The Commonwealth Fund

2008 Annual Report

THE COMMONWEALTH FUND

The Commonwealth Fund's Mission

The Commonwealth Fund is a private foundation that promotes a high performance health care system providing better access, improved quality, and greater efficiency. The Fund's work focuses particularly on society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

Cover photo: Paula Lerner

The Commonwealth Fund
2008 Annual Report

Working toward the goal of a high performance health care system for all Americans, the Fund builds on its long tradition of scientific inquiry, a commitment to social progress, partnership with others who share common concerns, and the innovative use of communications to disseminate its work. The 2008 Annual Report offers highlights of the Fund's activities in the past year.

Program Highlights, 2008 (continued)

You *Can* Get There from Here: Mapping the Way to a Transformed U.S. Health System

THE COMMONWEALTH FUND

President's Message
2008 Annual Report

President's Message

You *Can* Get There from Here: Mapping the Way to a Transformed U.S. Health System

Karen Davis
The Commonwealth Fund

Where We Stand Today

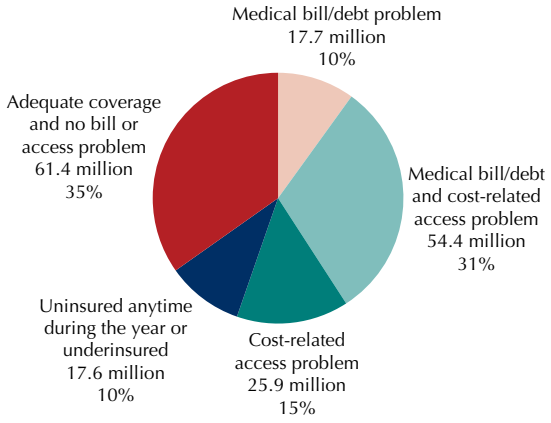
In a speech he gave nearly half a century ago, John F. Kennedy noted that the Chinese symbol for crisis comprises the characters representing both danger and opportunity. Today, his observation could not be more relevant. The potent combination of recent events in the United States has presented the nation's leaders with a historic opportunity to fix our broken health care system.

With 116 million adults under age 65 reporting health care-related financial issues, the nation's health care crisis and economic crisis have become inextricably intertwined. As unemployment grows, more Americans will join the ranks of the uninsured. States under pressure to balance their budgets are already making cuts in health programs that serve low-income adults and children. Already families—even those with insurance—are struggling to pay their share of premiums and medical expenses. Two-thirds of all adults under age 65 report being uninsured or underinsured, forgoing needed care, or struggling to pay medical bills or accumulated medical debt.[1]

Ours is the only industrialized nation that fails to ensure that all its citizens have access to affordable health care. We are slipping further behind what other countries achieve with their more modest investment in health care: the U.S. now ranks 19th out of a group of 19 major industrialized countries on an important measure of health system performance: mortality amenable to medical care. If we did as well as the best-performing countries, we would have 100,000 fewer deaths each year.[2]

Access is not the only problem. The poor performance of the U.S. health system also adds to the economic crisis. Currently, the United States spends twice as much per person as other major industrialized countries, saddling American businesses—especially those with aging workforces—with high expenses. It adds to burdens on taxpayers and squeezes other public priority needs, from education to the nation's aging infrastructure.

An Estimated 116 Million Adults Were Uninsured, Underinsured, Reported a Medical Bill Problem, and/or Did Not Access Needed Health Care Because of Cost, 2007



177 million adults, ages 19–64

Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*, The Commonwealth Fund, August 2008.

An Opening for Change

President Barack Obama has noted, rightly, that health care reform is integral to economic recovery. Investing now in the information technology and other tools needed to modernize our health system, as well as in children's health that will contribute to a healthy workforce in the future, will pay dividends in lower costs and greater productivity in the future.

As we have seen so recently in response to the financial crisis, when government and the business community work together they can creatively address urgent national needs. Reform of our health care system is such a need. Government, business, purchasers, providers, patients—each must be part of the solution. We must all be willing to change—and to put what is in the best interest of patients first—if we want to reap the rewards of a high-value, equitable health care system.

We are fortunate that within our imperfect health care system are examples of all the components that, properly organized, reformed, and financed, can enable the nation to provide high-quality, affordable care to virtually every American. Systematically applying and disseminating what we know works would help put the U.S. on the path to a high-performance health system.

As a nation, we stand today at the threshold of an era ripe with opportunity. A new administration in Washington—one that has promised serious attention to health care reform—gives us hope that providing insurance to all Americans, reducing costs, and improving quality and equity will all soon be in the forefront of our national policy debate.

Leading the Way to a High Performance Health System

The Commonwealth Fund Commission on a High Performance Health System has issued a call to action for health reform.[3] It underscores that a critical step toward achieving a high performance health system is to provide insurance coverage to all Americans. But equally essential are bold actions that simultaneously improve the quality and efficiency of health care delivery—so that we improve the lives of Americans, alter the trajectory of health care costs, and make it easier for patients to obtain the care they need and providers to practice the best of modern medicine.

The Commission calls for the following steps to be taken:

- *Provide affordable health coverage for all.* It is time that all Americans received the security of health care coverage enjoyed by citizens of every other major industrialized country. Providing everyone—regardless of age or employment status—with affordable insurance options, including a comprehensive package of benefits, will enhance access to care. This, in turn, will help reduce

disparities in care, increase the proportion of people receiving appropriate primary care to prevent illness, and improve the care and health of millions of Americans living with chronic conditions.

- *Reform provider payment.* Our open-ended fee-for-service payment system must be overhauled to reduce wasteful and ineffective care and to spur innovations that can save lives and increase the value of our health care dollars. We need to revamp our system for paying health care providers—reform that will reward high-quality care and prudent stewardship of resources, move toward shared provider accountability for the total care of patients, and correct the imbalance in payment whereby specialty care is rewarded more than primary or preventive care.
- *Organize our care delivery systems.* We need to reorganize the delivery of care, moving from our current fragmented system to one where physicians and other care providers are rewarded for banding together into integrated or virtual organizations capable of delivering 21st-century health care. Patients need to have easy access to appropriate care and treatment information, and providers need to be responsive to the needs of all their patients. Providers must also collaborate in delivering high-quality, high-value care, and they should receive the support needed for continuous improvement.
- *Invest in a modern health system.* The U.S. lags behind other countries in the adoption of health information technology and a system of health information exchange. In such a system, patient information would be available to all providers at the point of care, as well as to patients themselves through electronic health record systems, helping to ensure that care is well coordinated. Early investment in the infrastructure of a high performance health system—including information technology, research on comparative effectiveness of drugs, devices, and procedures, data on provider performance on quality and affordability, and a workforce that ensures a team approach to care—is an essential building block.
- *Ensure strong national leadership.* None of the above will be possible if government does not take the lead. The federal government—the nation's largest purchaser of health care services—has tremendous leverage to effect changes in coverage, care delivery, and payment. National leadership can encourage the collaboration and coordination among private-sector leaders and government officials that are necessary to set and achieve national goals for a high performance health system. It can also help set priorities and targets for improvement, create a system for monitoring and reporting on performance, and issue recommendations on the practices and policies required to achieve high performance.

Coverage for all Americans should be pursued simultaneously with the initiation of reforms aimed at improving the quality of care and efficiency of the health system. Universal coverage should not be held hostage until a more efficient health system is achieved. At the same time, coverage should not be expanded without at least beginning to make the system changes necessary to achieve a level of value that is commensurate with the nation's investment in health care.

Coverage: Building Toward Universal Coverage

The Obama Campaign Proposal

A transformed health system must start with health insurance for all. The Obama presidential campaign laid out a strategy for achieving affordable coverage

for every American that relies on a mixed system of private and public insurance options. Building on the best of what works, the plan would retain employer-sponsored health insurance, which now covers nearly 160 million Americans, and permit people who want to continue their current coverage to do so.[4] It would also retain Medicaid and the State Children's Health Insurance Program (SCHIP), and offer them as coverage choices to all low-income adults and children. Medicare, too, would continue to cover older and disabled adults.

But the Obama proposal would also provide small businesses and individuals with a choice of new affordable coverage options made available through a national health insurance exchange, modeled on the Massachusetts health reforms and the Federal Employees Health Benefits Program (FEHBP). In addition to private plans, there would be a new public health plan option.

A key question is how expanded coverage will be financed, especially premium assistance for low-income and moderate-income households. The Obama campaign proposal embraced shared financial responsibility for health care—with contributions from federal and state government, employers, and households. All except small businesses would be required to either cover their workforces or contribute to a fund for coverage. Households would also contribute to coverage, with premium assistance available to ensure affordability. Tax breaks for higher-income households, enacted during the Bush administration, would be repealed or allowed to expire to fund coverage expansions.

Depending upon a number of specific critical design decisions, these funds may not be sufficient to cover the federal budget cost of the plan. In a time of economic crisis, expanded health insurance coverage will help stimulate the economy and create jobs, as well as contribute to better health and productivity. Deficit financing in the early years can be justified as part of an economic recovery program. But financing sources in out-years are needed to ensure long-term fiscal soundness. Savings offsets are possible from payment and system reforms—these investments and changes should receive priority attention in the first phase of health reform as their impact is greater in out-years.

Still, other sources of long-term financing will need to be identified and assessed. These might include higher taxes on high-income households, or a redirection of funds "within the system," such as indirect subsidies for care of the uninsured. Taxes on harmful health products—such as sugared soft drinks and tobacco products—should be among the financing options considered.

The "Building Blocks" Approach

A health care reform framework developed by staff at The Commonwealth Fund shares many essential features with the Obama campaign proposal.[5] Known as "Building Blocks," it would retain our mixed private–public system of coverage, require employers to provide health insurance to employees or contribute to a fund, and establish a national health insurance exchange, or connector, to offer private plans as well as a public plan modeled on Medicare to small businesses and individuals. Combining a requirement for coverage under either a public plan or private plans with selected provider payment and health system reforms would make it possible to cover nearly everyone—at minimal cost to the federal budget and with total net savings to the health system.[6]

The Building Blocks framework, however, differs from the Obama campaign proposal in some important respects: it requires everyone to obtain health insurance coverage; it does not include tax subsidies

for businesses; and it improves benefits and financial protection for Medicare beneficiaries comparable to those under age 65.

Because it includes details on the amount of premium assistance that would be made available to lower-income families, the amount of employer contributions, and other features, it is possible to estimate the impact Building Blocks would likely have on total health system spending and on the federal budget. According to calculations by the Lewin Group,[7] public plan actuarial premiums would be 20 percent to 30 percent lower than premiums typically charged for employer-sponsored plans, especially those in the small-group market—largely because of Medicare's lower administrative costs and payment rates for providers. Overall, the Building Blocks framework could not only help ensure that affordable coverage is available to the uninsured, but it could ensure improved coverage at lower costs for many employers, the self-employed, and insured individuals who now buy coverage on their own.

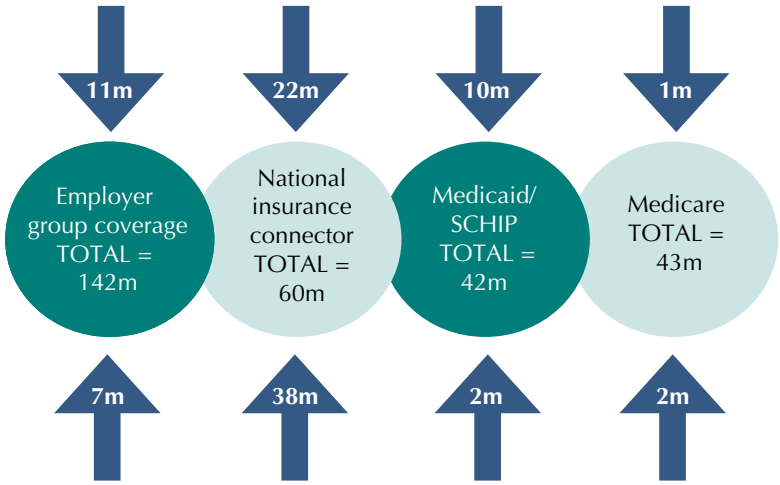
Gains in coverage. Near-universal coverage could also be achieved using the Building Blocks framework, according to the Lewin Group. Forty-four million people in the United States who are currently uninsured would have health insurance, or 99 percent of the total U.S. population. Premiums would be limited to no more than 5 percent of income for lower-income families, and 10 percent of income for other households.

The requirement that employers cover employees or contribute to coverage would persuade more employers to offer coverage. Premium assistance based on income would also make it possible for more low-wage workers to take up their employers' offers of health coverage.

In addition, under the Building Blocks framework all Medicare beneficiaries would have improved benefits and adequate financial protection, with premiums capped as a percentage of income. Elimination of the two-year waiting period for coverage of the disabled under Medicare would add an additional

Building Blocks for Automatic and Affordable Health Insurance for All

New coverage for 44 million uninsured in 2008



Improved or more affordable coverage for 49 million insured

Source: Based on analysis in C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs,* May/June 2008 27(3):646–57, from Lewin Group modeling estimates.

1 million people to Medicare, enabling them to get the early care needed at the onset of disability from serious conditions, such as cancer. Letting older adults and early retirees buy into Medicare would ensure them affordable coverage at a premium that reflects far better value than health plans offered in the individual insurance market—if they are available at all to people with health conditions.

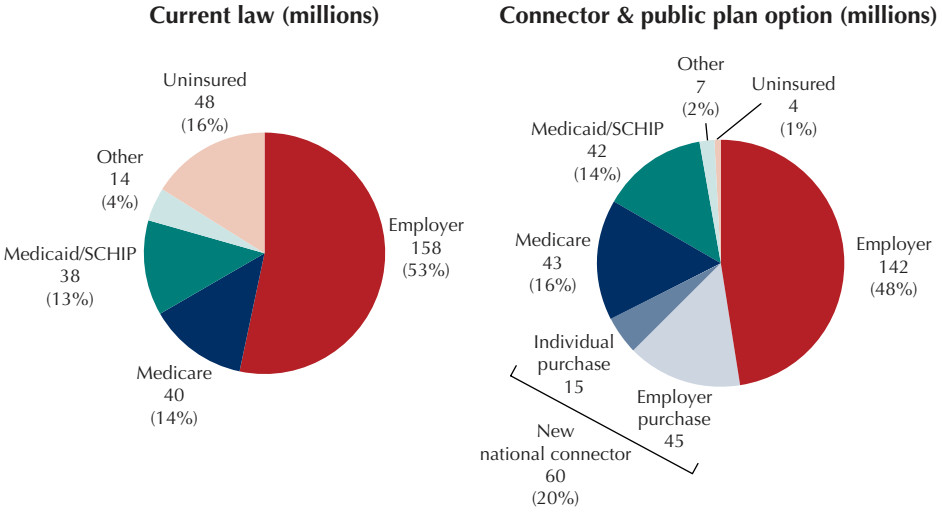
Better quality of coverage. For the 49 million people with insurance who change coverage, their health coverage would improve or their premiums would be lower. Small businesses (with fewer than 100 employees), in particular, would likely respond to the possibility of improved, lower-cost coverage by buying coverage through the national insurance connector instead of directly in the private market.

Altogether, total employer-based coverage—sponsored either directly by employer health plans or financed by employers through the connector—would increase from 158 million people to 184 million, or from 53 percent of the population to 63 percent. The change in coverage reflects decisions made by employers or, in some cases, by individuals, to switch to better health coverage—rather than a requirement that people change their current coverage.[8] Given that many Americans are satisfied with their current coverage, offering choices is likely to garner greater support than radical changes made to existing insurance.[9]

An estimated 60 million Americans would be covered through the national insurance connector, including those individuals whose employers purchase insurance through the connector. Approximately three-quarters, more than 45 million people, would obtain coverage through the new public plan option, and the remaining 15 million people would be in private plans.

Lower costs, more competition. The attraction of the public plan option modeled on Medicare is its lower premiums—an average of 20 to 30 percent lower—compared with private plan offerings.[10] Medicaid provider payment rates, which are substandard in

Building Blocks with Connector and Public Plan Option, 2008



Total population = 298 million

Source: Based on analysis in C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May/June 2008 27(3):646–57, from Lewin Group modeling estimates.

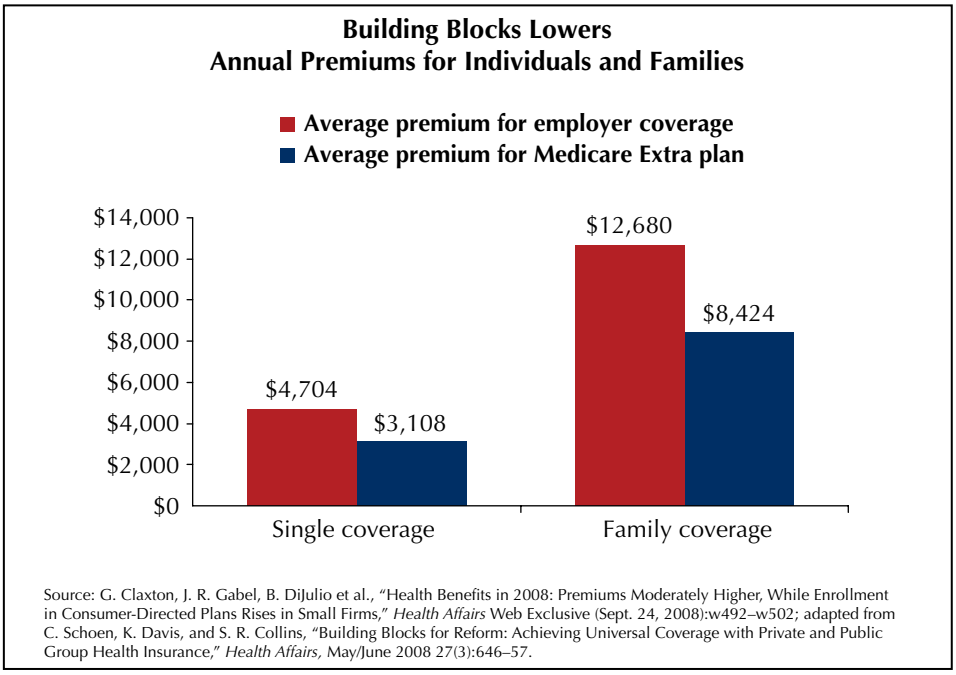
many states, would be raised to Medicare levels to ensure adequate provider participation. Covering the uninsured and underinsured largely through the public plan option and Medicaid/SCHIP is an economical way to expand coverage. Providers under the public plan option are paid at Medicare rates rather than at higher commercial insurer rates.

Private insurers are likely to respond to the competition from a public plan option by forming more highly integrated delivery systems or selecting high-value providers for participation in networks. However, if the public plan continues to be less expensive over time, it might be expected that more people would switch to public coverage. This could lead to further transformation of the private insurance market, as private insurers endeavor to "meet the competition" by lowering overhead and adopting innovative practices in pursuit of higher value or lower premiums. Private plans meeting certain conditions could also be permitted to pay at Medicare rates, with provider participation in Medicare and national health insurance exchange plans conditional on accepting such rates as payment in full.

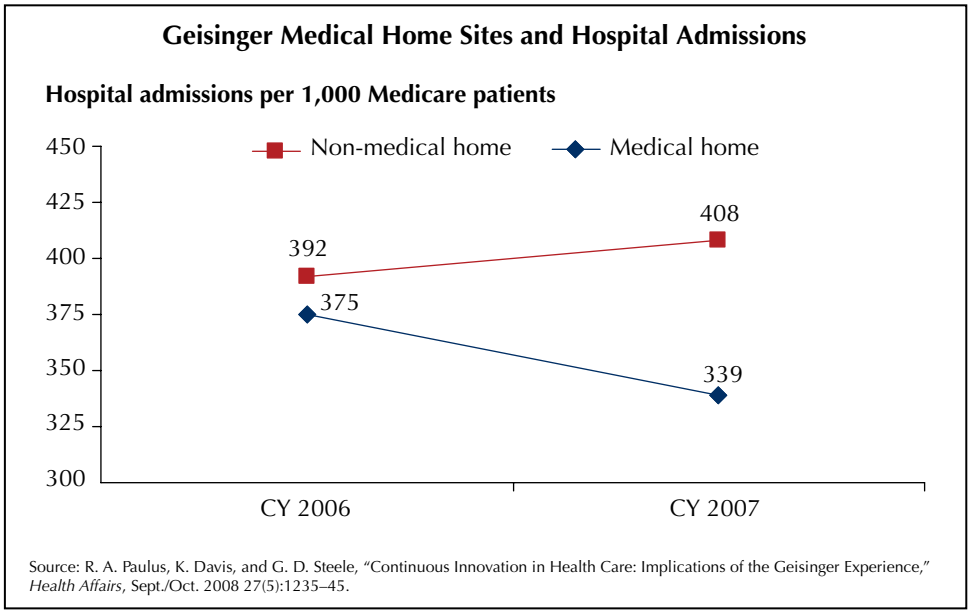
System reforms are a critical part of this plan, and they should include giving providers and patients the information they need to make appropriate health care decisions, revising methods for paying providers to encourage greater accountability for the care delivered, and encouraging preventive care use and health promotion. In a report for The Commonwealth Fund, *Bending the Curve*, The Lewin Group estimated the impact of 15 options to illustrate the potential of multifaceted approaches for addressing projected health care expenditure increases.[11] The most promising of these options are described in more detail below.

Cost: Reforming Payment by Leveraging Medicare's Purchasing Power

An essential step in transforming the health care system is changing the financial incentives for hospitals, physicians, and other health care organizations so that they become more accountable for patient health outcomes and the prudent use of resources. Medicare could lead the way by instituting a system for the rapid testing, adoption, and spread of innova-



Source: G. Claxton, J. R. Gabel, B. DiJulio et al., "Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises in Small Firms," *Health Affairs* Web Exclusive (Sept. 24, 2008):w492–w502; adapted from C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May/June 2008 27(3):646–57.



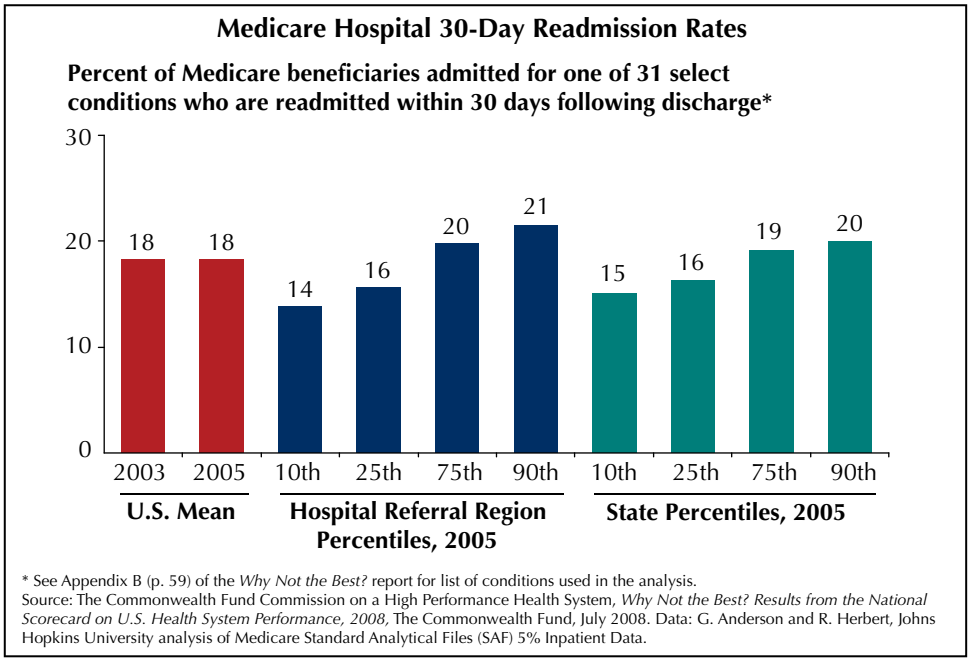
Source: R. A. Paulus, K. Davis, and G. D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs*, Sept./Oct. 2008 27(5):1235–45.

tive payment methods. These should include rewarding high-performing health care organizations for results, not for the quantity of services delivered.

The three most promising changes to provider payment are:

- *Recognizing physician practices or health systems that serve as patient-centered medical homes.* A Commonwealth Fund survey found that patients cared for by physician practices that are accessible and organized are much more likely to receive preventive care and assistance managing their chronic conditions.[12] With Fund support, the National Committee for Quality Assurance has developed standards for physician practices to qualify as patient-centered medical homes. In addition to current fee-for-service payments or a global primary care fee covering all primary care needed by enrolled patients, a medical home fee could also be paid to physician practices that meet medical home standards—that is, they provide accessible and coordinated care to patients and assume responsibility for ensuring patients get all appropriate preventive care and assistance with managing chronic conditions. The Commonwealth Fund is supporting an initiative to help safety-net clinics—which serve low-income and minority patients—transform themselves into patient-centered medical homes. Preliminary evidence from Fund-supported studies suggests that having a medical home can improve patients' experiences and the quality of clinical care while also reducing avoidable hospitalizations.[13] Moreover, estimates from the Fund's *Bending the Curve* report indicate that reforming provider payment to strengthen primary care and improve coordination could generate $194 billion in national health expenditure savings over 10 years.

- *Paying a global fee for acute hospital episodes, including 30-day follow-up care.* A new system of payment for hospital care would make a hospital or health care system accountable not only for the initial hospitalization but any subsequent complications, readmissions, or



* See Appendix B (p. 59) of the *Why Not the Best?* report for list of conditions used in the analysis.
Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, The Commonwealth Fund, July 2008. Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

emergency care. The Commonwealth Fund's State Scorecard on Health System Performance found wide variation in Medicare hospital readmission rates across states.[14] The percentage of Medicare patients readmitted to the hospital within 30 days averaged 18 percent in 2005, but hospital readmission rates varied from 14 percent in some areas to 21 percent in others. The Fund is supporting the Institute for Healthcare Improvement in its initiative to reduce avoidable hospitalizations by providing hospitals with practical guidance on ways to decrease complications during hospital stays, improve patient communications in the discharge process, and monitor patients after discharge.

Aligning financial incentives to reward hospitals for better transitional care from hospital to home or nursing home could spur such efforts and compensate hospitals for the additional cost of changing processes to improve care. Hospital systems, multi-specialty physician group practices, and integrated delivery systems that are willing and able to assume financial risk for the total care of patients over an episode of illness could be paid a global fee for each episode, starting with the initial hospitalization.[15]

Such a payment change could start with Medicare. For Medicare alone, preventing avoidable hospitalizations could save $12 billion in one year.[16] The Fund's *Bending the Curve* report estimates that such a change would reduce national health expenditures by $229 billion over 10 years.[17]

- *Providing financial rewards for top-performing providers.* Medicare could reward all physicians, hospitals, health systems, nursing homes, and other providers that excel at providing top-quality care. In recent years, the Medicare program has begun publicly reporting mortality rates and quality of care for selected hospitalized patients, including those with heart attacks, congestive heart failure, and pneumonia. Medicare demonstrations are also testing new payment methods

that peg payment to performance. Providing bonuses to hospitals that ranked in the top 20 percent on quality metrics for major conditions such as congestive heart failure and pneumonia improved quality and achieved savings from reduced readmissions and fewer complications.[18] Similarly, a demonstration of rewards to physician group practices for slowing the growth in Medicare outlays stimulated new ways to avoid hospitalization and achieve savings.[19] The *Bending the Curve* report estimates that spreading the Medicare hospital pay-for-performance demonstration to all hospitals would save $34 billion in national health expenditures over 10 years.

Each of these payment methods provides an incentive for health care providers to improve quality of care, coordinate care across care settings and over time, and prevent avoidable hospitalization and complications. In doing so, they create a dynamic that leads to higher-value care—better outcomes, higher quality, fewer complications, and lower costs.

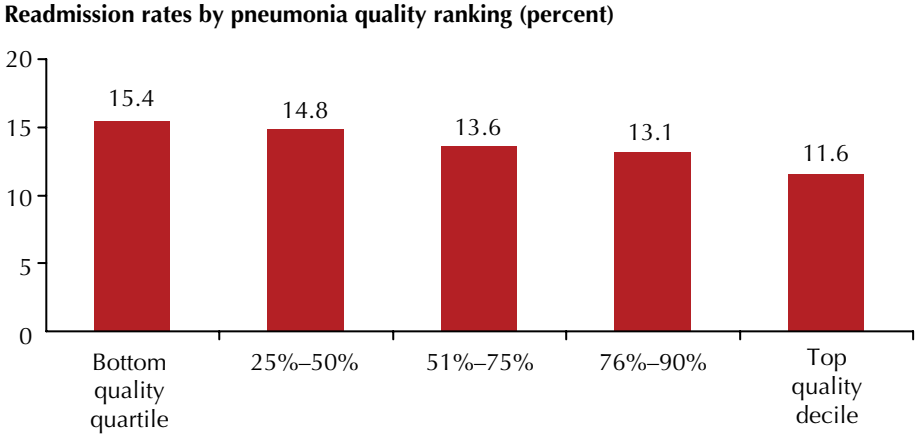
Delivery System Reform: Organizing the Health Care System Around the Patient

Providing modern, high-quality health care requires moving to a more organized delivery system that taps the expertise of a team of health professionals, from primary care and specialist physicians to nurses and pharmacists. As outlined above, Medicare can help lead the transformation of health care delivery by basing its payment policies on health outcomes and results, not on who provides a given medical service.

Medicare can also encourage greater organization of care by recognizing systems of care—from individual clinics to large integrated delivery systems—that reach high standards of care, report their results publicly, and assume accountability for patients. This includes making sure that every enrolled patient is up-to-date with all recommended preventive care, and that all patients with chronic conditions receive the follow-up care necessary to keep their conditions under control.

These principles should apply to the private plans that now serve Medicare beneficiaries. Current methods of payment and reporting for private Medicare

Medicare Experimenting with Pay for Performance
CMS-Premier Hospital Quality Incentive Demonstration:
Higher Quality Hospitals Have Fewer Readmissions



Source: Stephanie Alexander, "CMS/Premier Hospital Quality Incentive Demonstration Project: 1st Year Results," Presentation at an Institute of Medicine Pay for Performance Subcommittee Meeting, November 30, 2005.

Advantage plans do not encourage them to reach high levels of quality and efficiency. Rather, these plans are paid, on average, 13 percent more to care for patients than it would cost under traditional Medicare. Not surprisingly, the "overpayment" of private plans that was authorized by the 2003 Medicare Modernization Act has led to their rapid proliferation and to growth in their Medicare beneficiary enrollment. The *Bending the Curve* report estimates that leveling the playing field between Medicare Advantage plans and traditional Medicare would save $50 billion in national health expenditures over 10 years.

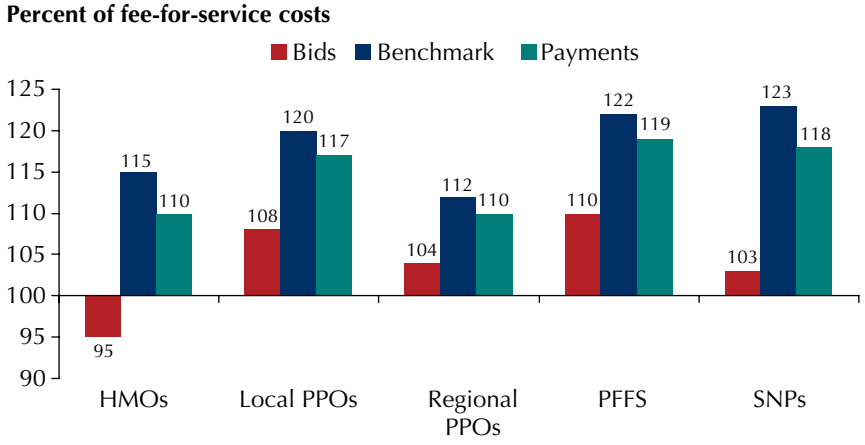
Infrastructure Investment: Meeting and Raising Benchmarks for Care

The federal government can also raise the bar for health system performance and help providers get the tools they need to reach the highest attainable levels of performance. This should start with setting explicit goals and priorities for improvement—including a focus on the most prevalent chronic conditions, which account for a large majority of health care costs.

For example, Medicare could join with private insurers and other payers to develop a database that lets providers and the public know how they are doing relative to what is possible. Having reliable comparative data, adjusted for differences in patient characteristics, is the first step along the path to improvement. Such a database should provide timely feedback on how each and every provider—whether health system, hospital, physician, or long-term care facility—is doing on quality and health outcome metrics that are tied to achievable benchmarks. The Commonwealth Fund is helping to support such a tool through its WhyNotTheBest.org Web site with data and tools to improve hospital clinical quality and patients' experiences.

Medicare, Medicaid, and private insurers can also ensure that the care they cover is based on the best and latest research findings on effectiveness. Insurers should cover all medications, devices, and procedures that have been scientifically shown to improve patient outcomes and quality of life. But insurers also should be prudent purchasers, paying no more for a

Payments to Medicare Advantage Plans as a Share of Medicare Fee-for-Service Costs, 2006



Note: HMOs = health maintenance organizations; PPOs = preferred provider organizations; PFFS = private fee-for-service plans; SNPs = special needs plans.
Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2007).

device or treatment than they would for another that is equally effective. The *Bending the Curve* report estimates that a center on medical effectiveness and health care decision-making could save $368 billion over 10 years, if insurance benefit design and payment were tied to evidence on cost-effectiveness.

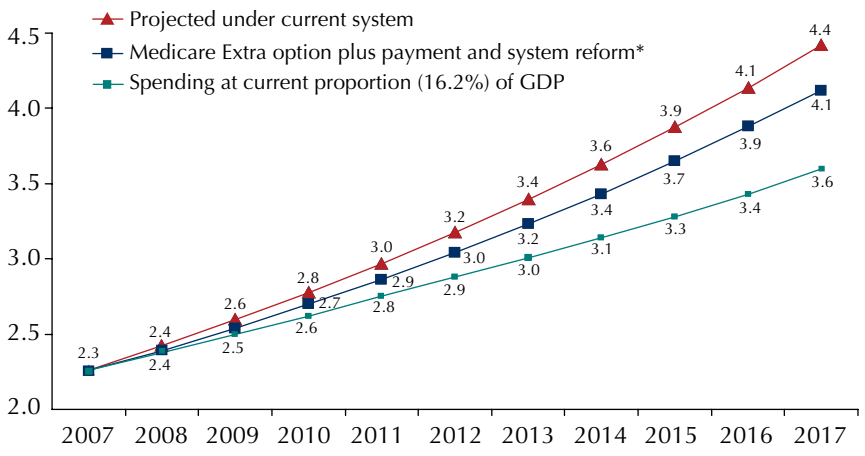
Modern health care also requires replacing antiquated paper-based medical records with systems that take advantage of modern health information technology. Medicare can do its share by joining with private payers in contributing funds to help those who cannot afford to purchase such technology on their own—especially safety-net clinics and hospitals serving uninsured and low-income patients. It can also create incentives for the adoption of information systems meeting approved standards, and help establish "health information networks" that allow patients and the health professionals that care for them to have all relevant medical information available at their fingertips. While such a change requires upfront investment, it would begin to pay dividends after seven years and generate net savings of $88 billion over a decade.

Ensuring Accountable National Leadership and Public–Private Collaboration

While it is clear what the federal government could do to help move the U.S. health system further along the path to high performance, carrying out change is difficult in a highly political environment where consensus must be reached among 535 members of Congress and endorsed by the President. That is why the federal government must assume a much greater leadership role.

Strong, effective leadership, however, requires independence and authority to act quickly to test and spread new ideas. By strengthening Medicare with a "board of directors"—an independent health board or health authority—it would be able to structure an appropriate set of incentives for beneficiaries and health care providers. This would involve setting payment methods and levels, making decisions on

Total National Health Expenditures, 2008–2017, Projected Under Connector with Public Plan Option with Payment and System Reform



* Selected individual options include improved information, payment reform, and public health.
Source: C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, The Commonwealth Fund, December 2007.

what drugs, devices, and procedures are covered, setting conditions of provider or health care organization participation, and ensuring rapid information feedback to providers and beneficiaries on outcomes, quality, accessibility, and efficiency of care achieved by different health care organizations and providers.

To ensure accountability, Congress would need to establish a framework for operation of the new health board. For example, there might be five-year targets on Medicare spending per beneficiary, along with a requirement that costs cannot be shifted to private payers, states, or beneficiaries. The health board should be required to make an annual report to Congress on the extent to which Medicare is improving outcomes, quality, access, equity, and efficiency of care for its beneficiaries—as well as the health system as a whole—and what key actions it proposes to implement in the coming year.

While Congress could retain the authority to override the proposed plan of action and substitute an alternative that achieves the same overall goals, the health board should be structured to ensure its independence and ability to implement a long-range vision. This might mean that full-time board members are appointed by the President to lengthy terms. Rather than representing the different interests affected by Medicare policy, all board members should have the requisite expertise to carry out the functions assigned to them.

In addition, the health board should be authorized to convene and collaborate with private payers and other parties to streamline and simplify many of the conflicting regulations and processes that burden the health care system. For example, one system of data reporting, one set of performance metrics, and one set of conditions for provider participation should greatly reduce current administrative costs and burdens on providers.

Putting It All Together: A Roadmap to a Transformed Health System

These actions, taken together, have the potential to achieve near-universal coverage, improve quality, and expand access—all while generating health system savings of at least $1.6 trillion over 10 years.[20] Broader health system reforms, if combined with coverage expansion, would also achieve federal budget savings that largely offset the cost of achieving universal coverage after five to 10 years.

On issues of cost, quality and coverage, a transformed Medicare payment system is the key to a transformed health system. As the discussion about reforming health care gathers steam during 2009, The Commonwealth Fund, together with its Commission on a High Performance Health System, will continue to make the case for an integrated approach to system reform, one in which issues of access, quality, and cost are considered concurrently. We will also continue to stress the importance of leadership and collaboration among business, government, insurers, providers, and patients—no matter what path reform takes. By providing information on promising initiatives, assessing the likely impact of proposed policies, and offering new ideas, we hope to assist health care leaders and policy officials who are committed to making the U.S. health system truly the best it can be.

Windows of opportunity for real health reform do not stay open for long. While the challenge is daunting and the stakes are high, it is imperative that our new federal leadership moves swiftly to change direction and put the U.S. health system on the path to high performance.

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7 The Lewin Group is a wholly owned subsidiary of Ingenix which in turn is owned by UnitedHealth Group. The Lewin Group maintains editorial independence from its owners and is responsible for the integrity of any data that it produces for the Fund.

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New Financial Realities: The Response of Private Foundations

THE COMMONWEALTH FUND

Executive Vice President and COO's Report
2008 Annual Report

New Financial Realities: The Response of Private Foundations

John E. Craig, Jr.

In recent months, the international financial system has experienced the most severe turmoil since the Great Depression of the 1930s—stresses that in September 2008 came close to completely freezing up the flow of credit that is the lifeline of all economic activity. The ensuing bankruptcies and fire sales of financial powerhouses, and the government's interventions, have fundamentally changed the structure of Wall Street and international financial markets.

At this point, actions by the U.S. Federal Reserve, U.S. Treasury, and other countries' financial overseers have brought the financial system back from the brink of collapse. The Obama administration and Congress have taken further steps, including the enactment of an economic stimulus package of unprecedented proportions. Efforts are also under way to identify improvements in regulatory and market structures needed to address the flaws that produced the crisis.

Although the real-world impact of financial chaos is just beginning to unfold, it is useful at this point to contemplate the implications for private foundations and the constituencies they serve. I begin with a summation of the causes of the crisis, and then discuss the impact on markets in general and private foundations in particular. Next, after presenting a framework for analyzing the extraordinarily diverse U.S. private foundation sector, I offer some lessons on endowment management that foundations might take from the ongoing crisis. Finally, I turn to thoughts on how the spending plans and program strategies of these institutions are likely to be affected as they survey the damage that has been inflicted in recent months.

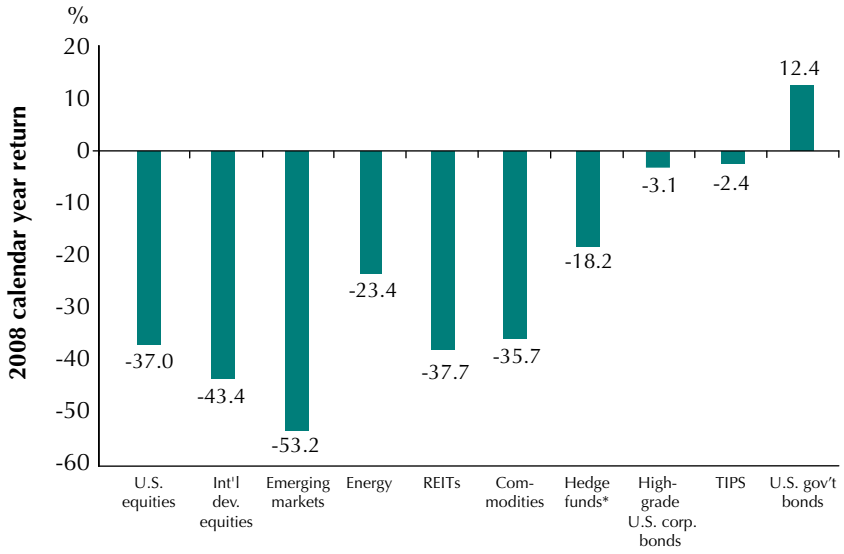
Market Environment

In the words of Ben Inker of the investment management firm GMO, "In 2007, the world saw the most profound bubble in risk assets ever seen, and it is the bursting of this bubble [in late 2008] that has led to the enormous loss of wealth we have experienced to date."[1]

As shown in Figure 1, in 2008, outside the safe haven of conventional U.S. government bonds, there was no place to hide from the financial storm. U.S. stocks, for example, fell by 37 percent (as measured by the S&P 500); international stocks (MSCI EAFE index), by 43 percent; emerging markets stocks, by 53 percent; energy stocks, by 23 percent; Real Estate Investment Trusts (REITS), by 38 percent; commodities, by 36 percent; and hedge funds, by 18 percent (through November 2008). Similarly, high-grade U.S. corporate bonds declined by 3 percent, high-yield corporate bonds by 26 percent, and even "safe" investments, such as U.S. Treasury inflation-protected bonds (TIPS), by over 2 percent. Among all the major market sectors, only U.S. Treasury bonds yielded positive returns (12%).

