



The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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Eliminating the “Doughnut Hole”

Could senior citizens and the disabled have full prescription drug coverage as well as fewer out-of-pocket costs, *without* causing any increase in total Medicare spending? According to researchers they could—if prescription drug prices in the United States were typical of the prices found in other industrialized countries.

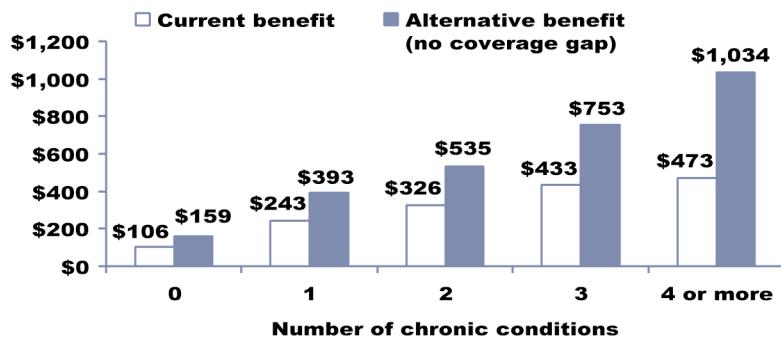
In a Fund-supported study led by Johns Hopkins University’s Gerard F. Anderson (see “[Doughnut Holes and Price Controls](#),” *Health Affairs* Web Exclusive, July 21, 2004), prices for a group of key prescription medicines were shown to be 34 to 59 percent lower in Canada, France, and the United Kingdom than in the U.S. If Medicare could match prices seen in these countries, whether through price negotiation, drug formularies, or some other mechanism, Anderson says the program could eliminate the new drug benefit’s coverage gap—the infamous “doughnut hole.”

Under the benefit slated to take effect in 2006, Medicare beneficiaries will experience this gap when their drug expenses exceed \$2,250 but have not yet reached \$5,100, at which point coverage resumes. This gap will mean a serious level of cost-sharing—more than \$3,600 for many Medicare beneficiaries during the benefit’s first year.

Continued on page 3

Reduction in Out-of-Pocket Costs Under Current and Alternative Medicare Drug Benefits, by Number of Chronic Conditions

Mean reduction in beneficiaries’ out-of-pocket spending



Source: G. F. Anderson et al., “[Doughnut Holes and Price Controls](#),” *Health Affairs* Web Exclusive (July 21, 2004): W4-396–W4-404.

Grantee Spotlight

Paul Dworkin, M.D.

Connecticut's Help Me Grow program for young children got its start in 1998 when agencies and organizations in Hartford banded together to support the "developmental surveillance" activities of the city's pediatric clinicians. Statewide expansion began in 2002. Developmental surveillance has gained currency over the last 15 years as the best way to detect problems in children at the earliest possible stage—by obtaining a developmental history, skillfully observing children's development, using parent questionnaires and screening instruments to gather further information, consulting with other professionals, and, perhaps most importantly, eliciting parents' opinions and concerns. Run by the Connecticut Children's Trust Fund in collaboration with community-based agencies, Help Me Grow connects at-risk children under age 5 with needed services through a toll-free telephone hotline. A Fund-supported project led by Paul Dworkin, M.D., Physician-in-Chief for Connecticut Children's Medical Center, is now seeking to strengthen Help Me Grow by training physicians to improve recognition and referral of at-risk children.

The principles of developmental surveillance haven't always been embraced in the U.S. How did you become convinced there was a better way to practice well-child care?

Paul Dworkin: I had never been enamored of the obligatory use of tests during well-child visits. I had concerns about their effectiveness, logistical constraints, and how these tests are used. I was interested in a more holistic approach. Then in the late 1980s, I learned about the British approach to child health supervision while on sabbatical at Oxford. They were more focused on developmental and behavioral monitoring, by talking to parents about their concerns, soliciting input from others who know the child, and administering questionnaires and tests periodically or when concerns arise.

How were these ideas initially received by the American pediatric establishment?

Dworkin: When I came back to the U.S., I tried to



promote developmental surveillance at an AAP [American Academy of Pediatrics] meeting. To call the reception lukewarm would be an understatement—it ranged from stone-cold to hostile. It was difficult to promote surveillance without appearing to be "anti-screening."

