of the adequacy of current medical error reporting and monitoring systems.

The 2001 survey of approximately 1,400 adults in each of the five countries (Australia, Canada, New Zealand, U.K., U.S.) reported on the quality of patient care, respondents' experiences with the health care system, and their concerns about the future. Additional questions on disparities in health for at-risk populations were also added to the 2001 survey.

The 2002 survey examined the health care experiences and concerns of 750 adults in each of the five countries (Australia, Canada, New Zealand, U.K., U.S.) who were in poor health, have been seriously ill, or were hospitalized in the last two years, and focused on doctor-patient communication, coordination of care, medical errors, access to and use of prescription drugs, emergency care, and financial barriers to care.

The 2003 international survey solicited the views of hospital chief operating officers or top executives of the largest general or pediatric hospitals in each country (100 in Australia; 102 in Canada; 28 in New Zealand; 103 in the U.K.; and 205 in the U.S.) on improving quality and patient safety and opportunities for innovation while coping with such diverse challenges as financial deficits, market competition, nursing and physician shortages, waiting lists, emergency room crises, and deteriorating infrastructure.

The 2004 survey sample included approximately 1,400 adults in each of Australia, Canada, New Zealand, the U.S. and 3,061 adults in the U.K. The survey assessed adults' primary care experiences including doctor-patient relationship and communication, coordination of care, emergency room use, prescription drugs, medication errors, and chronic illness management.

The 2005 survey sample included 700-750 adults in Australia, Canada, and New Zealand, and 1,500 or more in the U.K., U.S., and Germany. This survey focused on health care experiences of adults with health problems.

The 2006 survey focused on primary care physicians, covering topics such as information technology and systems to ensure quality of care, the availability of after-hours access, financial incentive performance, and the use of teams and systems for chronic care management. The survey sample included approximately 1,000 primary care physicians in Australia, Germany, the Netherlands, the U.K., and the U.S., and 500-600 in Canada and New Zealand.

The 2007 survey focused on the experiences of adults in seven countries. Topics included overall views of the health system, care coordination, medical errors, medical homes, and the doctor-patient relationship. The survey sample included 1,009 adults in Australia, 3,003 in Canada, 1,407 in Germany, 1,557 in the Netherlands, 1,000 in New Zealand, 1,434 in the United Kingdom, and 2,500 in the United States.

The 2008 survey focused on the experiences of sicker adults in eight countries. Topics included health system views and costs, access, care coordination and transitions, safety, pharmaceuticals, and chronic care management. The survey sample included 750 sicker adults in Australia, 2,635 in Canada, 1,202 in France, 1,201 in Germany, 1,000 in the Netherlands, 751 in New Zealand, 1,200 in the United Kingdom, and 1,205 in the United States.

### **1999, 2004 Health Care Survey of Older Adults**

The 1999 Survey of Older Americans was a telephone survey of 2,000 men and women between ages 50 and 70 in the continental U.S. that was conducted from August through November, 1999. The interviews included 1,523 adults age 50 to 64 and 477 adults age 65 to 70. The survey queries older Americans about their health insurance coverage and experiences with gaps in coverage, work status, marital status, disability, health status, and utilization of health care services. The survey explores the relationship between family or work status changes and having health insurance and the influence of health insurance on retirement decisions. Among those who recently became eligible for Medicare, respondents are asked to compare the quality and costs of health insurance before and after Medicare became their primary insurance policy.

The 2004 Commonwealth Fund Survey of Older Adults was a telephone survey of 2,007 men and women over 50 years old conducted from September to November of 2004. It presents new information on the health and financial security of adults ages 50 to 70. On average, older adults have high rates of chronic disease and high out-of-pocket medical spending. Rising out-of-pocket health costs, sluggish wage growth, and erosion of retiree health benefits threatens older adults' ability to save for retirement. The survey finds widespread support among older adults for policies that would help them save for their future health and long-term care costs not covered by Medicare. It also finds broad support for policies that would allow them to buy into Medicare before age 65.

### **2003 National Survey of Physicians and Quality of Care**

The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care was conducted from March 17, 2003 to May 30, 2003 and consists of a self-administered questionnaire with a random sample of 1,937 physicians selected from the American Medical Association list who were involved in direct patient care and had been in practice for at least 3 years post-residency. The survey explores physicians' use of quality improvement tools, including information technology tools, future plans to initiate quality improvement activities,

views of potential solutions and barriers, as well as physicians' access to data on their practices and performance and their willingness to share such data.

### **2001, 2003, 2005 and 2007 Biennial Health Insurance Survey**

The 2001 Health Care Quality Survey was a telephone interview survey conducted from April to November, 2001 among adults 18 and older living in households in the continental U.S. The survey yields a random national sample of 6,722 adults age 18 and older, including 3,488 whites, 1,153 Hispanics, 1,037 African Americans, and 660 Asian Americans. An oversampling of Hispanics and Asian Americans allows for relevant within group comparisons. The survey examines the degree to which preventive care, chronic disease management, and quality of care experiences varies by racial/ethnic groups. The survey data also contain information about income, immigration status, language use, and insurance status.