Photo: Commonwealth Fund Board members Jane E. Henney, M.D., professor of medicine at the University of Cincinnati Academic Health Center, Robert C. Pozen, chair of MFS Investment Management, and William Y. Yun, executive vice president of Alternative Investments for Franklin Templeton Investments. Pozen and Yun are members of the Fund's Investment Committee, which meets regularly to review the performance of the endowment and individual managers and reassess the allocation of investments.

Figure 1. The crash of 2008 devastated most financial markets, leaving few safe havens for endowment investors



Source: JPMorgan Chase and Cambridge Associates.

The shock that institutional and individual investors experienced in the autumn of 2008 was compounded by the suddenness with which the collapse across so many markets occurred. The first signs of the coming storm appeared in July 2007, when short-term credit markets seized up and a few heavily leveraged hedge funds failed. Still, the U.S. stock market went on to achieve its all-time high in early October. A further sign was the –9.5 percent return produced by the S&P 500 for the first quarter of 2008, but most were lulled by the fact that the major market index fell by "only" 2.7 percent in the second quarter of the year, during which period the first major Wall Street bankruptcy occurred. Through August, the year-to-date return on the S&P 500 was –11.4 percent—worrisome, but perhaps normal, given the amount of concern about the financial system and the economy overall. Thus, when the storm finally broke with a fury in September 2008, there was tumult throughout the financial sector. In the last three months of the year, the S&P 500 fell by 23.2 percent, and investors were reeling.

The causes of the market bubble are as clear in hindsight as they were disregarded in the making. In summing them up, it is only fair to draw primarily on the insights of investor Jeremy Grantham, a self-described "perma-bear" whose warnings went unheeded for so long:[2]

- Sustained increases in the U.S. money supply, beginning as an antidote to the Y2K fears of 2000 and augmented in response to the bursting of the technology stock bubble in the early 2000s;
- As a result, enormous credit expansion, increased leverage, and indebtedness throughout the U.S. and, indeed, worldwide economy (private and public), evidenced particularly in the housing price bubble;
- At the U.S. Federal Reserve, the view that bubbles cannot be tackled by authorities and can only be allowed to run their course;
- A weakening financial regulatory environment;

- The development over the last 20 years of increasingly complicated financial instruments whose market value can be difficult to ascertain or whose risk can be easily misjudged;
- Marked increase in risk-taking across all markets and investor groups.

In the crisis environment that has prevailed since September 2008, monetary authorities, U.S. Treasury officials, and their overseas counterparts have focused on massive temporary measures aimed at preventing a breakdown similar to that which led to the Great Depression. Missteps have undoubtedly occurred along the way, but recent narrowing of the difference between the cost of borrowing by corporations and the federal government (the "yield spread") suggests that the medicine may be beginning to take effect. Much serious thinking, however, needs to be given to addressing the policy and structural faults that produced the crisis, and to the potential long-term inflationary effects of the medicine that is being administered.

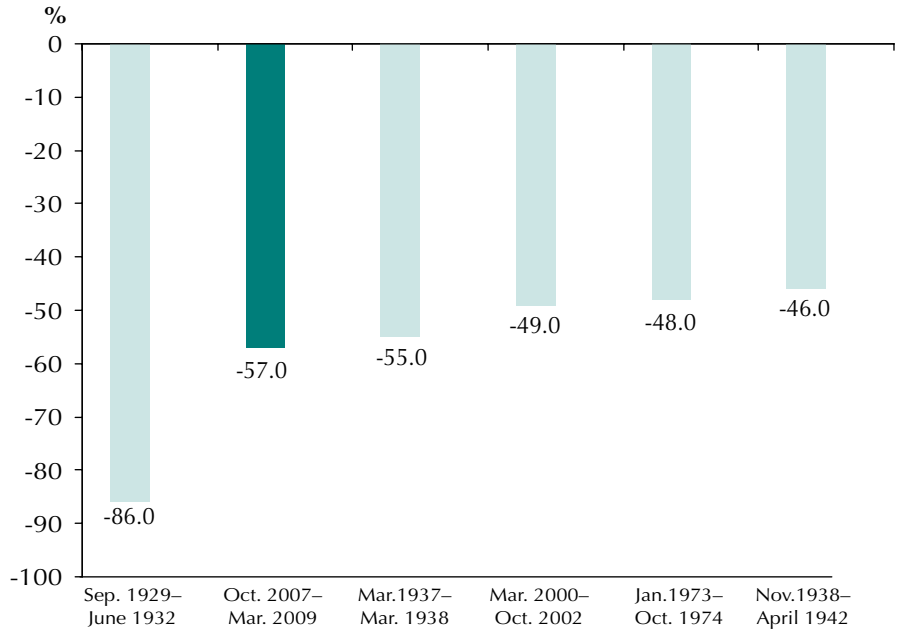
The Burst Market Bubble in Perspective

As severe as the current bear market in U.S. equities is, the data in Figure 2 reveal that it is not of unprecedented proportions. The Great Depression era bear market exceeded its damage (return of –55.5%) by wide margins. More relevantly, the current bear market's return (at least through March 9, 2009), while the lowest of any since the 1930s, is within striking range of two more recent severe bear markets: that of the 2000–02 technology stock bust (–49.1%) and that of the 1970s oil embargo (–48.2% in 1973–74).[3]

No one can say how this market will play out, but the historical record suggests three possible scenarios:

- A quick rebound, comparable to what happened after the crash of 1987;

Figure 2. The current bear market in stocks is the second most severe since 1926, but is close in scale to that of the technology stock crash of 2000–02 and the oil crisis of 1973–74



Source: Cambridge Associates.

- A two- to five-year period of market recovery, characterized by returns that are modest in comparison with that of the great bull stock market of 1982–2000 (S&P 500 average annual return of 19.5%), the principal reference point of the current generation of endowment managers;
- A "lost decade," comparable to the experience of the stagflation era of the 1970s to early 1980s, when the average annual real return on U.S. stocks was 0.3 percent.

Of these, the first seems highly unlikely, given the excesses that had built up in markets and the gravity of the underlying causes of the downturn. The third is not out of the question, but it can be averted if the monetary policy interventions now under way work and if the federal fiscal stimulus package just enacted encourages productive economic activity and addresses underlying problems working against the long-term health of the U.S. economy.

The most likely scenario is the middle one. Even a perma-bear like Grantham believes that the severely battered market has left most asset classes so undervalued that real (inflation-adjusted) returns of 5.7 percent (small-capitalization stocks) to 10.4 percent (high-quality stocks) are possible in U.S. equities over the next several years—with generally better returns possible in markets that are more undervalued than the U.S. market (e.g., international stocks). As importantly, truly skillful investment managers, taking advantage of buying opportunities not seen in such quantity since 1982, should be able to produce returns superior to these averages.[4]

This guarded optimism, however, must be qualified by the following two cautions:

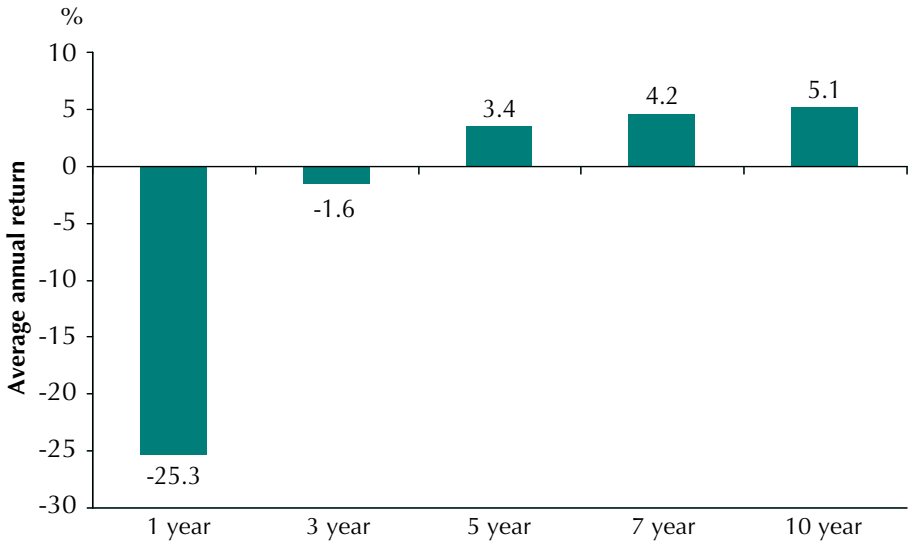
1. Markets tend to overshoot every bit as much on the way down as they do on the way up, which gives credence to the fear voiced by less-pessimistic managers than Grantham that the S&P 500 may yet dip below its low point so far (March 2009)—to 600 or worse—before rebounding.
2. The Japanese experience of the 1990s (following the crash of that country's 1980s bull market) demonstrates that, despite all that has been learned about monetary and fiscal policy since the 1930s, experts and policymakers may still fail to prevent a decade of lost economic growth.

The Damage to Foundation Endowments

Comprehensive data on the impact of the market crash on private foundations will not be available for some time, but the data in Figure 3 are indicative of what has happened. Looking at net returns through December 31, 2008, for 89 foundations, including The Commonwealth Fund, as well as the Multi-Asset Fund of The Investment Fund for Foundations (TIFF), we see that during the 2008 calendar year the average return for this group—which includes arguably some of the best-managed foundation endowments in the country—was –25.3 percent.[5] As a result of the market crash, the average annual return over the last three years was –1.6 percent. The average annual return over the last five-, seven-, and 10-year periods has been modestly positive, but not enough to keep up with inflation and, at the same time, enable foundations to meet their IRS-required spending rate of 5 percent. In contrast, at the end of June 2008, spending- and inflation-adjusted returns for all of these periods were decidedly positive for these foundations.

A very rough estimate of how much wealth has been lost in the entire private foundation sector can be arrived at by using the historical statistical association

Figure 3. In 2008, leading foundation endowments suffered severely negative returns, pulling down their long-term average annual returns to levels insufficient to cover the 5 percent payout requirement as well as inflation



Average annual returns for 89 foundation endowments, including the TIFF Multi-Asset Fund, periods ending 12-31-08

Source: Cambridge Associates.

between market returns (weighted according to the typical asset-class allocation of foundations) and year-to-year changes in foundations' total assets.[6] According to The Foundation Center, in 2007, the market value of the combined assets of all U.S. foundations was in the neighborhood of $670 billion. As a result of the market crash, total foundation assets by the end of 2008 were likely no more than $561 billion—a decline of $109 billion, or 16 percent (Figure 4). Knowledgeable observers argue that when the actual data are in, the decline will prove to be closer to 25 percent, or $167 billion.

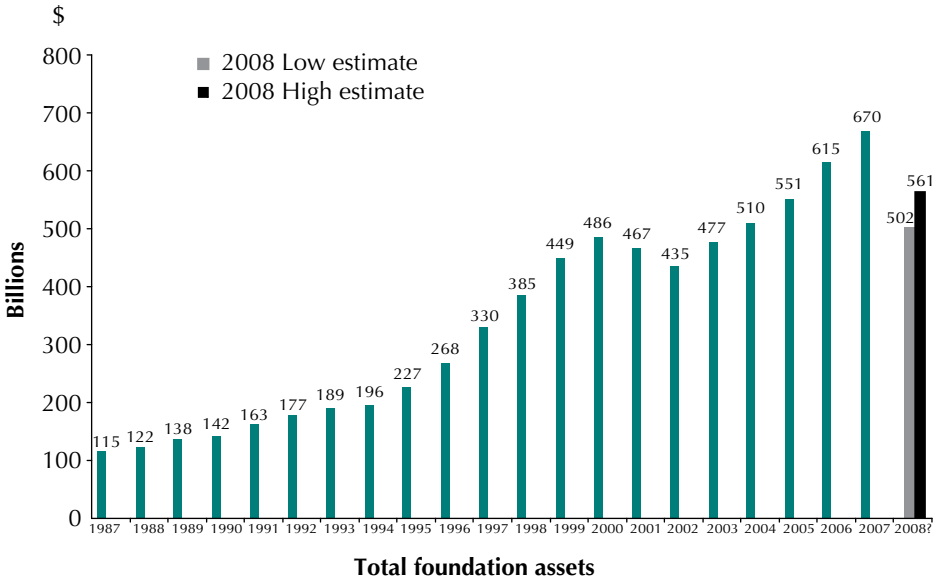
How the institutions bearing these losses are likely to respond to this startling new financial reality, in terms of endowment management practices, spending policies, and program strategies, will be addressed below. But first, it is useful to have a framework for thinking about these questions that takes into account unique characteristics of the foundation sector.

The Private Foundation Sector: A Framework for Analysis

Every study of private foundations emphasizes their pronounced diversity—by size, mission, goals, business model, and program strategies. For the purposes of this analysis, it is useful to group the approximately 72,500 foundations that existed in 2006 (the latest year for which data are available) by asset size and by key differentiating features of their business models and program strategies (Figures 5 and 6).[7]

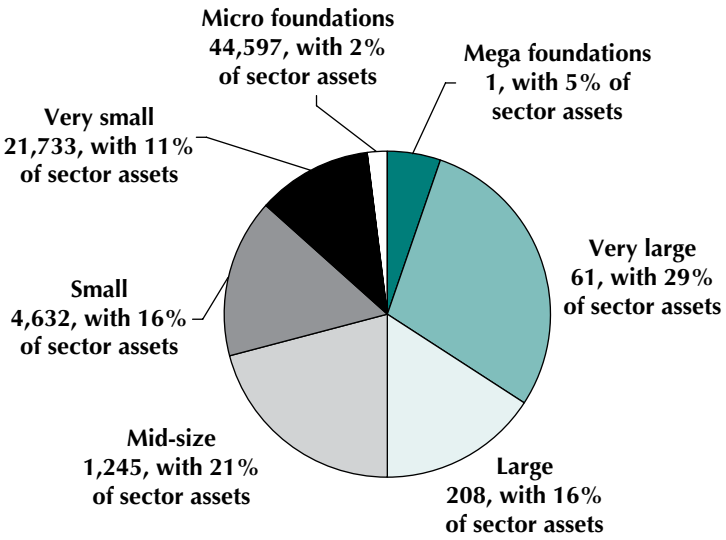
With respect to business model, foundations may choose to be either perpetual or to spend down assets over a designated period. A variation on the spend-down model is foundations that serve as "pass-through" conduits for annual giving by donors. Corporate-sponsored foundations are of the latter type, but so are many very small foundations. While there can be significant differences, both the investing and spending practices of spend-down and pass-

Figure 4. As a result of the 2008 market crash, total private foundation assets have likely declined by at least 16 percent



Source: Trend data, The Foundation Center; estimates, The Commonwealth Fund.

Figure 5. 270 private foundations with assets of $250 million or more in 2006 controlled 50 percent of the sector's resources; the vast majority of the 72,477 foundations are very small organizations, with assets under $10 million.



Mega foundations have assets of $15 billion or more; Very large, from $1 billion to $14.99 billion; Large, from $250 million to $999.99 million; Mid-size, from $50 million to $249.99 million; Small, from $10 million to $49.99 million; Very Small, from $1 million to $9.99 million; Micro foundations, less than $1 million. Source: The Foundation Center.

through foundations are generally quite similar. They are therefore not analyzed separately here.

On program strategy, foundations may choose to use funds principally for conventional charitable purposes—such as subsidizing the costs of building and running hospitals, schools, universities, social service organizations, and cultural organizations. Or they may seek to bring about fundamental improvements in society through investments in social infrastructure—for example, in the case of health foundations like The Commonwealth Fund, funding health policy research and demonstrations testing better models of providing health insurance and delivering health services.[8]

As shown in Figure 5, we know with a fair amount of precision the array of private foundations by asset size. It is a very concentrated distribution: the 270 foundations with assets of $250 million or more in 2006 controlled 50 percent of the entire sector's wealth, and those with $50 million or more, 71 percent of all foundation wealth. Meanwhile, 66,330 foundations with assets of less than $10 million accounted for just 13 percent of the sector's resources.

Much less can be said concretely about the frequency within each asset size category of perpetual/spend-down and social improvement/charitable giving organizations, but the data and notations in Figure 6 provide a close approximation. Setting aside the special case of the Bill and Melinda Gates Foundation (whose $33 billion in assets, prior to the recent infusion of funds from Warren Buffett, dwarf the Ford Foundation's $12.3 billion, the second-largest endowment), the bulk of private foundation assets lodge with perpetual mid-size to very large foundations, the great majority of which have essentially charitable missions. Significantly, the number of perpetual foundations dedicated to addressing fundamental societal ills is relatively small, and their share of total foundation resources is also small.[9] Given their share

Figure 6. Perpetual foundations aiming to address fundamental problems in society are relatively few in number and control a very small portion of total foundation assets in the U.S.

	Perpetual (# of foundations)		Spend-down/Pass-through (# of foundations)	
Purpose/Endowment Size	Social Improvement	Charitable	Social Improvement	Charitable
Assets $15 billion or more (1, with 5% of sector assets	0	0	1	0
Assets $1 billion–$14.99 billion (61, with 29% of sector assets)	19	40	1	1
Assets $250 million–$999.99 million (208, with 16% of sector assets)	20	176	0	12
Assets $50 million–$249.99 million (1,245, with 21% of sector assets)	Some	Numerous	Rare	Some
Assets $10 million–$49.99 million (4,632, with 16% of sector assets)	Some	Numerous	Rare	Some
Assets $1 million–$9.99 million (21,733, with 11% of sector assets)	Rare	Numerous	Very Rare	Numerous
Assets less than $1 million (44,597, with 2% of sector assets)	Extremely Rare	Some	Extremely Rare	Numerous

Source: The Foundation Center and The Commonwealth Fund.

of sector resources, the following endowment management analysis will concentrate on mid-size-to-large perpetual foundations.

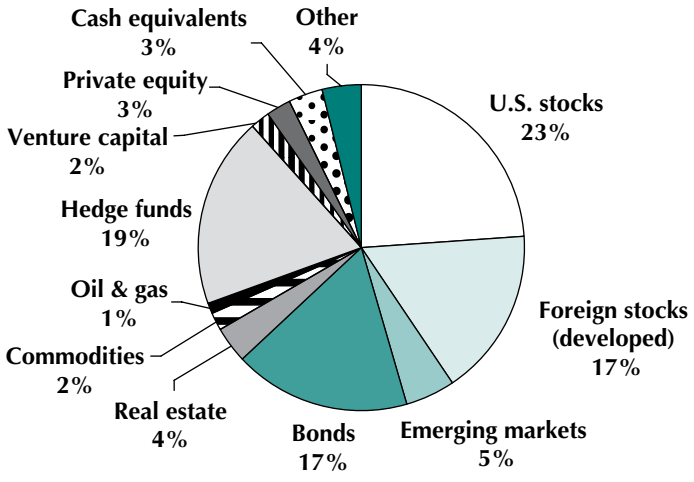
Lessons in Endowment Management from the Market Crisis of 2008

Over the last 25 years, many well-run large foundations have adopted an endowment management model featuring the extensive asset class diversification, shown in Figure 7, of 106 such institutions monitored by Cambridge Associates. Premised on financial market research showing that diversified portfolios with riskier assets can produce higher returns, with manageable risk, than less-diversified conventional portfolios, and drawing on the success of such major university endowments as that of Harvard, Yale, and Princeton in using this model, sizable foundations have successively dialed down the once-traditional 60:40 allocation between equities and fixed income: first to 70:30 (1980s), and then to 80:20 or lower (1990s). In doing this, they substituted riskier holdings like venture capital, real estate, emerging-markets equities, energy, commodities, private equity, and hedge funds for conventional stocks and bonds—in the end, leaving barebones fixed-income allocations to ensure liquidity and bolster returns in the event of deflation.

This model worked well through the second quarter of 2008, but faltered in the fall 2008 market collapse—as revealed by the widely reported large drops in the value of the Yale and Harvard endowments and the data on the recent endowment performance of large foundations. Yale's veteran endowment manager, David Swenson, argues that the diversified portfolio management model remains valid despite the recent experience: "[W]hen you have a market in which any type of equity exposure is being punished, it's going to hurt long-term performance."[10] Nonetheless, private foundations should consider the following lessons from this experience:

- As argued by Ben Inker and Jeremy Grantham at GMO, in the post-2003 "risk bubble," all riskier assets became overvalued, all but negating the

Figure 7. Over the last 25 years, larger private foundations have increasingly diversified their endowment portfolios, substantially increasing allocations to a variety of equity markets and reducing fixed income allocations

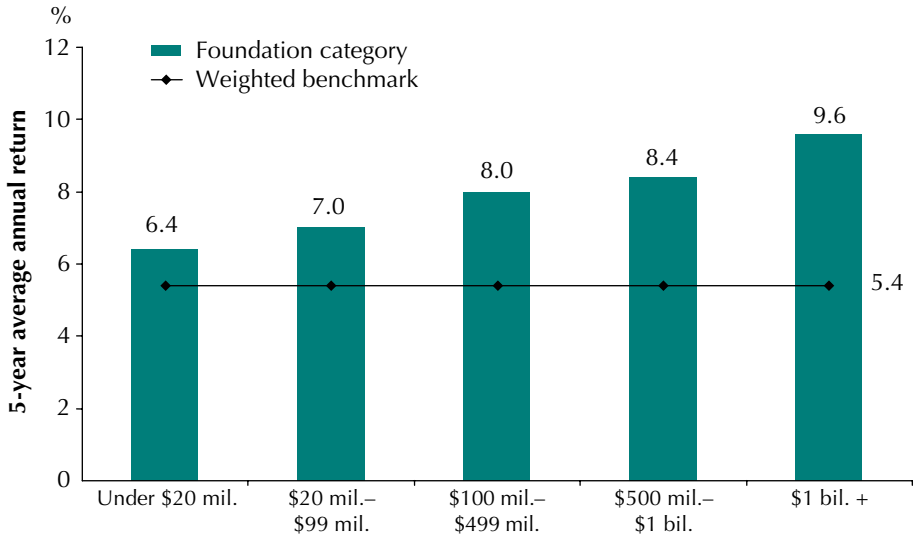


Median % allocation of 106 endowments with median assets of $266 million, June 30, 2008. Source: Cambridge Associates.

benefits of diversification. Thus, more attention needs to be paid to market valuations of asset classes, with the aim of underweighting those that appear to be overvalued. "Rather than having a static allocation to each class of…asset, it makes more sense to keep all of them on the menu, but shift the [policy] allocations as valuations, and therefore risk/return trade-off, shift."[11] To many, this advice may smack of market timing, a practice almost universally discouraged by experienced investors. But the core message is to pay more attention, particularly in frothy markets, to the relative valuation measures of different asset classes available from investment consultants. At a minimum, those responsible for foundation endowments should adhere more rigorously to the discipline of rebalancing to policy allocations—and those allocations merit more frequent reconsideration, especially in periods of excess.

- The Yale/Harvard endowment management model requires extensive experience and great skill at the staff and trustee level to make it work effectively; it is not one likely to be successful for amateurs. Not all foundations that have adopted the model have the intramural capacity needed to ensure its success, even with the help of investment consultants. Thus, as shown in Figure 8, larger foundations consistently achieve more from it than do smaller foundations. Furthermore, the spread of the model helped to bid up the prices of the risky assets it requires and, given the limited supply of truly talented investment managers, to generate a supply of managers ill-equipped to manage such assets.[12] As a result, enthusiasm in the endowment community for the model has probably heightened its risk.

Figure 8. Very large foundations are better equipped to execute sophisticated endowment management strategies than are smaller ones



Returns are for the five years ending September 30, 2008, for 106 foundations. Source: Cambridge Associates.

The lesson here is that foundations that have adopted the model need to reassess their capacity for implementing it effectively. Smaller foundations may see as a better course using organizations like The Investment Fund for Foundations (TIFF) or the Common Fund, which have the expert and experienced staffs required to enhance the chance of success. Alternatively, they may wish to eschew such sophisticated approaches altogether and use a simpler, index fund–dominated endowment management model.

Certainly, foundations that intend to follow this model, but lack the resources to assemble internally the high-quality professional investment team needed to produce the expected results, should take great care in selecting investment consultants and in using a fund-of-funds to build specific portfolios.[13]

Ensuring liquidity. One of the great surprises of the recent crisis was the drying up of liquidity, even for asset-rich and debt-free institutions like private foundations. While hopefully the freeze-up in credit markets that occurred is a once-in-80-years event, the lessons of the liquidity crunch that in many ways precipitated the stock market crash are nonetheless worth putting on record:

- Many nonprofits, including some foundations, were caught in the trap of investing in poorly understood short-term investment vehicles that produced higher yields than conventional money market or custodian bank short-term investment funds. In their reach for yield, some of these institutions ultimately found it impossible to withdraw funds, or saw the value of supposedly risk-free funds decline. Lesson: The purpose of short-term cash funds is to provide a safe and ready source of liquidity, and the potential cost of obtaining a slightly higher yield in a nonconventional vehicle outweighs the benefit. A further lesson is that endowment managers should monitor regularly the holdings in the conventional short-term investment vehicles that they use.
- The securities lending business is well developed and has long been regarded as a risk-free tool for increasing the return on an investment pool. This proved not to be the case in the recent market panic, when fears of counterparty risk and sharp declines in the market value of invested collateral for loans caused index funds and other pooled vehicles with securities lending programs to put limits on withdrawals or deny them altogether—often with no notice to clients, longstanding or otherwise. Lesson: Know what ancillary programs your index or other pooled funds use; seek contractual language guaranteeing liquidity; and, if need be, identify such funds not using securities lending programs.
- The diversified endowment management model adopted by many large foundations creates liquidity requirements beyond those arising from the foundation's philanthropic programs. Venture capital, private equity, real estate, and other partnership commitments are drawn down in unpredictable segments over multiyear periods. Moreover, hedge funds typically have once-a-year withdrawal dates and may have lock-ups for different vintages of invested funds. In the recent crisis, hedge funds put further restrictions on partners' access to their capital. Thus, private foundation endowment managers have seen the need to pay greater attention to their institutions' liquidity requirements and how best to manage them. Some have gone so far as to obtain lines of credit, should they be unable to sell securities to meet cash needs or unable to sell them at anything other than fire-sale prices.

Learning from the Madoff debacle. The current financial crisis has demonstrated that the market excesses that develop in a period of intense leveraging are rapidly exposed when deleveraging sets in. Bernard Madoff's Ponzi scheme—said to have involved up to $50 billion—demonstrates that deleveraging reveals not only legal excesses, but also illegal activities that remained sub rosa in a speculative market. The Madoff event, where astute investors, including a number of foundations (mainly donor-controlled), placed funds in a vehicle that no one understood and whose returns could not be explained, underscores the enduring value of the rule against investing in something that one does not understand. This scandal reveals also the disturbing extent to which even some foundations failed to undertake the due diligence that is essential before hiring any external manager or advisor.

The apparent use of the Madoff scheme by funds-of-funds also reinforces the lesson that foundations should take great care in delegating fiduciary responsibility to such vehicles. While numerous funds-of-funds are well run and adhere to best-practice due-diligence procedures, the Madoff episode suggests that foundations should first consider nonprofit investment organizations—created and run for the benefit of the sector—when they are in the market for a fund-of-funds vehicle (although this is not to say that TIFF and the Common Fund are immune to making mistakes in picking managers). These lessons are particularly apt for smaller foundations, which often fail to see the need for engaging a trustworthy and skilled investment consultant to help guide their endowment management decisions.

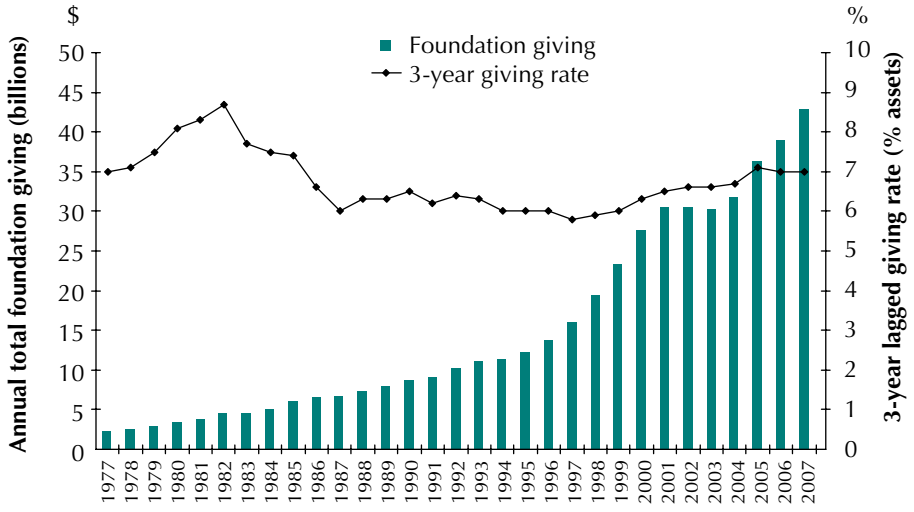
Seeking out opportunity. A final reminder regarding the aftermath of financial crisis is that adversity always creates opportunity. Nearly all astute investors expect that the post-crash environment will at some point create enormous opportunity—especially so for long-term investors like foundations that can weather short-term volatility. Real average equity market returns for the next several years may be modest by historical standards, but given current depressed asset prices, skilled investment managers will have the chance of a lifetime to achieve superior returns. To a considerable degree, only the fittest of hedge funds are likely to have survived, for example, and given the recent outflow of funds from both conventional and hedge fund managers, foundations will find open doors at previously inaccessible top-ranked hedge fund and other managers.[14] Provided that their investment committees are appropriately staffed for identifying able managers, foundations should be forward-looking in seeking opportunities that have arisen out of the crisis.

Implications for Foundations' Spending and Program Strategies

Under federal law, private foundations are required to distribute annually at least 5 percent of a rolling average of the market value of their assets. Many foundations, particularly very small ones, distribute considerably more than the minimum; indeed, U.S. foundations' average giving rate (excluding most intramural spending) in 2007 was 6.4 percent.

Most perpetual foundations use the rolling-average value of their assets over the preceding 12 quarters to determine their giving in any year. Historically, giving as a percentage of total assets in any year generally rises in bear financial markets and falls in bull markets toward the minimum IRS-required payout rate (Figure 9). This variation in the annual giving rate for all foundations occurs for three principal reasons: 1) the lag between spending and assets just noted; 2) the policy of many foundations to allow their spending

Figure 9. The annual average giving rate of foundations, mainly based on lagging three-year average assets, typically rises in bear markets and falls in bull markets



Source: The Foundation Center.

rates to drift upward in good times, and their tendency to be slow in adjusting those rates in bad times; and 3) the decision of many foundations to engage in countercyclical spending in bad times (discussed below).

No one can say for certain, but using the strong statistical relationship between total giving in any year and the lagged three-year average value of total foundation assets, a reasonable estimate of the effect of the financial crisis on foundation giving is that it will decline by about 6.5 percent, or nearly $3 billion, between 2007 and 2009.[15] Thus, at least in the short term, the effect of the market crash on giving will not be as great as it has been on foundation assets. If a quick recovery does not occur, however, the full impact of the crash will gradually come into play over the next several years.

Foundations can be expected to respond differently to the financial crisis, however, depending on their business model, program strategy, and size.

Perpetual charitable foundations. The federally mandated 5 percent spending rate for foundations is just barely consistent with the goal of perpetuity, given historical market returns. Most perpetual charitable foundations, finding themselves with considerably higher spending rates as a result of the recent decline in value of their endowments, are already taking steps to ratchet down spending. As noted above, however, because of the widespread application of a spending policy based on a lagged three-year average asset base, spending by these foundations is unlikely to fall immediately by as large a percentage as their assets did in 2008.

Some perpetual charitable foundations will choose to set aside their normal spending rate constraint in a time of economic crisis and undertake some countercyclical spending where they can clearly identify opportunities to sustain their constituency institutions and programs. Survey results recently published by The Foundation Center, for example, revealed that numerous community foundations, as well as such organizations as the Kresge Foundation, are doing just this.[16]

Nevertheless, the lesson of the 1970s stagflation era is still fresh in the minds of foundation managers. From 1968 to 1982, many foundations saw their inflation-adjusted assets erode by 67 percent or more—mainly due to the combination of very low or negative investment returns and high inflation, but also to maintenance of unsustainably high spending rates based on the assumption that the economic and financial market malaise would be short-lived. Most perpetual foundations, therefore, are likely to be cautious about spending significantly beyond their normal policy rate in the coming years, at least until there are clear signs that the financial system has been mended and economic recovery programs successfully launched.

Spend-down/pass-through foundations, and very small foundations. As shown in Figure 6, spend-down/pass-through foundations are rare in the universe of mid-size-to-large foundations; foundations with this business model, like the many very small, essentially pass-through foundations, account for only a small portion of total foundation sector assets. Spend-down foundations, however, have more flexibility for adjusting spending plans than do perpetual foundations, and it is likely that in a period of economic stress, they will see fit to increase their spending. As revealed by recent Foundation Center surveys, some corporate foundations—particularly those connected to the housing and credit industries—are indeed stepping up in a significant way to provide relief in beleaguered communities.[17] However, if the economic recession deepens and corporate profits decline further, these sources of foundation giving could quickly dry up.

Students of the foundation sector sometimes express concerns about the merits of very small foundations, owing to the challenges these institutions face in establishing and pursuing consistent missions and effective programs, as well as to governance issues. While their resources are insufficient to have much impact in fixing fundamental economic and social ills, small foundations have an opportunity during this period of economic stress to prove their worth, by helping institutions in their communities weather difficult times.

Perpetual social-improvement foundations. Perpetual social-improvement foundations are frequently described as the venture capital investors of the nonprofit and public policy sectors. They are by nature long-term investors, working on social and economic problems that at times seem all but intractable. To be effective, these institutions need to make large upfront investments in research to identify the underlying causes and implications of the problems they address; they must develop coherent program strategies to be implemented over an extended period; they need to invest in professionals who through career-long work advance understanding of issues and develop the expertise for developing and testing solutions; and they must work closely with their grantees to communicate the results of their work to influential audiences able to bring about the needed social changes. Foundations of this type do not just write checks: to be effective, they must develop strong intramural capacities giving them credibility in their fields and enabling them to develop and implement sophisticated grantmaking strategies, including working closely with grantees to design projects likely to produce results useful to change agents and partnering with grantees to communicate the results of research to policy audiences.

Given the long-term nature of the problems they address, perpetual social-improvement foundations must be particularly prudent in the management of their asset bases. As shown in Figure 6, foundations of

this type are comparatively few in number, and in any specific field, they are typically a rare breed, unlikely to be readily replaced should they disappear. With some exceptions, foundations of this type can therefore be expected to reduce their spending fairly quickly to accord with the new realities of their financial situations.[18]

Perpetual social-improvement foundations that are particularly threatened by the financial crisis are those that earlier had assets just barely sufficient to maintain ambitious grants programs in multiple areas—foundations with pre-crash assets of around $100 million. Such foundations now find themselves in substantially reduced circumstances that necessitate rethinking the feasibility of conducting work in multiple program areas and even the objective of perpetuity. Boards and management of such foundations will understandably find decisions on which programs to retain difficult, and they will be challenged in accommodating spending levels to altered financial circumstances. But addressing these issues head-on is preferable to setting the foundation on a slow death course, with attending diminishing program vitality. Among the options that should be entertained by foundations in this predicament is consolidation with another foundation, which would ensure the critical mass of financial and human resources needed to sustain the vitality of programs going forward. As an example, the James Picker Foundation, in 1986, transferred its assets of approximately $15 million to The Commonwealth Fund, thereby giving rise to a national program that has contributed significantly to the emergence of the patient-centered care movement.

While the reaction of The Commonwealth Fund to its endowment return of –27 percent in 2008 will not be typical of all perpetual social-improvement foundations, it is nonetheless instructive on how these institutions will go about addressing a difficult situation.

- Recognizing the need to address the pain early rather than to hope for the best, the Fund will likely reduce its spending by approximately 15 percent in 2009–10, and, barring a significant market turnaround, another 10 percent in 2010–11 and 8 percent in 2011–12. Even with these steps, the foundation's annual spending rate will rise above 7 percent in the short term.
- The Fund will make decisions on where to pare back spending based on strategic priorities, rather than simply applying across-the-board cuts. This said, no aspect of the foundation's activities will be exempt from consideration for contributing to the necessary belt-tightening.
- As a value-added foundation working on one of the most complex issues of the day—helping the U.S. move toward a truly high performance health system—the Fund regards its intramural professional staff as its most important asset, embodying intellectual capital that has taken years to develop and that is poised to make a unique contribution in the current favorable climate for U.S. health care reform. While the foundation will continue to devote most of its funds to extramural grants, it will aim to retain its skilled and experienced staff, even if the intramural share of total spending rises somewhat during a period of reduced total spending. To the extent that this share rises above the normal maximum level set by the Fund's board of directors, however, it will do so only temporarily and by a small margin.
- Every crisis presents opportunity, and the Fund has undertaken a "strengths, weaknesses, opportunities, and threats" analysis of each of its programs. The result will be some reorganization of programs to concentrate the foundation's work even more on the strategies that its Commission

on a High Performance Health System has identified for accomplishing health care reform: 1) achieving affordable health insurance coverage for all; 2) reforming the payment system to promote quality and efficiency in health care; 3) reforming the care delivery system to bring about patient-centered, coordinated care; 4) using benchmarking to promote high performance among health care organizations; and 5) achieving accountable leadership for the health system.

Within this framework, the foundation expects to be able to maintain its signature activities, including uniquely rich Web sites (commonwealthfund.org and WhyNotTheBest.org) for those engaged in advancing a high performance health system; its International Program in Health Policy and Practice; major recently launched initiatives to promote safety-net medical homes and reduce unnecessary rehospitalizations; its work with states to improve health system performance; and its Fellowship in Minority Health Policy program. Through each program strategy, the foundation will continue particularly to address health care disparities and the needs of vulnerable populations.

Rising numbers of uninsured and underinsured people, escalating health care costs, and growing recognition of quality and efficiency shortcomings in the U.S. health care system have created a climate, not seen since 1993–94, that is highly favorable for health care reform. If history is any guide, however, the road to reform will not be an easy one and could prove to be longer than anyone would like.[19]

Moreover, the experiences of countries that have long provided health insurance to all of their population offer ample evidence that, given the unique attributes of health care systems and marketplaces, the search for high performance is a continuing one. All countries, regardless of their chosen systems of delivery, finance, and regulation, struggle with questions of resource allocation, technology adoption, health care manpower, disparities, efficiency, and accountability that make the presence of independent bodies, like perpetual foundations, vital to developing and debating improved policies, as well as to stimulating and evaluating practice innovations. The mixed public–private health care system of the U.S., with its unusually strong role for for-profit enterprises both in delivering and paying for services and in influencing public policy, makes the role of independent private foundations in reform efforts an especially important one.

Thus, The Commonwealth Fund will simultaneously pare back spending as necessary to ensure that it remains a force for the long haul in the quest for health care reform, while concentrating its resources to help the nation seize the opportunity that lies before us.

Notes

[1] B. Inker, "When Diversification Failed," *GMO Quarterly Newsletter,* Dec. 2008, www.GMO.com. The Commonwealth Fund contracts with GMO to manage a portion of its endowment.

[2] J. Grantham, "Reaping the Whirlwind," *GMO Quarterly Newsletter,* Oct. 2008, www.GMO.com; "Doomsayers Who Got It Right," *Wall Street Journal*, Jan. 2, 2009, p. A1.

[3] A. Costello and K. Mack, *U.S. Market Commentary, What Does History Tell Us ? Putting the Current Market in Context,* Cambridge Associates, Oct. 2008.

[4] E. Chancellor, "The Flight of Credit: Lessons from Earlier Banking Panics," *GMO Commentary,* Oct. 10, 2008; Cambridge Associates, *Notes on Current Valuations,* Dec. 2008.

[5] The Multi-Asset Fund of The Investment Fund for Foundations (TIFF) enables small foundations to participate in a diversified portfolio with most of the asset classes shown in Figure 7. It has approximately $2.1 billion under management.

[6] In addition to the varying quality of the underlying historical data on foundation assets, the methodological shortcomings of the regression analysis used to make this estimate include its inability to incorporate the effects of the appearance of new foundations and disappearance of spend-down foundations. The adjusted R-square of the relationship between the change in total foundation assets and the weighted market benchmark return in any year is .64.

[7] S. Lawrence and R. Mukai, *Foundation Yearbook*, *2008 Edition*, The Foundation Center; S. Lawrence and R. Mukai, *Foundation Growth and Giving Estimates, 2008 Edition*, The Foundation Center.

[8] J. Fleishman, *The Foundation: A Great American Secret* (New York: Public Affairs, Perseus Book Group, 2007), pp. 46–50. Fleishman uses the term "instrumental giving" instead of "social improvement," and the term "expressive giving" instead of "charitable giving." Other students of foundations and philanthropy use still different terms to distinguish between the two principal types of giving, but the basic difference in objective in each case is generally recognized.

[9] Many large social-improvement foundations also engage in conventional charitable giving, and many large conventional foundations have some social-improvement activities, but most large foundations tend to be heavily oriented toward one or the other type of giving.

[10] "Yale's Swenson Sees 'Extraordinary' Opportunity to Snap Up Debt," www.Bloomberg.com, Jan. 2, 2002.

[11] Inker, "When Diversification Failed," 2008.

[12] J. Grantham, "Silver Linings and Lessons Learned," *GMO Quarterly Letter,* Oct. 2008, www.GMO.com.