And have things changed since then?

Dworkin: Yes. There's a role for professionally administered tests, but they must be used in the context of longitudinal monitoring. It's just taken 10-plus years to help people understand this distinction.

How does Connecticut's Help Me Grow program support parents and pediatricians?

Dworkin: First, it enables us to bring training in developmental surveillance to family physicians, pediatricians, physician assistants, nurse practitioners, and office support staff—all in a very feasible and effective way. Second, it links children and families to those programs and services that ultimately will promote healthy development.

Currently, you're leading an effort to train at least half of Connecticut's pediatricians in identifying and referring at-risk children. How is this done?

Dworkin: We start by contacting the office and scheduling a convenient time to come in and meet with practitioners and support staff. The sessions are short, typically 25 to 45 minutes—and we arrive with food in hand. We make a brief, succinct presentation on the principles of developmental surveillance and offer tools, like parent-completed questionnaires, that can be used to strengthen surveillance. We also share information on accessing Help Me Grow.

How have practices responded?

Dworkin: Incredibly positive. We see pediatricians almost immediately start referring families to the program. We're not asking them to do more than they're currently doing; we're just asking them to spend time doing what they're doing more efficiently and effectively.

Have other states followed Connecticut's model?

Dworkin: California is trying to use tobacco settlement dollars to develop a Help Me Grow-type approach, and there are programs in Vermont and North Carolina to strengthen developmental surveillance within well-child care. A manual we're creating will enable all states to replicate what we're doing in Connecticut.❖

For their study, Anderson and his colleagues created and priced a “market basket” of 30 widely prescribed medicines. Lipitor, they discovered, costs from 45 to 63 percent less in Canada, the U.K., and France than in the U.S., even assuming that listed wholesale prices are 20 percent higher than the prices Medicare would pay under the new law. Price differentials for the other drugs were in a similar range.

Higher U.S. prices, the authors say, could be brought into the range typical of the other countries studied. “Most other industrialized countries,” they note, “have instituted a variety of mechanisms to limit pharmaceutical spending.” One of those mechanisms is price negotiation. As the nation’s largest purchaser of health care, the Medicare program would be in prime position to obtain the best possible prices from pharmaceutical companies. However, the legislation that created the new drug benefit specifically prohibits Medicare from negotiating directly with drug manufacturers.

With the doughnut hole in place, prescription drug spending for Medicare beneficiaries in 2006 will be \$101.9 billion—\$31 billion coming from the pockets of those beneficiaries and \$44.5 billion from Medicare (third-party payers account for the rest). If prices are reduced as the authors believe to be possible and the savings are used to eliminate the doughnut hole, total drug spending would drop to \$73.6 billion. Medicare would continue to spend \$44.5 billion, but beneficiaries would owe far less out-of-pocket.

Such price reductions, furthermore, would benefit those who are most ill and the most likely to be affected by the coverage gap—the 15 percent of Medicare beneficiaries with five or more chronic conditions. Lower prices would save persons with four or more illnesses \$1,034 in 2006, the study finds.

Anderson acknowledges that lower drug prices mean less revenue for companies, which could lead them to reduce their investment in new medicines. “Policymakers in the United States have a choice,” he says. “It is possible to improve access to prescription drugs for Medicare beneficiaries if Medicare pays drug prices that are similar to the prices of Canada, the United Kingdom, and France.”♦

Code Red: Patient Debt, Hospital Collection Practices Point to Ailing Health System

Recent reports of hospitals billing uninsured patients at higher rates than insured patients and using aggressive collection practices are symptoms of two underlying trends in the U.S. health care system: growing instability in insurance coverage and rapid growth in the costs of care, according to testimony given before two congressional subcommittees in June.

Pricing practices at selected hospitals “are placing vulnerable patients at financial risk,” Fund President Karen Davis said in [invited testimony](#) June 22 before the House Ways and Means Committee’s Subcommittee on Oversight. Davis added that “hospitals play a pivotal role in making care accessible to those who cannot pay, but they also need to be financially viable.” Given that a “strong hospital system is essential to a strong nation,” she said all Americans are placed at risk by a “flawed financing system [that] undermines the financial security of the hospital sector.”