The Commonwealth Fund 2003 Health Insurance Survey was conducted from September 3, 2003 through January 4, 2004 and consists of 25-minute telephone interviews in either English or Spanish with a nationally representative sample of 4,052 adults age 19 and older living in the continental U.S. The survey builds upon 1999 and 2001 survey findings and provides a current picture of the stability and quality of health insurance coverage and financial and non-financial barriers to health care. The survey provides important trend information on insurance coverage, access barriers, and satisfaction with and confidence in the health care system. In addition, the survey examines new areas of research such as cost-sharing experiences in the form of premium increases and decreased benefits, and the impact of medical bill burdens and debt on family finances, and poor quality coverage on health. The survey also evaluates respondents' views on timely policy debates, such as the importance of candidate's views on health care reform in deciding the 2004 presidential candidate; the role of government, individuals, and employers in providing insurance; and limiting tax credits to finance health insurance security for all.

The 2005 survey was conducted from August 18, 2005 through January 5, 2006 and included a nationally representative sample of 4,350 adults age 19 or older, with an oversample of low-income families and 951 Americans age 65 and older. The survey updates information on coverage and access trends and explores emerging areas of policy concern, including the effect of high-deductible health plans and health savings accounts on lower-wage workers and people with chronic health conditions.

The 2007 survey was conducted from June 6 to October 24, 2007 and included a nationally representative sample of 3,501 adults ages 19 and older and living in the continental United States. The survey collects information on access and coverage, with findings highlighting the growing deterioration of insurance coverage over the last six years and the effect of the economic downturn on moderate-income families.

### **2006 and 2008 Survey of Public Views of the U.S. Health Care System**

The 2006 Survey of Public Views of the U.S. Health Care System sought to determine the public's perspectives on ways to improve patient care and on health policy priorities facing the President and Congress. The survey was conducted from June 1, 2006–June 5, 2006 and included a nationally representative sample of 1,023 adults age 18 or older living in households with telephones in the continental U.S. The survey design was random-digit telephone interviews.

The 2008 Survey of Public Views of the U.S. Health Care System to determine their experiences and perspectives on the organization of the nation's health care system and ways to improve patient care. It was conducted through phone interviews from May 23-27, 2008, and included a

nationally representative sample of 1,004 adults age 18 and older selected using random-digit dialing.

### **2007 National Survey of Nursing Homes**

The 2007 National Survey of Nursing Homes was conducted from February 16 to June 8, 2007, and was completed by a nationally representative sample of 1,435 directors of nursing. The sample was distributed as a paper and pencil mail survey to 4,000 nursing homes stratified by bed size, and excluded facilities located within a hospital and those that were Medicare only. The survey examined the penetration of the culture change movement at the national level and measured the extent to which nursing homes are adopting culture change principles and practicing resident-centered care.

## **II. Agency for Health Care Research and Quality**

### **Medical Expenditure Panel Survey (MEPS)**

<http://www.meeps.ahrq.gov/meepsweb/>

The Medical Expenditure Panel Survey (MEPS) is a nationally representative survey of health care use, expenditures, sources of payment and insurance coverage for the U.S. civilian non-institutionalized population, as well as a national survey of nursing homes and their residents. MEPS is designed to help understand how the recent growth in managed care and changes in the health care system have affected the kinds, amounts, and costs of health care that Americans use. MEPS consists of five component surveys:

The *Household Component* is a household interview of 10,500 families and 24,000 individuals in 190 communities across the U.S. The objective is to produce annual estimates for a variety of measures in health status, health insurance coverage, health care use and expenditures and sources of payment for health services.

The *Nursing Home Component* gathers information from 800 nursing homes and more than 5,000 residents nationwide on the characteristics of the facilities and services offered, individual resident expenditures and sources of payment, and resident characteristics. Data on the availability and use of community-based care prior to nursing home admission is also collected.

The *Medical Provider Component* covers 2,700 hospitals, nearly 2,000 physicians, and 300 home health care providers. Its purpose is to supplement information from respondents to the MEPS Household Component.

The *Insurance Component* consists of two surveys. The first survey interviews 9,200 employers, 300 union officials, and 400 insurers to obtain detailed information on the health insurance held by respondents to the MEPS Household Component. It also collects information about other health plans available to, but not chosen by, respondents. The second interviews managers at more than 20,000 establishments to obtain national and regional estimates of the availability of health insurance at the workplace.

### **Consumer Assessment of Health Plans (CAHPS)**

<https://www.cahps.ahrq.gov/default.asp>

Developed by a consortium of Harvard Medical School, RAND, and the Research Triangle Institute, and sponsored by the Agency for Healthcare Research and Quality (AHRQ), the

CAHPS survey is designed to provide information that can help consumers and purchasers assess and choose among health plans. The CAHPS questionnaires are designed for three different types of target populations: commercially insured, Medicaid, and Medicare managed care. The CAHPS Survey includes a core group of standard items, a small group of supplementary items targeted towards specific populations, and a survey designed for those who disenroll from plans. Among the areas that are covered by the survey are: perceived quality of health care, perceived quality of health plan, administrative burden, enrollment/payment, utilization of health services, health status, and respondent characteristics. Information about specific plan features, such as access to specialists, quality of patient/physician communication and interaction, and coordination of care, is included, as well as questions targeted to persons with chronic conditions or disabilities, children, and Medicare and Medicaid beneficiaries.