[13] Yale University's chief investment officer David Swenson stresses this point and is skeptical of the ability of institutions lacking multibillion dollar endowments to execute successfully the modern sophisticated endowment management model. *Wall Street Journal*, Jan. 13, 2009, p. C1.

[14] According to some estimates, institutional investing in hedge funds may fall by as much as 80 percent, resulting in the closing of numerous such funds (along with their proprietary trading desks) and across-the-board reduction in leverage in this sector. The surviving circle of hedge fund managers will typically have used the least amount of leverage, will have been the most skilled practitioners of their trade, and, going forward, will face less competition.

[15] This estimate is based on a linear regression model (adjusted R-square of .99) of the historical relationship between foundation giving and three-year lagged average asset levels, and the regression model described above for predicting changes in total foundation assets.

[16] S. Lawrence, *A First Look at the Foundation and Corporate Response to the Economic Crisis,* The Foundation Center, Jan. 2009; and L. T. McGill and S. Lawrence, *Grantmakers Describe the Impact of the Economic Crisis on Their Giving,* The Foundation Center, March 2009.

[17] Ibid.

[18] As indicated in The Foundation Center survey noted above, perpetual social-improvement foundations able to temporarily set aside spending restraints or reorient giving plans toward economic recovery activities are primarily very large foundations like the John D. and Catherine T. MacArthur Foundation and the Ford Foundation.

[19] K. Davis, "Health Reform in a New Era: Options for the Obama Administration," *From the President* (column), http://www.commonwealthfund.org/Content/From-the-President/2008/Health-Reform-in-a-New-Era--Options-for-the-Obama-Administration.aspx, Nov. 2008.

Left to right: Commonwealth Fund chair James R. Tallon, Jr., president of the United Hospital Fund, and Board members Cristine Russell, reporter, and Benjamin K. Chu, M.D., president, Southern California region, Kaiser Foundation Health Plan and Hospital

Foreground, left to right: Commonwealth Fund Board members William R. Brody, M.D., president of the Salk Institute for Biological Studies, and Glenn M. Hackbarth, J.D., consultant

The Fund's Mission, Goals, and Strategy

James R. Tallon, Jr.
Chairman

The mission of The Commonwealth Fund is to promote a high performance health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

The Board of Directors has identified the following goals to be pursued by the Fund over the next several years:

Commission on a High Performance Health System

- *Move the United States towards a high-performing health care system that achieves better access, improved quality, and greater efficiency, and focuses particularly on the most vulnerable due to income, inadequate insurance, minority status, health, or age.* This goal is being advanced through the Fund's Commission on a High Performance Health System, which is charged with setting and tracking national and state performance targets, developing policy options, and disseminating innovative practice changes that would improve the functioning of the U.S. health system. The Fund's grantmaking programs support and enhance the Commission's work.

Programmatic Goals Directly Associated with the Commission

- *Achieve an efficiently run health insurance system that makes available to all Americans comprehensive, affordable coverage,* by analyzing market- and policy-driven changes in employer-based insurance and public insurance programs for people under age 65 and determining how those changes may affect the numbers of people covered and the quality of coverage; documenting the consequences of being uninsured and underinsured with regard to access to care, health, personal financial security, and economic productivity; and developing and evaluating strategies to expand and stabilize health coverage, make it more affordable, and enhance efficiency in its administration.
- *Help Medicare be an innovative leader in coverage, quality improvement, and value,* by enhancing the program's ability to ensure access to the health care needed by the nation's elderly and disabled and protecting the most vulnerable among them

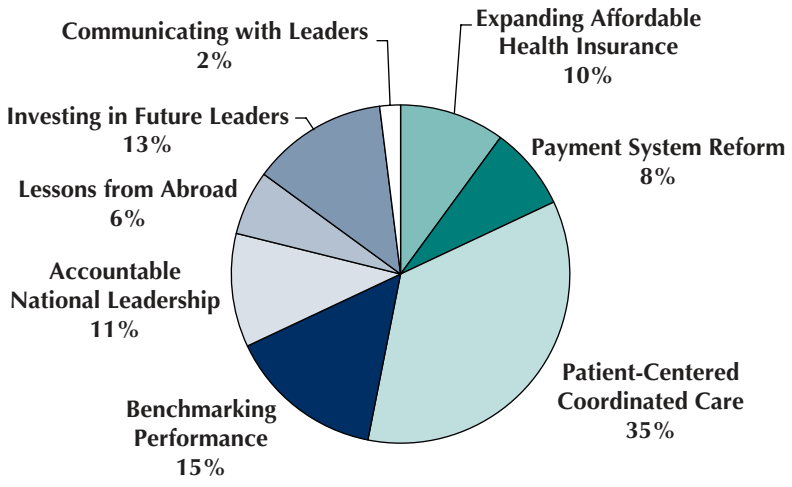
from financial hardship; identifying ways in which Medicare can become more effective and efficient, so it can remain solvent and provide appropriate, high-quality care for an aging population; and helping enable Medicare, as the nation's largest payer for health care, serve as a standard-setter and agent for promoting better performance throughout the health system.

- *Improve the quality and promote the efficiency of health care services,* by encouraging the development and widespread adoption of health care quality and efficiency measures; assessing and enhancing the capacity of health care organizations to provide better care more efficiently; and stimulating the development and adoption of payment and incentive models that encourage providers to improve quality and efficiency.
- *Spur the redesign of primary care practices and health care systems around the needs of the patient,* by encouraging the collection of information on patients' experiences with care and the public reporting of that information as a way to stimulate quality improvement in primary care; promoting the adoption of models and tools to help primary care practices restructure and improve care to meet patients' preferences and ensure care coordination; and advancing improvements in policy that support coordinated patient-centered care.
- *Improve state and national health system performance,* by stimulating and spreading integrated, state-level strategies for expanding access to care and promoting high-quality, efficient care, particularly for vulnerable populations. This goal includes supporting work in the Fund's own community, New York City.

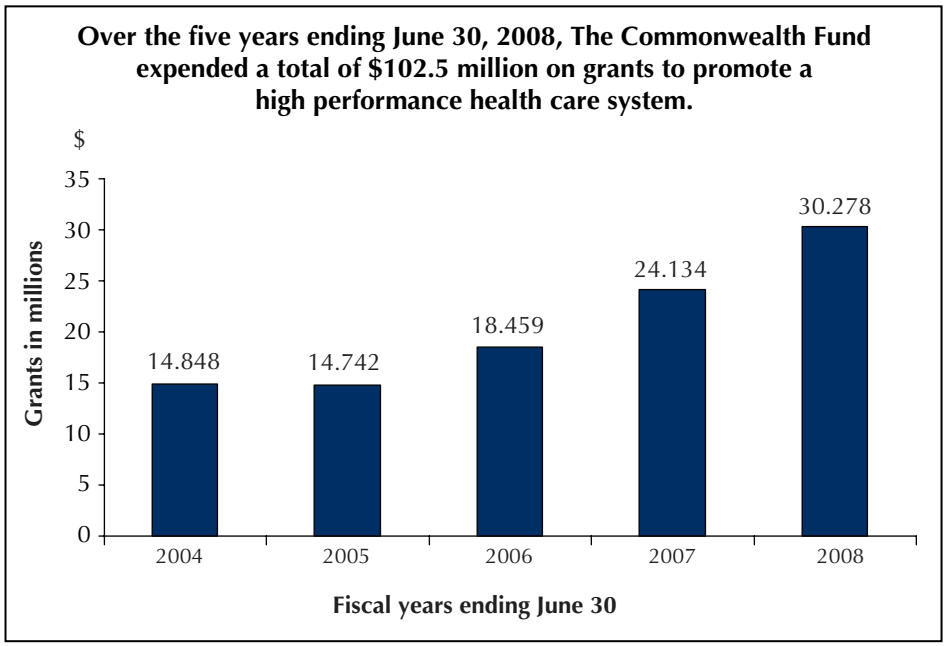
Goals for Programs Addressing Special Populations

- *Improve the quality of health care delivered to low-income Americans and members of racial and ethnic minority groups and reduce racial and ethnic health disparities,* by promoting models of high performance health systems for the underserved; promoting health care that is culturally

The Fund's grants programs, in concert, pursue eight strategies for promoting a high performance health care system.



Allocation of grants from July 2005 through November 2008.



competent and patient-centered; and supporting the development of public policy that will lead to improvement in health care systems serving minority and low-income populations.

- *Encourage, support, and sustain improvements in preventive care for young children—particularly those services dealing with their cognitive, emotional, and social development*, by promoting the establishment of standards of care and use of these standards in quality measurement and monitoring; identifying and disseminating models of pediatric practice that enhance the efficiency and effectiveness of care; and encouraging reforms that remove barriers to quality care and align provider incentives with desired clinical practices.
- *Transform the nation's nursing homes and other long-term care facilities into "resident-centered" organizations that are good places to live and good places to work,* by identifying, evaluating, and spreading models of resident-centered care; equipping nursing home operators to lead transformational change; and promoting policy options that support resident-centered care.
- *Foster the growth of the knowledge, leadership, and capacity needed to address the health care needs of a growing minority population,* by training leaders and by identifying policies and practices that will promote equitable health outcomes for minority, low-income, and other underserved populations, eliminate existing disparities in care, and enhance the performance of safety-net systems of care.

Goals for the International Program

- *Promote international exchange on health care policy and practice,* by preparing future leaders committed to cross-national analysis of health policy and practice; sustaining a growing international network of policy-oriented health care researchers and practitioners; encouraging cross-national comparative research to identify international examples of high-performing health care systems and organizations; helping keep policymakers in the United States informed of developments in, and transferable lessons from, other industrialized societies; and fostering the development of international collaborative

programs to improve care, including opportunities to learn from variations in performance across or within countries.

Goals for Communications/Dissemination

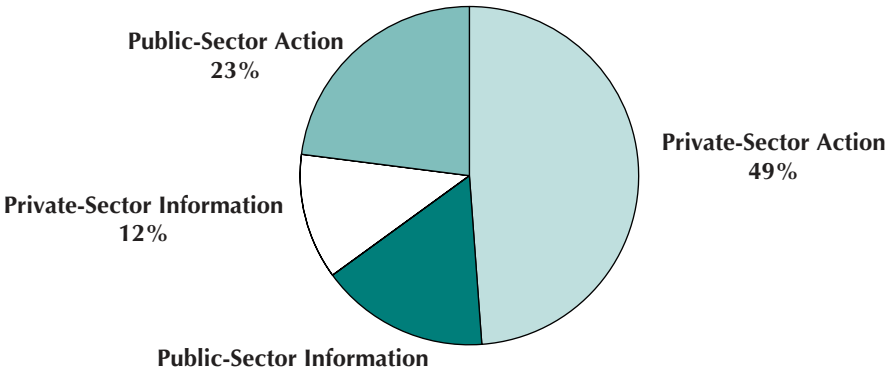
- *Augment the Fund's leadership in effectively and broadly disseminating credible, authoritative information* about policy options and innovative approaches to moving the United States toward a high-performing health care system, particularly for the most vulnerable due to income, minority status, health, or age, through the use of electronic publishing and other communications tools.

The Commonwealth Fund has developed eight strategies for advancing these goals, and most cut across program lines:

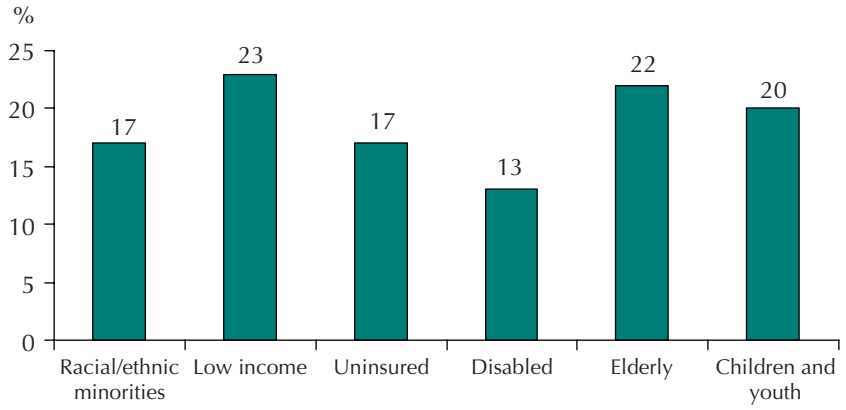
- expanding affordable health insurance, the recent allocation of extramural grant funds for which is 10 percent
- advancing payment system reforms that include financial incentives to enhance value and achieve savings (8%)
- promoting patient-centered, coordinated care that is of high quality and is accessible (35%)
- using benchmarking of health care providers to improve performance (15%)
- ensuring accountable national leadership and public–private collaboration (11%)
- bringing the international experience to bear on U.S. health system reform (6%)
- investing in future health care leaders (13%)
- communicating results to influential audiences (2%).

Over the five-year period ending June 30, 2008, the Fund expended $102.5 million on grants to advance its goals. The Fund's budget increased markedly in 2007–08 and 2008–09 as a result of the earlier very strong performance of the endowment. Like other foundations, however, the Fund will need to reduce its budget in 2009–10 and probably in several subsequent fiscal years, as a result of the severe market contraction arising from the ongoing international financial crisis. Through strategic concentration of its resources, the foundation, even with a reduced budget,

In structuring programs and selecting grants, The Commonwealth Fund seeks to achieve an appropriate balance within each program between research and action-oriented work, and between public- and private-sector work.



The Commonwealth Fund's work seeks particularly to address problems vulnerable populations face in accessing affordable, high-quality, and efficiently delivered care.



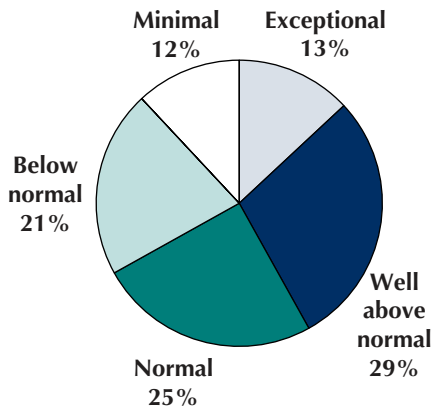
Distribution of Board-level grants, 1995-2008

will continue to help the nation seize the opportunity for health reform that currently exists.

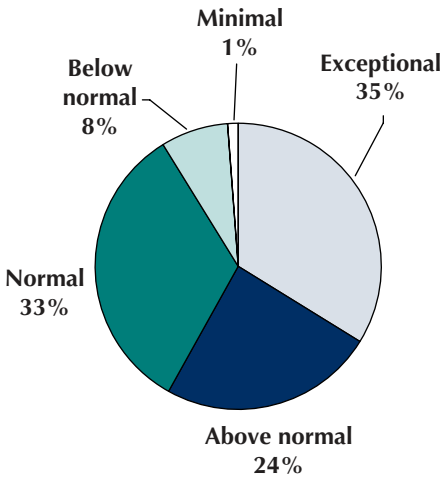
Reflecting the foundation's value-added approach to grantmaking, approximately 33 percent of the total budget is devoted to intramural units engaged in research, program development, and management, collaborations with grantees, and dissemination of program results. This allocation includes approximately $2.5 million annually to communicate the results of Fund-sponsored work and funds to operate programs directly managed by the foundation. The portion of the foundation's total budget devoted to administration is 5.5 percent.

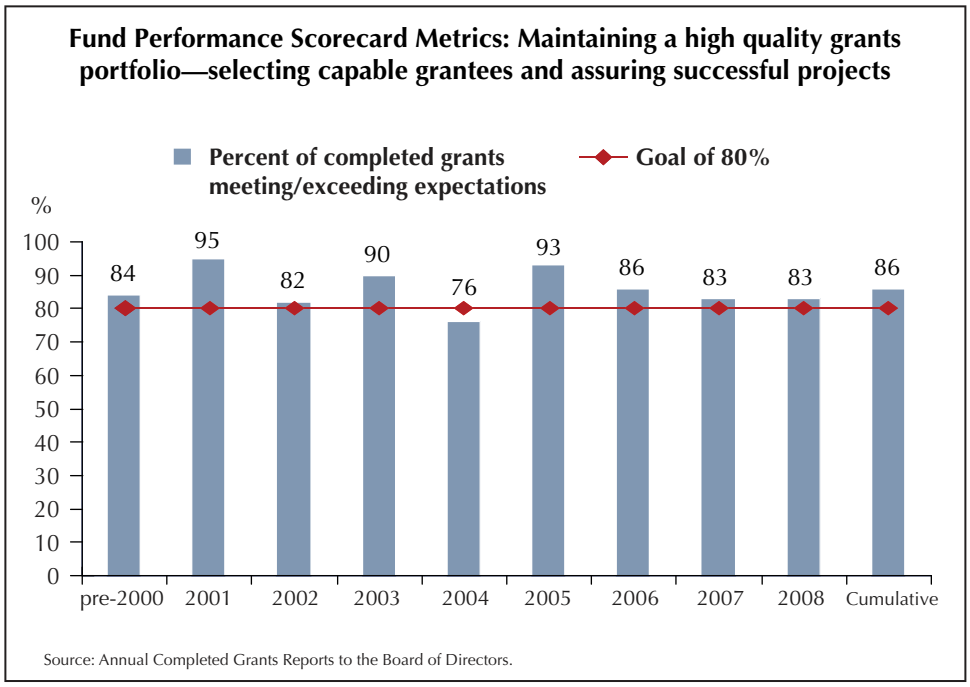
An important role of the Fund's value-adding staff is to identify project risks and work closely with project directors in managing them to achieve success.

Risk of Board-level grants (2000-08)



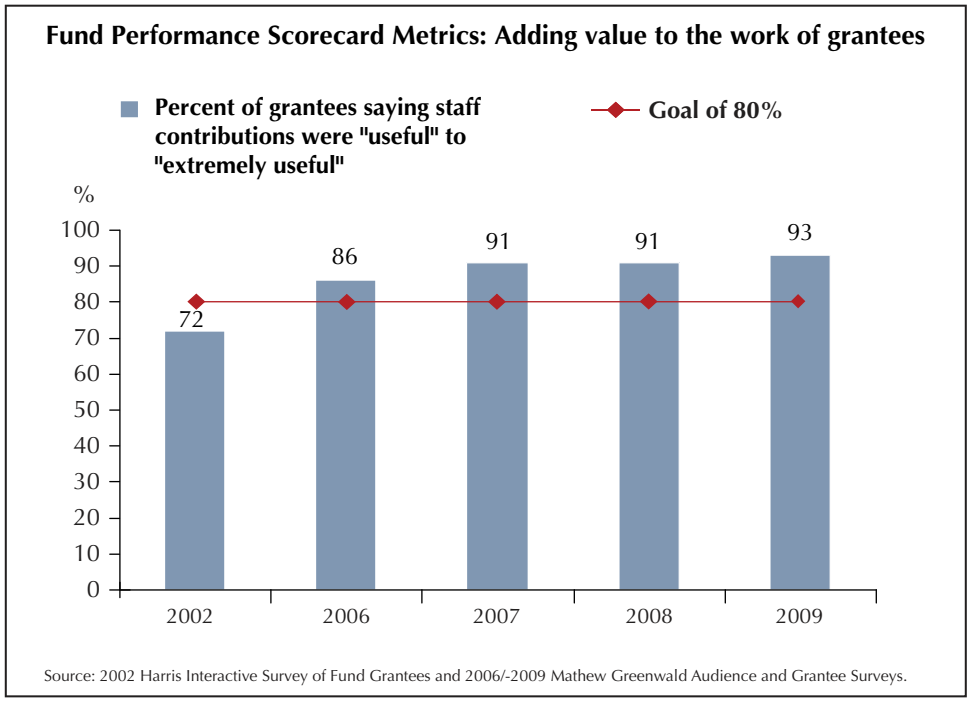
Staff effort applied to Board-level grants (2000-08)



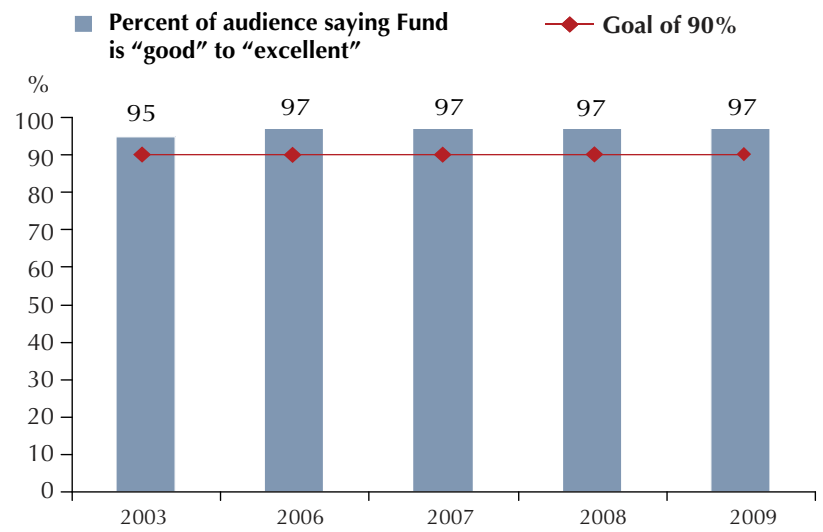


In all its work, the Fund seeks particularly to target issues that affect vulnerable populations. It also aims to achieve a balance between information-generating and action-oriented activities, and between public- and private-sector work. Other concrete objectives that help guide its grantmaking strategy include keeping its doors open to new talent, working in partnership with other funders, being receptive to new ideas, undertaking appropriate risks, and contributing to the resolution of health care problems in its home base, New York City, while pursuing a national and international agenda.

The Fund is one of only a handful of foundations using an annual performance scorecard to provide



Fund Performance Scorecard Metrics: Providing credible, reliable, timely, and unique information meeting needs of influential customers—audience views

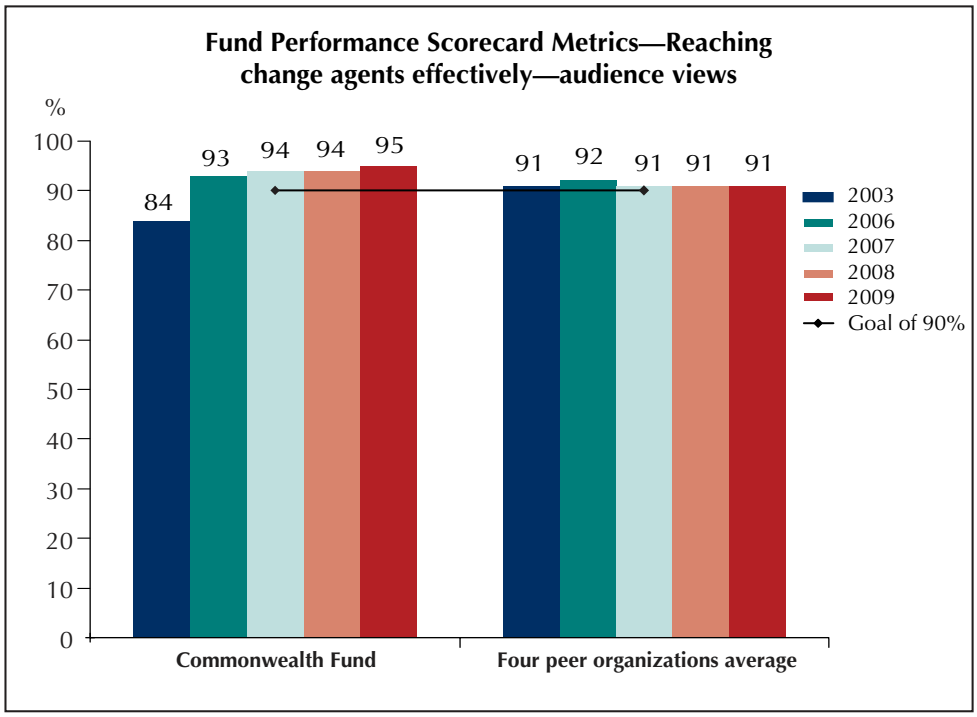


Source: 2002 Harris Interactive Survey of Fund Grantees and 2006/-2009 Mathew Greenwald Audience and Grantee Surveys.

their boards with a means of achieving a comprehensive assessment of the institution's overall performance and spotting weaknesses needing attention. The scorecard has 23 metrics, covering four dimensions: financial performance, audience impact, effectiveness of internal processes, and organizational capacities for learning and growth.

To help ensure a continued record of success and institutional vitality, the performance scorecard includes the objective of launching each year at least four new strategic initiatives that spur the foundation to take on new goals and strategies. "Stretch initiatives" for 2007–08 were as follows: the Commission on a High Performance Health System's report *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*; the Commission's report *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America*; initiating a Netherlands Harkness Fellowship in Health Policy, with cofunding; and engaging the business community in the Fund's work.

The first two of these were achieved through the development and publication of the indicated publications. The Netherlands Harkness Fellowship was developed as planned, and, in addition, funding for a Swiss fellow was obtained from the Zurich-based Careum Foundation. A noteworthy achievement not on the original stretch list for the fiscal year was the launch of the Fund's *New Directions in Health Care* podcasts, aimed at bringing the work of the foundation's programs to life though audio interviews with health care professionals, administrators, policymakers, advocates, and patients on the frontlines of health care. Less progress than intended was made on engaging the business community in the Fund's work, and continuing attention is being given to this objective.



Stretch initiatives set out for 2008–09 are as follows: launch of the Fund's Safety-Net Medical Homes Initiative; launch of the Preventing Unnecessary Rehospitalizations Initiative; development of WhyNotTheBest.org, a new Web site enabling health care providers to benchmark their performance and learn from each other about successful performance-enhancing strategies; and helping shape the health care agenda for the new federal administration. Grants have been made to carry out each of these initiatives, and progress on each is evident. Notably, WhyNotTheBest.org was launched at the Institute for Healthcare Improvement's National Forum on Quality Improvement in Health Care in Nashville in December 2008.

Photographs

Martin Dixon: page 2

The Commission on a High Performance Health System, established by The Commonwealth Fund's Board of Directors in 2005, is a distinguished group of experts and leaders representing every sector of health care. Its mission is to promote a high-performing health system that provides all Americans with affordable access to high-quality, safe care while maximizing efficiency in its delivery and administration. Pictured above (left to right): Commission members Sandra Shewry and Glenn D. Steele, Jr., M.D., Ph.D. Pictured below: Commission members Fernando Guerra, M.D. (center), with Robert M. Hayes, J.D., and Sheila T. Leatherman.

Commission on a High Performance Health System

James J. Mongan, M.D.
Commission Chairman

While the United States spends much more on health care than other industrialized countries, it does not receive comparable value in return. Tens of millions of Americans have no health insurance, or otherwise have difficulty accessing affordable care, including preventive services and treatment for chronic conditions. Moreover, the quality of care—and the efficiency with which it is delivered—varies greatly from physician to physician, from hospital to hospital, and from state to state.

In establishing the Commission on a High Performance Health System in 2005, The Commonwealth Fund's board of directors recognized the need for national leadership to revamp, revitalize, and retool the U.S. health care system. The Commission's 14 members, a distinguished group of experts and leaders representing every sector of health care, including the state and federal policy arena, the business sector, professional societies, and academia, are charged with promoting a high-performing health system that provides all Americans with affordable access to high-quality, safe care while maximizing efficiency in its delivery and administration. Of particular concern to the Commission are the most vulnerable groups in society, including low-income families, the uninsured, racial and ethnic minorities, the young and the aged, and those in poor health.

The Commission monitors health system performance through its national and state scorecards, analyzes health reform proposals, and develops policy options for achieving universal coverage, improving the quality and efficiency of care delivery, and increasing value in health spending. In addition, the Commission engages and informs policymakers by sponsoring meetings and public briefings.

Tracking Performance of the Nation's Health Care System

In its first national scorecard released two years ago, The Commission on a High Performance Health System found that the U.S. falls far short of benchmarks for access, quality, efficiency, and other key measures of health system performance. The 2008 edition of the scorecard paints an even more sobering picture.

The report, *Why Not The Best? Results from the National Scorecard on U.S. Health System Performance, 2008,* highlights evidence that the health system is severely underperforming.[1] In nearly every category measured, the health system performs worse than two years ago—scoring just 65 out of 100 across 37 indicators, where 100 represents not what is ideal but what has actually been achieved in some places for some groups of people.

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

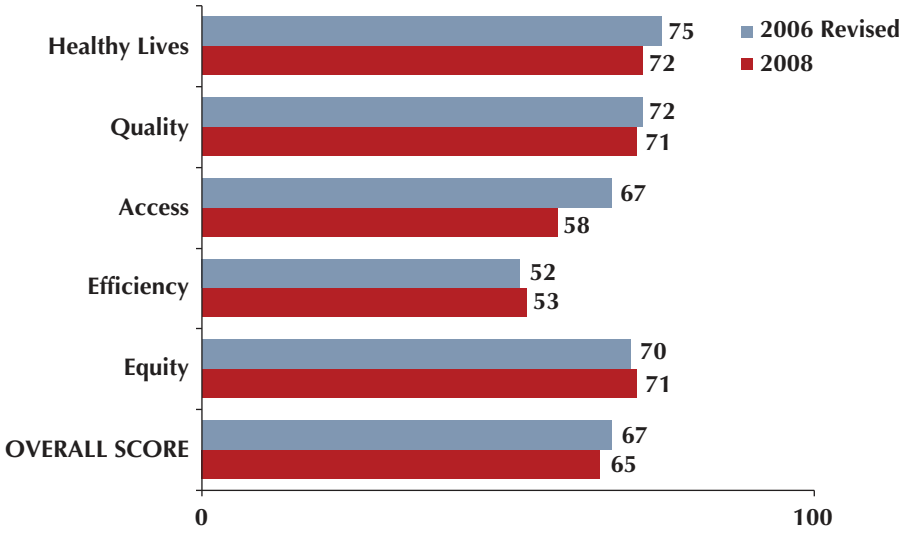
The Scorecard takes a broad look at how well the U.S. health care system is doing, where improvements are needed, and what examples of good care exist that could serve as models for the rest of the country. It looks at specific issues: Do people have access to the health care they need? Are they getting the highest-quality care? Are we spending money and using health care resources efficiently?

One of the primary reasons for the system's poor performance is worsening access to care. In 2007, more than 75 million adults—42 percent of all adults ages 19 to 64—were either uninsured or underinsured during the year, up from 35 percent in 2003. This means that millions of Americans are unable to get the care they need. The Scorecard also found evidence that the billions spent on U.S. health care—far more than any other industrialized country—are often squandered on administrative costs, inefficient systems, wasteful care, or treatment of preventable conditions. Tellingly, the U.S. fell from 15th to 19th among industrialized nations in the number of premature deaths that potentially could have been prevented with timely access to care.

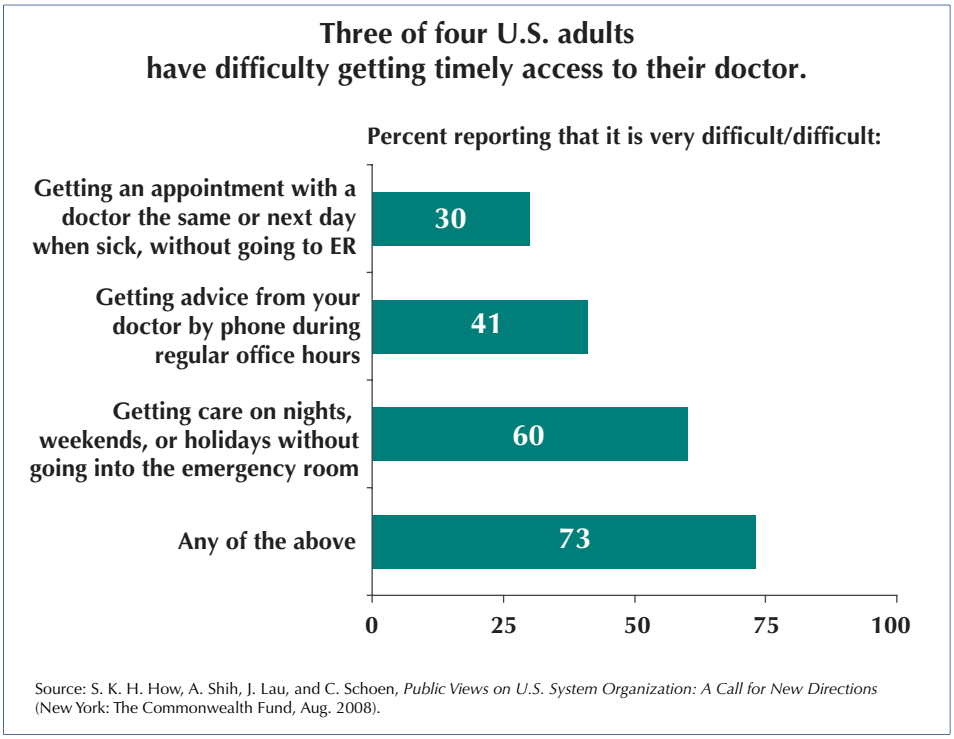
There is also some good news in the report. For example, performance on a key measure of patient safety—hospital-standardized mortality ratios, which were targeted in the Institute for Healthcare Improvement's "100,000 Lives" campaign—improved significantly, by 19 percent from 2000–2002 to 2004–2006. And hospitals are increasingly meeting evidence-based treatment guidelines.

Still, the health care system overall is performing "unevenly and well below its potential," says James J. Mongan, M.D., the Commission's chairman. "While there are pockets of improvement and excellence, it is clear that we need strong leadership and concerted public and private efforts to achieve and raise stan-

Overall, the U.S. health system's performance has slipped since 2006, particularly in ensuring access to health care.



Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance*, 2008 (New York: The Commonwealth Fund, July 2008).



dards of performance nationwide and ensure that significant progress occurs in the future."

Exploring Better Ways to Improve U.S. Health Care Delivery

Given the results from the national scorecard, it is perhaps no surprise that dissatisfaction with the U.S. health care system runs high, and that four-fifths of respondents to a Commonwealth Fund survey said that it should be fundamentally changed or completely rebuilt.

As reported in *Public Views on U.S. Health System Organization: A Call for New Directions*, nine of 10 U.S. adults surveyed during the presidential campaign said it was important that the two major candidates propose reforms that would improve health care quality, ensure that all Americans can afford health care and insurance, and decrease the number of uninsured.[2] Respondents also reported that they are frustrated with the way health care is delivered. In the past two years, 47 percent of those answering the survey said they experienced poorly coordinated medical care, meaning they were not informed about test results or had to call repeatedly to get them, important medical

MEETING PERFORMANCE BENCHMARKS: THE BENEFITS

If the U.S. health system were to achieve benchmark levels of performance, there would be significant benefits in terms of health, patient experiences, and savings, according to the 2008 National Scorecard on U.S. Health System Performance. The report shows that:

- 37 million more adults would have an accessible primary care provider, and 70 million more adults would receive all recommended preventive care.
- 100,000 fewer people would die from causes that could have been prevented by good care.
- Medicare could save at least $12 billion a year by reducing readmissions or reducing hospitalizations for preventable conditions.
- Lowering the administrative costs of health insurance to the level found in Germany, which like the U.S. has a blended public–private health system, could save $51 billion a year.

Anne K. Gauthier, M.S.
Commission Deputy Director
Fund Assistant Vice President

Cathy Schoen, M.S.
Commission Research Director
Fund Senior Vice President

information was not shared among doctors and nurses, or communication between primary care doctors and specialists was poor.

Addressing Americans' concerns, the Commission report *Organizing the U.S. Health Care Delivery System for High Performance* describes strategies that could lead to an organized, efficient health care system while simultaneously improving care and cutting costs.[3] Specifically, the authors call for:

- Payment reform to ensure that health care providers and hospitals are paid for delivering high-quality, patient-centered, coordinated care
- Incentives that encourage patients to go to the health care professionals and institutions that provide the most efficient, highest-quality care
- Regulatory changes to remove barriers that prevent physicians from sharing information essential for well-coordinated care and safe transitions for patients
- More rigorous accreditation of providers and health systems
- Federal support for provider training in the delivery team-based care, for the broad adoption and use of health information technology, and for performance improvement activities.

"There is no one policy, or practice that will make our health care system run like an efficient, well-oiled machine," notes Mongan, the Commission's chairman. "This is going to take strong national leadership and a commitment from all of the players in our health care system."

REPORTS WITH IMPACT

One of the most influential reports The Commission on a High Performance Health System has issued to date is *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, which showed that comprehensive health reform can lead to surprising savings in both the near and long term.[4] Released in December 2007, the report examines 15 federal policy options that could lower health spending by $1.5 trillion over 10 years, relative to projected trends. Along with enactment of health insurance coverage for all, the synergistic policies would improve health care access, quality, and outcomes, as well as the value of our health spending.

In addition to a *New York Times* editorial devoted to the report's findings, the analysis was the subject of a briefing held by the independent, Washington, D.C.–based Alliance for Health Reform and a special bipartisan briefing for members of Congress cohosted by Representatives Michael C. Burgess, M.D., (R-Texas) and Tom Price (R-Ga.) and Delegate Donna M. Christensen (D-V.I.).[5] In June 2008, Commonwealth Fund president Karen Davis discussed options from *Bending the Curve* at the U.S. Senate Finance Committee's "Prepare for Launching Health Reform Summit." And following a recommendation in the report, Vermont added a claims tax to support a $32 million, 10-year health information technology fund.

Informing Policy Leaders

The Commonwealth Fund also seeks to build strong relationships with national policymakers to help inform the health reform debate more directly and to disseminate the Commision's key findings and recommendations to leaders who are positioned to bring about change.

Congressional Member and Staff Retreats

The Commonwealth Fund, in partnership with the Alliance for Health Reform, hosted its 10th annual Bipartisan Congressional Retreat in 2008, bringing together 11 key members of Congress who are engaged in health policy and health care issues. The private setting for these meetings allows members to discuss issues openly with experts and with one another while acquiring a depth of knowledge that is not possible in other venues.

At the end of each retreat, members emerge with a fuller understanding of health policy choices and their potential implications. They also learn about proposals being considered by their colleagues across the aisle—and about opportunities for bipartisan cooperation.

Sessions at last year's retreat focused on the following topics:

- The future of employer coverage
- Strategic choices for health system reform, and federal and state roles in achieving high performance health care
- Organizing the care delivery system
- Lessons from other countries in expanding use of health information technology
- Achieving savings to improve health system performance: federal policy options
- Stemming the rising tide of costs in Medicare.

The Alliance for Health Reform also holds a retreat for Democratic and Republican senior congressional staff and officials from federal agencies. Co-sponsored by the Fund and the Catholic Health Association of the United States, the sessions delved into issues surrounding Medicare's future, insurance market reform, and cost-containment.

Capitol Hill Briefings

Throughout the year, the Commission works in partnership with the Alliance for Health Reform to conduct eight briefings for members of Congress, journalists, and representatives of health policy organizations. The briefings have attracted thousands of participants from both political parties, affording the opportunity to find common ground on key health policy issues. Briefing topics in the past year included state health reform initiatives, cutting costs while improving quality, the presidential candidates' health reform proposals, reducing racial and ethnic disparities, public options for expanding coverage, and a system for assessing the comparative effectiveness of medical procedures and technologies.

Looking Ahead

Now in its fourth year, the Commission on a High Performance Health System is developing detailed recommendations for the steps need to raise the benchmark levels of health system performance. In the coming year, the Commission will issue recommendations in a number of areas, including the organization of the health system, innovation and improvement, and national accountability for system performance. With a new presidential administration in Washington committed to health care reform, the Commission's work in these areas is more important than ever.

Notes

[1] Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008).

[2] S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. System Organization: A Call for New Directions* (New York: The Commonwealth Fund, Aug. 2008).

[3] A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008).

[4] C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

[5] "Slowing the Rise in Health Costs," *New York Times* editorial, Dec. 20, 2007.

Photographs

John Troha: page 2 (top
Amanda Stevenson: page 2 (bottom)

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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Food services industry employees are among the millions of workers in the United States who often lack health insurance coverage because their employers do not offer health benefits. Commonwealth Fund experts and grantees are developing and analyzing policy options for extending coverage to such workers—and to all Americans who lack access to an affordable health plan.

The Future of Health Insurance

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

Today, an estimated 48 million people in the United States do not have any health insurance, and 25 million more are underinsured—meaning the coverage they do have fails to protect them against burdensome health care costs. The lack of adequate health coverage makes it difficult for many Americans to get the care they need, or leads to large medical bills and financial hardship when they do get care.

Believing that universal health coverage is a building block of a high performance health system, The Commonwealth Fund's Program on the Future of Health Insurance envisions an efficiently run system through which all Americans can obtain comprehensive, affordable coverage.

In pursuit of this vision, the program:

- analyzes market- and policy-driven changes in employer-based insurance and public insurance programs for people under age 65, and determines how those changes may affect the number of people covered and the quality of coverage
- documents the consequences of being uninsured or underinsured in terms of access to care, health, personal financial security, and economic productivity
- develops and evaluates strategies to expand and stabilize health coverage, make coverage more affordable, and administer it more efficiently.

Options for Health Insurance Reform

For the first time in quite a while, the prospects for achieving far-reaching health care reforms are real. Not only did most of the 2008 presidential candidates have substantial, and often detailed, reform proposals, but opinion polls and surveys have indicated a groundswell of support among Americans for real changes in our health care system. The major impetus for change is, above all else, the tens of millions of children and adults in the U.S. without adequate insurance—or any coverage at all.

The Candidates' Plans

In its role as an evaluator of health reform strategies, the Fund's Future of Health Insurance program issued an analysis in October comparing the proposals of presidential candidates John McCain and Barack Obama.[1] Released at the height of the campaign, the analysis, *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America*, described how each candidate would seek to expand health insurance coverage, improve the quality and efficiency of the health system, and control costs. An interactive feature also available on www.commonwealthfund.org enabled side-by-side comparisons of the Obama and McCain plans in 24 different areas.