In separate [testimony](#) at a June 24 hearing of the House Energy and Commerce Committee’s Subcommittee on Oversight and Investigations, Fund

With the doughnut hole in place, prescription drug spending for Medicare beneficiaries in 2006 will be \$101.9 billion—\$31 billion coming from the pockets of those beneficiaries.

In light of rapidly rising hospital costs, major reforms are needed to fill the “cracks in our fragmented health care financing system.”

Senior Program Officer Sara R. Collins, Ph.D., maintained that discriminatory hospital pricing for uninsured patients and aggressive efforts to recover payment from those who cannot pay will only exacerbate the problems accessing and paying for needed medical care among the nation's uninsured and underinsured families.

“The pressures that gave rise to the conflict [between hospitals and uninsured patients] will continue to grow apace,” Collins said. Until major steps are taken to expand access to affordable insurance coverage and reduce health care inflation, she argued, the nation will not be able to adequately address the “affordability crisis” in U.S. health care. In her testimony, Collins cited findings from the latest **Commonwealth Fund Biennial Health Insurance Survey**, which found that in 2003, two of five adults ages 19 to 64—more than 70 million people—had problems paying their medical bills in the last 12 months or were paying off medical debt accrued over the last three years.

Speaking before the Ways and Means subcommittee, Fund President Davis said that in light of rapidly rising hospital costs, major reforms are needed to fill the “cracks in our fragmented health care financing system” and improve

the performance of the health care sector overall. She outlined a number of health system reforms, among them:

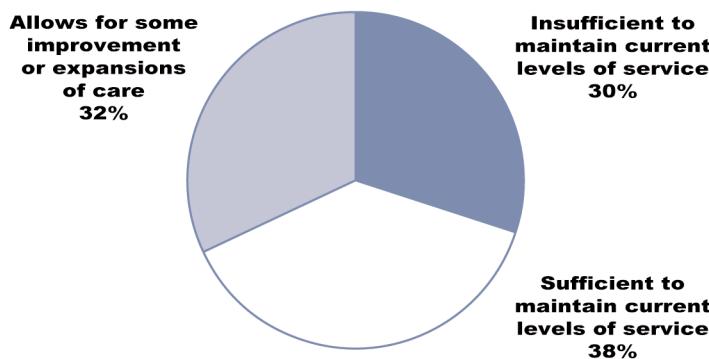
- ensuring automatic and affordable health insurance coverage for all Americans;
- strengthening the financial standing of the safety net hospital and health care sector, which serves a disproportionate number of Americans who are poor and uninsured;
- making publicly available information about the quality and efficiency of all health care providers;
- insurance-based incentive payments that reward hospitals and other providers demonstrating superior quality and efficiency of their patient care; and
- investing in the health system’s capacity to adopt modern information technology and systems to ensure safe care.❖

High-Performing Hospitals Share Their Secrets

Talk of quality improvement has become increasingly prevalent in the hospital industry. In fact, most hospitals are involved in some kind of quality improvement project—be it benchmarking, collecting data, or forming monitoring committees. So what differentiates these hospitals from the top-tier, high-performing hospitals that consistently provide high quality at low cost?

According to Jack A. Meyer, Ph.D., founder and president of the Washington, D.C.-based Economic and Social Research Institute (ESRI), the high-performers distinguish themselves by backing up their words with concrete actions. They make quality a continuous, living process of drilling down into data, feeding information back, tracking progress, and making needed changes.

Current Financial Situation of U.S. Hospitals



Meyer and his ESRI colleagues conducted in-depth site visits and interviews at top-performing hospitals from around the country for their report *Hospital Quality: Ingredients for Success*, released by The Commonwealth Fund at the Health Forum and American Hospital Association's Leadership Summit on July 27. The report presents findings from the case studies as well as guidance and action steps for other hospitals.

During a panel discussion at the hospital summit, Meyer revealed the formula for quality care is a mix of the right culture, people, processes, and tools. Each piece supports the next: the right culture attracts talented people, who in turn instill practices that make the hospital a better, safer place to work, added Lee Domanico, another panelist. Domanico, the CEO of El Camino Hospital in Mountain View, California—one of the hospitals highlighted in the report—calls this a “reinforcing circle.”