### **Healthcare Cost and Utilization Project (HCUP)**

<http://www.ahrq.gov/data/hcup/>

The Healthcare Cost and Utilization Project (HCUP) is a family of administrative, longitudinal databases, web-based products and software tools developed and maintained by the Agency for Healthcare Research and Quality (AHRQ) as part of a Federal-State-Industry partnership to build a standardized, multi-state health data system. HCUP is based on data collected by individual States and provided to AHRQ by the States. HCUP data are used for research on hospital utilization, access, charges, quality and outcomes. The data are used to describe national, regional and state level patterns of care for uncommon as well as common diseases, analyze hospital procedures, including those that are performed infrequently, and study the care of population sub-groups such as minorities, children, women, and the uninsured.

### **III. Other Surveys**

#### **Assessing the New Federalism**

##### **The Urban Institute**

<http://www.urban.org/center/anf/index.cfm>

"Assessing the New Federalism" is a multi-year research project to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, job training, and social services. The project employs three data collection strategies to monitor decentralization, program changes, and well-being.

The *State Database* incorporates state specific data from 1993 onward in several broad areas: income security, health, well-being, state fiscal and political conditions, demographic characteristics, and social services. The data include aggregate measures of budget growth or decline, tradeoffs among major spending categories, discretionary tax increases and decreases, and certain indicators of how programs are changing.

*Case Studies* focus on the development and implementation of policies in 13 states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington and Wisconsin. The studies concentrate on developments in Medicaid and related health assistance programs, welfare, employment and training, and social services.

The *National Survey of America's Families* is a survey of approximately 44,000 households. The survey provides information on employment, economic hardship and income, child care and child support, health insurance coverage, access to care and health care use, and the behavior and emotional well being of children, families, and individuals.

### **Community Tracking Study**

**Center for Health System Change and the Robert Wood Johnson Foundation**

[www.hschange.com](http://www.hschange.com)

The Community Tracking Study focuses on changes in the health care system in 60 communities that are representative of the nation. It documents changes, their effects in the organization of health services over time, and their impact on individuals' access to care, the delivery and cost of health care services, and the perceived quality of care. Surveys included in the study are:

The *Household Survey*, a nationally representative telephone survey of the civilian, non-institutionalized population, includes 43,771 persons in 23,554 families;

The *Physician Survey*, a nationally representative telephone survey of non-federal, patient care physicians; includes 9,264 physicians, of whom, 5,160 are primary care physicians;

The *Employer Survey*, a nationally representative telephone survey of approximately 2,000 employers that 1) tracks change in premiums and insurance offerings over time, and 2) describes the role of employers in the market; and

*Site Visit Case Studies* provides a detailed look at health system change in 12 communities: Boston, Cleveland, Greenville, SC, Indianapolis, Lansing, MI, Little Rock, Miami, Newark, NJ, Orange County, CA, Phoenix, Seattle, and Syracuse.

### **Behavioral Risk Factor Surveillance System**

**Centers for Disease Control and Prevention**

<http://www.cdc.gov/brfss/>

The Behavioral Risk Factor Surveillance System (BRFSS) is one of several public health surveillance systems supported by the Centers for Disease Control and Prevention. The BRFSS collects uniform state-based data on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the U.S. Data are collected through monthly telephone interviews conducted among a sample of each state's adult population. The survey consists of a standard set of questions asked by all states each year, an optional set of questions on specific topics which states may choose to include or not include on their questionnaires, and state-added questions which provide information on issues of local interest and emerging issues. The data are used to provide state and national information on access to preventive services such as breast, cervical, and colorectal cancer screenings and immunizations. Other health information includes high-risk behaviors, lack of physical exercise, obesity and data about smoking habits. Socio-demographic data, including age, education, income, and racial and ethnic background are also available

### **National Survey of Enrollees in Consumer-Directed Health Plans**

**Kaiser Family Foundation**

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

This Kaiser survey looks at the views and experiences of people enrolled in consumer-directed health plans as compared to people with traditional health insurance. Consumer-directed plans, which involve high deductibles coupled with tax-preferred saving options that consumers can use to pay for their care out of pocket, are intended to make consumers more active participants in decisions about their health care, including on cost issues.

The survey was conducted among 1,389 people, including 272 who are enrolled in consumer-directed health plans, plans with a high deductible that also involve a Health Savings Account or Health Reimbursement Arrangement, and 715 with more traditional employer-sponsored insurance. The margin of sampling error for the survey is plus or minus 7 percentage points for the consumer-directed group, and plus or minus 5 percentage points for the group with more traditional plans.