According to Fund assistant vice president Sara R. Collins, Ph.D., lead author of the analysis, the two plans were rooted in differing philosophies. "President Obama was proposing to build on the broadest risk pools in the system, strengthening large employer-sponsored coverage and expanding Medicaid and the State Children's Health Insurance Program, while fixing the individual insurance market with consumer protections, benefit standards, and income-related premium assistance. Senator McCain's plan would have shifted coverage away from employers to the individual market, letting people make their own insurance choices." Such a dramatic change, she said, could make coverage unaffordable, or unavailable, for older adults or people with serious health risks.

The two proposals also differed widely in their potential impact on the uninsured. Researchers at the Urban Institute/Brookings Institution Tax Policy Center estimated that McCain's plan would have insured 2 million uninsured Americans, out of a projected 67 million, in 10 years, compared with 34 million who would gain coverage during that time under Obama's plan.

HELPING YOUNG ADULTS GET COVERAGE

Young adults, ages 19 to 29, are one of the largest segments of the U.S. population without health insurance. Every year since 2003, the Fund has published an issue brief documenting the crisis in young adults' health coverage and outlining potential policies that would improve access to insurance for them. In the 2008 edition, the authors reported further deterioration of coverage for this age group as the number of uninsured young adults climbed to 13.7 million in 2006 from 13.3 million in 2005. Often dropped from their parents' policies or from public insurance programs at age 19 or on graduation day, they are left to find insurance on their own, according to the brief, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update*. Almost two of five (38%) high school graduates who do not enroll in college and one-third of college graduates are uninsured for a time during the first year after graduation. By far, the young adults most at risk of lacking coverage are those from low-income households.[4] In recent years, 20 states have passed legislation to increase the age of dependency for young adults for the purpose of private insurance coverage.

Building on What Works

How health insurance reform is designed will be critical for achieving universal coverage, as well as for improving the quality of care and controlling costs. Commonwealth Fund staff also produced two reports in the past year that explored ways to expand and improve health coverage by building on the systems and infrastructure that are already in place—and that have worked well.

In October 2007, the Commission on a High Performance Health System released *A Roadmap to Health Insurance for All: Principles for Reform,* which examined three different reform approaches proposed by governors, the 2008 presidential candidates, and congressional lawmakers.[2] Prepared by Sara Collins and her Fund colleagues, the report assessed not only each approach's ability to achieve universal coverage, but also its potential to improve quality and efficiency and rein in spiraling health care costs. The reform approaches included:

- Plans that rely primarily on tax incentives and the individual insurance market
- Reforms that would build on the nation's current mix of public and private insurance options, with responsibility for financing shared by government, employers, and households
- Public insurance options, under which nearly all Americans would be covered through a program like Medicare.

While the Commission has not endorsed a specific legislative proposal, it views a mixed private/public

Insurance reform based on group insurance principles is likely to yield greater benefits to the health care system overall.

Principles for Reform	Tax Credits and Minimum State Rules for Individual Insurance Market	Mixed Private–Public Group Insurance with Premium Subsidies and Consumer Protections
Covers everyone	0	+
Standard benefit floor	–	+
Premium/deductible/ out-of-pocket costs affordable relative to income	–	+
Easy, seamless enrollment	0	+
Choice	+	+
Pool health care risks broadly	–	+
Minimize dislocation, ability to keep current coverage	+	++
Administratively simple	–	+
Improve health care quality and efficiency	0	+

0 = Minimal or no change from current system; — = Worse than current system;
+ = Better than current system; ++ = Much better than current system
Source: S. R. Collins, C. Schoen, K. Davis et al., *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund Commission on a High Performance Health System, Oct. 2007).

group insurance system as the most pragmatic approach—one that would minimize dislocation for the millions of Americans who currently have good coverage.

One of the major objections to proposals for universal health insurance coverage is that they would force Americans who are perfectly content with their health plan to enroll in a one-size-fits-all government program. That is why a health reform proposal developed by experts at The Commonwealth Fund holds considerable promise as a practical framework for achieving universal health coverage while containing health care costs.

As described in a *Health Affairs* article and Fund issue brief, both published in May 2008, the "Building Blocks" approach is designed to cover 44 million of the estimated 48 million uninsured Americans in 2008 and lower overall health spending—without creating major disruptions to Americans who are satisfied with their current health plan.

Conceived by Fund president Karen Davis, senior vice president Cathy Schoen, and Sara Collins, Building Blocks would preserve employer-sponsored health insurance, Medicaid, and the recently reauthorized and expanded Children's Health Insurance Program (CHIP), while also expanding and improving Medicare—one of the most successful public programs. In addition, small businesses, the self-employed, and everyone else lacking access to group coverage would have a choice of an enhanced Medicare plan or private plans in which they could enroll through a health insurance "connector."

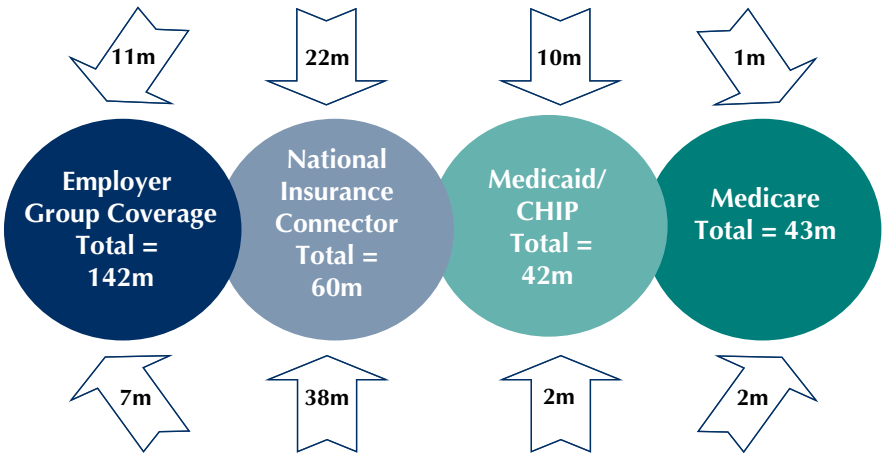
The proposal's specifics include:

- A new Medicare option—"Medicare Extra"—that would be open to everyone and would offer enhanced benefits as well as premiums 30 percent lower than the average premiums currently charged to employers
- A national insurance connector through which individuals and small businesses would have a choice of private plans or the new Medicare Extra plan
- A requirement that all applicants be given health insurance at standardized rates, regardless of their health status
- Tax credits to make sure premiums are affordable
- Expansion of Medicaid and CHIP to cover all low-income adults and children below 150 percent of the federal poverty level, with modest copayments and no premiums
- A requirement that everyone enroll in a health plan
- A mandate that employers either provide health insurance or pay 7 percent of payroll into a pool to help to finance coverage
- Medicare reforms that would extend Medicare Extra benefits to current Medicare beneficiaries, eliminate the two-year waiting period for the disabled, and allow adults ages 60 to 64 to buy into the program.

Estimates prepared by the Lewin Group show the expansion would have a negligible effect on total national health spending. That is because of offsetting savings on administrative and other costs, which would limit the plan's financial impact to a net increase of $15 billion, or less than 1 percent of estimated total health spending for 2008.

According to the Fund's Davis, "This approach demonstrates that it is possible to buy more for our health care dollars, cover all Americans with high-quality insurance, and institute real reforms to stem rising health care costs."

The Building Blocks proposal is designed to make health insurance automatic and affordable to all.



Source: Based on analysis in C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May 13, 2008 27(3):646–57, from Lewin Group modeling estimates.

Consequences of a Failed Insurance System

Underinsured and At Risk

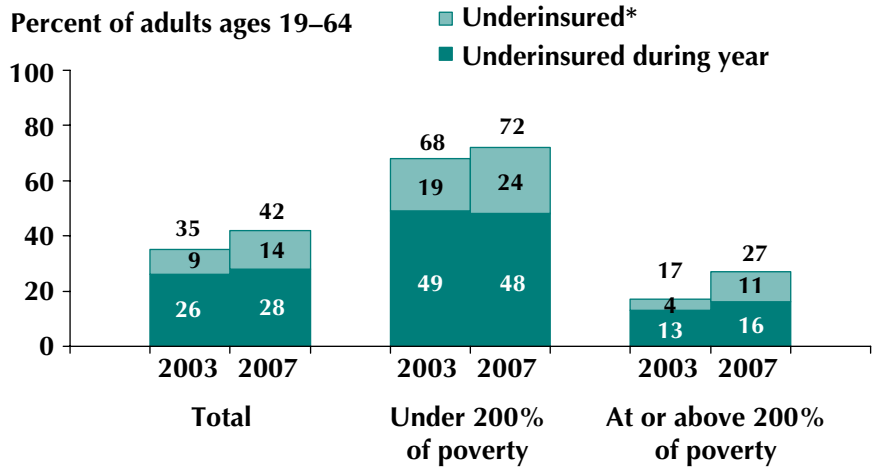
Employer-based coverage forms the backbone of America's voluntary health insurance system, with employer health plans covering more than 160 million workers and their dependents, or 62 percent of the population under age 65. But rising health care costs have led employers to shift a greater share of their costs to employees, and many small businesses have discontinued coverage. In addition to the 48 million people in the U.S. who are uninsured, there are many millions more who are *underinsured.*

A Commonwealth Fund study published by the journal *Health Affairs* in June 2008 found that as of 2007, there were an estimated 25 million underinsured adults in the U.S., an increase of 60 percent over the 16 million who were underinsured in 2003.[3] Most of this growth came from rising underinsured rates among middle- and higher-income families, the authors found. The analysis, which was conducted by Cathy Schoen and other Fund researchers, was based on data from the Commonwealth Fund 2003 and 2007 Biennial Health Insurance Surveys.

While low-income people remain the most likely to be underinsured or uninsured, underinsured rates nearly tripled since 2003 for adults with incomes equivalent to twice the federal poverty level or above (an annual family income of approximately $40,000). Adults ages 19 to 64 were classified as underinsured if they were insured all year yet spent 10 percent or more of their income (or 5 percent if low-income) on out-of-pocket medical expenses, or if they had per-person deductibles that equaled 5 percent or more of their income.

"We are seeing the sharp increase in the underinsured because the insured are facing higher cost-shares and limits in insurance benefits—premiums are up but people are buying less protection," said Schoen, a senior vice president at the Fund. "Today you can have health

The number of underinsured adults under age 65 rose to 25 million in 2007, up from 16 million in 2003.



*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income. Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).

insurance and still go bankrupt if you get sick. This puts individuals, families, and the nation's health and economic security at risk." The sharp increase in the number of underinsured adults, say the authors, is partly due to changes in insurance benefits—like higher deductibles and caps on physician visits—that leave individuals financially vulnerable.

Impact on Medicare Beneficiaries

Commonwealth Fund–supported research published in two of the nation's leading medical journals vividly illustrates the importance of having health insurance coverage not only for ensuring access to needed care, but also for reducing the need for health care later in life and controlling overall health costs.

A team of Harvard Medical School researchers led by John Z. Ayanian, M.D., and J. Michael McWilliams, M.D., reported in the *New England Journal of Medicine* that among U.S. adults ages 59 to 64 who had been diagnosed with hypertension, diabetes, heart disease, or stroke, those lacking insurance coverage had much higher medical costs—51 percent higher—after becoming eligible for Medicare at age 65 than did those with insurance coverage.[5] The uninsured also reported 13 percent more doctor visits and 20 percent more hospitalizations than adults who had coverage before enrolling in Medicare. Higher use of services and higher costs persisted through age 72.

John Z. Ayanian, M.D.
Harvard Medical School

"These findings support the hypothesis that previously uninsured adults used health services more intensively and required costlier care as Medicare beneficiaries than they would have if previously insured," wrote McWilliams and his colleagues. The costs of providing health insurance to people earlier in life, he said, may be partly offset by reduced spending on health care after age 65.

In another article, this one published in the *Journal of the American Medical Association,* McWilliams and his coauthors presented the strongest evidence to date that health improves significantly when people gain health insurance.[6] Using comprehensive self-reported health measures, the researchers analyzed data for more than 7,000 older adults over a 12-year period. They found that while individuals who had continuous health insurance coverage did not report a significant change in their health trends as they transitioned to Medicare, those who had no or little previous coverage reported substantial improvements.

ASSESSING THE GAINS OF EXPANDING MEDICARE TO OLDER ADULTS UNDER 65

Goal	To inform policymakers about the potential health gains of expanding Medicare coverage to older adults under 65, how the cost of such an expansion could be offset by program savings, and whether Medicare spends more on adults who were uninsured prior to enrollment than it does on those who were insured.
Award Amount	$200,289 (Phase 1) and $219,288 (Phase 2)
Timeframe	9/1/06–2/29/08 (Phase 1) and 3/1/08–6/30/09 (Phase 2)
Lead Investigator	John Z. Ayanian, M.D., Harvard Medical School
For more information	E-mail Dr. Ayanian at ayanian@hcp.med.harvard.edu.

Peter J. Cunningham, Ph.D.
Center for Studying Health System Change

Out-of-Pocket Costs

Even prior to the current deep recession, rising health care costs and stagnant incomes were creating greater financial burdens for U.S. families as they struggled to pay bills and accumulated medical debt. In a Commonwealth Fund–supported study published in *Health Affairs,* researchers with the Center for Studying Health System Change, led by Peter Cunningham, Ph.D., and the Agency for Healthcare Research and Quality wrote that more than one of six Americans lived in families that spent more than 10 percent of their after-tax income on health care in 2004.[7] The authors said the overwhelming majority of people who face such a high financial burden had private health insurance.

After accounting for general inflation, total average out-of-pocket spending on health care increased by $373 to $2,656 a person in 2004, about a 16 percent increase from 2001. In contrast, average family incomes during the same period were largely unchanged after accounting for inflation. For people with employer coverage, out-of-pocket spending for premiums and services rose 21 percent during the same period.

Sherry A. Glied, Ph.D.
Mailman School of Public Health, Columbia University

EXAMINING TRENDS IN OUT-OF-POCKET MEDICAL COSTS AND THEIR IMPLICATIONS FOR HEALTH CARE ACCESS

Goal	To measure recent increases in families' out-of-pocket medical expenditures and premium shares and identify the causes.
Award Amount	$184,981
Timeframe	5/1/06–5/31/07
Lead Investigator	Peter J. Cunningham, Ph.D., Center for Studying Health System Change
For more information	E-mail Dr. Cunningham at PCunningham@hschange.org.

Who Pays When Workers Are Uninsured?

The public, along with workers, foot the bill when employers fail to provide their full-time employees with health insurance, according to a Commonwealth Fund–supported study by Columbia University grantee Sherry Glied, Ph.D., *Who Pays for Health Care When Workers Are Uninsured?*[8] Together with her colleague Bisundev Mahato, Glied calculated that eroding employer-sponsored health insurance is costing U.S. taxpayers $45 billion a year, which includes $33 billion to cover public insurance, such as Medicaid, for full-time workers and their dependents, and $12 billion for uncompensated health care that would otherwise be covered by the workers' private insurance. The researchers say that public costs associated with uninsured and publicly insured workers and their dependents were 45 percent greater in 2004 than in 1999.

In a companion study, Glied and Mahato show that low-wage workers—those earning less than $9.80 per hour (in 2003 dollars)—are more likely than high-wage workers to be uninsured.[9] Low-wage workers are less likely to go to the doctor when they are sick, to have a usual source of care, or to receive preventive services such as blood-pressure checks. Both studies conclude that falling rates of employer-sponsored coverage are

placing an increasing burden on taxpayers, public health insurance programs, and workers themselves—particularly low-wage earners.

Grants to Watch

Health care cost growth and the national recession will continue to press workers and businesses, likely leading to increases in the number of uninsured and underinsured Americans. The Program on the Future of Health Insurance will continue to track the scope of the problem and trends by measuring the consequences of being uninsured and underinsured and providing analysis to inform policies to expand health insurance.

Jon Gabel, a senior fellow with the National Opinion Research Center, has received Commonwealth Fund support to compare the affordability of small-group, large-group, and individual market insurance plans, based on premiums and out-of-pocket medical expenses. Gabel and colleagues also will examine the benefit structure of plans available in individual markets in 10 states and compare the expected out-of-pocket expenses for those enrolled in individual and group plans. The design and implementation of a national health insurance connector will be the focus of a project led by Melinda Buntin, Ph.D., and colleagues at RAND, who will seek to determine how such a mechanism could improve accessibility and affordability of coverage, especially for the uninsured and underinsured.

These and other Fund-supported projects will provide critical information to policymakers and the public in the national discussion over health care reform.

Notes

1 S. R. Collins, J. L. Nicholson, S. D. Rustgi, and K. Davis, *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America* (New York: The Commonwealth Fund, Oct. 2008). Also see the earlier report comparing the health reform proposals of all major Democratic and Republican primary candidates, S. R. Collins, J. L. Nicholson, S. D. Rustgi, and K. Davis, *Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals* (New York: The Commonwealth Fund, Sept. 2008).

2 S. R. Collins, C. Schoen, K. Davis, A. K. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).

3 C. Schoen, S. R. Collins, J. L. Kriss, M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008:w298–w309.

4 J. L. Kriss, S. R. Collins, B. Mahato, E. Gould, and C. Schoen, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update* (New York: The Commonwealth Fund, May 2008).

5 J. M. McWilliams, E. Meara, A. M. Zaslavsky, and J. Z. Ayanian, "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine,* July 12, 2007 357(2):143–53.

6 J. M. McWilliams, E. Meara, A. M. Zaslavsky, et al., "Health of Previously Uninsured Adults After Acquiring Medicare Coverage," *Journal of the American Medical Association* Dec. 26, 2007 298(24):2886–94.

7 J. S. Banthin, P. Cunningham, and D. M. Bernard, "Financial Burden of Health Care, 2001–2004," *Health Affairs,* Jan./Feb. 2008 27(1):188–95.

8 S. Glied and B. Mahato, *Who Pays for Health Care When Workers Are Uninsured?* (New York: The Commonwealth Fund, May 2008).

9 S. Glied and B. Mahato, *The Widening Health Care Gap Between High- and Low-Wage Workers* (New York: The Commonwealth Fund, May 2008).

Photographs

Roger Carr: page 2 (bottom)

While state policymakers and program officials may have the desire and will to undertake health system reforms, they do not necessarily have all the technical knowledge and practical experience needed to implement new policies and practices effectively. At a meeting in Seattle of the Commonwealth Fund–sponsored State Quality Improvement Institute, experts from AcademyHealth respond to state officials' needs for assistance and share best practices from around the country.

State Innovations

Anne K. Gauthier, M.S.
Assistant Vice President

As "laboratories of innovation," the states can point the nation to promising approaches for improving the performance of the U.S. health care system. Although the prospects for national health care reform appear brighter, individual states are not waiting to take action to control escalating health care costs, expand insurance coverage, and promote quality and efficiency in care delivery.

The Commonwealth Fund's State Innovations program aims to improve the performance of our health care system by supporting, stimulating, and spreading states' strategies to expand access to care and by promoting high-quality, efficient care, particularly for vulnerable populations. The program has made grants to:

- identify and assess promising public and private sector policies
- disseminate state innovations
- evaluate comprehensive and targeted state health reform proposals
- respond to state needs for technical assistance and research.

Learning About What Works

Two projects supported by the State Innovations program in 2007–08 exemplify its efforts to assess states' activities aimed at improving the quality of patient care, improving care coordination, and reigning in costs.

Policy analysts from the Lewin Group investigated the role states play as employers providing health benefits to public employees and retirees. As health care purchasing entities serving government workers, public employee health plans (PEHPs) are responsible for an increasingly large share of state health care spending, second only to state Medicaid programs. The most recent data show state spending on public employee and retiree health benefits accounted for about 16 percent of total state health spending (excluding the federal share), up from 10 percent in fiscal year 1997, according to a February 2008 Commonwealth Fund report.[1]

According to the authors, PEHPs are taking a variety of steps to improve quality and control costs in health care. These include:

- promoting provider adherence to clinical guidelines and best practices;

- publicly disseminating provider performance information;
- implementing performance-based incentives;
- developing coordinated care interventions; and
- taking part in multipayer quality collaborations.

Here are two examples of the work undertaken by state PEHPs:

Massachusetts. In 2004, the Massachusetts Group Insurance Commission (GIC), which purchases health benefits for about 267,000 public employees and their dependents, began requiring participating health plans to submit medical, mental health, and pharmacy claims data for a consolidated database on provider performance. Using this database of claims information, GIC is developing strategies to improve efficiency and care quality.

Arkansas. The Arkansas Foundation for Medical Care used funding and technical support from the Robert Wood Johnson Foundation and Center for Health Care Strategies to launch a new multipayer regional quality improvement initiative in 2006. The initiative, which involves Medicaid, the Arkansas State Employees Insurance Plan, and other large payers, is collecting claims and other data from health care purchasers to develop a uniform set of quality measures to facilitate performance monitoring and develop quality improvement programs.

Aaron McKethan, Ph.D.
Brookings Institution

"Even though the PEHPs have grown to become big purchasing entities, they have not previously been integrated into the larger health care reform activities in the states," explained Aaron McKethan, Ph.D., research director for the Brookings Institution's Engleberg Center for Health Care Reform and one of the authors of the Fund report. "Just like any large purchaser, their best opportunities involve learning what other larger purchasers are doing so that they can align their performance improvement efforts with that of other purchasers and work together to create a less fragmented health system."

In a similar way, Commonwealth Fund–supported researchers sought to gather and analyze data on the variety of "e-health" initiatives being undertaken across the U.S., and then disseminate that information so that states can learn from each other's experiences. E-health—which encompasses any health care practice supported by electronic processes and communication, including health information technology and electronic health information exchanges—holds promise in improving the delivery and coordination of health care services. It can also help make physician practices and other care providers operate more efficiently.

To understand the e-health activities in the states, the National Governors Association partnered with Health Management Associates (HMA) and George

THE STATE PUBLIC EMPLOYEE HEALTH PLAN FORUM

Goal	To enhance information exchange among the states about the role that public employee health plans could play in efforts to improve the quality of health care.
Award Amount	$193,628
Timeframe	7/1/07-10/31/08
Lead Investigator	Aaron McKethan, Ph.D., Brookings Institution
For more information	E-mail Dr. McKethan at amckethan@brookings.edu.

States in Action Newsletter

Since publication began in March 2005, the Commonwealth Fund e-newsletter *States in Action* has proven to be an effective vehicle for raising awareness of innovative state coverage expansions and quality improvement initiatives. The bimonthly publication reaches an audience of more than 11,000 state policymakers, administrators, researchers, and others who are working on ways to stretch health care dollars to meet the needs of their state's residents. "Each state has its own circumstances, politics, and culture—that means you can't always lift one program from one state and replicate it in another," says Sharon Silow-Carroll, a principal with Health Management Associates who co-writes *States in Action*. "It doesn't make sense for each state to build individual but similar programs from nothing when other states have already struggled with the start-up and development issues. By sharing information in the newsletter, we can at least allow them to start at a much more advanced place."

Washington University to survey states about their state health information technology and electronic health information exchange activities. As discussed in a February 2008 Commonwealth Fund report, most states place a high priority on e-health: nearly 70 percent report "very significant" e-health activities.[2]

Surveying States About Their E-Health Activities

Goal	To identify challenges facing states in facilitating electronic health information exchange, and to learn how states plan to address them.
Award Amount	$50,000
Timeframe	5/1/07–1/15/08
Lead Investigator	Vernon Smith, Ph.D., Health Management Associates
For more information	E-mail Dr. Smith at vsmith@healthmanagement.com.

E-health applications, for example, are enabling states to implement initiatives to promote quality improvement and greater transparency, and public-private consortiums are aiding the creation of standardized measures of utilization and performance.

Vernon Smith, Ph.D.
Health Management Associates

"State officials see the opportunity to facilitate the development of such technology as electronic health records, e-prescribing, electronic health exchanges, and the ability to access multiple databases of information across payers and across providers," said Vernon K. Smith, Ph.D., a principal at HMA and former director of Michigan's Medicaid program. "When you look at the opportunities to improve the health care delivery system through e-prescribing, for example, in reducing prescribing errors alone, the benefits are incalculable," Smith added.

State governors' two highest e-health priorities over the next two years, the survey found, are fostering the development of electronic health information exchanges and ensuring interconnectivity among health care providers. At the same time, states will need to overcome significant barriers to the widespread adoption of interoperable health information technology and a nationwide network of electronic information exchanges, including privacy and security concerns and limited funding.

"Even though the states participate in the health care system and do not control the system," HMA's Smith said, "they are in a position to facilitate change that goes across all payers and purchasers and affects everyone in the population."

Evaluating State Health Reform

One of the most significant accomplishments of any state engaged in health reform is the dramatic improvement in insurance coverage Massachusetts achieved after implementing its ambitious health care plan in December 2006. The Massachusetts plan expanded the state's Medicaid program, established income-related subsidies, created a new private insurance plan for individuals, and required that individuals and employers to participate in the health insurance system or pay a fine.

A Fund-supported evaluation of the plan showed that the Bay State cut the proportion of uninsured working-age adults nearly in half, from 13 percent to 7 percent. Published in the journal *Health Affairs,* the study findings showed that among adults with incomes below 300 percent of the federal poverty level, the proportion of those who were uninsured dropped by nearly 11 percentage points from 24 percent in the fall of 2006 to 13 percent a year later.[3]

MONITORING THE IMPACT OF HEALTH REFORM IN MASSACHUSETTS

Goal	To evaluate the impact of Massachusetts's health care reform legislation, including impact on insurance status, access to and use of health services, and out-of-pocket spending, particularly among the uninsured and individuals with low and moderate income.
Award Amount	$145,717
Timeframe	7/1/07–8/31/08
Lead Investigator	Sharon Long, Ph.D., The Urban Institute
For more information	E-mail Dr. Long at slong@urban.org.

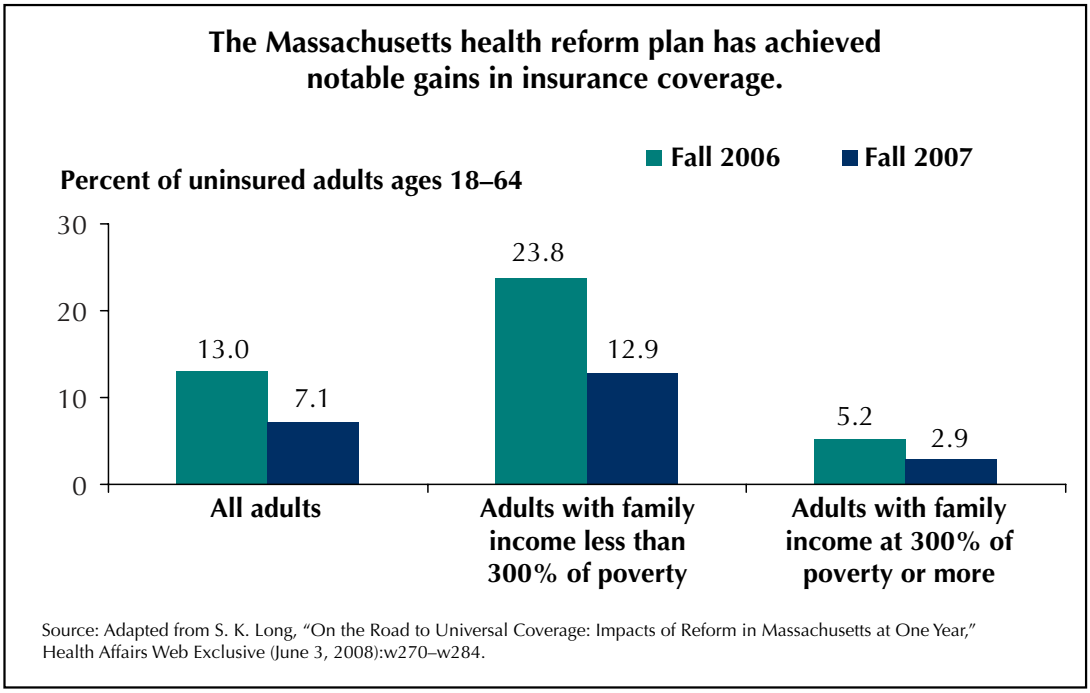
Sharon Long, Ph.D.
The Urban Institute

In addition to improvements in insurance coverage, the state had significant gains in access to care, said Sharon K. Long, Ph.D., a researcher with the Urban Institute who led the evaluation.

For the study, Long did two rounds of interviews with about 3,000 adults ages 18 to 64 in Massachusetts in each round. One round was done in the fall of 2006, just before implementation, and one was done in the fall of 2007, one year after the reform effort began.

"Our findings are strongly positive, but there are suggestions of potential problems in access to care, specifically in terms of finding or getting to see a doctor," Long said in an interview. "There are some solutions focused on increasing the supply of providers. The Blue Cross Blue Shield of Massachusetts Foundation and the state have joined together to initiate a loan forgiveness program with primary care providers. There are also incentives to bring in providers from other states."

Long said the ongoing evaluation has identified opportunities to improve the efficiency of care delivery in Massachusetts. "We found high levels of emergency room use, including high levels of ER use for nonemergency conditions, combined with problems getting to see a health care provider in the community," she noted. "These findings suggest there are cost savings to be had by providing care in more appropriate settings. As part of the third phase of the Fund-supported Massachusetts health reform evaluation, the researchers will assess the impact of the state's individual employer mandate.



Source: Adapted from S. K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," Health Affairs Web Exclusive (June 3, 2008):w270–w284.

Responding to States' Needs for Technical Assistance

While state policymakers and program officials may have the desire and will to undertake health system reforms, they do not necessarily have all the technical knowledge and practical experience needed to implement new policies and practices effectively. To respond to states' needs for such assistance, The Commonwealth Fund sponsored an effort by AcademyHealth, an organization of health services researchers, policy analysts, and practitioners in Washington, D.C., to launch the State Quality Institute. The institute is designed to help states plan and implement efforts to improve health system performance and to share best practices. Its leaders are hoping to address the wide variability in quality and value in health spending across the United States, as documented by the State Scorecard on Health System Performance, released by the Fund's Commission on a High Performance Health System in June 2007.[6]

Through a competitive process, nine states were selected to participate in the institute: Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont, and Washington. Representatives from each state are focusing on improving performance on at least two quality indicators from the Fund's state scorecard. Kansas, for example, aims to establish medical homes for 85 percent of children and reduce the rate of avoidable hospitalizations for pediatric asthma to no more than 82 per 100,000 for children under age 18 by 2012.

"A majority of the nine states are working on programs to develop medical homes," explained project

Massachusetts: Dramatic Gains in Health Insurance Coverage

Three-quarters of Massachusetts residents who were previously uninsured now have medical coverage under the state's health reform program.[4] Since the program began in 2006, 439,000 more residents have enrolled in health insurance, and nearly half of them signed up for private insurance not funded by taxpayers. Prior to 2006, studies had estimated that about 600,000 Massachusetts residents lacked health insurance.[5]

Enrique Martinez-Vidal
AcademyHealth

lead Enrique Martinez-Vidal, a vice president with AcademyHealth. "The medical home concept is significant because it offers these states a way to bring together the whole idea of chronic care management and system redesign, and it can help engage patients in wellness and illness prevention."

Another way the Fund is assisting states is by supporting the design of Medicaid pay-for-performance programs. Under a Fund grant, the Center for Health Care Strategies, Inc. (CHCS), is helping states learn to adapt the pay-for-performance (P4P) programs prevalent in the private sector to meet the specific needs and goals of their Medicaid programs.

HELPING STATES DEVELOP QUALITY IMPROVEMENT ACTION PLANS

Goal	To assist nine state teams in developing and implementing sustainable quality improvement action plans centered around value-based purchasing, quality reporting, care coordination, or chronic care management.
Award Amount	$444,246
Timeframe	12/1/07–4/30/09
Lead Investigator	Enrique Martinez-Vidal, M.P.P., AcademyHealth
For more information	E-mail Mr. Martinez-Vidal at enrique.martinez-vidal@academyhealth.org

ACHIEVING EQUITY IN STATE HEALTH CARE REFORM

Insurance coverage expansions are important but insufficient to improve the health and health care of minority and low-income Americans. That is the conclusion reached by Brian D. Smedley, Ph.D., the research director for The Opportunity Agenda, a New York–based advocacy organization. In a Commonwealth Fund-supported article in *Health Affairs*, Smedley argued that states must make comprehensive efforts to eliminate the root causes of health care disparities.[7] States, he believes, should seek to improve access to care for minority and low-income populations by:

- increasing racial and ethnic diversity among health care professionals
- streamlining enrollment procedures for public health insurance programs
- increasing participating in public health insurance among the underserved.

In the companion Fund report, *Identifying and Evaluating Equity Provisions in State Health Care Reform*, Smedley and co-authors outlined policies that promote equitable health care access and quality for all populations and evaluated existing laws in California, Illinois, Massachusetts, Pennsylvania, and Washington.[8]

CHCS is helping six states develop incentives for Medicaid providers to deliver high-quality care to enrollees, a disproportionate number of whom are minorities, have low income, and chronic illnesses. With additional funding from the Robert Wood Johnson Foundation, CHCS will develop a P4P Purchasing Institute Technical Assistance (PITA) Series to develop P4P programs.

Grants to Watch

In addition to supporting the Urban Institute's ongoing evaluation of the Massachusetts health reform plan, the State Innovations program is helping researchers Amy Lischko, Ph.D., at Tufts University and Sara Bachman, Ph.D., at Boston University to assess the operation and impact of that state's health insurance "connector," established to facilitate the purchase of quality, affordable health insurance by small businesses and individuals who lack access to employer-sponsored health coverage. Findings from the project will help determine how the connector contributes to Massachusetts' health reform and are expected to provide valuable lessons for other states and the nation.

Under another Fund grant, Jill Rosenthal, M.P.H., at the National Academy for State Health Policy is studying partnerships formed by states to enable government agencies and private sector stakeholders to join forces to measure and improve the quality of care, publicly report quality information to consumers and providers, and develop policy recommendations. So far, 10 quality improvement partnerships have been selected for study: the Colorado Center for Improving Value in Health Care, the Kansas Health Policy Authority, the Massachusetts Health Care Quality and Cost Council, the Maine Quality Forum, Minnesota's QCARE, the Oregon Health Care Quality Corporation, the Pennsylvania Governor's Office of Healthcare Reform, the Rhode Island Quality Institute, the Vermont Blueprint for Health, and the Washington Quality Forum.

Notes

1 A. McKethan, T. Savela, and W. Joines, *What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples From the States* (New York: The Commonwealth Fund, Jan. 2008).

2 V. K. Smith, K. Gifford, S. Kramer et al., *State E-Health Activities in 2007: Findings from a State Survey* (New York: The Commonwealth Fund, Feb. 2008).

3 S. K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs* Web Exclusive, June 3, 2008:w270–w284.

4 Massachusetts Division of Health Care Policy and Finance, *Health Care in Massachusetts: Key Indicators—August 2008* (quarterly report).

5 K. Lazar, "439,000 More Get Health Coverage. State Shows Big Gains in Landmark Program," *Boston Globe,* Aug. 20, 2008, p.1.

6 J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund Commission on a High Performance Health System, June 2007).

7 B. D. Smedley, "Moving Beyond Access: Achieving Equity in State Health Care Reform," *Health Affairs,* March/April 2008 27(2):447–55.

8 B. D. Smedley, B. Alvarez, R. Panares, C. Fish-Parcham, and S. Adland, *Identifying and Evaluating Equity Provisions in State Health Care Reform* (New York: The Commonwealth Fund, April 2008).

Photographs

Dan Lamont: page 2 (top), page 8

The Commonwealth Fund supports efforts to strengthen and improve the Medicare program—to ensure that it will continue to meet the needs of the country's elderly and disabled. Additional efforts are focused on making Medicare a model for broader health care reform.

Medicare's Future

Stuart Guterman
Assistant Vice President

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

- protect vulnerable beneficiaries, by enhancing Medicare's ability to ensure access to care for disabled, low-income, chronically ill, institutionalized, and other beneficiaries
- improve the quality and efficiency of the Medicare program, by making traditional Medicare, the Part D prescription drug benefit, and the private plan option under Medicare Advantage more effective in providing beneficiaries with access to the care they need while maintaining the program's viability
- make Medicare a model for broader health reform, by designing and implementing improvements that can be leveraged to improve the efficiency and quality of the nation's health system.

Tracking Beneficiaries' Experience Under the Medicare Drug Benefit

In 2003, Congress significantly improved coverage under the Medicare program when it enacted the Part D prescription drug benefit. The benefit has succeeded in extending prescription coverage to the majority of seniors who previously lacked it.

Still, many seniors who have signed up for the new benefit still have relatively high out-of-pocket spending for medications. A Commonwealth Fund–supported survey conducted by researchers at Tufts–New England Medical Center found that in 2006, Part D enrollees did not fare as well as individuals who had coverage through their employer or the Veterans Administration (VA).[1] Published in the journal *Health Affairs*, the study, which was also supported by the Kaiser Family Foundation, found that elderly Americans with prescription coverage from any source were less likely to face high monthly drug expenses, or to skip medications because of the cost, than seniors without any prescription coverage. But those in Part D plans were more likely to report these problems than those with employer or VA coverage.

Despite the advent of Part D, many low-income Medicare beneficiaries remain without drug coverage, the survey found. Those lacking it were likely to be older and African American, and more likely to live in a rural area. Although low-income seniors can qualify

Dana Gelb Safran, Sc.D.
Tufts University,
Blue Cross Blue Shield
of Massachusetts

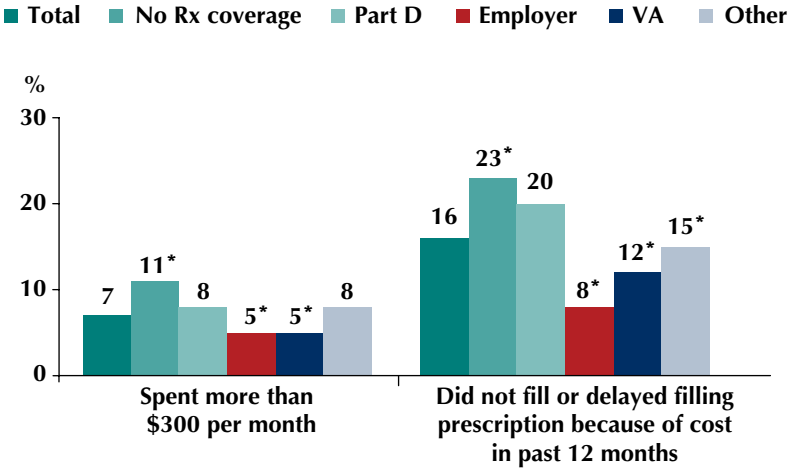
for a subsidy to pay for coverage and help with out-of-pocket costs, many are simply not aware that such help is available to them. Much work remains to be done, the authors concluded, to strengthen Part D and reach those beneficiaries still without drug coverage.

Additional research by the Tufts researchers has determined that the Medicare drug benefit has been a boon for many beneficiaries. A longitudinal observational study led by Dana Gelb Safran, Sc.D., an associate professor at Tufts and a vice president with Blue Cross Blue Shield of Massachusetts, found increased use of prescription medications, lower out-of-pocket spending, and increased patient adherence to medication regimens among 9,500 beneficiaries age 65 and older with Part D coverage. The study showed that in its first year, the Part D drug benefit appears to have moderated out-of-pocket prescription spending and the cost burden for those who previously had meager drug benefits or none at all. It also indicated that some low-income, chronically ill seniors have not taken advantage of the program fully, signaling the need for stepped-up outreach efforts.

EXAMINING BENEFICIARIES' EXPERIENCES WITH THE MEDICARE DRUG BENEFIT

Goal	To survey seniors in all 50 states to gather national and state-specific information on prescription drug coverage, use, and costs among the elderly.
Award Amount	$299,655
Timeframe	9/1/02–6/30/08
Lead Investigator	Dana Gelb Safran, Sc.D., Tufts Medical Center, Inc.
For more information	E-mail Dr. Safran at dana.safran@bcbsma.org.

Out-of-pocket spending and cost-related problems filling prescriptions among elderly Americans with various sources of drug coverage (2006).



Notes: Limited to the 89% of respondents who reported taking at least one medication. VA is Department of Veterans Affairs.
Reference group for statistical significance is Part D coverage (*p<0.05).
Data: Kaiser/Commonwealth/Tufts-New England Medical Center National Survey of Seniors and Prescription Drugs, 2006.
Source: Adapted from T. Neuman et al., "Medicare Prescription Drug Benefit Progress Report: Findings from a 2006 National Survey of Seniors," *Health Affairs* Web Exclusive (Aug. 21, 2007):w630–w643.

Examining the Role of Private Plans in Medicare

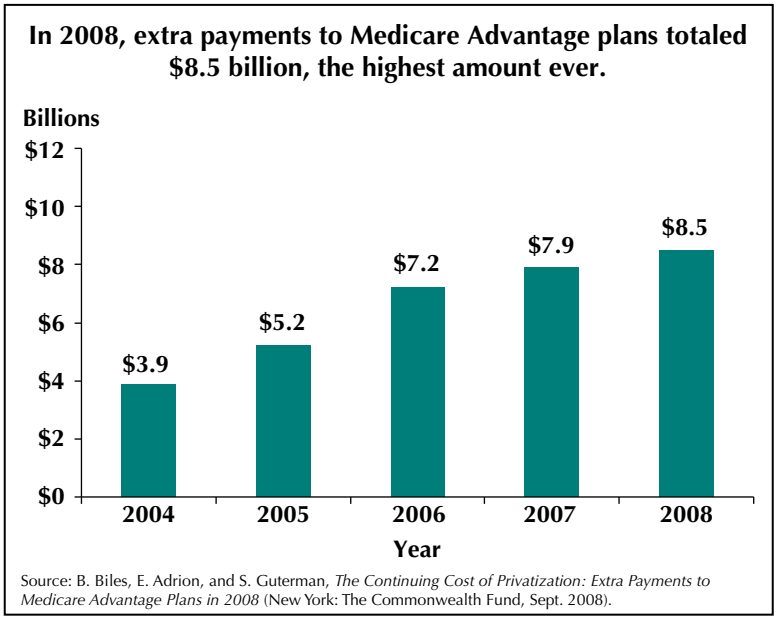
The Medicare Modernization Act of 2003, which authorized the Part D drug benefit, also raised the level of payments to private health plans serving Medicare beneficiaries. Since the law went into effect, Medicare Advantage plans, as they are called, have been paid substantially more for covering their enrollees than those same enrollees would have cost under traditional fee-for-service Medicare.