Domanico said that the concept of quality permeates the culture at El Camino. It is not limited to medical care. “Every aspect of the hospital has quality measurements—in registration, in billing. We measure registration times. We measure billing accuracy,” he explained.

El Camino—located in the heart of California’s Silicon Valley—illustrates the critical role information technology can play. Not only was it the first hospital to develop a computerized physician order entry system (with help from the Lockheed Corporation), it also employs an automated supply chain and bar coding and “wanding” of medications. “We use technology to eliminate variability, to make it as hard as possible for a mistake to be made,” Domanico said. In 2002, El Camino was able to reduce its medication dispensing error rate to 0.003 percent. Moreover, of the 40 reported errors, 39 were classified as minor.

Technological advances, however, cannot eliminate all error. Creating a safe environment for hospital staff to report errors, the report finds, is imperative as well. Blair Sadler, the CEO of San Diego Children’s Hospital, told conference participants that a significant error—surgery performed on the wrong child—motivated his hospital to create a “blame-free” environment where employees feel secure reporting errors. “It all starts with the attitude that it’s okay to come forward,” Sadler said.

The biggest challenge hospitals face, Sadler believes, is the lack of a business case for quality. For a hospital with a high percentage of patients covered by Medicaid or other public insurance programs that pay hospitals on a per diem basis, quality initiatives that reduce length of stay are simply not profitable. “Do you get rewarded? You get economically punished,” he said.

ESRI’s Meyer agrees that more work is required to build a business case. To help hospitals, he advocates a “Marshall Plan” for health care. “It takes money and expertise,” Meyer said. “We need SWAT teams to go out and help hospitals.” ♦

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With Help, NYC Clinics Improve Primary Care

Community health centers deliver primary health care to much of New York City’s low-income population. But the design and delivery of services at these clinics can be flawed. There often are delays in access to care, making it difficult to get an appointment. Inefficiencies in patient flow also are common, resulting in office visits that are needlessly long.

In the past several years, however, dozens of New York clinics have cut their waiting times, become more patient-friendly, and improved their

finances. What's their secret? Collaborative learning and an ongoing commitment to sustaining change, according to a new Commonwealth Fund report, *Achieving a New Standard in Primary Care for Low-Income Populations*.

Since 1994, the nonprofit Primary Care Development Corporation (PCDC) has been working with staff from health care clinics serving New York's low-income, underserved communities to redesign their systems to become more patient-focused and efficient. The vehicle for this is the "learning collaborative"—a six-to-nine-month process during which clinic teams work with PCDC's experts to examine the facility's systems operation, develop changes, and implement them. Efforts to sustain innovations are ongoing.

At [Union Health Center](#) in Manhattan, for example, patients can now see their own provider within 24 hours of calling for an appointment—a vast improvement over the previous 15-day average wait before PCDC helped the center's staff revamp their scheduling process. PCDC also worked with the [Jerome Belson Health Center](#) in the Bronx to shorten average patient visit time and with [Urban Health Plan](#) in the South Bronx to develop a marketing and customer service program for bringing in new patients. And average reimbursement per visit increased 55 percent at the [Brownsville Multi-Service Family Health Center](#) in Brooklyn.

Once a new system is in place, PCDC works with staff to ensure that changes will be sustained. "We have to combat the belief that changes are permanent, or what we call the myth of the self-maintaining innovation," said Ronda Kotelchuck, PCDC's executive director. Pamela Gordon and PCDC's Matthew Chin, the authors of the Fund report, characterize the improvement

process as "a never-ending commitment that requires continued organizational focus, resources, and course corrections."

For more information about PCDC and its learning collaboratives, contact Ivy Fairchild at ifairchild@pcdcny.org. ♦

Through collaborative learning and an ongoing commitment to sustaining change, dozens of New York clinics have cut their waiting times and improved their finances.

Lost in Translation? Not These Innovations

In today's cost-conscious health care environment, translating evidence-based quality innovations into clinical practice is a tall challenge. Limited resources mean providers and health systems must follow proven methods for diffusing and adopting effective interventions.

A new Commonwealth Fund issue brief, *Translating Research into Practice: Speeding the Adoption of Innovative Health Care Programs*, offers key lessons for successfully implementing and spreading quality improvement initiatives. Elizabeth H. Bradley, director of the Health Management Program at the Yale School of Medicine, teamed up with colleagues from a number of institutions across the country to examine four novel clinical programs that have made a real difference in people's lives—and are now being adopted by health care organizations across the nation.

"Researchers devote substantial resources to developing and testing the efficacy of clinical innovations that improve the health of patients and their families," says Bradley, "yet there are numerous examples of evidence-based programs and interventions that are only partially adopted into clinical practice, if adopted at all."

The authors zeroed in on four different innovations, three focusing on frail elders and one on very young children:

- [The Hospital Elder Life Program \(HELP\)](#), a program shown to reduce

delirium among older, hospitalized adults by 40 percent, and at no additional cost. A full-time Elder Life Specialist, a part-time advanced practice geriatric nurse, a part-time geriatrician, and trained volunteers implement the program, supported by computer systems that prompt recommended interventions, track patient progress, and report clinical and financial progress. HELP was launched in 13 hospitals, with assistance from the Yale University-based dissemination team; the program is now being distributed to approximately 24 additional facilities.



The Hospital Elder Life Program is helping to improve the well-being of elderly hospital patients by reducing the incidence of delirium, a common problem. (Photo courtesy of Yale University)

- **The Wellspring Model**, launched by an alliance of 11 nonprofit nursing homes in Wisconsin to improve the quality of clinical care as well as lower turnover and raise morale among nursing assistants—the “front-line” workers most involved in day-to-day resident care. Formal evaluations of Wellspring revealed lower staff turnover, better performance on federal quality indicators, and improved interactions between staff and residents, at no higher cost. Four additional nursing home alliances comprising a total of 50 facilities have now embraced the model.
- **The Fleetwood Project**, which reduces potentially inappropriate medication use for nursing home residents, under-treatment of diseases common to residents, and rates of “adverse drug events.” Prospective drug regimen review and formalized pharmaceutical care planning are keys to the program, as is direct communication between consultant pharmacists and prescribing clinicians. Fleetwood, which initially began in three Wisconsin nursing homes, has since been disseminated to 13 homes in North Carolina.

- **Healthy Steps for Young Children**, a national initiative that fosters closer relationships between pediatric clinicians and parents to better promote the physical, emotional, and intellectual growth of children during their most developmentally crucial time—birth to age 3. Central to the program is the addition of the Healthy Steps Specialist to the pediatric practice, a professional trained in child development who offers parents individualized visits and educational support. Of the original 24 sites that implemented Healthy Steps between 1996 and 1998, 11 continue with the program as originally designed, while nine have adapted the program substantially. An additional 24 practices, HMOs, clinics, and residency training programs have incorporated the approach since that time.

Despite their varying approaches, all four innovations have followed a similar path to adoption by health care organizations, the authors note. One of the first steps was securing strong support from senior management to obtain financial backing as well as to advocate for

“There are numerous examples of evidence-based programs and interventions that are only partially adopted into clinical practice, if adopted at all.”

the program both internally and externally. Credible data were essential in this regard to convince administrators that the innovation was well worth the effort and expense. Clinical leaders with savvy about organizational dynamics were also critical in championing each program.

Perhaps most important was realizing that diffusion never occurs spontaneously. Any adopting organization must be prepared to change its very culture to make room for the new way of thinking and behaving. And it must also develop a plan and commit the necessary resources to sustain the program from the very start.

"In the cases we reviewed, dissemination and diffusion required more dedicated staff resources and infrastructure than originally planned," observed Bradley. "The process of embedding new methods takes a lot more than most people expect." ♦

Ninety-four percent of children with elevated blood lead in New York are African American, Hispanic, or Asian American.

NYC's Poor at Greater Risk for Chronic Diseases

Black and Hispanic New Yorkers, as well as poor city residents regardless of race or ethnicity, are more likely than whites to have diabetes, HIV, and other diseases—and more likely to die prematurely, according to a report released by the New York City Department of Health and Mental Hygiene. The report, which was prepared with support from the Fund, also found that poor health is concentrated in heavily minority, low-income neighborhoods.