With Commonwealth Fund support, George Washington University's Brian Biles, M.D., has been studying the role and impact of private plans in Medicare for the better part of a decade. In an issue brief prepared for the Fund, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans in 2008*, he and colleagues reported that extra payments to Medicare Advantage, or MA, plans in 2008 amounted to $986 over fee-for-service costs for each of the approximately 8.7 million Medicare beneficiaries enrolled in these plans, for a total of more than $8.5 billion—bringing the total of these extra payments to nearly $33 billion since the law went into effect[2].

The rationale for overpaying private MA plans was to encourage the proliferation of private plans; indeed, since 2004, MA plan enrollment has increased from 4.8 million to 8.7 million. But combined with rapidly increasing private plan enrollment, the higher payments have resulted in tens of billions in additional Medicare spending over this period. According to Biles, extra payments "put pressure on both Medicare and the federal budget, drain resources from other, potentially more productive, uses, and dilute the incentive for Medicare Advantage plan efficiency—which was one of the original reasons for including a private plan option in Medicare."

Although payments to MA plans will be modestly reduced starting in 2010, beneficiaries enrolled in these plans will still cost the Medicare program more than their counterparts in traditional Medicare.

Biles and his colleagues also produced a companion analysis that reviewed the efficiency of Medicare Advantage's private fee-for-service plans.[3] They found that in 2008, these plans were paid an average of 16.6 percent more per enrollee than what the same



Source: B. Biles, E. Adrion, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans in 2008* (New York: The Commonwealth Fund, Sept. 2008).

beneficiaries would have cost under Medicare fee-for-service.

The study, published in October 2008, estimated that extra payments to the plans amounted to $1,248, compared with traditional fee-for-service, for each of the 2 million enrollees in those plans—for a total of nearly $2.5 billion. Private fee-for-service plans are not required to have a contract or other network arrangement with physicians, hospitals, and other providers. Instead, they can pay providers with which they have no contracts at Medicare fee-for-service rates. In addition, they are exempt from quality reporting and disclosure requirements that other plans must meet.

The extra payments to private fee-for-service have resulted from rapid growth in plan enrollment—from 220,000 enrollees in December 2005 to nearly 2 million in February 2008. Not surprisingly, the number of health insurers offering Medicare PFFS plans rose from four in 2004 to 70 in 2008.

PRIVATE PLANS IN MEDICARE: ASSESSING VALUE AND IMPACT

Goal	To examine Medicare Advantage policies to determine what additional benefits, if any, those plans provide and to whom they accrue, and what the implications are for beneficiaries and the Medicare program.
Award Amount	$267,511
Timeframe	1/1/08–6/30/09
Lead Investigator	Brian Biles, M.D., M.P.H., George Washington University
For more information	E-mail Dr. Biles at bbiles@gwu.edu.

Brian Biles, M.D.
George Washington University

"While some suggest that PFFS plans are important because they are located in rural areas, PFFS enrollment and extra payments are heavily focused in urban areas," Biles says. "If new Medicare legislation fails to address these issues, we will continue to see PFFS plan enrollment centered on high-extra-payment urban areas and Medicare spending billions of dollars that unnecessarily deplete federal resources."

Medicare: A Model for Broader Payment Reform?

Commonwealth Fund staff have been developing a framework for reforming Medicare payment to encourage less fragmented and more integrated health care delivery. By providing incentives for delivering high-quality care in an efficient manner and encouraging greater coordination among health care providers, Medicare can provide a model for moving toward a higher-performance health system.

In a *Health Affairs* article published in January 2009, Fund experts unveiled a new framework for revising the Medicare program's provider payment system to "slow Medicare's cost growth, improve the value for the dollars it spends, and serve as a model for broader health system change."[4] At the core of the proposal, developed by the Fund's Stuart Guterman, Karen Davis, and Stephen C. Schoenbaum, M.D., and IPRO's Anthony Shih, M.D., is an array of bundled payment options for physician group practices, hospitals, and health systems, with incentives to encourage greater integration in health care delivery and greater coordination of beneficiaries' care.

Under the plan, qualified physician practices, for example, would receive a monthly risk-adjusted per patient global fee to cover all primary care services, with part of the amount covering the services associated with a patient-centered medical home. An integrated system, meanwhile, could be paid a global payment per enrollee to cover all Medicare services, including inpatient and post-acute care, ambulatory care, and prescription drugs.

"We face great peril if our health system continues on our current course of high cost and suboptimal performance," write the authors. By using payment incentives, they say, Medicare—the nation's largest health care payer—could lead the nation to higher health system performance and yield great benefits for individuals, providers, and society as a whole."

In a previous collaboration, "Medicare: Starting Now on the Path to Higher Value," Fund president Karen Davis and assistant vice president Stuart Guterman suggested strategies Medicare could use to reform its payment mechanisms to improve efficiency and promote equity. These policy options are designed to correct imbalances while improving quality and containing costs:[5]

- Establish a center for medical effectiveness and health care decision-making to generate information and create payment and cost-sharing incentives for providers and consumers. Having such a resource could save an estimated $368 billion over 10 years.[6]
- Strengthen primary care and care coordination though patient-centered medical homes. Physician practices that serve as medical homes would offer accessible, coordinated care and receive a per-enrollee fee from private and public insurers.
- Limit or freeze Medicare payment rate increases in high-cost areas. Taking this step would help level payments among providers and save Medicare $260 billion over 10 years.
- Eliminate waste by developing incentives to reduce hospital readmissions and continue Medicare's current initiative to eliminate reimbursement for hospital-acquired infections and avoidable other "never events."
- Establish a Medicare pay-for-performance program in all hospitals to spur payment reform outside of Medicare.

Davis and Guterman acknowledge that embarking on payment reform will be "daunting for many stakeholders." But with health care costs placing an ever-greater burden on the economy, they argue there is no other choice but to "transform our inequitable, inefficient, and inflationary payment methods."

Grants to Watch

Throughout 2009, The Commonwealth Fund will continue to support efforts that seek to strengthen and improve Medicare to ensure that it will continue to meet the needs of the country's elderly and disabled. Additional efforts are focused on making Medicare a model for broader health care reform. Fund staff, for example, will continue to develop and analyze payment reform options to encourage better coordination of health care and reward high performance. Among the Fund's grantees, Peter Neumann, Sc.D., at the Tufts University School of Medicine, will continue to analyze the use of clinical and cost evidence in Medicare coverage and payment decisions. Sean Tunis, M.D., M.Sc., at the Center for Medical Technology Policy, and Gail Wilensky, Ph.D., at Project HOPE, are seeking to identify the key issues that confound

efforts to establish a mechanism for producing better evidence for clinical decision-making and how such a mechanism could be established and maintained.

These and other Fund-supported projects will demonstrate how changes to Medicare are affecting beneficiaries and the program's overall performance, while helping to point the way to broader improvements in health system performance.

Notes

1 P. Neuman, M. K. Strollo, S. Guterman et al., "Medicare Prescription Drug Benefit Progress Report: Findings From a 2006 National Survey of Seniors," *Health Affairs* Web Exclusive, Aug. 21, 2007:x630-w643.

2 B. Biles, E. Adrion, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans in 2008* (New York: The Commonwealth Fund, Sept. 2008). For an update on these payments, see B. Biles, J. Pozen, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009*.

3 B. Biles, E. Adrion, and S. Guterman, *Medicare Advantage's Private Fee-for-Service Plans: Paying for Coordinated Care Without the Coordination* (New York: The Commonwealth Fund, Oct. 2008).

4 S. Guterman, K. Davis, S. C. Schoenbaum, and A. Shih, "Using Medicare Payment Policy to Transform the Health System: A Framework for Improving Performance," *Health Affairs* Web Exclusive, Jan. 27, 2009:w238–w250.

5 K. Davis and S. Guterman, "Medicare: Starting Now on the Path to Higher Value," *From the President*, The Commonwealth Fund, Feb. 28, 2008.

6 C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

Photographs

Roger Carr: page 2 (top)
Dan Lamont: page 2 (bottom)

Above: A surgeon at Parkland Health and Hospital System in Dallas—one of the organizations participating in a Commonwealth Fund–supported study of health information technology in U.S. hospitals—uses the OpTime computer system, which provides surgical staff with easy access to information about patients, including canceled cases, status of current cases, and daily schedules. *Below:* Parkland emergency department doctors enter data into EmSTAT, which helps ensure consistent, complete, and efficient documentation of patient care.

Quality Improvement and Efficiency

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

The latest health system scorecard released by The Commonwealth Fund Commission on a High Performance Health System estimates that more than 100,000 deaths could be prevented annually, and up to $100 billion saved, if the nation as a whole achieved the levels of performance reached by some states and health care systems either in the United States or abroad. Combined with other evidence of overuse of services, inappropriate care, and waste, it is clear the U.S.—the nation with the highest health care spending in the world—is not getting what it pays for.

Supporting providers and health care organizations in their efforts to reach higher levels of quality and efficiency is the mission of the Fund's Program on Health Care Quality Improvement and Efficiency. The program pursues its goal through three strategies:

- promote the development and broad adoption of performance measures
- assess and enhance the capacity of health care organizations to provide better care more efficiently
- promote the development and adoption of payment and other incentive models that encourage providers to improve quality and efficiency.

Developing Measures of Quality and Efficiency

Harnessing the Power of Electronic Health Records

Electronic health records (EHRs) make it feasible to create more sensitive and clinically relevant indicators of health care quality, which could be used to improve care processes and patient outcomes. However, migrating from current data sources—administrative claims records, abstracted medical charts, and patient surveys—to EHRs will require creation of new quality measures and valid methods of data analysis.

Under a Commonwealth Fund grant, Jinnet B. Fowles, Ph.D., and Jonathan Weiner, Dr.P.H., sought to identify and categorize "e-indicators," or performance indicators that can be used in conjunction with EHRs or other health information technology. The researchers, who are based at the Park Nicollet Institute in Minneapolis, also formed a consortium of integrated delivery systems that are on the forefront of EHR use; this enabled the investigators to examine the experiences of these organizations in developing, testing, and implementing performance indicators for use in EHR systems.

The project yielded a practical framework for measuring quality using EHR technology, providing guidelines for health care organizations to evaluate and

enhance their IT systems. In their Commonwealth Fund report, *Performance Measures Using Electronic Health Records: Five Case Studies*, Fowles, Weiner, and their colleagues created a taxonomy of e-indicators and described how they are being used by health care organizations to improve the quality and efficiency of patient care.[1]

For example, the Billings Clinic in Billings, Mont., deployed "IT-enabled" e-indicators, which are linked to such technologies as computerized provider order entry, clinical decision support systems, or Web-based patient portals. Clinic staff developed an automated alert that is set off when a patient who is taking warfarin is prescribed an antibiotic that interacts with that drug. The alert system led to a 25 percent decrease in antibiotic–warfarin interactions. Other e-indicators are translated from existing measurement sets for use in health IT platforms. By using electronic health records to track blood pressure control among hypertensive patients, HealthPartners in Minneapolis, Minn., was able to increase the number of patients who have their blood pressure taken, recorded, and well controlled.

Jinnet B. Fowles, Ph.D.
Park Nicollet Institute

"By developing appropriate indicators now, we can integrate them into evolving EHR systems early on rather than try to add them after the fact—a much more difficult task," said Fowles, a senior vice president at Park Nicollet. "The providers' success in implementing their EHR-based quality measures demonstrates that such measures are adaptable to different EHR systems, they're amenable to improvement, and they're worth pursuing."

With additional Fund support, the researchers are developing e-indicators for pediatric care, focusing on conditions such as obesity and developmental screening. The Robert Wood Johnson Foundation, the project's major funder, is building on this work through its Aligning Forces for Quality initiative.

DEVELOPING AND TESTING ELECTRONIC HEALTH RECORD–BASED QUALITY INDICATORS FOR AMBULATORY CARES

Goal	To identify a set of core quality-of-care indicators drawn from electronic health record systems, and to compare the utility of conventional quality indicators with that of the new e-indicators.
Award Amount	$153,378
Timeframe	12/1/05–10/31/07
Lead Investigator	Jinnet B. Fowles, Ph.D., Park Nicollet Institute
For more information	E-mail Dr. Fowles at jinnet.fowles@parknicollet.com.

Measuring the Quality and Efficiency of Physician Care

Across the country, coalitions of health plans, employers, and physician organizations are collecting and disseminating data about the quality and efficiency of care physicians provide. But the lack of standardized performance measures is limiting the validity and usefulness of this information. That is why The Commonwealth Fund supported a research team at the National Committee for Quality Assurance, led by Joachim Roski, Ph.D. (now with the Brookings Institution), to help develop *HEDIS: Technical Specifications for Physician Measurement,* part of a nationally recognized and widely used performance measurement resource.[2]

Joachim Roski, Ph.D., M.P.H., Brookings Institution

For their project, the researchers compiled 150 physician-level measures of health care quality drawn from HEDIS—the Healthcare Effectiveness Data and Information Set—as well as from indicators developed by RAND and the Agency for Healthcare Research and Quality. Through rigorous process, these were winnowed down to 27 measures that gauge how often recommended care was delivered over a two-year period to managed care patients. For example, measures assessed the percentage of older female patients ages 50 to 69 who had a mammogram performed, and the percentage of diabetics ages 18 to 75 who had their blood-sugar level tested.

The HEDIS physician measurement standards, which have been shared with regional collaboratives and other groups involved in physician measurement, are expected to increase the reliability, standardization, and transparency of physician quality and cost measurement. They could also lead to improved provider performance, by enabling health plans to provide feedback, reward superior performance, and publicly report performance results.

A recent agreement beween the New York State Attorney General's office and the state's health plans that codified rules for measuring health care quality was modeled on the new specifications.

DEVELOPING STANDARD MEASURES OF PHYSICIAN QUALITY AND EFFICIENCY

Goal	To create a set of standardized performance metrics for gauging the quality and costs of primary care and specialist physicians and physician groups.
Award Amount	$279,181
Timeframe	1/1/5–10/31/06
Lead Investigator	Joachim Roski, Ph.D., M.P.H., Brookings Institution
For more information	E-mail Dr. Roski at roski@brookings.edu.

Building the Capacity for Improvement

Helping Hospitals Achieve Effective Clinical IT Systems

An increasing number of hospitals are adopting clinical information technologies such as electronic medical records, computerized order entry, and electronic decision support. Yet, few tools exist to help hospital administrators evaluate and improve their information systems, and little is known about their potential benefits.

A recently concluded Commonwealth Fund grant led by Neil Powe, M.D., M.P.H., at Johns Hopkins University assessed the clinical IT capabilities of a diverse group of urban hospitals in Texas. The project—the Texas Clinical Information Technology Evaluation (TEXCITE!)—was the first study to explore how hospital staff interact with technology in the course of their work and how useful they find it. Among its key findings:

- Hospitals that create easy-to-use, automated information systems for note-taking and recordkeeping, order entry, and clinical decision support experience fewer lives lost, fewer complications, and lower costs. For example, hospitals that had more automated notes and records systems had 15 percent lower odds of fatal hospitalizations for all causes. And those with more automated systems for tracking test results had $110 lower average adjusted costs for all hospital admissions.

- Hospitals that devote staff and resources to information technology appear to have more useable and effective systems.
- Many hospitals have not yet incorporated information technologies into their clinical processes.

Neil Powe, M.D., M.P.H.
Johns Hopkins University

The hospitals participating in the study are now better able to take steps to improve their clinical IT systems. More broadly, its findings will inform hospital leaders and policymakers across the nation, promoting the development of effective IT systems and helping to make the case that health information technology can lead to higher-quality, higher-value care.

ASSESSING THE QUALITY AND COSTS OF CLINICAL IT SYSTEMS IN HOSPITALS

Goal	To assess the structural and functional capabilities of clinical information technology systems in Texas hospitals and determine whether these capabilities translate into improved quality and lower costs.
Award Amount	$266,731
Timeframe	7/1/05–6/30/08
Lead Investigator	Neil Powe, M.D., M.P.H., Johns Hopkins University
For more information	E-mail Dr. Powe at npowe@jhmi.edu.

Helping Physicians Improve Their Management of Chronic Illness

The first National Survey of Physician Organizations, conducted in 2000, found that most group practices were not taking of advantage of evidence-based care management processes that have been proven to improve treatment of patients with chronic illnesses—and that the lack of payment incentives and information technology capacity were partly to blame. With cofunding from The Commonwealth Fund, a team led by Stephen Shortell, Ph.D., M.P.H., of the University of California, Berkeley, has resurveyed large physician group practices to evaluate progress made in the management of chronic illness, as well as the effectiveness of interventions and tools such as payment incentives and IT.

Findings based on the survey are just now beginning to appear in leading health care journals. For example, in an article based on the study, published in *Health Affairs* in September 2008, Rittenhouse and colleagues reported on progress made by the nation's group practices in adopting components of the "medical home" model of primary care—which appears to be particularly well suited for addressing the complex needs of the chronically ill. According to the article, "Measuring the Medical Home Infrastructure in Large Medical Groups," physician practices have generally been slow to adopt key medical home "infrastructure," including care teams, electronic health record systems, and enhanced patient services such as consultation by e-mail.[4]

With additional Fund support, Shortell and his team are studying how medical groups that have implemented care management processes were able to do so.[5]

The largest practices in the study—those with more than 140 physicians—and those owned by a

Stephen Shortell, Ph.D., M.P.H., University of California, Berkeley

hospital or HMO scored highest on critical measures of the medical home model. "The medical home model holds great promise for the transformation of primary care, but this transformation won't happen overnight," said Rittenhouse.

WhyNotTheBest.org

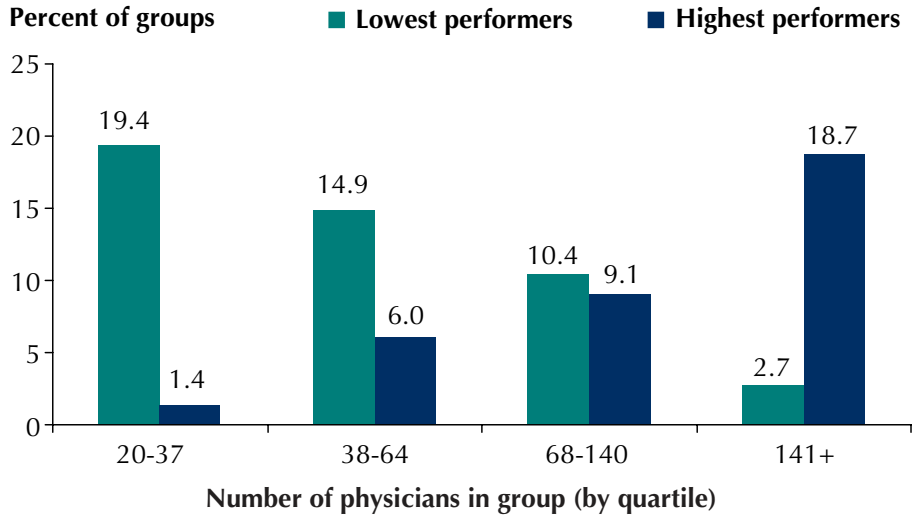
WhyNotTheBest.org is a new Web resource created to stimulate improvement in the quality and efficiency of health care delivery. The site, which was developed by Fund staff in collaboration with IPRO, Inc., and launched at the annual conference of the Institute for Healthcare Improvement in December 2008, helps hospitals and other health care organizations compare their performance against their peers and learn about "best practices" from leaders in the field. In addition to

IT'S ABOUT QUALITY, NOT QUANTITY

From value-based purchasing to pay-for-performance programs, efforts to extract greater value from each health care dollar have been growing in prominence. To be effective, these initiatives require an understanding of how the effectiveness of care relates to the level and cost of resources used. As part of a Commonwealth Fund–supported study, Joachim Roski, Ph.D., and colleagues showed that the number and intensity of resources and services provided by health plans for the treatment of chronic conditions—in this case, diabetes—are not necessarily reflected in the quality of the care patients receive.

In reviewing medical and pharmacy claims data for more than 300,000 patients with diabetes across 31 health plans, the researchers reported in the *American Journal of Medical Quality* that resource use, such as physician visits and pharmaceuticals, varied considerably more—three to five times more—than quality of care. Resource use and quality may be "largely independent factors in health care delivery," the authors found, meaning that it is possible to achieve higher efficiency without sacrificing the quality of patient care.[3]

The larger the physician group, the higher its score on an index of patient-centered medical homes.



Source: D. R. Rittenhouse, L. P. Casalino, R. R. Gillies et al., "Measuring the Medical Home Infrastructure in Large Medical Groups," *Health Affairs*, Sept./Oct. 2008 27(5):1246–58. Data: National Study of Physician Organizations and the Management of Chronic Illness, March 2006–March 2007.

ANALYZING HOW PHYSICIAN GROUP PRACTICES MANAGE CHRONIC ILLNESS

Goal	To evaluate progress that physician group practices have made in their management of patients with chronic illness, and to determine the effectiveness of payment incentives, IT investments, and other improvement tools.
Award Amount	$249,936
Timeframe	8/1/05–3/31/09
Lead Investigator	Stephen Shortell, Ph.D., M.P.H., University of California, Berkeley
For more information	Contact Dr. Shortell at shortell@berkeley.edu.

measuring themselves against a variety of quality benchmarks, providers will also be able to track their performance over time.

WhyNotTheBest.org is still evolving. Currently, the site presents data on hospital performance measures that have been endorsed by the Centers for Medicare and Medicaid Services (CMS) and other public and private sector organizations. There are also case studies of high-performing hospitals and health systems, which offer valuable insights about how institutions made the leap to high performance.

A number of possible new features are being considered for WhyNotTheBest.org:

- data on hospital readmissions, mortality, and hospital-acquired infections, as well as measures of efficiency;
- a performance improvement "calculator" to help hospitals estimate what they stand to gain if they were to attain various benchmarks, and to help them identify which areas of performance are ripest for improvement;[7]
- custom features for safety-net hospitals, state officials, and other audiences;
- quality improvement tools; and
- a mechanism to allow users to interact and learn from one another.

In addition, the Fund will also explore the possibility of including comparative information for other types of providers, such as community health centers, health plans, and physician group practices.

Grants to Watch

With the strong possibility of comprehensive health reform in the near future, there will likely be an even stronger federal push to achieve improvements in quality and efficiency throughout the health care system. In the coming year, The Commonwealth Fund will continues to support research to help further this goal. Recently awarded grants to watch include a

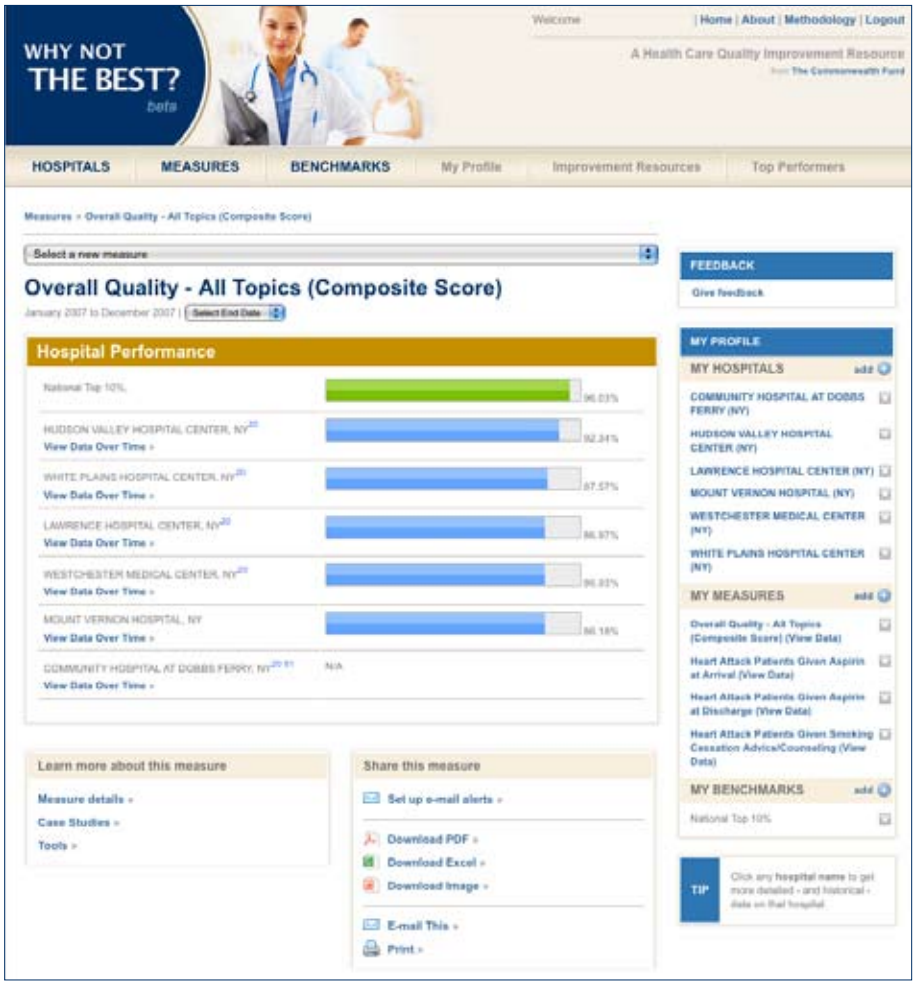
PROMETHEUS PAYMENT: AN UPDATE

The payment model developed by Prometheus Payment, Inc., is one of the most prominent efforts to date to find a better way to pay for health care delivery. Commonwealth Fund support for the work of François de Brantes, CEO of Bridges to Excellence, significantly advanced the Prometheus model, which is driven by evidence-informed case rates (ECRs). Based on the costs of all the resources required to deliver an episode of care according to clinical guidelines, the ECR gives health care providers a single, risk-adjusted payment across inpatient and outpatient settings to care for a patient diagnosed with a specific condition.[6]

The prototype ECRs will now be pilot-tested as part of a $6 million initiative funded by the Robert Wood Johnson Foundation. If testing is successful, this payment model will advance a key goal of any high performance health system: aligning financial incentives with the delivery of high-quality, efficient care.

planned five-year demonstration project to reduce rehospitalizations in up to five states, led by Amy E. Boutwell, M.D., of the Institute for Healthcare Improvement. Ample evidence exists that many hospitalizations—which consume nearly one-third of the $2 trillion spent on health care in the United States—are preventable through proper discharge planning, patient education, and patient support.

Under another grant, a team led by Barry Greene, Ph.D., at the University of Iowa will use a new assessment tool to gauge the effectiveness of leadership at U.S. hospitals—from chief executive officers to governing boards—in improving the quality of care. Project staff will work with the Medicare Quality Improvement Organizations to develop and implement a technical assistance protocol for improving leadership at low-performing hospitals. An evaluation will determine whether hospitals implementing the protocol improved their performance on the leadership assessment as well as on quality-of-care measures.



Notes

[1] J. Briggs Fowles, J. P. Weiner, K. S. Chan et al., *Performance Measures Using Electronic Health Records: Five Case Studies, The Commonwealth Fund* (New York: The Commonwealth Fund, May 2008).

[2] Copies are available for purchase from NCQA at http://www.ncqa.org/tabid/78/Default.aspx#HEDISMD.

[3] J. Roski, S. Turbyville, D. Dunn et al., "Resource Use and Associated Care Effectiveness Results for People with Diabetes in Managed Care Organizations," *American Journal of Medical Quality*, Sept./Oct. 2008 23(5):365–74.

[4] D. R. Rittenhouse, L. P. Casalino, R. R. Gillies et al., "Measuring the Medical Home Infrastructure in Large Medical Groups," *Health Affairs*, Sept./Oct. 2008 27(5):1246–58.

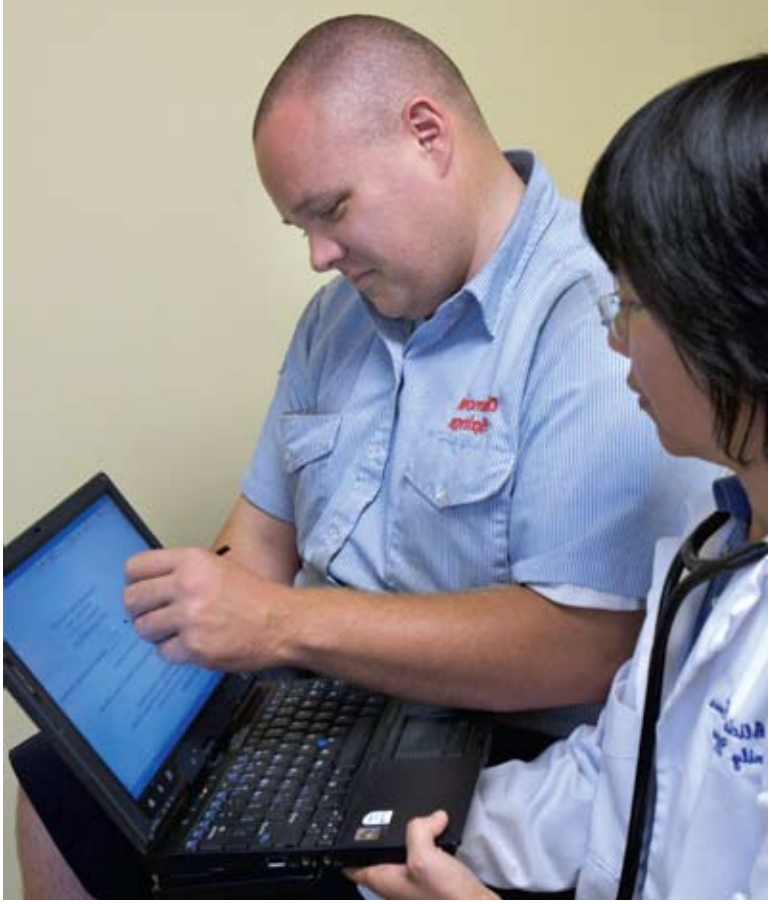
[5] For more information about this grant, see http://www.commonwealthfund.org/grants/grants_show.htm?doc_id=584785.

[6] F. de Brantes and A. Rastogi, *Evidence-Informed Case Rates: Paying for Safer, More Reliable Care* (New York: The Commonwealth Fund, June 2008).

[7] In the fall of 2008, CMS began making performance payments based on Hospital Quality Alliance measures.

Photographs

Karen Campbell: page 2



Above: A patient enters information into his electronic medical record at the Midlothian Family Practice (Somerville, Va.), one of 36 primary care practices participating in a demonstration of the TransforMED patient-centered care model. The Commonwealth Fund sponsored an evaluation of the initiative. *Below:* A physician and her patient at Seattle's Polyclinic Family Medical Practice, one of 12 case studies of high-performing patient-centered primary care developed by Dale Shaller and Susan Edgman-Levitan and published on www.commonwealthfund.org.

Patient-Centered Primary Care Initiative

Melinda K. Abrams, M.S.
Assistant Vice President

As defined by the Institute of Medicine, patient-centered care is "health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care." In primary care, such care is best provided in a medical home—a physician practice or network, health center, or other source of care that ensures patients have enhanced access to their clinicians (for example, through the availability of evening or weekend appointments), coordinates care, and engages in continuous quality improvement.

The goal of The Commonwealth Fund's Patient-Centered Primary Care Initiative, established in 2005, is to improve the quality of primary care by making it more patient- and family-centered. The initiative supports projects that:

- promote the collection of information on patient experiences and the delivery of care to facilitate public reporting and quality improvement;
- stimulate adoption of effective practices, models, and tools to make primary care practices patient- and family-centered; and
- improve policy to encourage patient- and family-centered care in medical homes.

Testing the Promise of the Medical Home

There has been great interest in making the patient-centered medical home a springboard to improved primary care. Individual components of the medical home have been associated with a number of positives—higher quality care, lower costs, and higher satisfaction for patients and practice staff, among them—but there have been only limited evaluations of the model as a whole.

To test the promise of medical homes, a group of commercial health plans and public insurance programs across the United States have agreed to change the way they pay primary care practices. Whether it is providing practices with a monthly per-patient care management fee or an annual pay-for-performance

Jonathan Sugarman, M.D., M.P.H., Qualis Health

bonus, the idea is to encourage the delivery of enhanced services and better care coordination for patients. In April 2008, the Fund awarded a grant to Qualis Health in Seattle to run a five-year medical home demonstration project that will seek to transform 63 safety-net primary care clinics into patient-centered medical homes that achieve benchmark levels of quality, efficiency, and patient experience.

In the project's first year, Qualis president and CEO Jonathan Sugarman, M.D., M.P.H., and his staff developed the curriculum for improvement, convened a panel of experts to provide guidance, and generated awareness of the initiative among potential stakeholders. By December, they began reviewing state proposals.

"The solicitation for proposals revealed two factors about the interest among safety-net clinics for patient-centered medical homes," Sugarman said. "First, we found that there is a formidable reservoir of interest in medical home transformation among safety-net practices across the nation, which demonstrates that the Fund's interest in this initiative was well placed. In addition, although many applicants reported impressive progress toward medical home transformation, most acknowledged that much distance remains to be covered along the road to becoming fully functional medical homes that excel at patient experience, quality, and efficiency."

In the end, five states were selected for the safety-net medical home initiative: Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania.

Marshall Chin, M.D., and a team of researchers at the University of Chicago were awarded a Fund grant to evaluate whether the participating clinics in fact become medical homes, how medical homes affect quality and efficiency, and what factors are associated with a clinic's successful implementation of this care model. The project team will draw from organizational and patient survey data, interviews with clinic staff, a review of clinical data, and patient claims data.

The Fund is supporting additional evaluations of medical home demonstration projects. Each study is assessing improvements in patients' experiences, in addition to changes in costs and clinical quality. These include:

- A collaboration involving the Taconic Independent Physician Association and six health plans in New York's Hudson Valley region. As part of the demonstration—the largest of its kind in the U.S.—the plans will pay primary care practices $10,000 per physician annually if they meet patient-centered medical home standards developed by the National Committee for Quality Assurance (NCQA).
- A multipayer initiative in Colorado and Ohio involving five of the nation's leading insurers. A key component is the introduction of a monthly,

TRANSFORMING SAFETY-NET PRACTICES INTO MEDICAL HOMES

Goal	To help 50 safety-net primary care clinics become patient-centered medical homes that achieve benchmark levels of quality, efficiency, and patient experience.
Award Amount	$699,997
Timeframe	5/1/08–4/30/09
Lead Investigator	Jonathan Sugarman, M.D., M.P.H., Qualis Health
For more information	E-mail Dr. Sugarman at jonathans@qualishealth.org.

per-member care management fee, as well as performance bonuses, to usual fee-for-service reimbursement.

- Capitol District Health Plan, in Albany, N.Y., which will test a new model of medical home reimbursement. Physician practices will receive risk-adjusted, per-patient fees that will cover all primary care services, health information technology, clinician salaries, and an expansion of patient services.
- A public–private, multipayer medical home demonstration in Rhode Island, under which public and private health plans serving the majority of the state's insured population have agreed to support core services of the patient-centered medical home.
- A demonstration in New York conducted by the insurer EmblemHealth, which is providing primary care practices with assistance to transform their offices into patient-centered medical homes. Payment for practices has been restructured to include a base care management fee as well as a performance-based incentive.

Collecting Information on the Delivery of Patient Care

With Commonwealth Fund support, NCQA has worked with the nation's leading primary care specialty societies—the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association—to develop practical criteria for assessing and recognizing physician practices as patient-centered medical homes. NCQA has incorporated 18 patient-centered care measures into the standards for its Physician Practice Connections–Patient-Centered Medical Home program. Under the program, medical practices must meet nine standards regarding:

- patient access and communication
- patient tracking and registry functions
- care management
- patient self-management support
- electronic prescribing
- test tracking
- referral tracking
- performance reporting and improvement
- advanced electronic communications.

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

"Our tool is used to qualify practices to make them eligible for demonstrations where they may receive additional payment or other kind of rewards," explained NCQA's Sarah H. Scholle, Dr.P.H. "We have been trying to identify the key concepts of the

MEASURING MEDICAL HOMES

Goal	To promote nationwide use of standardized criteria for certifying physician practices as patient-centered medical homes.
Award Amount	$296,847
Timeframe	12/1/07–11/30/08
Lead Investigator	Sarah H. Scholle, Dr.P.H., National Committee for Quality Assurance
For more information	E-mail Dr. Scholle at scholle@ncqa.org.

medical home that should be enhanced, amplified, or added to the existing standards. At the same time, we are being mindful of not putting so many requirements on practices that it becomes discouraging, confusing, or impractical to meet the requirements."

Supported by a subsequent Fund grant, Scholle's team is disseminating the measures and advising organizations on their use—among them, the Colorado Clinical Guidelines Collaborative and the Pennsylvania Governor's Office on Health Care Reform, which are developing medical home demonstrations. The NCQA team also is developing and testing additional medical home measures related to the quality of patient–physician communication, family and community involvement in care, and care coordination.

"Preliminary evidence from one small study suggests that the patient-centered medical home model is associated with reductions in the cost of care by reducing avoidable costs, such as those for inpatient hospitalizations and emergency room visits," Scholle said. "The two aspects of the medical home that seem to be operative here are, first, whether the practice is tracking and providing information about quality to its physicians, and second, whether the practice is using decision-support tools."

Case Studies of High-Quality Patient-Centered Practices

In another effort to gather data on patient-centered primary care, a team led by Susan Edgman-Levitan of Massachusetts General Hospital is documenting the experiences of 12 patient-centered primary care practices and assessing how characteristics of each organization—from leadership style, to the use of technology, to quality improvement methods—affects patients' experiences with physician care. In case studies developed for The Commonwealth Fund, the researchers found some common themes across the practices, including:

Susan Edgman-Levitan, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital

- robust primary care training experience and positive physician role models
- an organizational culture characterized by strong leadership, a focus on team work, and a supportive work environment
- attention to human resource functions, such as recruitment, retention, and reward and recognition programs
- physician compensation tied to performance measures, including patient survey scores
- physical design that facilitates teamwork and communication
- support for information technology, human resource functions, financial management, and patient education resources.

PATIENT-CENTERED CARE IN PRACTICE

Goal	To document the experiences of 12 patient-centered primary care practices and assess how organizational characteristics affect patients' experiences.
Award Amount	$151,106
Timeframe	5/1/06–4/30/07
Lead Investigator	Susan Edgman-Levitan, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital
For more information	E-mail Ms. Edgman-Levitan at sedgmanlevitan@partners.org.

"We found that practices can't use the same quality improvement approach that they would use for clinical care," explained Edgman-Levitan. "Making practices more patient-centered requires that they put a lot of attention on the practice culture and how they take care of their staff. Patients aren't going to get the highest quality care if the people who are taking care of them don't feel supported and cared for, or if the practice doesn't have systems that allow the staff to deliver what patients need."

A SMALL PRACTICE ACHIEVES BIG SUCCESS

The Cardinal Primary Care Medical Group, a three-physician practice in Concord, Calif., is one of 12 practice sites that Susan Edgman-Levitan and others at the Massachusetts General Hospital have profiled in a report on high-performing patient-centered primary care practices. In the case studies, researchers are documenting models of high-quality, patient-centered care and are extracting lessons regarding the organizational factors and specific processes these practices use to achieve favorable patient experiences.

The Cardinal Group was selected from more than 2,000 sites on the basis of its ability to achieve exceptional scores across multiple domains on patient experience surveys. One of the reasons the Cardinal Group was chosen was its exceptional efforts to improve patient access to care. The staff made a deliberate effort to change work flow so that it could return patient calls the same day and give patients same-day appointments.

The group also has excelled at offering information and education to its patients, the case study researchers say. For its patients with diabetes, for example, the group provides fact sheets from the American Diabetes Association and offers other information on the Web. In addition, the group uses RelayHealth, an electronic information system that allows patients to get up-to-date account information, pay their bills online, and create a personal health record. Download the complete case study.

To date, the Fund has published online four of the case studies, including Cardinal Primary Care Medical Group in Concord, Calif., Polyclinic Family Medicine Practice in Seattle, Wash., Grant Community Clinic in Cassville, Wis., and Wheaton Franciscan Medical Group in Racine, Wis. In addition, two podcasts feature interviews with staff of these high performing patient- and family- centered primary care practices.

Promoting Effective Practices, Models, and Tools

Becoming a patient-centered medical home also requires a degree of personal transformation on the part of individual physicians—as well as help for physicians in bringing about that change. That is one of the seminal lessons drawn by Commonwealth Fund–supported researchers at the University of Texas Health Sciences Center at San Antonio.

Led by Carlos Jaén, M.D., Ph.D., the research team surveyed patients served by the 36 physician practices taking part in the American Academy of Family Physicians' TransforMED demonstration, which is testing a new patient-centered care model. Participating practices are implementing a comprehensive set of innovations to improve health care quality, safety, efficiency, patient-centeredness, access to care, and information systems.

In a paper published in the journal *Family Practice Management*, Jaén and colleagues laid out simple strategies, based on the survey findings, to help doctors structure office visits to ensure that patients' concerns are addressed, and that doctor and patients are in agreement at the end of the visit about the next steps in the care plan.[1]

Carlos Jaén, M.D., Ph.D.
University of Texas
Health Sciences Center
at San Antonio

Through the research, Jaén and his team have found that focusing on patient-centeredness appears to increase satisfaction of both patients and doctors. "We have some evidence that as the practices transformed, the patients not only appeared to be more satisfied but also got the sense of receiving the care they need when they need it and how they need it," he said.