The researchers analyzed disparities by income and race/ethnicity across a variety of health measures and neighborhoods, from infant mortality to life expectancy. Among their findings:

- The poorest New Yorkers report poor overall health at four times the rate of the wealthiest.

- In 2001, the life expectancy in the poorest neighborhoods was eight years shorter than in the wealthiest ones.
- Ninety-four percent of children with elevated blood lead in New York are African American, Hispanic, or Asian American.

While noting some progress in reducing health disparities in the city, the report says that substantial inequalities remain, including access barriers. "Identifying the scope, location, and source of health care disparities in our communities is a crucial step toward addressing this problem," said Fund President Karen Davis. "This report provides the basis for health leaders, clinicians, policymakers, and the public to move forward together to find solutions." ♦

States Tackling Disparities from Multiple Angles

In 1998, racial and ethnic disparities in health care emerged as a major issue when President Bill Clinton and Surgeon General David Satcher, M.D., announced a goal of eliminating disparities by 2010 in six health categories, including infant mortality, HIV/AIDS rates, and child and adult immunization levels. In subsequent years, the initiative received significant attention as well as bipartisan backing, including from President George W. Bush and Senate Majority Leader Bill Frist.

No real progress has been made, however, since the announcement of that lofty goal. According to consumer health care advocate John A. McDonough, Dr.P.H., there is little reason to believe that any targets will be met by that date. But while momentum has stalled at the national level, a range of activities now under way at the state and local levels provide reason for hope, he says.

In a [report](#) published by the Fund, McDonough, executive director of the Massachusetts-based organization Health Care for All, and colleagues illustrate how states can play important roles in eliminating disparities and informing federal policy. Promising developments are occurring on many fronts, the authors say. In California, for example, Los Angeles County has pioneered the development of cultural and linguistic competency standards for health care providers serving publicly insured residents, many of whom are recent immigrants or members of minority groups. In another initiative in Massachusetts, hospitals are required to provide language interpreters for certain acute care services, such as emergency room visits.

Other programs focus on specific diseases and conditions that disproportionately affect minorities. A program developed by South Carolina's Office of Minority Health, for instance, promotes early detection of prostate cancer among African American men by enlisting community-based organizations such as churches and fraternities.

Additional steps, the authors say, that could lead to reduced disparities include fostering greater minority participation in the health care workforce, collecting data on patients' race and ethnicity—which helps policymakers and health officials identify problems in the first place—and improving outreach to minorities to enroll the uninsured in public coverage programs.

McDonough, a former Massachusetts state legislator, says providing health insurance coverage for every American, while not likely to totally eliminate health care disparities, "would certainly go a long way toward addressing the problem." In the meantime, he says that "targeted improvements for vulnerable groups are important steps toward the goal of equity."♦

Well-Child Care Needs Overhaul, Fund Expert Says

Pediatric preventive care in the U.S. needs "major" revisions if chronic health problems and unmet behavioral and developmental needs are to be addressed, according to a leading child health expert writing in the journal *Pediatrics* ([special article](#), July 2004).

Pointing to the prevalence of obesity, attention-deficit/hyperactivity disorder, behavior disorders, depression, adolescent risk behaviors, and the stresses faced by parents, Edward L. Schor, M.D., head of the Fund's Child Development and Preventive Care Program, warns that "the term 'well-child care' is applicable to fewer children."

Acute pediatric medical care is increasingly becoming the work of hospitals, emergency physicians, and pediatric subspecialists. Well-child care, Schor argues, must incorporate new approaches—to pediatric office practice, to the scheduling of office visits, and to health care partnering.

Schor cites a number of serious problems in the nation's well-child care:

- Ninety-four percent of American parents report unmet parenting guidance, education, or screening needs by pediatric clinicians.
- Minority or economically disadvantaged parents are two to four times more likely to express dissatisfaction with the developmental care their children receive than white, nonpoor, insured families.
- Children attend fewer than half of the recommended well-child visits, even when there are no financial barriers.

Pediatricians themselves report an array of obstacles, among them: time constraints, low levels of reimbursement for preventive pediatric care, lack of training in child development, and few external

Fostering greater minority participation in the health care workforce, collecting data on patients' race and ethnicity, and improving outreach to minorities to enroll the uninsured in public coverage programs could reduce health disparities.

The schedule of well-child care should include office visits whose timing reflects or coincides with children's key developmental transition points.

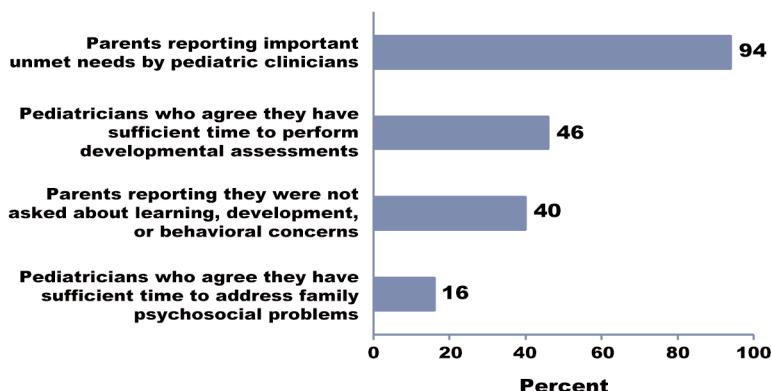
incentives. Schor notes that these obstacles are systemic, not personal. With current guidelines and practices, "it seems there simply is too much to do," he says.

Schor argues the current schedule of well-child care visits is not scientifically based and needs to be completely rethought. Ideally, the schedule should include office visits whose timing reflects or coincides with children's key developmental transition points.

As part of an overhaul of the system, Schor recommends dispensing with terminology such as the "six-month" or "nine-month" pediatrician visit. These names, he says, tell parents little about the visit's purposes. Naming each visit to highlight its focus would make the value of each visit more clear. Schor suggests that the nine-month visit, for example, might be called the "Understanding Your Child's Personality" visit, during which issues of temperament are discussed. Naming visits not only allows pediatricians to prioritize the content, it helps parents anticipate some of the issues and gives them an opportunity to formulate questions.

Schor also calls for the elimination of unnecessary procedures. He notes that performing a physical exam at the time of every office visit is most likely without value in identifying physical problems.

The State of Well-Child Care: A Snapshot



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

His other proposed changes have to do with the mechanics of office visits. Schor has three suggestions for making better use of the time before and after an office visit: prompt parents more carefully about the next office visit in order to help them prepare; use pencil and paper or computerized structured-screening tools before meeting with physicians in order to increase efficiency; and then reinforce advice, guidance, and counseling with printed or other material. ♦

Maine Further Along in Plan to Cover Uninsured

The state of Maine faces considerable health care challenges.

Approximately 14 percent of its residents lack even basic health coverage. It has the highest incidence of chronic disease and illness in New England, as well as the region's highest hospital utilization rates. Maine's small businesses, meanwhile, saw their health insurance premiums rise 58 percent between 1996 and 2001.

According to state officials, however, hope is now well on the way. Change first arrived in June 2003 with enactment of the Dirigo Health Reform Act, which the state says will ensure affordable health coverage for all uninsured residents—approximately 140,000 people—by 2009, and better-quality care to boot. In the latest development, Governor John E. Baldacci announced this past June that Anthem Blue Cross and Blue Shield of Maine had submitted a bid to partner with the state to administer the Dirigo Health Plan, saying "we are a step closer to providing affordable health care" for all of Maine's uninsured.

"Maine's health care system has largely become unsustainable and our high costs are a significant drag on the economy," said Trish Riley, director of

the Governor's Office of Health Policy and Finance. "Dirigo Health is our solution to these obstacles."

The Dirigo plan is premised on the belief that the three primary concerns with health care—costs, quality, and access—must be dealt with equally and simultaneously. As described in an [overview of the program](#) by Jill Rosenthal and Cynthia Pernice of the National Academy for State Health Policy (NASHP), the Dirigo initiative hopes to alleviate the cost burdens associated with bad debt and charity care by expanding coverage. Currently, Maine spends over \$275 million a year caring for uninsured and underinsured patients.