Satisfaction among physicians has increased as well, Jaén said. "The qualitative analysis shows that there is clearly a sense of resurgence of motivation and commitment among physicians to providing patient care," he commented. "Physicians in these practices seem to be getting up from the stupor of practice and now are doing something that is exciting and that is approaching the vision they had for themselves when they went into medicine. For some physicians, the patient-centered approach has been a personal transformation that has reactivated them in a way that we didn't think was possible."

Jaén and his colleagues continue to collect data on the three dozen practices involved in the project, and both the TransforMED team and the Academy are disseminating the evaluation findings as they become available.

ASSESSING THE EFFECTS OF A PATIENT-CENTERED CARE DEMONSTRATION

Goal	To determine if TransforMED, a nonprofit initiative to transform primary care practice, is helping to make care more patient-centered.
Award Amount	$238,822
Timeframe	1/1/07–6/30/09
Lead Investigator	Carlos Jaén, M.D., Ph.D., University of Texas Health Sciences Center at San Antonio
For more information	E-mail Dr. Jaén at jaen@uthscsa.edu.

The Power of Policy

Although further study is needed, the medical home model appears to have great potential to bring effective primary care to millions of Americans. But what will it cost practices to become medical homes? A project jointly sponsored by The Commonwealth Fund and the American College of Physicians (ACP) is seeking to answer that question, and to develop payment options that would support medical home adoption.

As part of their research, the ACP's Michael S. Barr, M.D., and co-investigator Robert Berenson, M.D., of the Urban Institute are visiting primary care practices and working with organizations representing employers, payers, and consumers, as well as physicians. Barr and Berenson hope the information yielded by their study will help insurers and policymakers understand how providers should be compensated for delivering the comprehensive care associated with the medical home. In a 2008 article in *Health Affairs*, Berenson discussed the multifaceted challenges physician practices face in implementing the medical

Michael S. Barr, M.D.
American College
of Physicians

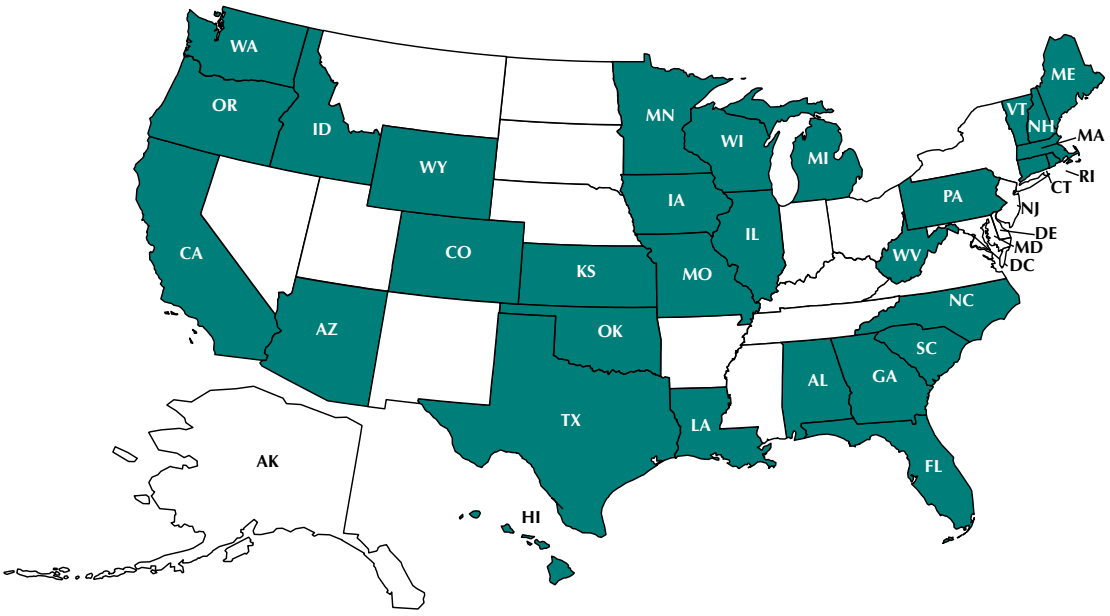
home model—among them, management capability, physician leadership, and an ability to develop processes and information technology systems.[2]

A few state Medicaid programs already have developed promising medical home models. For example, Community Care of North Carolina has improved the quality of care and achieved considerable cost savings through a primary care case management program offering an array of enhanced services. In addition, a number of states have passed, or are considering, legislative or

HOW ONE STATE SUPPORTS MEDICAL HOMES FOR ITS MEDICAID ENROLLEES

The main approach taken by Illinois Health and Family Services to help primary care practices fulfill their roles as medical homes is to provide access to valuable information about their patient population, along with outreach and support efforts. For example, the agency provides practices with secure access to two years of Medicaid claims data on prescription drugs, immunizations, office visits, hospitalizations, diagnosis, and procedures. This information provides clinicians with a better understanding of their patients' histories and helps them plan patient care. In addition, provider service representatives lend support to providers and their staff on site, through training sessions and monthly webinars on such topics as quality assurance and EPSDT support.[3]

Thirty-one states have at least one initiative underway to advance medical homes in their Medicaid and CHIP programs.



Source: Analysis by Neva Kaye and Mary Takach, National Academy for State Health Policy, Nov. 2008.

Neva Kaye
National Academy for State Health Policy

regulatory reforms to promote patient-centered medical homes for Medicaid beneficiaries, among them Colorado, Louisiana, Minnesota, Pennsylvania, New York, Rhode Island, Washington, and West Virginia. Given this growing interest, state Medicaid officials require guidance in implementing medical home models and designing the requisite payment systems.

To assist states, Neva Kaye and the National Academy for State Health Policy (NASHP) are working with state Medicaid officials to inform policymakers of the benefits of patient-centered medical homes, promote financing and policy options for implementing them, and track states' implementation efforts.

In July 2008, Medicaid and officials from eight states—Colorado, Idaho, Louisiana, Minnesota, Oklahoma, Oregon, New Hampshire, and Washington—were selected from among 30 applicants to attend a summit in Washington, D.C., on ways to advance the medical home model in their states. NASHP has been following up with the states to check on their progress to date. In addition, the team also has held three webinars for the states, focusing on reimbursement policy and achieving savings, implementing medical home infrastructure, and the states' roles in medical home demonstrations involving private and public payers.

WHAT DOES A PATIENT-CENTERED MEDICAL HOME COST?

Goal	To define incremental costs and payment options associated with the implementation and operation of a patient-centered medical home.
Award Amount	$224,995
Timeframe	12/1/07–11/30/08
Lead Investigator	Michael S. Barr, M.D., M.B.A., F.A.C.P., American College of Physicians
For more information	E-mail Dr. Barr at mbarr@acponline.org.

ADVANCING MEDICAL HOMES IN MEDICAID PROGRAMS

Goal	To encourage state Medicaid agencies to adopt the patient-centered medical home model, and to provide states with assistance in implementing it.
Award Amount	$150,157
Timeframe	12/1/07–11/30/08
Lead Investigator	Neva Kaye, National Academy for State Health Policy
For more information	E-mail Ms. Kaye at nkaye@nashp.org.

Grants to Watch

In the year ahead, The Commonwealth Fund plans to continue to promote the patient-centered medical home, particularly in safety-net practices and settings where patients with chronic conditions receive care. Evaluations of medical home demonstrations will provide objective information about the impact on clinical quality, the experiences of patients and physicians, and the costs of care. And lessons gleaned from successful medical home models will help insurers, policymakers, and others promote the medical home as the new standard of primary care.

Notes

[1] R. M. Epstein, L. Mauksch, J. Carroll et al., "Have You Really Addressed Your Patient's Concerns?" *Family Practice Management*, March 2008 15(3):35–40.

[2] R. A. Berenson, T. Hammons, D. N. Gans et al., "A House Is Not a Home: Keeping Patient at the Center of Practice Redesign," *Health Affairs,* Sept./Oct. 2008 27(5):1219–30.

[3] M. Takach, N. Kaye, and R. Beesla, "Strategies States Can Use to Support the Infrastructure of a Medical Home," NASHP *State Health Policy Briefing*, May 2008.

Photographs

John Troha: page 2 (top), page 7
Dan Lamont: page 2 (bottom)

Racial and ethnic disparities in health care access and quality are well documented. Fortunately, there are models of care—most notably the patient-centered medical home—that hold promise in ameliorating disparities and bringing high-performance health care to minority populations. The Commonwealth Fund supports an array of projects focused on improving care for minority populations and other vulnerable groups in the U.S.

Health Care Disparities

Anne C. Beal, M.D., M.P.H.
Assistant Vice President

Disparities in health care access and quality are well documented. While differences in income, insurance status, or medical need play important roles in the discrepancy of care delivery, racial and ethnic disparities persist even after accounting for these factors. Fortunately, there are models of care that hold promise in ameliorating disparities and helping to bring high-performance health care to minority populations.

The Program on Health Care Disparities builds on efforts to improve the quality of care overall in the United States, focusing on safety-net hospitals, clinics, and other health care settings that serve large numbers of low-income and minority patients. The program's strategies are to:

- identify opportunities for improving the performance of safety-net providers
- enhance the capacity of safety-net providers to improve performance
- foster incentives and policies that promote better performance of safety-net providers.

Understanding Disparities: Where They Occur and Why

While there is broad consensus on the existence of racial and ethnic disparities in health care, that is not necessarily the case when it comes to the root causes of disparities. Seeking clarification, James D. Reschovsky, Ph.D., and Ann S. O'Malley, M.D., Commonwealth Fund–supported senior health researchers at the Center for Studying Health System Change, examined the socioeconomic and insurance characteristics of patient populations served by different health care providers.

Using data from the 2004–05 Community Tracking Study Physician Survey, Reschovsky and O'Malley found that primary care physicians who treat a disproportionate share of black and Latino patients provide more charity care, see more patients, depend more heavily on low-paying Medicaid, and earn lower incomes than physicians with largely white patient populations.

Such payment constraints, the researchers found, are an important reason why physicians treating large numbers of minority patients report more problems delivering high-quality care than other physicians. For instance, physicians treating large numbers of minority patients typically spend less time with each patient—about 30 percent less—and have a harder

James Reschovsky, Ph.D., Center for Studying Health System Change

time obtaining specialty care referrals than do other physicians. The study's findings were published in a *Health Affairs* Web Exclusive article in April 2008.[1]

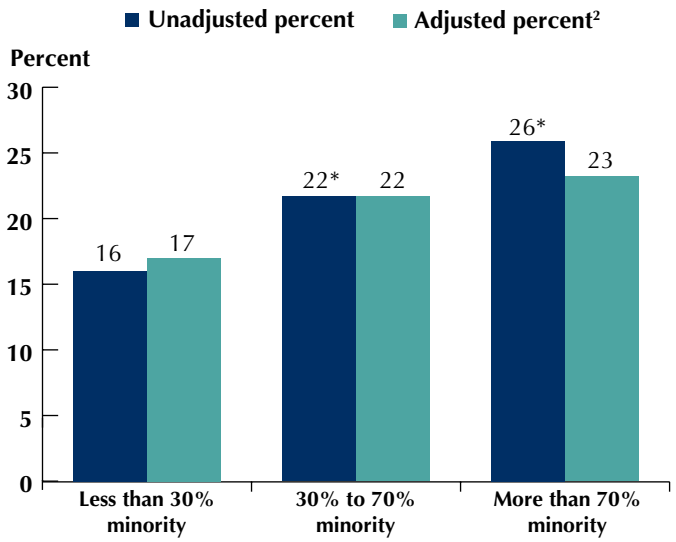
The researchers said that expanding insurance coverage, raising Medicaid payments to equal Medicare payments, and increasing the resources available to physicians who serve low-income and minority populations could all go a long way toward reducing disparities in quality.

In addition to the problems primary care physicians face when treating minority patients, research also shows that compared with whites, minority Americans tend to have doctors with less clinical training, see specialists that achieve poorer clinical

DELIVERING HIGHER-QUALITY CARE TO MINORITY PATIENTS

Goal	To identify physician practice characteristics associated with lower- or higher-quality care for minority patients, and using these findings to improve allocation of resources for reducing disparities and inform the design of pay-for-performance programs.
Award Amount	$74,980
Timeframe	8/1/06–7/31/07
Lead Investigator	James Reschovsky, Ph.D., Center for Studying Health System Change
For more information	E-mail Dr. Reschovsky at jreschovsky@hschange.org.

Physicians in practices with a high proportion of minority patients report greater difficulty providing quality care, in part because of lower resource levels.[1]



[1] Based on disagreement with the statement, "It is possible to provide high-quality care to all my patients."
[2] Adjusted for practice resource levels (payer mix, reimbursement levels, and interactions between the two).
* Differs from physicians in low-minority practices at $p \leq 0.05$.
Source: HSC Community Tracking Study Physician Survey, 2004–05.

Darrell J. Gaskin, Ph.D.
University of Maryland

outcomes, and seek care at lower-performing hospitals. In his Commonwealth Fund–supported study, the University of Maryland's Darrell J. Gaskin, Ph.D., and colleagues found that when minority and white patients seek care at the same hospital, they receive the same standard of care. The results highlight a fundamental rule: minority patients receive the best care when they are treated in hospitals that deliver the highest-quality care.

"More attention needs to be devoted to eliminating disparities in quality across hospitals rather than within hospitals," wrote Gaskin in a *Health Affairs* article about the study.[2]

Fund-supported researchers at the Mount Sinai School of Medicine discovered that this rule also holds true for at-risk infants in New York City. Elizabeth A. Howell, M.D., Mark Chassin, M.D., and their colleagues reported in the March 2008 issue of the journal *Pediatrics* that neonatal mortality rates for very-low-birth-weight (VLBW) infants (those weighing less than 1,500 grams, or 3 pounds, 5 ounces) in New York hospitals ranged from 9.6 to 27.2 deaths per 1,000 births.[3] They also found that nearly half (49%) of all white VLBW births took place in hospitals with the lowest mortality, compared with 29 percent of all black VLBW infants. The researchers estimated that if black VLBW infants had been born in the same hospitals as white VLBW babies, the mortality rate for black infants would fall almost 5 percent.

Elizabeth Howell, M.D.
Mount Sinai School of Medicine

"It is important to understand why black very-low-birth-weight infants in New York City are more likely to die in their first month of life than white infants. This study tells us that a big part of that difference can be attributed to the hospital where the baby is born," Howell said. "It further tells us that we have an opportunity to save the lives of babies and eliminate a significant portion of the black–white gap."

The study team suggested that quality improvement efforts at the lowest-performing hospitals could narrow the disparity effectively. "Because effective treatments for prematurity exist, ensuring that such treatments are used consistently at all hospitals at which VLBW infants receive care is a vital first step toward this improvement goal," they wrote.

In the treatment of patients with breast cancer, Fund-supported researchers found additional

THE QUALITY OF HOSPITAL CARE IN MINORITY AND LOW-INCOME COMMUNITIES

Goal	To determine which hospitals provide the best care to minority and low-income patients, and which characteristics and best practices are associated with high-performing hospitals serving these populations.
Award Amount	$249,983
Timeframe	12/1/05–5/31/07
Lead Investigator	Darrell J. Gaskin, Ph.D., University of Maryland
For more information	E-mail Dr. Gaskin at dgaskin@aasp.umd.edu.

IMPROVING THE DELIVERY OF EFFECTIVE CARE TO MINORITIES

Goal	To investigate the underuse of effective medical services for treating four conditions (breast cancer, recurrent stroke, hypertension, and prematurity of newborn) and test interventions to improve the delivery of care in underserved New York City communities.
Award Amount	$125,000 (Phase 3)
Timeframe	12/1/05–8/31/07
Lead Investigator	Mark Chassin, M.D., M.P.P., M.P.H., Mount Sinai School of Medicine
For more information	E-mail Dr. Elizabeth Howell at elizabeth.howell@mountsinai.org.

disparities in care. Supplementary treatments for breast cancer such as radiotherapy, chemotherapy, or hormonal therapy can increase the chances of survival, but many women do not receive them. In some cases, patients may decline treatment, or physicians may not recommend it; in other cases, the system fails these patients who would benefit from such treatment.

According to Nina A. Bickell, M.D., a researcher at the Mount Sinai School of Medicine and the lead author of a *Journal of Clinical Oncology* article, one-third of women did not receive adjuvant therapies for breast cancer because of system failures, such as breakdown in interactions between surgeons and medical oncologists and between physicians and patients.[4] Minority women and women with Medicaid coverage were more likely to suffer from system failures than were white women or those with Medicare or commercial insurance.

Bickell and her coauthors say that coordination for these patients could be improved by a referral system that feeds results back to surgeons; patient assistant providers that help facilitate conversations, coach patients, and navigate the health care system; and Medicaid reimbursement policies that reward coordinated care.

Nina A. Bickell, M.D.
Mount Sinai School of Medicine

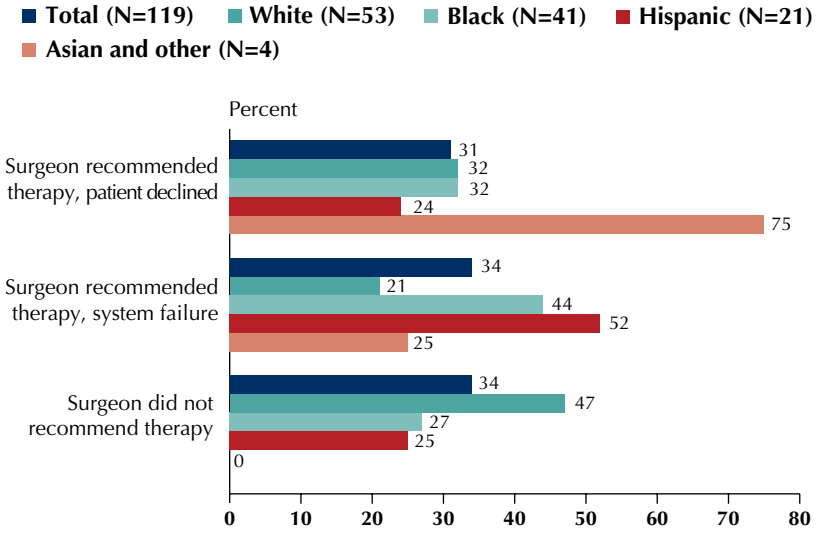
Grants to Watch

The Commonwealth Fund is currently supporting efforts to assess the performance of safety-net providers serving minority populations and identifying the factors associated with high performance. Other projects are focused on evaluating innovative care delivery models and practices and assessing the effects of payment policies on the performance of safety-net providers.

Four grants are funding assessments of safety-net hospital performance:

- The University of California's Alicia Fernandez, M.D., and Hilary Seligman, M.D., are evaluating a survey instrument called the Patient Assessments of Cultural Competency (PACC), which was developed with prior Fund support. The investigators will determine how patients' experiences and cultural competency in care delivery affect patient outcomes at large safety-net hospitals. The Russell Sage Foundation is cofunding the project.

Minority women are much less likely to receive recommended adjuvant therapy for breast cancer compared with white women, principally due to "system failure"—breakdowns in communication or care coordination.



Notes: Percentages may not sum to 100 percent because of rounding.
Source: Adapted from N. A. Bickell, F. LePar, J. J. Wang et al., "Lost Opportunities: Physicians' Reasons and Disparities in Breast Cancer Treatment," *Journal of Clinical Oncology*, June 20, 2007 25(18):2516–21.

- Linda Cummings, Ph.D., and colleagues from the National Public Health and Hospital Institute are identifying safety-net hospitals that have eased overcrowding and improved patient flow in emergency departments. The project team will develop an educational program for 15 public safety-net hospitals that are working to improve emergency department throughput.
- Sara Singer, M.B.A., Ph.D., and Nancy Morgan Kane, M.B.A., D.B.A., at the Harvard School of Public Health are at work identifying governance practices and organizational characteristics (such as ownership or affiliation with a Medicaid managed care plan or primary care clinic) of top safety-net hospitals. Their findings will point lower-performing hospitals to "best practices" that can lead to better financial performance and quality of care.
- Romana Hasnain-Wynia, Ph.D., and colleagues from the Health Research and Educational Trust and Northwestern University are conducting the first national study of quality in safety-net hospitals, using data from the Hospital Quality Alliance and American Hospital Association. The researchers will zero in on the treatment of patients with myocardial infarction, congestive heart failure, and community-acquired pneumonia, and recommend steps safety-net hospitals can take to achieve higher performance.

Two additional Fund grants are supporting assessment of community health center performance:

- Jordon Peugh of Harris Interactive is leading a survey of chief executive officers at federally qualified health care centers—important providers of care to low-income, uninsured, and minority patient populations—to assess the capacity of these facilities to serve as medical homes for their patients and to engage in quality improvement activities.

- Deborah Gurewich, Ph.D., and Donald S. Shepard, Ph.D., of Brandeis University are working to determine the extent to which community health centers in California, Massachusetts, and Texas provide cost-effective and high-quality care at reasonable cost. The Texas Association of Community Health Centers is providing cofunding.

The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: 2008–2009 Fellows

Addressing disparities in health and health care also requires trained, dedicated physician leaders who can promote policies and practices that improve minority Americans' access to high-quality care. Since 1996, the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy has played an important role in addressing this need.

During the year-long fellowship, physicians undertake intensive study in health policy, public health, and management. Fellows also participate in leadership forums and seminars with nationally recognized leaders in minority health and public policy. As of the spring of 2008, 61 Fund fellows have graduated since the program began.

In the past, the Commonwealth Fund has partnered with other funders to support additional fellows. The California Endowment, Delta Dental, and the federal Health Resources and Services Administration have supported 19 fellows, bringing the total number of fellows who have participated in the program to 80. Beginning in the 2008–09 academic year, Harvard will dedicate one tuition scholarship to support a Commonwealth Fund fellow's studies at the Harvard School of Public Health.

The following six fellows make up the class of 2008–09.

- **Aymen Elfiky, M.D.**

A fellow in hematology/oncology at Yale University Cancer Center, Dr. Elfiky has received academic awards and honors including a Fulbright Scholarship.

- **Thomas Halligan, M.D.**

The associate medical director of La Clinica de la Raza in Oakland, Calif., Dr. Halligan is a family physician serving an ethnically diverse, mainly immigrant community.

CHARTBOOK ILLUSTRATES HOW DISPARITIES OFTEN RESULT FROM FACILITY QUALITY

Many studies have pointed to the roles of bias, miscommunication, and lack of trust in creating health disparities. The Commonwealth Fund publication, *Racial and Ethnic Disparities in Health Care: A Chartbook,* prepared by researchers at George Washington University, presents compelling evidence that health care disparities in hospitals are often due to the quality of the facilities minorities visit. As the data presented in the chartbook make clear, minorities fare worse than white Americans on almost every measure of health status and outcomes. What's more, minorities are much more likely than whites to be uninsured and to face barriers to accessing health care.

The Fund's chartbook, published in March 2008, also provides a snapshot of minority health and outlines quality improvement techniques for reducing disparities.

MINORITY HEALTH FELLOWSHIP ALUMNI IN ACTION

Dora Hughes, M.D., M.P.H. (2000), who worked as an aide in President Obama's Senate office before becoming a key health policy adviser during Obama's 2008 presidential campaign, was recently named Counselor to the Secretary, Health and Human Services. Hughes represented the campaign at health industry conferences, speaking about the potential shape of health care reform in the Obama administration. After the 2008 election, Dora was named to the presidential transition team as one of only two doctors in the health care policy working group. In her new role, she will likely help keep disparities in health care on the national health policy agenda.

Previously, Dr. Hughes served as Deputy Director for Health for Senator Edward M. Kennedy on the Committee on Health, Education, Labor and Pensions in the U.S. Senate. Before arriving on Capitol Hill, she served as a senior program officer at The Commonwealth Fund. Dr. Hughes earned her M.D. from Vanderbilt University and completed residency at Brigham and Women's Hospital in Boston.

Yvette Roubideaux, M.D., M.P.H. (1995) was chosen by President Obama in March 2009 to head the U.S. Indian Health Service (IHS). Dr. Roubideaux, a scholar with extensive research on American Indian health issues, a physician who has spent years as a provider in tribal communities, and a member of the Rosebud Sioux tribe, is the first woman nominated to lead the IHS. U.S. Senator Tim Johnson (D-S. Dak.), a member of the Senate Indian Affairs Committee, said, "Combined with her firsthand knowledge of the many important issues regarding health care in our tribal communities, there are few people more qualified to lead IHS."

Dr. Roubideaux has been confirmed by the Senate Committee on Indian Affairs and is awaiting confirmation by the full Senate. Currently, she is an assistant professor in the College of Medicine at the University of Arizona in Tucson. She obtained her B.A, M.P.H., and M.D. from Harvard University.

Jacqueline Nwando Olayiwola, M.D., M.P.H., F.A.A.F.P. (2005) was recently named chief medical officer of the Community Health Center, Inc., Connecticut's largest network of health centers, serving patients in 142 locations in more than 160 communities. As medical director, Olayiwola presides over a staff of more than 50 medical providers treating some 80,000 patients, who receive a variety of medical, dental, mental health, and prenatal care services, case management, HIV/AIDS treatment, and social services.

Olayiwola—a native of Nigeria who grew up in Columbus, Ohio—was profiled in the October 2008 issue of the *Journal of the National Medical Association.* Olayiwola said of her fellowship training: "Not only are you put into the fellowship with very intelligent and bright leaders from around the country who were at various stages of their leadership development, but also you are submerged in an environment where there is a strong emphasis on creating effective health policy and being leaders in improving the health of minority populations. It is second to none among the experiences I've had."

Dr. Onyejekwe received her M.D. from the Ohio State University College of Medicine and Public Health and completed her residency in family practice at Columbia University Medical Center/New York–Presbyterian Hospital.

- **Samantha Kaplan, M.D.**

Dr. Kaplan is an attending physician in the Department of Obstetrics and Gynecology at Boston Medical Center, where she is also the assistant clerkship director of medical student education. She is also a clinical instructor of obstetrics and gynecology at the Boston University School of Medicine.

- **Julea Leshar McGhee, M.D.**

Dr. McGhee is finishing a psychiatry residency at the Harbor UCLA Medical Center in Torrance, Calif., and has held research assistant positions with the UCLA Child Psychiatry Health Services Research Division, where her work focused on detained adolescents with psychiatric disorders, and the UCLA General Internal Medicine Health Services Research Division.

- **Pamela Riley, M.D.**

The associate medical director for pediatrics at the Ravenswood Family Health Center in East Palo Alto, Calif., Dr. Riley is also a clinical instructor in the Division of Pediatrics at Stanford University School of Medicine.

- **Sanjeev Sriram, M.D.**

Dr. Sriram is chief resident at the UCLA Tri-Campus Pediatrics Program, UCLA Community Health and Advocacy Training Program. Formerly a faculty advisor for the National Youth Leadership Forum on Medicine, he has volunteered as a health aide for California congressman Henry Waxman.

Notes

[1] J. D. Reschovsky and A. S. O'Malley, "Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?" *Health Affairs, May/June 2008 27(3):*w222–w230. *E-published* Apr. 22, 2008.

[2] D. J. Gaskin, C. Spencer, and P. Richard, "Do Hospitals Provide Lower-Quality Care to Minorities Than to Whites?" *Health Affairs,* March/April 2008 27(2):51827.

[3] E. A. Howell, P. Hebert, S. Chatterjee et al., "Black/White Differences in Very Low Birth Weight Neonatal Mortality Rates Among New York City Hospitals," *Pediatrics,* March 2008 121(3):e407–e415.

[4] N. A. Bickell, F. LePar, J. J. Wang et al., "Lost Opportunities: Physicians' Reasons and Disparities in Breast Cancer Treatment," *Journal of Clinical Oncology* June 20, 2007 25(18):2516–21.

Photographs

Susie Fitzhugh: page 2 (top & bottom)

Through their regular contact with families, child health care providers can foster positive parenting behaviors, promote optimal development, and initiate early intervention when needed. Projects supported by The Commonwealth Fund are helping to establish the infrastructure practitioners and policymakers need to improve preventive care for young children, especially those at risk for cognitive, emotional, and behavioral problems.

Child Development and Preventive Care

Edward L. Schor, M.D.
Vice President

The success children have in school and later in life depends on their early experiences and the ability of their parents and caretakers to anticipate and meet their developmental needs. Through their regular contact with families, child health care providers have a unique opportunity to foster positive parenting behaviors, promote optimal development, and initiate early intervention when problems appear imminent. Yet in the United States, the quality of pediatric preventive care—commonly referred to as well-child care—varies greatly. Despite the best efforts of physicians and other child health professionals, many children do not get the care they need.

The Commonwealth Fund's Child Development and Preventive Care Program is helping to establish the infrastructure practitioners and policymakers need to improve preventive care for young children, especially those who have, or are at risk for, cognitive, emotional, and behavioral problems. In particular, the program supports projects that:

- promote the establishment of standards of care and use of these standards in quality measurement and monitoring
- identify and disseminate models of pediatric practice that enhance the efficiency and effectiveness of care provided
- encourage reforms that remove barriers to quality care and align provider incentives with desired clinical practices.

A Scorecard for Child Health Care

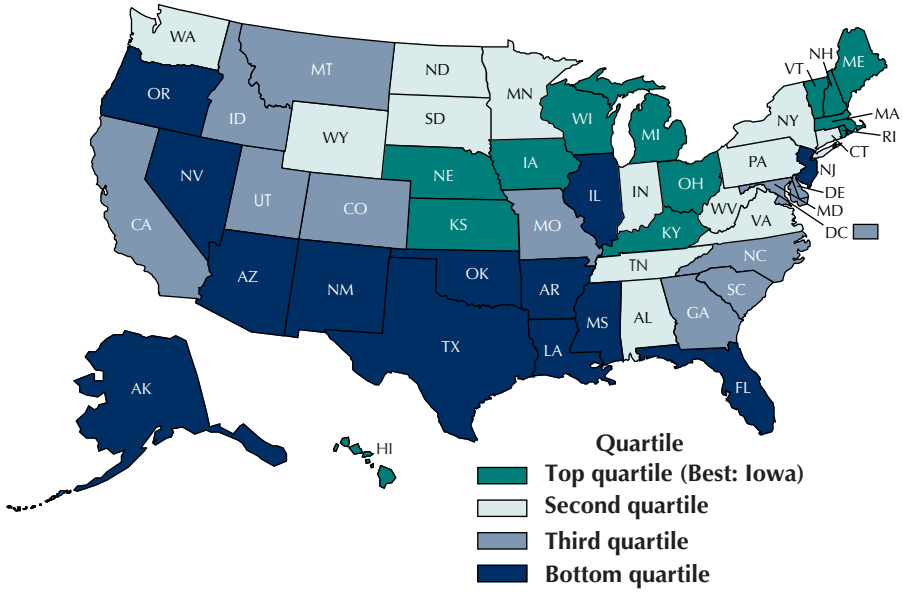
One of the most widely cited reports published by The Commonwealth Fund in 2008 was *U.S. Variations in Child Health System Performance: A State Scorecard*. Published in May, the report shows wide variation across the United States in children's access to care and illustrates just how closely better access to care is linked to better quality of care. The authors—Katherine Shea, M.P.H., Karen Davis, Ph.D., and Edward L. Schor, M.D.—examined variations among the health systems for children in each of the 50 states, focusing on 16 performance indicators in five broad areas: access, quality, costs, equity, and the potential to lead healthy lives.

The report reveals critical areas in which state and federal policies are needed to improve child health system performance in the United States. It also shows

that when states invest in children's health, they reap the benefits of having children who are able to learn in school and become healthy, productive adults. Top-performing states, such as Iowa and Vermont, have adopted policies to expand children's access to care and improve the quality of care.

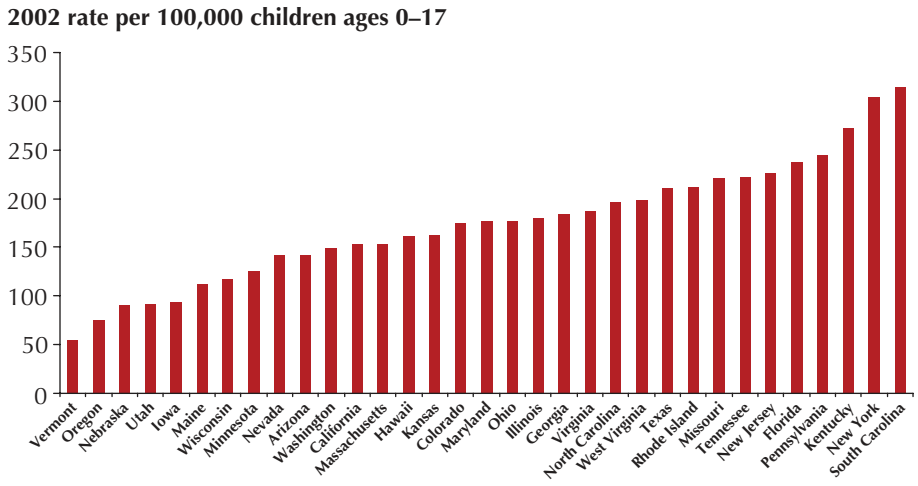
If all states achieved top levels on each dimension of performance, 4.7 million more children would be insured and nearly 12 million more children would receive at least one medical and dental preventive care visit per year. More than 750,000 more children ages 19 to 35 months would be up-to-date on all

How the states rank on child health care.



Source: K. Shea, K. Davis, and E. Schor, *U.S. Variations in Child Health System Performance: A State Scorecard* (New York: The Commonwealth Fund, May 2008). Rankings based on measures of health care access, quality, cost, healthy lives, and equity.

U.S. hospital admission rates for children with asthma range widely across the states.



Source: K. Shea, K. Davis, and E. Schor, *U.S. Variations in Child Health System Performance: A State Scorecard* (New York: The Commonwealth Fund, May 2008).

recommended doses of five key vaccines, and more than 412,000 fewer children with special health care needs who needed specialist care would have problems getting referrals to specialty care services, the report shows.

Clearly, some states do better than others in promoting the health and development of their youngest residents. The proportion of children who are uninsured ranges from 5 percent in Michigan to 20 percent in Texas, for example. The proportion of children who have regular medical and dental preventive care ranges from 46 percent in Idaho to 75 percent in Massachusetts. Among the 33 states reporting the proportion of children hospitalized for asthma, there is a range of 55 per 100,000 children in Vermont to 314 per 100,000 in South Carolina.

All states have opportunities to improve, the authors note. They argue for national leadership and collaboration across public and private sectors to develop strategies to improve children's health care.

MAKING THE CASE FOR SCREENING CHILDREN FOR DEVELOPMENTAL PROBLEMS

Goal	To determine the effectiveness of pediatricians' efforts to detect developmental delays in early childhood.
Award Amount	$7,990
Timeframe	12/1/05–7/31/06
Lead Investigator	Laura Sices, M.D., Boston Medical Center
For more information	Contact Dr. Sices at laura.sices@bmc.org.

Helping Pediatricians Make Developmental Screening Part of Their Practice

As many as 16 percent of U.S. children have some form of impairment, including speech, language and cognitive delays, learning disabilities, and emotional or behavioral problems. For low-income children, such problems are even more prevalent. Common in early childhood, developmental delays and related conditions can lead to learning and behavioral difficulties for children as they grow older.

Laura Sices, M.D.
Boston University School of Medicine/Boston Medical Center

Laura Sices, M.D., assistant professor of pediatrics at Boston University School of Medicine/Boston Medical Center, sought to determine the effectiveness of efforts by primary care providers to detect developmental delays in early childhood. In a report published by the Fund in December 2007, Sices detailed significant underdetection: early intervention programs aimed at addressing these concerns, she found, serve only 2.3 percent of children under age three.[1]

Guidelines from the American Academy of Pediatrics (AAP) recommend that pediatricians use validated developmental screening tools, but these instruments are neither widely nor systematically used in pediatric practice, Sices found. "Using developmental screening tools is particularly important if we look at the timing of when children with delays are identified," Sices explained. "Many of them are not picked up until kindergarten, especially those whose delays may be subtle or who have language-based delays that are amenable to early treatment."

In the report, Sices outlines a number ways to strengthen developmental surveillance and screening.

One of the most important steps is to address financial, organizational, and time constraints to physicians' use of developmental screening tools. In addition, residents in pediatrics and family medicine need to be trained to use these tools as part of routine pediatric care.

"Systematic developmental screening will mean that greater numbers of children with developmental delays are identified," Sices said. "That means that planning and resource allocation at the state and federal levels are needed to ensure sufficient resources for their evaluation and treatment."

Under a new Commonwealth Fund grant, Sices is developing guidelines for pediatricians to assist them in communicating screening results to parents and referring families to appropriate intervention services.

Choosing the Right Screening Instruments

The sheer number of developmental screening methods can make the selection of developmental screening instruments a challenge for practices that are committed to using them, says Dennis Drotar, Ph.D., director of the Center for Adherence Promotion and Self-Management at Cincinnati Children's Hospital Medical Center. Some instruments are intended for general screening, while others are for identifying specific problems, such as autism. Moreover, practitioners administer some instruments, and parents administer others.

With Commonwealth Fund support, a research team led by Drotar prepared an online manual to help practitioners select instruments for a variety of practice settings.[2] Available on The Commonwealth Fund's Web site, the manual helps practitioners define their needs and allows them to compare developmental screening instruments for their clinical utility and validity in different populations and at various ages. An interactive online feature helps match practices with the most suitable instrument based on answers they provide to questions.

Dennis Drotar, Ph.D.
Cincinnati Children's Hospital Medical Center

The instruments reviewed included parent-completed and practitioner-administered surveys aimed at identifying general developmental delay and language delay in the general population and in high-risk groups, as well as a parent-administered instrument used to screen specifically for autism.

"Some physicians have been using screening instruments for a long time, but the data suggest that the majority of pediatricians are either doing little screening or are doing it haphazardly," Drotar said in an interview. "What we need are champions or early adopters who are showing how using these instruments enhance care in significant ways."

WHAT IS DEVELOPMENTAL SURVEILLANCE?

In their online manual, *Pediatric Developmental Screening: Understanding and Selecting Screening Instruments,* Dennis Drotar, Ph.D., and colleagues characterize developmental surveillance as a flexible, continuous, cumulative process. It involves:

- documenting and maintaining the child's developmental history
- making accurate and informed observations of the child's development
- identifying the presence of risk and protective factors for developmental delay
- documenting surveillance and screening activities.

RATING DEVELOPMENTAL SCREENING INSTRUMENTS

Goal	To review screening tools for children age 3 and younger and develop recommendations for pediatric practices in selecting the most appropriate instruments.
Award Amount	$97,480
Timeframe	12/1/05–5/31/07
Lead Investigator	Dennis Drotar, Ph.D., Cincinnati Children's Hospital Medical Center
For more information	E-mail Dr. Drotar at dennis.drotar@cchmc.org.

North Carolina's Screening Model

Since 2000, pediatricians in North Carolina have been using developmental screening instruments with great success. As one of the original states participating in The Commonwealth Fund's Assuring Better Child Health and Development (ABCD) initiative, North Carolina developed a model for integrating screening into well-child care visits. A central component is a requirement of the state's Medicaid program that all pediatric providers screen children for developmental disorders at periodic visits using a standardized instrument. Collaboration between local and state agency staff and families is another key feature.

Marian F. Earls, M.D., a pediatrician at Guilford Child Health in Greensboro, N.C., and the driving force behind the program, says that screening rates for designated well-child visits have risen dramatically since implementation.[3] "Since we started the ABCD program in 2000 as a quality improvement activity within our community care networks for Medicaid, we know from the quarterly reports we get by county and by network that practices in North Carolina are doing screening about 70 to 80 percent of the time when they are doing an EPSDT [Early Periodic Screening, Diagnosis, and Treatment program] examination," Earls said in an interview.

Marian F. Earls, M.D.
Guilford Child Health

The good results prompted a change in North Carolina Medicaid policy: screening now takes place in all primary practices that perform EPSDT examinations. North Carolina's success also convinced officials from around the country to request guidance from North Carolina in replicating the model in their own states. With Fund support, Earls and her team have developed a wide range of practical resources for use by other states and pediatric practices to help them on their way. These include an office resource guide to help primary care practices integrate standardized

DIFFUSING A NORTH CAROLINA MODEL FOR PROVIDING DEVELOPMENTAL SCREENING AND SERVICE

Goal	To assist pediatric practices and state health policy officials in five states in adapting North Carolina's successful model for integrating standardized developmental screening into well-child care visits.
Award Amount	$143,413
Timeframe	5/1/06–4/30/07
Lead Investigator	Marian F. Earls, M.D., Guilford Child Health
For more information	E-mail Dr. Earls at mearls@gchinc.com.

developmental screening into their workflow; a service schedule for recommended developmental and social–emotional screening; and practice staff training materials.

Building a Quality Improvement Infrastructure

Recognizing the value of spreading successful child-health programs, The Commonwealth Fund has supported two projects to build infrastructure for child health quality improvement in the states. The first is the Healthy Development Learning Collaborative, a joint project of the Vermont Child Health Improvement Program (VCHIP) and the Center for Children's Healthcare Improvement in North Carolina—and funded jointly by the Fund and the Vermont Department of Health. Eight Vermont practices and ten North Carolina practices are participating.

The mission of the collaborative is to improve preventive and developmental care for children up to age 5 by supporting primary care physicians in engaging families to promote positive developmental and psychosocial outcomes for children. Among the participating practices, 89 percent have implemented structured developmental screening and 50 percent have performed psychosocial assessment, and all are working on systems to improve how they determine and meet parents' needs for information.