Other cost-control approaches will include public price disclosure, which will allow consumers greater access to pricing and quality information; simplified administrative functions and reduced paperwork; and "enhanced" public purchasing, under which public programs will coordinate their health care buying to demand higher-quality and more cost-effective services.

Meanwhile, a quality watchdog group, the Maine Quality Forum, will be charged with adopting quality and performance measures to compare provider performance, promoting evidence-based medicine, and conducting technology assessment reviews to guide the diffusion of the latest health care innovations. In addition, the Forum will conduct consumer education campaigns and promote more effective data sharing among state agencies, employers, insurers, providers, and other groups.

The Dirigo Health Plan will look like other insurance products on the market, with covered services to include hospital, physician, and specialist visits, as well as prescription drugs. Revenue to cover premiums will come from employers, individuals, Medicaid, and funds

recovered through bad debt and charity recovery. Maine hopes to sign up 31,000 previously uninsured residents in year 1. More information on the Dirigo Health Reform Act is available at <http://www.dirigohealth.maine.gov>.♦

Yun Joins Fund's Board

William Y. Yun, president of the Fiduciary Trust, a unit of Franklin Templeton Investments, was elected to The Commonwealth Fund's board of directors in July. Yun is responsible for investment management and research activities at Fiduciary Trust, as well as for overseeing the company's international offices.

Fund Board Chairman Samuel O. Thier, M.D., said, "William Yun brings a wealth of experience to the Fund's board. His global background in investment management will be particularly valuable for the oversight of the foundation's endowment. At a time of increased attention on the governance of nonprofit organizations, we are fortunate to have a person of Bill's caliber join the board."

Yun's tenure at Fiduciary Trust has included the World Trade Center attacks of September 11, 2001, when the company lost 86 employees, as well as visiting business partners. Yun said the company's business disaster recovery efforts began immediately. "We began working to recover business information," says Yun, "but that was secondary to trying to assess who was where, who was missing, who was safe."

Yun has an M.B.A. from The Amos Tuck School of Business Administration at Dartmouth College, and a B.A. from Harvard University. He currently serves as chair of the Christ Church Day School and is a trustee of the South Street Seaport Museum, both in New York.♦

Maine's Dirigo health plan is premised on the belief that the three primary concerns with health care—costs, quality, and access—must be dealt with equally and simultaneously.

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Publications described in this *Quarterly* can be downloaded by visiting the Fund's website at www.cmwf.org.

Recent and Forthcoming Commonwealth Fund Publications, Summer 2004

Fund Reports

- B. Biles, L. H. Nicholas, and B. S. Cooper, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans*, May 2004
- D. Blumenthal, C. Vogeli, L. Alexander et al., *A Five-Nation Hospital Survey: Commonalities, Differences, and Discontinuities*, May 2004
- E. H. Bradley, T. R. Webster, D. Baker et al., *Translating Research into Practice: Speeding the Adoption of Innovative Health Care Programs*, July 2004
- S. R. Collins, *Health Care Costs and Instability of Insurance: Impact on Patients' Experiences with Care and Medical Bills*, Congressional testimony, June 24, 2004
- The Commonwealth Fund, *First Report and Recommendations of The Commonwealth Fund's International Working Group on Quality Indicators*, June 2004
- L. A. Cooper and N. R. Powe, *Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance*, July 2004
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- T. Trail, K. Fox, J. Cantor et al., *State Pharmacy Assistance Programs: A Chartbook*, August 2004

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- G. F. Anderson, D. G. Shea, P. S. Hussey et al., "Doughnut Holes and Price Controls," *Health Affairs* Web Exclusive (July 21, 2004): W4-396-W4-404
- G. Flores, M. Abreu, D. Sun et al., "Urban Parents' Knowledge and Practices Regarding Managed Care," *Medical Care* 42 (April 2004): 336-45
- C. Homer, D. Iles, D. Dougherty et al., "Exploring the Business Case for Improving the Quality of Health Care for Children," *Health Affairs* 23 (July/August 2004): 159-66
- I. B. Horn and A. C. Beal, "Child Health Disparities: Framing a Research Agenda," *Ambulatory Pediatrics* 4 (July/August 2004): 269-75
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