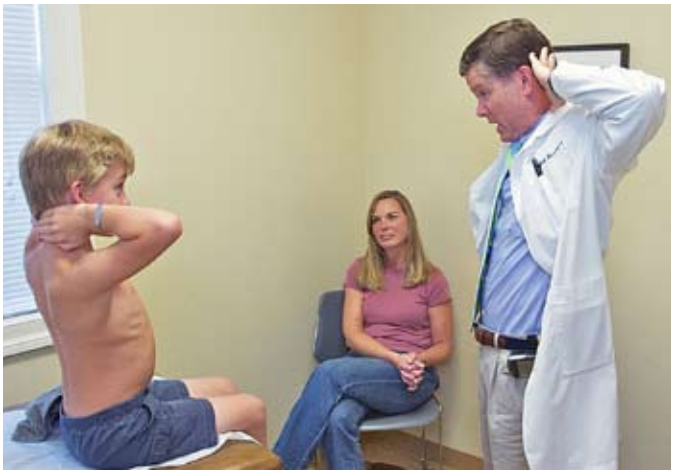
Judith Shaw, M.P.H., R.N.
University of Vermont

In 2004, the Fund provided a grant to the University of Vermont to support the development of state and local initiatives in Arizona, the District of Columbia, New York, Rhode Island, and Washington and to bring together officials from public health departments, Medicaid agencies, and pediatric and community organizations to improve preventive and developmental services for young children. All five sites have successfully matched the Fund's support with local resources to launch the initiatives, engaged physicians in projects to improve developmental services, and outlined strategies to improve the quality of children's health care. In the next phase of work, project staff brought this quality improvement model to five other states: Ohio, Oklahoma, Michigan, Minnesota, and West Virginia.

Another way the Fund is helping to spread the word about how pediatricians can address children's emotional and behavioral issues is through its sponsorship of Open Forums. Originally developed by the North Carolina Chapter of the American Academy of Pediatrics (AAP), these meetings—typically held three to four times annually in various locations in a state—have proven to be a highly effective vehicle for practicing pediatricians, state officials, child advocacy leaders,

SPREADING VERMONT'S COLLABORATIVE IMPROVEMENT MODEL

Goal	To foster partnerships among a range of stakeholders—from public health departments and Medicaid agencies to pediatric organizations and community organizations—to improve preventive and developmental services for young children.
Award Amount	$316,967
Timeframe	1/1/07–12/31/08
Lead Investigator	Judith Shaw, M.P.H., R.N., University of Vermont
For more information	Contact Ms. Shaw at Judith.Shaw@uvm.edu.



and health care payers to exchange information and air concerns on a variety of child health and pediatric practice concerns.

Pediatricians participating in the forums have been able to foster relationships with government administrators and child health advocates; identify the benefits and drawbacks of various developmental screening tools; work with families and communities to advance early childhood development plans; and discuss issues related to reimbursement.

Thanks in part to a grant from The Commonwealth Fund, the AAP is spreading the Open Forum concept to more chapters around the country. In 2006, the Fund gave eight AAP chapters $1,000 each to host at least two Open Forums in their states on early childhood development issues. The chapters were in California, Iowa, Kansas, Maine, Maryland, Oregon, Puerto Rico, and Virginia. More recently, through the AAP, the Fund supported grants to four additional states—Alabama, Arizona, Illinois, and New Hampshire—to begin hosting the forums.

Grants to Watch

Building on the success of the developmental screening initiatives it has supported, the Fund's Child Development and Preventive Care Program is now engaged in a series of projects to study how children who have been identified with problems are linked or referred to appropriate services in their communities. For example, under the direction of Neva Kaye, senior program director for the National Academy for State Health Policy, the third phase of the ABCD program will establish a three-year learning collaborative of five state Medicaid agencies that will identify and implement policy, system, and practice changes to improve referral and care coordination between pediatric primary care practices and community agencies.

Judith C. Dolins, M.P.H.
American Academy
of Pediatrics

Another project, led by Sharon Silow-Carroll of Health Management Associates, will study and report

PROVIDING OPEN FORUMS FOR CHILD HEALTH CARE STAKEHOLDERS

Goal	To foster partnerships between practicing pediatricians and government agencies, elected officials, child health advocates, insurers, and others by providing a vehicle for exchanging information and airing concerns on practice-related issues.
Award Amount	$13,966
Timeframe	7/1/05–6/30/06
Lead Investigator	Judith C. Dolins, M.P.H., American Academy of Pediatrics
For more information	E-mail Ms. Dolins at jdolins@aap.org.

on some of the most promising models of care coordination being tried in states and communities across the nation. While these innovative efforts are early in their development, they offer potentially successful approaches that others might adopt.

Notes

1 L. Sices, *Developmental Screening in Primary Care: The Effectiveness of Current Practice and Recommendations for Improvement* (New York: The Commonwealth Fund, Dec. 2007).

2 D. Drotar, T. Stancin, and P. Dworkin, *Pediatric Developmental Screening: Understanding and Selecting Screening Instruments* (online manual), The Commonwealth Fund, Feb. 2008.

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

Photographs

Paula Lerner: page 2
Cincinnati Children's Hospital Medical Center: page 6
John Troha: page 9 (top left)

Most Americans dread the thought of living a nursing home—a term that in many people's minds conjures up a hospital-like institution with rigid schedules and routines. The Commonwealth Fund supports the view that nursing homes in the U.S. need to undergo "culture change"—to transform themselves into residences that provide long-term care delivered in accordance with the needs and desires of the people who live there.

Quality of Care for Frail Elders

Mary Jane Koren, M.D., M.P.H.
Assistant Vice President

The Picker/Commonwealth Program on Quality of Care for Frail Elders aims to transform the nation's nursing homes and other long-term care facilities into resident-centered organizations that are good places to live and work, capable of providing the highest-quality care. The program does so by:

- Identifying, evaluating, and spreading effective practices, models, and tools for achieving "resident-centered" long-term care, or care delivered in accordance with the needs and desires of those who live in long-term care facilities
- Promoting policy initiatives that support high performance in long-term care.

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

A grassroots movement proposes a radical departure from the traditional nursing home model—in effect a total "culture change"—that aims to improve the lives of the individuals who live in these facilities. Believing long-term care residents can and should direct their own lives, proponents of this culture change recommend replacing large impersonal units with households of small groups of residents and staff.

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

Working to Improve the Culture

Recognizing the importance of the culture change movement, The Commonwealth Fund is supporting a nationwide campaign called Advancing Excellence in America's Nursing Homes, which aims to create a culture of person-centered, individualized care, and an empowered workforce in nursing homes. Started in 2006, it is the first voluntary, national effort to measure quality by setting measurable and quality-focused

goals. Participants include a broad-based coalition of long-term care providers, caregivers, medical and quality improvement experts, government agencies, and consumers.

In addition to the 28 national organizations that make up the coalition, the campaign also has established 49 Local Area Networks for Excellence, which exist in almost every state to provide peer support, information, best practices, and technical assistance to campaign participants.

More than 7,200 nursing homes—about 45 percent of all nursing homes in the United States—have enrolled in the campaign. Participating facilities select and set improvement targets in at least three of the eight goals (four in areas related to clinical quality and four in organizational improvement areas). Data from the first 18 months of the campaign showed that participating nursing homes experienced faster improvements in all four clinical goals than similar facilities that were not participating had achieved. Specifically, progress has been made in reducing the prevalence of pressure ulcers and the use of physical restraints and improving pain management for residents.

"Several years ago, the restraint rate was way above 10 percent of all patients in the United States, and under this campaign, those nursing homes participating in this campaign have dropped the rate to below 5 percent," said Carol Benner, Sc.M., field director for the local networks. "So, now we are dropping the goal to 3 percent of all residents." Benner said that at the start of the campaign, Arkansas, a state where all the nursing homes participate in the campaign, had a restraint rate of nearly 14 percent; today it is 6 percent.

"What's magical about this endeavor," Benner said, "is that everyone has embraced it—consumers, providers, and the government."

With Fund support, Harris Interactive conducted the first national survey to measure the extent to which culture change has taken hold in the U.S. nursing home industry. As detailed in the May 2008 report, *Culture Change in Nursing Homes: How Far Have We Come?*, many nursing homes have adopted at least some practices associated with resident-centered care, such as involving residents in decisions related to their daily activities and giving direct-care workers more say in the care of residents. At the same time, critical structural and management changes have been slow to arrive.

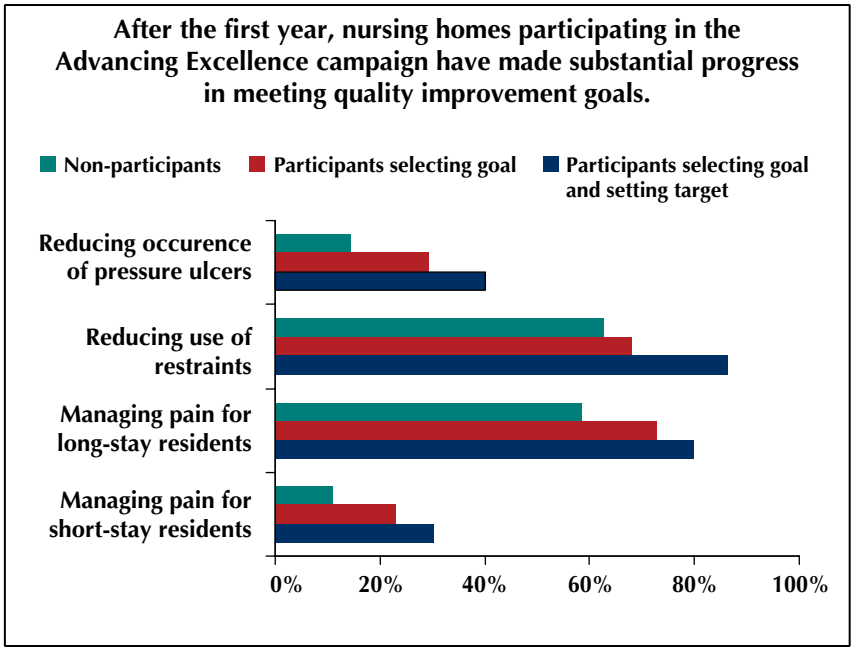
Encouragingly, the survey showed that facilities that incorporate some aspects of culture change had benefits in terms of staff retention, occupancy rates, competitive position, and operational costs. The authors of the report said they believe that as the awareness of these and other competitive and operational advantages become known, more nursing homes will shift toward resident-centered care.

Increasing Quality of Life

To improve the quality of residents' daily lives, nursing homes need firsthand information about their experiences. A Fund-supported research team led by Howard B. Degenholtz, Ph.D., associate professor of

ADVANCING EXCELLENCE IN AMERICA'S NURSING HOMES

Goal	To bring about demonstrable improvements in nursing home residents' care and quality of life.
Award Amount	$354,936
Timeframe	8/1/07–7/31/08
Lead Investigator	William L. Minnix, D.Min., American Association of Homes and Services for the Aging
For more information	E-mail info@aahsa.org.



Health Policy & Management at the University of Pittsburgh, is testing a structured interview guide to enable nursing home staff to ask residents directly about problems they experience and then design interventions to correct them.

"In this project, we are developing a way to do a consistent, structured resident assessment on quality of life that generates actionable recommendations for care planning in nursing homes," Degenholtz explained. "This is a missing piece of the overall resident-assessment and regulatory system. So much of the system is geared toward measuring and improving quality of care, but limited attention is paid to quality of life."

The project team also has funding from The Commonwealth Fund to determine the prevalence and use of health information technology (HIT) in nursing homes. "There is some very interesting overlap between these two efforts, in part because we have learned so much from the HIT project that is helping the quality-of-life project," said Degenholtz. "We have done focus groups with nursing home administrators, directors of nursing, medical directors, consulting pharmacists, advanced practice nurses, and nurse aides. We're asking them about specific micro-level processes for which they might be using technology, and we are finding that there is a lot of consensus that adoption of HIT is not very far along in nursing homes."

ASKING NURSING HOME RESIDENTS ABOUT THEIR QUALITY OF LIFE

Goal	To develop and test a structured interview guide that will enable nursing home staff to ask residents directly about problems they are experiencing and then design interventions to correct them.
Award Amount	$348,419
Timeframe	7/1/07–6/30/09
Lead Investigator	Howard B. Degenholtz, Ph.D., University of Pittsburgh
For more information	E-mail Dr. Degenholtz at degen@pitt.edu.

Bonnie S. Kantor, Sc.D.
Pioneer Network

Efforts to Change the Culture in Nursing Homes

The Pioneer Network, an organization in Rochester, N.Y., that has spearheaded the culture change movement since 1997, offers training, practical tools, and other resources to institutions seeking to transform their facilities. With Fund support, the group organized a symposium in April 2008 in Washington, D.C., where Pioneer representatives and officials from the Centers for Medicare and Medicaid Services (CMS) explained how facilities can use innovative environmental design to create a home and community for nursing home residents that supports resident-centered care.

Approximately 600 symposium attendees—among them, long-term care innovators, regulators, researchers, architects, advocates, and public officials—heard presentations on issues related to every aspect of the physical space of nursing homes, including environmental innovations and regulatory challenges associated with transforming nursing homes into comfortable, pleasant places for elders to call home. A second workshop was held the next day for national stakeholders seeking to examine how regulations might inhibit or advance innovative design.

"What's exciting about the symposium is that it was a starting point," said Bonnie S. Kantor, Sc.D, executive director of the Pioneer Network. "No one could have predicted what we were starting at the symposium, the funding that has come from other sources as a result of it, and the way the participants have rallied around the ensuing initiatives. Those initiatives will make a big difference in the way we care for our elders as we go from an institutional model of care delivery to a resident-centered model of care delivery."

Barbara Bowers, Ph.D.
University of Wisconsin-Madison School of Nursing

In an effort to provide step-by-step guidance for putting resident-centered concepts into practice, Barbara Bowers, Ph.D., of the University of Wisconsin-Madison School of Nursing, received Fund support to update and expand an organizational readiness and implementation guide for nursing homes. The handbook includes case studies, exercises, tools, and examples for nursing home staff to use.

"At most nursing homes, staff are struggling to figure out how to implement resident-centered care," Bowers explained. "Most of the struggle to implement

THE PIONEER NETWORK INITIATIVE: MOVING INTO THE SECOND DECADE

Goal	To support Pioneer as it seeks to define core competencies of resident-centered care, collaborate with the Centers for Medicare and Medicaid Services to explore creative ways by which traditional facilities can be made to look and feel more like a home, and enlist new partners in the effort to spread resident-centered practices.
Award Amount	$227,317
Timeframe	8/1/07–7/31/08
Lead Investigator	Bonnie S. Kantor, Sc.D., Pioneer Network
For more information	E-mail Ms. Kantor at bonnie.kantor@pioneernetwork.net.

this model of care involves good leadership principles. And the guide we produced is largely about how to engage in organizational change and how to develop the required leadership principles."

Addressing Workforce Issues

One of the most pressing issues America's nursing homes face is finding and retaining staff. The Institute of Medicine's ad hoc Committee on the Future Health Care Workforce for Older Americans assessed the health care needs of Americans over age 65 and issued a report that was supported by the John A. Hartford Foundation, the Atlantic Philanthropies, and The Commonwealth Fund. The report, *Retooling for an Aging America: Building the Health Care Workforce*, was published in April 2008 and is available on the Web site of the National Academies Press (www.nap.edu).

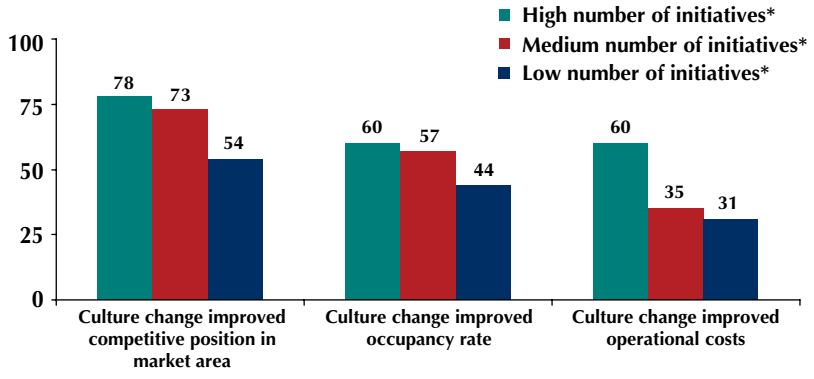
Fund grantee Dale Yeatts, Ph.D., of the University of North Texas, investigated workforce issues and self-managed work teams in nursing homes as a potential remedy for problems related to persistent absenteeism and high workforce turnover. For his research, Yeatts measured the effects of staff empowerment on job satisfaction and retention in five nursing homes where self-managed work teams were implemented. He and his UNT colleague Cynthia Cready, Ph.D., have published several papers discussing their work in this area.[1]

Dale Yeatts, Ph.D.
University of North Texas

"By letting staff make decisions, you are letting people who have the best understanding of those residents influence care," said Yeatts. "The staff know what the residents want and need. So when they communicate these needs, they are helping to improve care, especially if communication is lacking."

Improvements in business and operations are greatest in nursing homes that have undertaken the highest number of 'culture change' initiatives.

Percent of nursing homes indicating that culture change has had the following impact: (Base: Definition of culture change describes this nursing home completely, for the most part, or in a few respects)



* Respondents were asked whether their home was currently implementing any of 11 different resident-centered, staff, or physical environment initiatives associated with culture change. High=7 or more initiatives; Medium=4 to 6 initiatives; Low=3 or less initiatives.
Source: M. M. Doty, M. J. Koren, and E. L. Sturla, *Culture Change in Nursing Homes: How Far Have We Come? Findings From The Commonwealth Fund 2007 National Survey of Nursing Homes* (New York: The Commonwealth Fund, May 2008).

Assessing the Costs of Care

As it is throughout the health care sector, cost is at or near the top of the list of challenges facing nursing home care providers and payers. Until recently, little has been known about spending for hospitalizations of nursing home residents, which in New York State alone rose from $608 million in 1999 to $972 million in 2004.

With a grant from The Commonwealth Fund, Nancy R. Barhydt, Dr.P.H., R.N., of the New York State Department of Health, in collaboration with Harvard Medical School's David Grabowski, Ph.D., set out to study whether acutely ill residents can be managed safely in the nursing home rather than being transferred to a hospital. A large percentage of resident hospitalizations in New York are for such ailments as pneumonia and kidney or urinary tract infections—conditions that could have been addressed in the nursing home with proper prevention and treatment.

Nancy R. Barhydt, Dr.P.H., R.N., New York State Department of Health

In a study published by *Health Affairs,* the researchers found that better prevention and treatment of common ambulatory conditions, like pneumonia, in nursing homes could reduce avoidable hospitalizations for residents while saving Medicare and other public programs money. Of the more than 122,000 nursing home hospitalizations for 14 ambulatory care-sensitive conditions over the five-year study period, nearly one-third were found to be potentially avoidable.

David Grabowski, Ph.D. Harvard Medical School

"The high concentration of spending in relatively few conditions suggests that targeted prevention and treatment interventions in nursing homes could be particularly fruitful," said Grabowski.

Such interventions might require the Centers for Medicare and Medicaid Services to modify how it pays for care. Grabowski was asked if it is realistic to expect CMS to modify its method for paying nursing homes based on the research findings. "CMS is currently embarking on a pay-for-performance demonstration—separate from anything ongoing in New York," he said. "They're trying a similar model to reward nursing homes for decreasing hospitalizations, among other quality indicators. So, there is definitely interest in this issue at CMS."

USING INCENTIVES TO REDUCE HOSPITALIZATIONS FOR NURSING HOME RESIDENTS IN NEW YORK STATE

Goal	To study the relationship among hospitalizations, availability of clinical resources in nursing homes, and costs, and design a new payment model that rewards better management of at-risk or acutely ill patients.
Award Amount	$395,848
Timeframe	8/1/05–7/31/07
Lead Investigator	Nancy R. Barhydt, Dr.P.H., R.N., New York State Department of Health
For more information	E-mail David Grabowski, Ph.D., at grabowski@hcp.med.harvard.edu.

Grants to Watch

In the coming year, The Commonwealth Fund will support projects aimed at raising the visibility of culture change in an effort to make resident-centered care a reality in many more nursing homes. Building on the success of the Advancing Excellence in America's Nursing Homes campaign in its first year, a team led by William L. Minnix, Jr., at the American Association of Homes and Services for the Aging is helping to build local area networks' capacity to lead quality improvement efforts, reach out to facilities that have not yet joined, and maintain progress toward meeting improvement targets. Alice Bonner, Ph.D., R.N., and her team at the Massachusetts Senior Care Foundation will enable Advancing Excellence to develop new metrics for measuring progress toward goals. In addition, the Quality of Care for Frail Elders program is supporting the efforts of Joseph G. Ouslander, M.D., and his team at the Boca Institute for Quality Aging to refine tools that nursing homes can use to manage acute medical conditions and avoid the trauma of transfer to a hospital emergency room.

Notes

[1] See, for example, D. E. Yeatts and C. M. Cready, "Consequences of Empowered CNA Teams in Nursing Home Settings: A Longitudinal Assessment," *Gerontologist,* June 2007 47(3):323–39; and C. M. Cready, D. E. Yeatts, M. M. Gosdin, "CNA Empowerment: Effects on Job Performance and Work Attitudes," *Journal of Gerontological Nursing,* March 2008 34(3):26–35.

Photographs

Roger Carr: page 2 (top)

At The Commonwealth Fund's 2008 International Symposium on Health Care Policy in Washington, D.C., Lord Ara Darzi (above), Parliamentary Undersecretary of State at the U.K. Department of Health and author of a major review of the National Health Service published in June 2008, joined health ministers from other leading industrialized countries to discuss the best ways to expand access to care and maximize value in health care spending. Seated next to him are Franz Knieps, Director General, German Ministry of Health; Abraham Klink, Health Minister, Netherlands; Laurent Degos, M.D., Chair, National Authority for Health, France; and Susan Dentzer, Editor-in-Chief, Health Affairs. Also joining in the discussion was Thomas Björn Zeltner, Secretary of State for Health, Director General, Federal Office of Public Health, Switzerland (below), pictured here with the Netherlands' Klink and Germany's Knieps.

International Program in Health Policy and Practice

Robin L. Osborn, M.B.A.
Vice President

As the nation that spends more on health care than any other and yet receives less in return than most, the United States can learn a great deal from the experiences of other countries in providing health insurance coverage and delivering cost-effective, timely, quality health care. Cross-national learning, sharing, and collaborating are what drive The Commonwealth Fund's International Program in Health Policy and Practice. Its mission is to:

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

Among the program's notable activities are an annual international symposium for ministers of health and experts in health policy, an annual survey of industrialized nations, and the Harkness Fellowship program for promising health care policy researchers and practitioners.

2008 International Symposium

For the Commonwealth Fund's 11th annual International Symposium on Health Care Policy, more than 70 health policy experts from nine industrialized countries gathered to discuss best practices for expanding access to care and maximizing value in health care spending. Participating in the event were health ministers, or their designates, from Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, the United States—and, for the first time, France and Switzerland—as well as senior government officials and leading researchers from each nation.

In his keynote address, U.K. Secretary of State for Health Alan Johnson discussed the ambitious reform agenda of the National Health Service (NHS), including efforts to shorten waiting times for patients, institute pay-for-performance programs, empower patients, and reduce inequalities. Later, Ab Klink, the Netherlands' Minister of Health, Welfare, and Sport, briefed participants on recent reforms of the Dutch health care system and the successful effort to achieve universal coverage through private insurance. He also emphasized the importance of regulation in ensuring the proper functioning of the health care marketplace, as well as the need for payment reform to stimulate innovation and more integrated care.

IN THEIR OWN WORDS

"An issue that concerns me is whether we genuinely can tackle the growing problems of lifestyle diseases, an aging population, and the need to integrate our National Health Service with adult social care....There is an increasing need to knit the two together. And if we get it wrong, if we don't tackle these enormous problems through prevention, through more care in the communities, through a patient-centered clinically led service, then we're going to run into huge difficulties.... That's enough, I think, to keep any politician awake at night without even the economic crisis."

— U.K. Secretary of State for Health Alan Johnson

The following are some other highlights from the 2008 symposium:

- For the seventh John M. Eisenberg International Lecture, Laurent Degos, M.D., chair of France's National Authority for Health, shared innovative French policies and practices for reducing medical errors and improving cardiac care. He also highlighted the importance of integrated care to making care safer and reducing adverse health outcomes.
- James R. Tallon, Jr., president of the United Hospital Fund and chairman of the Fund's Board, moderated a policy roundtable that enabled the health ministers to exchange views on the best ways to make the health care system perform better for patients with chronic illness. The discussion also turned to the relative advantages—based on each country's experience—of enacting sweeping reform of the health system over a series of incremental changes.
- Findings presented from a seven-country study led by Elias Mossialos, M.D., of the London School of Economics and Sherry Glied, Ph.D., of Columbia University sparked lively debate about the performance of European health systems. Experts compared the public/private mix of health coverage in each country, as well as policies on risk-adjustment, cost-sharing, regulation, and competition.

International Health Policy Survey

The Commonwealth Fund's 2008 International Health Policy Survey focused on the experiences of chronically ill patients in eight industrialized nations—Australia, Canada, France, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. Its findings were sobering: U.S. respondents were by far the most likely to report forgoing care because of the cost, as well as most likely to experience medical errors, care coordination problems, and high out-of-pocket costs.

Perhaps not surprisingly, patients in the U.S. were significantly more likely than those in the other countries to call for fundamental change in the health care system, with one-third saying the system needs to be rebuilt completely. The journal *Health Affairs* published the findings online in November 2008.[1]

According to the survey, more than half (54%) of U.S. chronically ill patients did not get recommended care, fill prescriptions, or see a doctor when sick because of the cost, compared with 7 percent to 36

IN THEIR OWN WORDS

"We went from a budget-oriented system, which heavily focused on the rationing of the health care system, to a more market-oriented system. But still then, and even then, and especially then, you need regulation. And without any regulation you don't get a market. And what strikes me, and struck me when I was in the United States, is that although you have the reputation of being very much market-oriented, actually there is not too much competition, because the employers...choose the insurance companies."

— Dutch Health Minister Ab Klink

The U.S. stands apart for the health care access, coordination, and safety problems encountered by chronically ill patients.

Base: Adults with any chronic condition

Percent reported in past two years:	AUS	CAN	FR	GER	NETH	NZ	UK	US
Access problem because of cost*	36	25	23	26	7	31	13	54
Coordination problem**	23	25	22	26	14	21	20	34
Medical, medication, or lab error***	29	29	18	19	17	25	20	34

* Because of cost, respondent did NOT: fill Rx or skipped doses, visit a doctor when had a medical problem, and/or get recommended test, treatment, or follow-up.
** Test results/records not available at time of appointment and/or doctors ordered test that had already been done.
*** Wrong medication or dose, medical mistake in treatment, incorrect diagnostic/lab test results, and/or delays in abnormal test results.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

percent in the seven other countries. About one-third of U.S. patients—again, the highest proportion—experienced medical, medication, or lab/diagnostic test errors. One-third encountered poorly coordinated care, including duplication of tests or medical records that were unavailable at the time of an appointment. And, reflecting the pervasiveness of high cost-sharing and coverage gaps, 41 percent of U.S. patients spent more than $1,000 in the past year on out-of-pocket medical costs, compared with 4 percent in the U.K. and 8 percent in the Netherlands.

"The study highlights major problems in our broken health care system and the need to make major changes," said Cathy Schoen, a senior vice president at The Commonwealth Fund and lead author of the *Health Affairs* article. "Patients are telling us about inefficient, unsafe, and often wasteful care. Moreover, a lack of access as well as poor coordination of care is putting chronically ill patients at even higher health risk."

International Meeting on Quality of Health Care

Improving care for people with chronic illness was the theme for the ninth international meeting on quality of health care hosted by The Commonwealth Fund and the U.K.'s Nuffield Trust, held in Boston in July 2008. Senior policymakers and health researchers from the U.S. and U.K. discussed how medical homes can coordinate treatment for patients' chronic conditions, how patient–provider agreements can raise the level of patient engagement and care coordination, and how physicians can be motivated to provide the extra level of support needed to care for these patients.

Participants left the meeting with a better understanding of each nation's quality improvement policies and strategies, and which elements might be transferable. The 10th meeting in this transatlantic series will be held in July 2009 to examine the potential gains in quality and efficiency from reforming provider payment policy.

THE DUTCH HEALTH CARE REFORMS: A MODEL FOR THE U.S.?

Three years ago, the Netherlands launched a sweeping national health care initiative to provide universal health care coverage for its population. Not a single-payer system, the Dutch approach combines mandatory universal health insurance with competition among private health insurers. According to "Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?"—a Commonwealth Fund–supported study published in *Health Affairs*[2]—the Dutch system may be of particular interest to policymakers in the U.S. as they search for ways to address stubbornly high uninsured rates and a shortage of affordable coverage.

The Dutch reform requires all people who legally live or work in the Netherlands to buy health insurance from one of a number of competing private insurance companies, which are required to accept each applicant. The government set up a Web site where consumers can compare all insurers and all hospitals on various performance indicators and other criteria. To finance the reform, individuals make annual income-based contributions, through the tax system, for which employers are required to provide compensation; these in turn are transferred to a "risk equalization" fund that compensates insurers for taking on high-risk enrollees.

In April and November 2008, The Commonwealth Fund and the Alliance for Health Reform sponsored briefings for congressional staff and others on Capitol Hill to highlight innovations in the Dutch health care system and recent reforms in insurance to achieve universal coverage.

Harkness Fellows in Health Care Policy and Practice

Aimed at developing promising health care policy researchers and practitioners in Australia, Germany, the Netherlands, New Zealand, and the United Kingdom, the Harkness fellowships provide a unique opportunity for individuals to spend up to a year in the United States conducting a policy-oriented research study, gaining firsthand exposure to managed care and other models of health care delivery, and working with leading policy experts.

Through four newly developed partnerships, the Harkness program saw significant expansion this year. Beginning in 2008, the B. Braun Foundation agreed to provide support for a third German Harkness Fellow to build further capacity in nursing policy leadership. In the Netherlands, two Dutch fellowships—one supported by the Dutch Ministry of Health—were established, with the first fellows arriving in September 2008. A commitment by the Zurich-based Careum Foundation made possible the launch of the Harkness Fellowships in Switzerland in July 2008, with the first Swiss Fellow to join the program in September 2009. In addition to four U.K. Harkness Fellowships supported by The Commonwealth Fund, the Nuffield Trust will provide support for the program beginning with the 2009–10 class.

Harkness Fellows' work is informing policy thinking in the U.S. and fellows' home countries. Kalipso Chalkidou, M.D. (U.K.) and Stephanie Stock, M.D. (Germany), both 2007–08 fellows, briefed a high-level audience at the Institute of Medicine on the U.K.'s approach to cost-effectiveness review and Germany's statutory Disease Management Programs. In April 2008, U.K. fellow Geraint Lewis, M.D., served as a keynote speaker at a U.S. Veterans Administration conference and was given an award for improving veteran's health care for his work on "virtual wards." In the U.K., Harkness alumni assumed leadership positions at all three top health policy foundations: Jennifer Dixon, M.D., (1990–91) was named director of the Nuffield Trust; Anna Dixon (2005–06) became director of policy at the King's Fund; and Martin Marshall, M.D. (1998–99) assumed the role of director of clinical quality at the Health Foundation. In New Zealand, Mark Booth (2006–07) was made senior adviser to the health minister.

2008–09 Harkness Fellows in Health Care Policy and Practice

Jako Burgers, M.D., Ph.D. (The Netherlands)
Senior Researcher
Scientific Institute for Quality of Healthcare
Radboud University Nijmegen Medical Centre
Senior Consultant/Dutch Institute for Healthcare Improvement (CBO)
Project: *Addressing Multi-Morbidity in Healthcare Quality Improvement*
Placement: Harvard School of Public Health
Mentors: Eric C. Schneider, M.D.; Carolyn M. Clancy, M.D.

Mirella Cacace, M.A. (Germany)
Research Fellow
University of Bremen
Project: *Fair Financing and Equal Access to Health Care: A Comparison of Canada, Germany, and United States*
Placement: Columbia University Mailman School of Public Health
Mentors: Sherry Glied, Ph.D.; Lawrence Brown, Ph.D.

Sarah Clifford, M.Sc., Ph.D. (United Kingdom)
Lecturer in Medicines in Health
School of Pharmacy, University of London
Project: *Enhancing Diabetes Care for Adolescents: Linking Home and School Settings with Primary Care*
Placement: University of Rochester School of Medicine
Mentors: Jonathan Klein, M.D.; Roger Platt, M.D.

Mark Dobrow, Ph.D., M.Sc. (Canadian Harkness Associate)
Scientist
Cancer Services & Policy Research Unit, Cancer Care Ontario
Assistant Professor
Health Policy, Management and Evaluation, University of Toronto
Project: *Accountability for Performance in Cancer Care Systems: Insights from Canada and the U.S.*
Placement: Memorial Sloan Kettering Cancer Center
Mentors: Peter Bach, M.D., MAPP; Terry Sullivan, Ph.D.

Robin Gauld, Ph.D. (New Zealand)
Associate Professor of Health Policy
Department of Preventive and Social Medicine, University of Otago
Project: *Policy and Organizational Strategies to Reduce Clinical Performance Variations*
Placement: Boston University Health Policy Institute
Mentors: Alan B. Cohen, Sc.D.; David Blumenthal, M.D.

Jörg Haslbeck, M.Sc.N. (Germany)
Harkness/B. Braun Foundation Fellow
Research Associate
Department of Health Services Research and Institute of Nursing Science
School of Public Health, Bielefeld University
Project: *Self-Management Support for Elderly Patients Living Alone with Chronic Conditions*
Placement: Yale University School of Nursing
Mentors: Ruth McCorkle, Ph.D., FAAN; Penny H. Feldman, Ph.D.

Carolyn Hullick, B.Med., FACEM (Australia)
Director of Emergency Medicine
John Hunter Hospital and Greater Newcastle Acute Care Hospitals
Clinical Leader for Emergency Services
Hunter New England Area Health Service
Project: *Improving the Emergency Care Experience for the Elderly*
Placement: New York–Presbyterian Health System/Cornell–Weill Medical School
Mentors: Mark S. Lachs, M.D.; Neil Flomenbaum, M.D.

Rachel Lewis, M.A. (United Kingdom)
Harkness/Health Foundation Fellow
Community Matron
Manchester Community Health
Nurse Adviser
Department of Health
Project: *Organization Strategies to Institutionalize Evidence-Based Practice*
Placement: Boston Veterans Administration Center for Organization, Leadership, and Management Research
Mentor: Martin P. Charns, D.B.A.

Karen Luxford, Ph.D. (Australia)
General Manager
National Breast and Ovarian Cancer Centre
Project: *Transforming Services to Deliver Patient-Centered Care: The Role of Leadership and Patient Engagement*
Placement: Beth Israel Hospital/Harvard Medical School
Mentors: Thomas Delbanco, M.D.; Dana Safran, Sc.D.

Christopher Millett, Ph.D., M.Sc., M.Phil., FFPH (United Kingdom)
Consultant in Public Health
Imperial College Faculty of Medicine
Project: *Impact of Pay-for-Performance Programs on Health Disparities in Chronic Disease Management*
Placement: University of California, San Francisco
Mentor: Andrew Bindman, M.D.

Rubin Minhas, M.B.Ch.B. (United Kingdom)
General Practitioner
Honorary Senior Lecturer
University of Kent
Project: *Developing Guideline-Based Quality Indicators*
Placement: RAND Corporation
Mentors: Elizabeth A. McGlynn, Ph.D.; Paul G. Shekelle, M.D.

Patricia O'Connor, RN, M.Sc.N. (Canadian Harkness Associate)
Associate Director of Nursing and Co-Director of Best Practices Program
McGill University Health Centre
Project: *Innovations in Interdisciplinary Health Service Delivery in the U.S. and Canada*
Mentor: Maureen Bisognano

Ruth Thorlby, M.Sc. (United Kingdom)
Harkness/Health Foundation Fellow
Fellow in Health Policy/King's Fund
Project: *Quality for Equality: How Data on Race and Ethnicity Are Used to Improve Quality in Health Care*
Placement: Harvard Medical School
Mentors: John Z. Ayanian, M.D.; Bruce Siegel, M.D.

Bert Vrijhoef, Ph.D. (The Netherlands)
Director of Research
Department of Integrated Care, University Medical Hospital Maastricht
Associate Professor
Department of Health Care and Nursing Science, Maastricht University
Project: *Responding to the Burden of Chronic Disease: Development and Validation of a Framework for Integration of Care*
Placement: Group Health Cooperative of Puget Sound
Mentor: Edward Wagner, M.D.

Claus Wendt, M.A., Ph.D. (Germany)
Harkness/Robert Bosch Stiftung Fellow
Research Fellow and Project Director
Mannheimer Center for European Social Research, University of Mannheim
Project: *Analyzing Trust in Different Types of Health Care Systems*
Placement: Harvard School of Public Health
Mentor: Robert Blendon, Sc.D.

HARKNESS ALUMNI CONTINUE TO ADVANCE U.S. POLICY THINKING

A multinational research team including 1998–99 fellow **Carmel M. Hughes, Ph.D., Elizabeth Roughead, Ph.D.** (2003–04), and **Ngaire Kerse, Ph.D.** (2002–03) undertook a review of nursing home medication policies in four nations. In an article they authored for the journal *Healthcare Policy,* the researchers revealed that U.S. nursing homes have been more successful in preventing or reducing the unnecessary use of psychotropic medications than facilities in Australia, New Zealand, and the U.K., but less successful in promoting best practices of appropriate medication use overall.[3]

In an article in *Health Affairs,* Harkness Fellow **Ruth Lopert** (2006–07) and Marilyn Moon, Ph.D., who directs the Health Program for the American Institutes for Research, proposed steps for restructuring the Medicare prescription drug benefit and putting Part D on a more value-driven path. They argued that a long-term objective should be to integrate drug benefits with comprehensive health coverage, by melding Medicare Parts A, B, and D into a single benefit.[4]

And in a commentary published in the *Journal of the American Medical Association,* **Kalipso Chalkidou, M.D., Ph.D.,** a 2007–08 Harkness Fellow from the U.K., teamed up with Gerard F. Anderson, Ph.D., of the Johns Hopkins Bloomberg School of Public Health to argue that spending more on health care does not ensure that patients are healthier and happier with that care.[5] They highlighted several studies demonstrating that the level of health spending is a relatively poor predictor of health outcomes and satisfaction.

Packer Policy Fellowships

The Packer Policy Fellowships, a "reverse Harkness Fellowship" program established in 2002, are designed to enable two mid-career U.S. policy researchers or practitioners to spend up to 10 months in Australia conducting research and gaining an understanding of Australian health policy issues relevant to the U.S. Chaired by Andrew Bindman, M.D., the selection committee met in November 2008 and selected the following fellow:

Michael Pignone, M.D.
Associate Professor of Medicine and Chief
Division of General Internal Medicine
University of North Carolina, Chapel Hill
Project: *Colorectal Cancer Screening in Australia Compared to the United States*

Partnerships with International Foundations

In 2008, the International Program established a new partnership with the France's Haute Authorité de Santé (National Authority for Health) to enable the inclusion of France in the Fund's international health policy survey. Also in 2008, the Ontario Quality Council and Commissaire à la Santé et au Bien-être (Commissioner for Health and Welfare) du Québec partnered with the Fund to expand the Canadian survey. Beginning in 2009, the Federal Office of Public Health in Switzerland has agreed to partner with the Fund and support the inclusion of Switzerland in the survey.

As mentioned above, a new partnership with the Zurich-based Careum Foundation has enabled the launch of the Harkness Fellowships in Switzerland, and partnerships with the Dutch Ministry of Health and Germany's B. Braun Foundation have helped achieve a critical mass of fellows in Germany and the Netherlands.

The Fund is also pleased to recognize its ongoing partners. Since 2006, the Stuttgart-based Robert Bosch Foundation has collaborated with the Fund to provide support for a Harkness Fellow from Germany.

The Fund's continuing partnerships with the German Institute for Quality, the Dutch Ministry for Health, the Dutch Ministry of Health, Welfare and Sport, and the Scientific Institute for Quality of Healthcare at Radboud University Nijmegen Medical Centre have enabled the Fund to include Germany and the Netherlands in its international surveys. In addition, the Fund's collaborations with the U.K.-based Health Foundation and the Health Council of Canada allow the Fund's international health policy surveys to include expanded samples for individual country analyses.

Each year since 2001, two Canadian Harkness Associates have participated in all aspects of the fellowship program as part of a collaboration between the Fund and the Canadian Health Services Research Foundation. The Fund continues to build on its longest-standing partnership with the Nuffield Trust, with which the Fund has cosponsored the International Meeting on Health Care Quality since 1999, and which will provide funding for the U.K. Harkness Fellowship beginning in 2009.

Grants to Watch

The Fund's efforts to learn from other countries' experiences are bolstered by projects and commissioned papers that explore health care innovations and reforms abroad. Recently awarded grants that are expected to produce valuable information in the near future include:

- A project led by Elias Mossialos, M.D., of the London School of Economics and Sherry Glied, Ph.D., of Columbia University Mailman School of Public Health to establish a European–U.S. Experts Advisory Group to identify and compare best practices in European countries and gauge their transferability to the U.S.
- A project led by Richard Grol, Ph.D., of the Scientific Institute for Quality of Healthcare at Radboud University Nijmegen Medical Centre to provide a more nuanced understanding of how medical homes work by surveying physicians and patients in primary care practices in Denmark, the Netherlands, and the United Kingdom.
- A grant to former Harkness Fellow Kalipso Chalkidou, M.D., of the U.K.'s National Institute for Clinical Excellence to assemble a team of experts to examine the centralized approaches to comparative effectiveness review of pharmaceuticals and health technologies in the U.K., Australia, France, and Germany, and to make recommendations for setting up such a decision-making entity in the U.S.

Notes

[1] C. Schoen, R. Osborn, S. K. H. How, M. M. Doty, and J. Peugh, "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008," *Health Affairs* Web Exclusive, Nov. 13, 2008, w1–w16.

[2] W. P. M. M. van de Ven and F. T. Schut, "Universal Mandatory Health Insurance in The Netherlands: A Model for the United States?" *Health Affairs,* May/June 2008 27(3):771–81.

[3] C. M. Hughes, E. Roughead, and N. Kerse, "Improving the Use of Medicines for Older People in Long-Term Care: Contrasting the Policy Approach of Four Countries," *Healthcare Policy,* Feb. 2008 3(3): 37–51.

[4] R. Lopert and M. Moon, "Toward a Rational, Value-Based Drug Benefit for Medicare," *Health Affairs,* Nov./Dec. 2007 26(6):1666–73.

[5] G. F. Anderson and K. Chalkidou, "Spending on Medical Care: More Is Better?" *Journal of the American Medical Association* May 28, 2008 299(20):2444–45.

Photographs

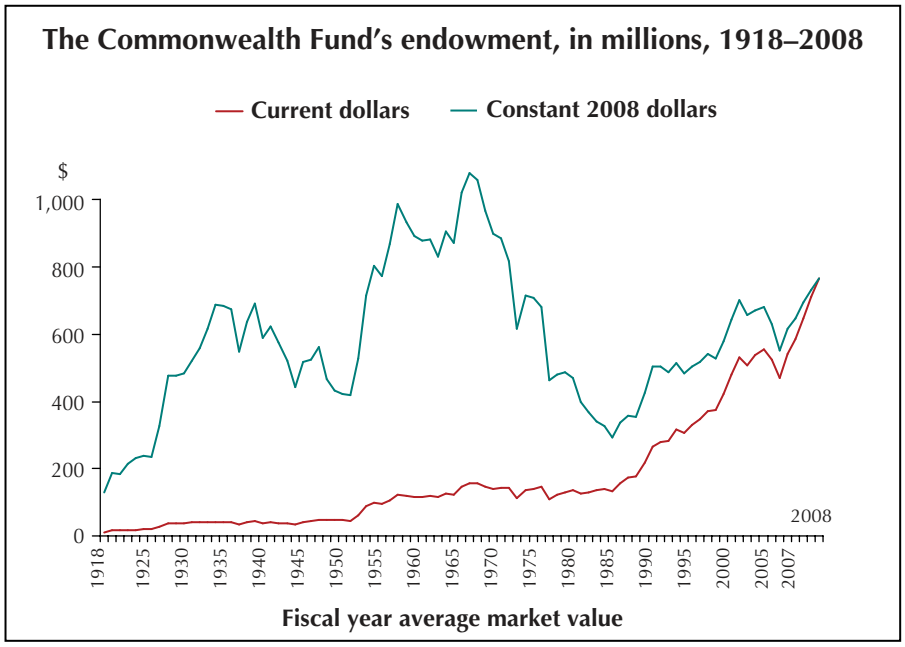
John Troha: page 2

Treasurer's Report

John E. Craig, Jr.

The Investment Committee of The Commonwealth Fund's Board of Directors is responsible for the effective and prudent investment of the endowment, a task essential to ensuring a stable source of funds for programs and the foundation's perpetuity. The committee determines the allocation of the endowment among asset classes and hires external managers, who do the actual investing. Day-to-day responsibility for the management of the endowment rests with the Fund's executive vice president and COO/treasurer, who, with the assistance of Cambridge Associates consultants, is also responsible for researching investment strategy questions to be addressed by the committee. The committee meets at least three times a year to review the performance of the endowment and individual managers, reassess the allocation of the endowment among asset classes and managers and make changes as appropriate, deliberate investment issues affecting the management of the endowment, and consider new undertakings.

The value of the endowment fell from $770.6 million on June 30, 2007, to $750.8 million on June 30, 2008, reflecting a return of 2.9 percent on the investment portfolio during the year combined with total spending (including programs, administration, investment management fees, and taxes) of $40.1 million. In that 12-month period, the return of the Wilshire 5000 index of U.S. stocks was –12.9 percent; the return of the Lehman Aggregate Bond index was 7.1 percent; and the return of a benchmark portfolio

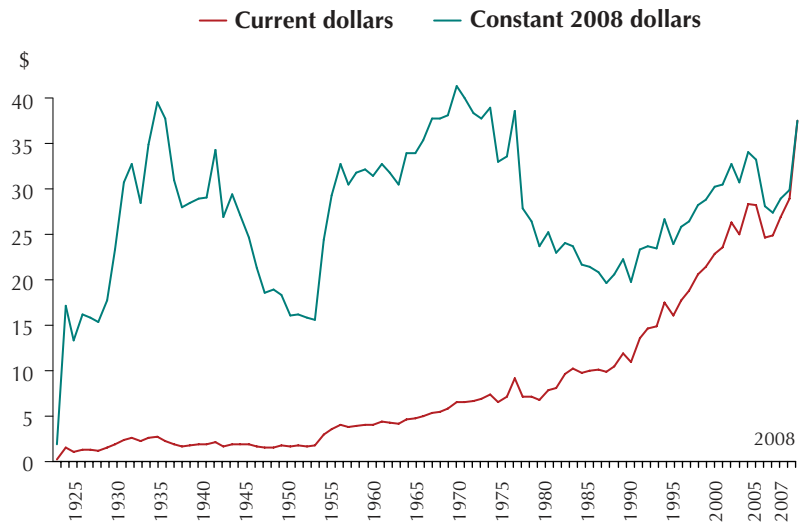


weighting these two broad market indexes according to the Fund's target allocations of stocks and bonds during the year was –9.0 percent. The Fund's overall investment performance exceeded not only that of the weighted market benchmarks, but also the –3.4 percent produced by the median U.S. balanced manager during the fiscal year.

debt securities and foreign currencies in the midst of a growing international financial crisis.

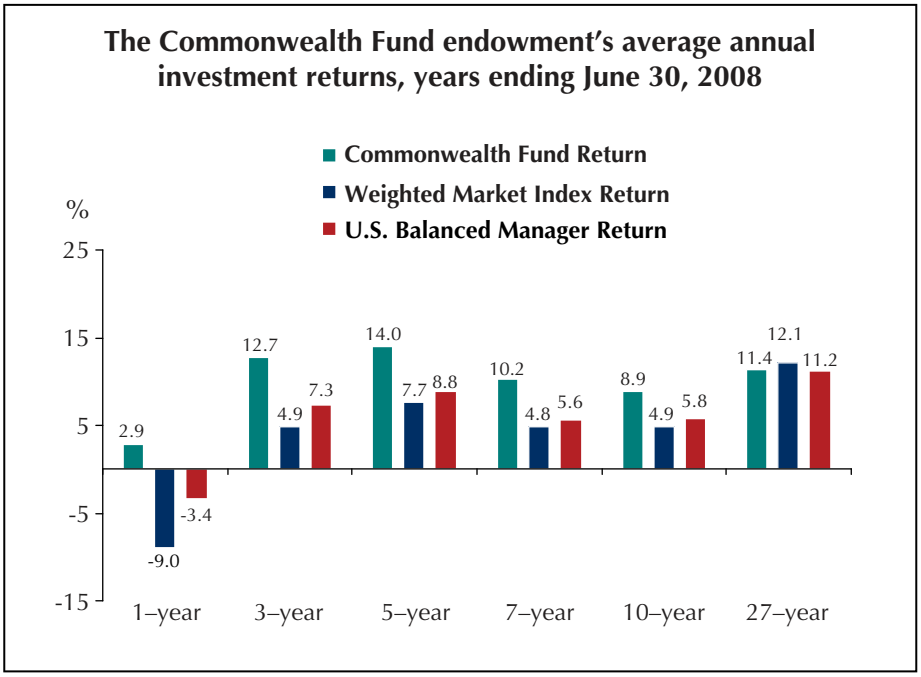
As shown in the figure, the Fund's investment managers as a group outperformed the overall portfolio market benchmark and the median balanced U.S. manager by wide margins over the three-, five-, seven-, and 10-year periods ending June 30, 2008.

The Commonwealth Fund's annual spending, in millions, 1919–2008: total spending of $768 million over 89 years, or $2.47 billion in constant 2008 dollars



The Fund's team of equity (U.S. and international) managers produced a combined 12-month return of 2.7 percent, well above the Wilshire 5000's –12.9 percent and the median U.S. equity manager's –12.4 percent. The foundation's energy and commodities allocations played a significant role in producing its better-than-benchmark equities return. The Fund's bond manager team (including a global fixed-income manager), in contrast, underperformed the Lehman Aggregate bond index benchmark (3.3% vs. 7.1%) in 2007–08—the result of being invested in corporate

The salient features of the Fund's current investment strategy are summarized in the accompanying figure. Key among these are an overall target commitment of 88 percent of the portfolio to equities (publicly traded and private) and 12 percent to fixed-income securities; a 20 percent commitment to publicly traded U.S. equities, paired with a 20 percent commitment to international equities, including a 5 percent allocation to emerging markets; active large capitalization value stock managers; assignment of responsibility for 20 percent of the endowment to marketable



alternative equity (hedge fund) managers; a 10 percent commitment to nonmarketable alternative equities (venture capital and private equities); and an 18 percent allocation to inflation hedges, including real estate, oil and gas, and TIPS.

The Investment Committee devoted particular attention during the year to building up the foundation's nonmarketable alternative equities—venture capital and private equities—and non-marketable oil & gas and natural resources portfolios. New commitments to five partnerships totaling $22 million, following $43 million in such commitments in the preceding year, have put the foundation well on the road to meeting the target allocations for these types of investments.

The Commonwealth Fund's endowment management strategy

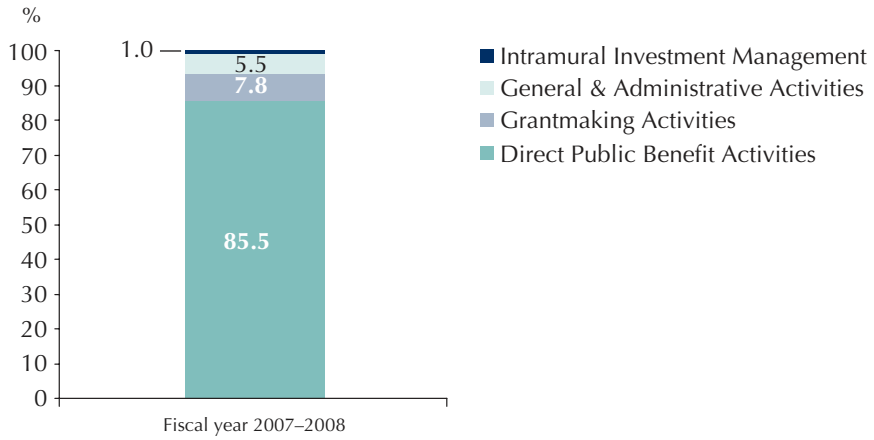
	Allocation on December 31, 2008	Long-term target	Permissible range
Total endowment	100%	100%	
Asset Class			
Total Equity	76%	88%	80-90%
U.S. equity marketable securities	16%	20%	15-30%
Non-U.S. equity marketable securities	18%	20%	15-30%
Marketable alternative equity	16%	20%	0-20%
Non-marketable alternative equity	10%	10%	0-15%
Inflation Hedges	16%	18%	5-20%
Fixed Income	24%	12%	10-20%

The committee periodically reviews asset class allocation targets and the permissible ranges of variation around them. Except in very unusual circumstances, the portfolio is rebalanced when market forces or manager performance cause an allocation to diverge substantially from its target.

As a value-adding foundation, The Commonwealth Fund seeks to achieve an optimal balance between its grantmaking and intramural research and program management activities, while minimizing purely administrative costs. Recognizing that data on expenditures reported in the Internal Revenue Service 990PF annual tax return inadequately reflect the purpose of many expenditures, the analysis in the figure sorts out the foundation's 2007–08 expenditures according to four categories recommended by the Foundation Financial Officers Group: direct public-benefit activities (extramural grants and intramurally conducted programs, such as research, communications, and fellowships); grantmaking activities, including grants management; general and administrative activities; and intramural investment management. In 2007–08, the Fund's total direct public-benefits activities accounted for 85.5 percent of its annual expenditures. Value-adding oversight of grants took up 7.8 percent of the Fund's budget, and the intramural costs of managing the endowment, 1 percent. Appropriately defined, the Fund's administrative costs amounted to 5.5 percent of its budget.

Three considerations determine the Fund's annual spending policy: the aim of providing a reliable flow of funds for programs and planning; the objective of preserving the real (inflation-adjusted) value of the endowment and funds for programs; and the need to meet the Internal Revenue Service requirement of distributing at least 5 percent of the endowment for charitable purposes each year. Like most other institutions whose sole source of income is their endowment, the Fund found it necessary to adjust spending plans to the realities of the severe bear equities market that began in early 2000—reducing its budget by 10 percent in 2003–04 and allowing only very modest

The Fund's total direct public benefit activities—including extramural grants and intramural research, communications, and programs conducted by the foundation—account for 86 percent of its annual expenditures. Value-adding oversight of grants takes up 8 percent of the Fund's budget.



increases through 2006–07. Heartened by the apparent recovery of the market value of the endowment and a comparatively strong average annual return since the bear market began, the Fund's Board approved a 30 percent increase in annual spending for the 2007–08 fiscal year, and another 8.5 percent increase for 2008–09.

The worldwide financial crisis in the fall of 2008, which resulted in a 37 percent decline in the value of U.S. stocks for the calendar year, has dashed hopes, for now, of continuing to expand the Fund's budget. The return on the foundation's endowment of –27.0 percent for the calendar year was typical of that of other endowments; the endowment's value fell from $750.8 million on June 30, 2008, to approximately $538 million on December 31. In recognition of the new financial realities, the Fund will likely reduce its spending by about 15 percent in 2009–10, and, barring a significant market turnaround, another 10 percent in 2010–11 and 8 percent in 2011–12. Even with these steps, the foundation's annual spending rate will rise to over 7 percent in the short term.

The Commonwealth Fund will make decisions on where to pare back spending based on strategic priorities, rather than simply applying across-the-board cuts. Because it is a value-added foundation, and because of the window of opportunity for contributing to U.S. health care reform, the Fund will place a high priority on retaining its skilled and experienced staff, even if the intramural share of total spending rises somewhat during a period of reduced total spending. The foundation will not, however, allow the share of intramural spending to rise above the maximum level set by the Board of Directors.

Based on the Fund's own analysis of its programs' strengths, weaknesses, opportunities, and threats, there will be some reorganization of programs to concentrate the foundation's work even more on the health care reform strategies identified by its Commission on a High Performance Health System. Through each of its programs, the Fund in particular will continue to seek to address health care disparities and the needs of vulnerable populations. We are confident that, even with somewhat reduced resources, we can contribute substantially to national and state efforts to bring about the reforms needed to ensure a high performance health system.

Independent Auditors' Report

The Commonwealth Fund

We have audited the accompanying statements of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2008 and 2007 and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the Fund's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such financial statements present fairly, in all material respects, the financial position of the Fund at June 30, 2008 and 2007 and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

October 29, 2008

THE COMMONWEALTH FUND
STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2008 and 2007

	2008	2007
ASSETS		
CASH	$328,107	$374,518
INVESTMENTS – At fair value (Notes 1 and 2)	748,342,094	771,312,919
INTEREST AND DIVIDENDS RECEIVABLE	133,819	163,748
PROCEEDS RECEIVABLE FROM SECURITY SALES – NET	360,880	484,863
TAXES REFUNDABLE	1,009,149	–
PREPAID INSURANCE AND OTHER ASSETS	23,908	20,196
RECOVERABLE GRANTS	59,665	86,891
LANDMARK PROPERTY AT 1 EAST 75TH STREET – At appraised value during 1953, the date of donation	275,000	275,000
FURNITURE, EQUIPMENT AND BUILDING IMPROVEMENTS – At cost, net of accumulated depreciation of $ 1,316,995 at June 30, 2008 and $1,134,297 at June 30, 2007 (Note 1)	4,325,799	3,973,430
TOTAL ASSETS	$754,858,421	$776,691,565
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable and accrued expenses	$1,123,751	$1,410,281
Taxes payable – net	–	181,201
Program authorizations payable (Note 3)	18,026,149	17,216,632
Accrued postretirement benefits (Note 4)	2,194,182	2,194,182
Deferred tax liability (Note 5)	2,953,974	4,275,720
Total liabilities	24,298,056	25,278,016
NET ASSETS:		
Unrestricted	730,560,365	751,413,549
Total net assets	730,560,365	751,413,549
TOTAL LIABILITIES AND NET ASSETS	$754,858,421	$776,691,565

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2008 and 2007

	2008	2007
REVENUES AND SUPPORT:		
Interest and dividends	$18,527,914	$10,950,773
Contribution and other revenue	–	73,779
Total revenues and support	18,527,914	11,024,552
EXPENSES:		
Program authorizations and operating program	34,896,076	27,156,624
General administration	2,066,699	2,019,445
Investment management	4,872,386	3,986,702
Taxes (Note 5)	(378,796)	2,751,130
Unfunded retirement and other postretirement (Note 4)	75,298	241,803
Total expenses	41,531,663	36,155,704
EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS	(23,003,749)	(25,131,152)
NET INVESTMENT GAINS:		
Net realized gains on investments	68,238,483	80,022,275
Change in unrealized appreciation of investments	(66,087,918)	46,717,255
Total net investment gains	2,150,565	126,739,530
CHANGES IN UNRESTRICTED NET ASSETS	(20,853,184)	101,608,378
Net assets, beginning of year	751,413,549	649,805,171
Net assets, end of year	$730,560,365	$751,413,549

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2008 and 2007

	2008	2007
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets:	$(20,853,184)	$101,608,378
Net investment gains	(2,150,565)	(126,739,530)
Depreciation expense and retirement of assets	248,897	928,643
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Decrease in interest and dividends receivable	29,929	16,547
Increase in taxes refundable – net	(1,009,149)	–
Decrease in proceeds receivable from securities sales – net	123,983	487,569
Decrease (increase) in prepaid insurance and other assets	(3,712)	52,167
Decrease in recoverable grants	27,226	13,109
Increase (decrease) in accounts payable and accrued expenses	(286,530)	446,823
Decrease in taxes payable – net	(181,201)	(702,414)
Increase in program authorizations payable	809,517	1,354,006
Increase (decrease) in deferred tax liability	(1,321,746)	934,345
Net cash used in operating activities	(24,566,535)	(21,600,357)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of furniture, equipment, and building improvements – net	(601,266)	(227,154)
Purchase of investments	(384,535,842)	(380,100,469)
Proceeds from the sale of investments	409,657,232	402,192,601
Net cash provided by investing activities	24,520,124	21,864,978
NET INCREASE (DECREASE) IN CASH	(46,411)	264,621
CASH, BEGINNING OF YEAR	374,518	109,897
CASH, END OF YEAR	$328,107	$374,518
SUPPLEMENTAL INFORMATION–		
Taxes paid: excise and unrelated business income	$2,133,300	$3,290,058

See notes to financial statements.

THE COMMONWEALTH FUND

Notes to Financial Statements

Years Ended June 30, 2008 and 2007

1. Summary of Significant Accounting Policies

The Commonwealth Fund (the "Fund") is a private foundation supporting independent research on health and social issues.

a. *Investments* – Investments in equity securities with readily determinable fair values and all investments in debt securities are carried at fair value, which approximates market value. Assets with limited marketability, such as alternative asset limited partnerships, are stated at the Fund's equity interest in the underlying net assets of the partnerships, which are stated at fair value as reported by the partnerships. Realized gains and losses on dispositions of investments are determined on the following bases: FIFO for actively managed equity and fixed income, average cost for commingled mutual funds, and specific identification basis for alternative assets.

In accordance with Financial Accounting Standards Board Statement No.133, *Accounting for Derivative Instruments and Hedging Activities,* the Fund records derivative instruments in the statements of financial position at their fair value, with changes in fair value being recorded in the statement of activities. The Fund does not hold or issue financial instruments, including derivatives, for trading purposes. Both realized and unrealized gains and losses are recognized in the statements of activities.

b. *Fixed Assets* – Furniture, equipment, and building improvements are capitalized at cost and depreciated using the straight-line method over their estimated useful lives.

c. *Contributions, Promises to Give, and Net Assets Classifications* – Contributions received and made, including unconditional promises to give, are recognized in the period incurred. The Fund reports contributions as restricted if received with a donor stipulation that limits the use of the donated assets. Unconditional promises to give for future periods are presented as program authorizations payable on the statement of financial position at fair values, which includes a discount for present value.

d. *Use of Estimates* – The preparation of financial statements in conformity with generally accepted accounting principles requires the Fund's management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of additions to and deductions from the statement of activities. The calculation of the present value of program authorizations payable, present value of accumulated postretirement benefits, deferred Federal excise taxes and the depreciable lives of fixed assets requires the significant use of estimates. Actual results could differ from those estimates.

e. *Cash* – Cash consists of all checking accounts and petty cash.

At times the Fund's cash exceeds federally insured limits. This risk is managed by using only large established financial institutions.

2. Investments

Investments at June 30, 2008 and 2007 comprised the following:

	2008		2007	
	Fair Value	Cost	Fair Value	Cost
U.S. Equities	$127,147,784	$135,831,825	$178,200,640	$150,499,301
Non-U.S. Equities	163,647,060	129,060,300	186,180,119	109,367,300
Fixed income	113,058,535	102,600,613	114,529,147	105,097,342
Short-term	13,108,097	13,108,097	8,037,978	8,037,978
Marketable alternative equity	121,695,638	70,284,736	110,157,503	54,169,656
Nonmarketable alternative equity	51,223,975	50,055,506	46,905,079	38,349,529
Inflation hedge	158,461,005	99,702,330	127,302,453	92,005,808
	$748,342,094	$600,643,407	$771,312,919	$557,526,914

At June 30, 2008, the Fund had total unexpended commitments of approximatwely $91.0 million in various nonmarketable alternative equity investments.

The Fund's investment managers may use futures contracts to manage asset allocation and to adjust the duration of the fixed income portfolio. In addition, investment managers may use foreign exchange forward contracts to minimize the exposure of certain Fund investments to adverse fluctuations in the financial and currency markets. At June 30, 2008 and 2007, the Fund had no outstanding derivative positions.

3. Program Authorizations Payable

At June 30, 2008, program authorizations scheduled for payment at later dates were as follows:

July 1, 2008 through June 30, 2009	$14,556,082
July 1, 2009 through June 30, 2010	3,457,070
Thereafter	181,951
Gross program authorizations scheduled for payment at a later date	18,195,103
Less adjustment to present value	168,954
Program authorizations payable	$18,026,149

A discount rate of 4.64 % was used to determine the present value of the program authorizations payable at June 30, 2008.

4. Unfunded Retirement and Other Postretirement Benefits

The Fund has a noncontributory defined contribution retirement plan, covering all employees, under arrangements with Teachers Insurance and Annuity Association of America and College Retirement Equities Fund and Fidelity Investments. This plan provides for purchases of annuities and/or mutual funds for employees. The Fund's contributions approximated 17% and 18% of the participants' compensation for the years ended June 30, 2008 and 2007. Pension expense under this plan was approximately $951,000 and $895,000 for the years ended June 30, 2008 and 2007, respectively. In addition, the plan allows employees to make voluntary tax-deferred purchases of these same annuities and/or mutual funds within the legal limits provided for under Federal law.

The Fund also has a group of former employees who retired prior to the inauguration of the above plan and certain other former employees to whom pension benefits have been approved, on an individual case basis, by the Board of Directors. Benefits under this program are paid directly by the Fund to these retirees. These pension payments approximated $71,000 for each of the years ended June 30, 2008 and 2007 In addition, the Fund provides health and life insurance to certain former employees.

Effective July 1, 2001, the Fund established a fully-funded Key Employee Stock Option Plan ("KEYSOP") for certain key executives which exchanges deferred compensation benefits for options to purchase mutual funds. In addition, the KEYSOP awarded options to purchase mutual funds to certain employees in exchange for certain pension benefits. The Fund no longer makes contributions to the KEYSOP.

Effective July 9, 2002, the Fund established a Section 457 Plan for certain employees that provides for unfunded benefits with employer contributions made within the legal limits provided for under Federal law.

The Fund provides postretirement medical insurance coverage for retirees who meet the eligibility criteria. The postretirement medical plan, which is measured as of the end of each fiscal year, is an unfunded plan, with 100% of the benefits paid by the Fund on a pay-as-you-go basis. Such payments approximated $121,000 for each of the years ended June 30, 2008 and 2007.

Expected contributions under the postretirement medical plan for the fiscal year ended June 30, 2009 are expected to be approximately $121,000. Additional required disclosure on the Fund's postretirement medical plan for the years ended June 30, 2008 and 2007 is as follows:

Benefit obligation at June 30	$2,194,182	$2,194,182
Fair value of plan assets at June 30	–	–
Status – unfunded	$2,194,182	$2,194,182
Actuarial loss	–	–
Accrued benefit cost recognized	$2,194,182	$2,194,182
Net periodic expense	$120,825	$120,480
Employer contribution	$120,825	$120,480

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

	2008	2007
Discount rate	4.80%	5.03%
Health care cost trend rates – Initial	7.3%	7.3%
Health care cost trend rates – Ultimate	7.1%	7.1%

At June 30, 2008, benefits expected to be paid in future years are approximately as follows:

Year ended June 30, 2009	$121,000
Year ended June 30, 2010	$131,000
Year ended June 30, 2011	$148,000
Year ended June 30, 2012	$188,000
Year ended June 30, 2013	$193,000
Five years ended June 30, 2018	$929,090

5. Tax Status

The Fund is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code, but is subject to a 1% or 2% (depending if certain criteria are met) Federal excise tax on net investment income. For the years ended June 30, 2008 and 2007, that excise tax rate was 1% and 2% respectively. The Fund is also subject to Federal and state taxes on unrelated business income. In addition, The Fund records deferred Federal excise taxes, based upon expected excise tax rates, on the unrealized appreciation or depreciation of investments being reported for financial reporting purposes in different periods than for tax purposes.

The Fund is required to make certain minimum distributions in accordance with a formula specified by the Internal Revenue Service. For the year ended June 30, 2008, distributions approximating $16.6 million are required to be made by June 30, 2009 to satisfy the minimum requirements of approximately $37.1 million for the year ended June 30, 2008.

In the Statements of Financial Position, the deferred tax liability of $2,953,974 and $4,275,720 at June 30, 2008 and 2007, respectively, resulted from expected Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2008 and 2007, the tax provision was as follows:

	2008	2007
Excise taxes – current	$869,980	$1,686,925
Excise taxes – deferred	(1,321,746)	934,345
Unrelated business income taxes – current	72,970	129,860
	$(378,796)	$2,751,130

6. Fair Value of Financial Instruments

The estimated fair value amounts have been determined by the Fund, using available market information and appropriate valuation methodologies. However, considerable judgment is necessarily required in interpreting market data to develop the estimates of fair value. Accordingly, the estimates presented herein are not necessarily indicative of the amounts that the Fund could realize in a current market exchange. The use of different market assumptions and/or estimation methodologies may have a material effect on the estimated fair value amounts.

All Financial Instruments Other Than Investments – The carrying amounts of these items are a reasonable estimate of their fair value.

Investments – For marketable securities held as investments, fair value equals quoted market price, if available. If a quoted market price is not available, fair value is estimated using quoted market price for similar securities. For alternative asset limited partnerships held as investments, fair value is estimated using private valuations of the securities or properties held in these partnerships. The carrying amount of these items is a reasonable estimate of their fair value. For futures and foreign exchange forward contracts, the fair value equals the quoted market price.

7. Contributions Received

In fiscal years 1987 and 1988, the Fund received a total of $15,415,804 as a grant from the James Picker Foundation, with an agreement that a designated portion of the Fund's grants be identified as "Picker Program Grants by the Commonwealth Fund." The Fund fulfills this obligation by making Picker Program

Grants devoted to specific themes approved by the Fund's Board of Directors. For the years ended June 30, 2008 and 2007, Picker program grants totaled approximately $1,902,000 and $1,346,000 respectively.

In April 1996, the Fund received The Health Services Improvement Fund, Inc.'s ("HSIF") assets and liabilities, $1,721,016 and $57,198, respectively, resulting in a $1,663,818 increase in net assets. In accordance with the terms of an agreement with HSIF, this contribution enables the Fund to make Commonwealth Fund/HSIF grants to improve health care coverage, access, and quality in the New York City greater metropolitan region.

During the year ended June 30, 2002, the Fund received a bequest of $3,001,124 from the estate of Professor Frances Cooke Macgregor as a contribution to the general endowment, with the amount of annual grants generated by this addition to the endowment to be governed by the Fund's overall annual payout policies. An additional amount of $100,000 was received during the year ended June 30, 2004. This gift was made with the provisions that in at least the five-year period following its receipt, grants made possible by it will be used to address iatrogenic medicine issues, and that grants made possible by the gift be designated "Frances Cooke Macgregor" grants. During the years ended June 30, 2008 and 2007, the Frances Cooke Macgregor grants totaled approximately $299,000 and $314,000, respectively.

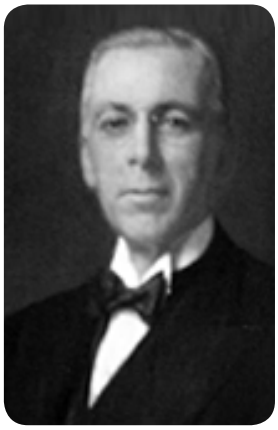
8. Subsequent Event

Since June 30, 2008, the financial markets have continued to experience downward pressure. As of the close of business on October 28, 2008, the Wilshire 5000 U.S. Equities index had declined by 28.6% and the MSCI EAFE index had declined by 23.5%.

The approximate value of the Fund's investments at the close of business on October 28, 2008 was $569,000,000.

* * * * * *

Founders and Benefactors

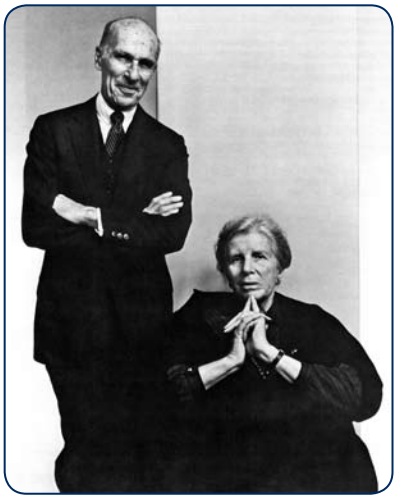


Anna Harkness and Edward Stephen Harkness

The story of The Commonwealth Fund begins with the family of Stephen V. Harkness, an Ohio businessman who began his career as an apprentice harnessmaker at the age of 15. His instinct and vision led him to invest in the early refining of petroleum and to make a further investment at a critical moment in the history of the fledgling Standard Oil Company. After her husband's death in 1888, Anna Harkness, Stephen's wife, moved her family to New York City, where she gave liberally to religious and welfare organizations and to the city's major cultural institutions. In 1918, she made an initial gift of nearly $10 million to establish a philanthropic enterprise with the mandate "to do something for the welfare of mankind," a broad and compelling challenge. Anna Harkness placed the gift in the wise hands of her son Edward Stephen Harkness, who shared her commitment to building a responsive and socially concerned philanthropy. During his 22 years as president of the foundation, Edward Harkness added generously to the Fund's endowment and led a talented and experienced staff to rethink old ways, experiment with fresh ideas, and take chances, a path encouraged by successive generations of leadership.

Jean and Harvey Picker

In 1986, Jean and Harvey Picker joined the $15 million assets of the James Picker Foundation with those of The Commonwealth Fund. James Picker, a prime contributor to the development of the American radiologic profession, had founded the Picker X-ray Corporation, an industry leader in its field. Recognizing the challenges faced by a small foundation, the Pickers chose the Fund as an institution with a common interest in improving health care and a record of effective grantmaking, management, and leadership. The Commonwealth Fund strives to do justice to the philosophy and standards of the Picker family by shaping programs that further the cause of good care and healthy lives for all Americans.



Walter Massey, Ph.D., retired from The Commonwealth Fund Board of Directors in November 2008 after 15 years of distinguished service.

Michael Drake, M.D., chancellor of the University of California, Irvine, since July 2005, joined the Fund's Board of Directors in January 2008.

Glenn Hackbarth, J.D., chair of the Medicare Payment Advisory Commission (MedPAC) and an independent consultant, joined the Fund's Board of Directors in July 2008.

Directors and Staff

Walter E. Massey retired from the Board of Directors of The Commonwealth Fund on November 11, 2008, having provided distinguished service for 15 years. He was a highly valued member of the Board's Governance and Nominating and Audit and Compliance Committees. His career as a physicist, science laboratory and research institute leader, university system executive, and college president made him ideally suited for helping guide the Fund's efforts to improve health care coverage, quality, and efficiency—particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and the elderly.

Dr. Massey's career-long commitment to helping spread the teaching of science throughout society, particularly to disadvantaged and minority young people, enlarged the pool of talent for addressing health care disparities and contributed to the Fund's work both to address disparities and to develop future minority health policy leaders. His devotion to mentoring young people, especially those from disadvantaged backgrounds, and fostering in them the skills and confidence needed to become leaders in science, health policy and practice, and other fields augmented the Fund's historic commitment to helping create the future leaders needed to ensure a high performance health system. In all his interactions with colleagues on the Fund's Board and in other settings, he set the highest standards for integrity, scientific inquiry, focus on mission, clear and strategic thinking, and respect for others. In every respect a model Board member, Dr. Massey will be missed.

Michael V. Drake, M.D., was elected to The Commonwealth Fund Board of Directors on January 18, 2008. Dr. Drake has been chancellor of the University of California, Irvine, since July 2005. Before becoming Irvine's chancellor, Dr. Drake served for five years as vice president for health affairs at the University of California, overseeing education policy and research activities at the university's 15 health sciences schools. In that capacity, he also directed the University of California Special Research Programs in tobacco-related disease, breast cancer, and HIV/AIDS research and was co-chair of the California/Mexico Health Initiative. Earlier, Dr. Drake was Steven P. Shearing Professor of Ophthalmology and senior associate dean for admissions and extramural academic programs at the University of California, San Francisco, School of Medicine. Dr. Drake is a member of the National Academies' Institute of Medicine and the American Academy of Arts and Sciences. He is past national president of the Alpha Omega Alpha Honor Medical Society and past chair of the board of directors of the Association of Academic Health Centers. In 2004, Dr. Drake received the Herbert W. Nickens Award from the Association of American Medical Colleges, recognizing career-long efforts to promote social justice through medical education.

Dr. Drake brings to the Fund's Board deep experience in the challenges that academic health centers face in contributing to the national goal of a high performance health system, and strong commitment and experience in promoting the development of health care leaders from racial and ethnic backgrounds.

He received his A.B. degree from Stanford University and his M.D. degree from the University of California, San Francisco; his post-graduate medical training was at the Martin Luther King Jr. General Hospital in Los Angeles and the Massachusetts Eye & Ear Infirmary, Harvard Medical School.

Glenn Hackbarth, J.D., M.A., chair of the Medicare Payment Advisory Commission (MedPAC) and an independent consultant, was elected to the Commonwealth Fund Board of Directors on July 15, 2008. In addition to serving as MedPAC chair since 2001, Mr. Hackbarth is a member of The Fund's Commission on a High Performance Health System and is widely regarded in health policy circles for his depth of knowledge of the health system and unusual ability to analyze tough issues and help groups reach consensus. Earlier in his career, Mr. Hackbarth was chief executive officer and cofounder of Harvard Vanguard Medical Associates, a nonprofit multi-specialty group practice which serves as a major teaching affiliate of Harvard Medical School. Between 1988 and 1997, he was an executive of the Harvard Community Health Plan, serving as president of the Health Centers Division from 1992 to 1997. He was deputy administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) for the U.S. Department of Health and Human Services from 1986 to 1988. Mr. Hackbarth also serves on the boards of the National Committee for Quality Assurance and the Foundation of the American Board of Internal Medicine. He received his B.A. from Pennsylvania State University and his M.A. and J.D. from Duke University.

With health care reform high on the agenda of the new Administration and U.S. Congress and in many states, the Fund is fortunate to have enlisted Dr. Drake and Mr. Hackbarth in helping guide its work to advance a high performance health system.

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*As of April 2009.

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Sabrina K. H. How, *Senior Research Associate, Commission on a High Performance Health System*
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Michelle G. Ries, *Program Associate, International Program in Health Policy and Practice*
David Squires, *Program Associate for Research, International Program in Health Policy and Practice*
Heather Drake, *Program Assistant, Medicare's Future*
Claire Kiefer, *Program Assistant, Grants Management and Administration, International Program in Health Policy and Practice*
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White & Case, *Counsel*
Owen J. Flanagan and Company, *Auditor*

Grants Approved, 2007-08

Commission on a High Performance Health System

Commission Activities

AcademyHealth
$507,571
Commission on a High Performance Health System: Program Direction
Since July 2006, the Fund's Commission on a High Performance Health System has issued a framework statement laying out the attributes of high performance, released two scorecards on national health system performance and one on state performance, and produced a series of papers on key health system reform issues. The Fund's grants to AcademyHealth pay for basic staff support for important activities of the Commission on a High Performance Health System.

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Alliance for Health Reform
$313,987
Commission on a High Performance Health System: Meetings

This grant enables the Alliance to handle logistics for three annual meetings of the Fund's Commission.

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Alliance for Health Reform
$267,575
Health Policy Seminars and Congressional Staff Retreat, 2008

Alliance for Health Reform briefings are a valuable resource for congressional staff and journalists seeking the latest health policy information and analysis. In the coming year, the Alliance will conduct eight briefings on such topics as: results of the Commission on a High Performance Health System's state scorecard, state policies promoting high performance, achieving and investing savings to improve health system performance, results from the Fund's new quality survey, achieving universal coverage, learning from Medicare's payment demonstration programs, nursing home policy, and international health policy perspectives. The Congressional Staff Retreat, meanwhile, is a unique opportunity for up to 100 senior health staff from both political parties to engage in an informal, off-the-record exchange of ideas.

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Alliance for Health Reform
$360,177
Commonwealth Fund Bipartisan Congressional Retreat, 2008

The Fund's annual Bipartisan Congressional Retreat gives members of Congress the opportunity to learn about timely health policy issues and engage in substantive discussion, while enabling the Fund to reach the most influential audience directly. With the formation of the Commission on a High Performance Health System in 2005, it became possible to link the Commission's policy agenda to the retreat. Sessions at the 2008 retreat included: options for achieving and reinvesting savings; improving value through comparative effectiveness research; insurance coverage expansion proposals and the future role of employer-based coverage;

international quality improvement activities; and expanding patients' access to a medical home.

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The Commonwealth Fund

$70,000
Analytic Work for Developing and Updating the U.S. Health System Scorecard

This authorization will allow the research director of the Commission on a High Performance Health System to develop the third U.S. health system scorecard to assess health outcomes, access, quality, efficiency, and innovation.

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President and Fellows of Harvard College

$125,730
ImproveHealthCare: Promoting Health Systems Literacy

Medical education in the United States does a poor job of addressing larger health system issues that affect every health care professional's ability to deliver care to their patients. ImproveHealthCare seeks to help new physicians become engaged in improving health system performance by hosting patient-centered case discussions and Web-based educational modules focused on health care access, quality, and disparities. It has achieved moderate success so far; continued Fund support will allow for organizational stability and an expanded reach. The proposed project includes assembling content from case studies and filmed lectures to create a formalized curriculum; hosting an annual symposium for medical students; supporting students' health system improvement projects; and organizational development to expand capacity and scale.

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Issues Research, Inc.

$317,167
Maintaining the National and State Scorecards and Developing Content for Newsletters, Publications, and Research Tools, 2008

The Fund seeks to stimulate higher performance within the U.S. health system, in part by educating stakeholders about the nature and scope of performance deficits, the implications for Americans' health and well-being, and promising approaches for addressing problems. The development and production of innovative information resources is important for this ongoing educational process. This project will engage the services of Issues Research, Inc., for a second year to provide research, writing, and advisory services in support of the national and state health system scorecards, the Fund's Quality Matters and States in Action newsletters, case studies, and related Fund publications and online research tools.

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Rutgers, The State University of New Jersey

$284,375
The Commonwealth Fund State Scorecard on Health System Performance, 2009

The State Scorecard released by the Commission on a High Performance Health System in June 2007 was the first-ever multidimensional assessment of state-by-state health system performance. Its findings stimulated much discussion among policymakers about the wide variations in performance that were documented, and about ways to address performance gaps. With this grant, the Rutgers Center for State Health Policy will work with the Fund to prepare the first update of the State Scorecard and improve measurement of health system performance using new indicators and data where available. The new scorecard will also highlight trends in state performance in the previous two years. Findings will be targeted to state and federal policy leaders and health system leaders, who will likely use the information to help set priorities for remedial action.

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Stoiber Health Policy, LLC

180,000

Designing the Policy and Regulatory Infrastructure Needed to Achieve a High Performance Health System

This grant will support the addition of a senior analyst with extensive policy and management experience to the staff of the Commission on a High Performance Health System. Such an individual is needed to study health policy and regulatory infrastructure issues that the Commission would like to see explored. Susanne Stoiber, until recently executive officer of the Institute of Medicine, will conduct research and work closely with selected grantees and staff to help ensure that the Commission's work achieves a high impact.

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Small Grants—Commission Activities

AcademyHealth

$41,000

Netherlands Health Study Tour

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Health Policy Alternatives, Inc.

$36,600

Developing a Public Policy Transition Agenda

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Johns Hopkins University

$50,000

'Holding the Line:' Options for Containing National Health Care Expenditures

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New America Foundation

$45,500

Innovation Dissemination: Communicating Examples of High Performance

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Program on the Future of Health Insurance

AcademyHealth

$265,202
The Future of Health Insurance: Analytic and Program Support

The Program on the Future of Health Insurance analyzes changes in the breadth and comprehensiveness of health coverage for people under age 65, explores the consequences of being uninsured or underinsured, and develops and evaluates strategies for expanding coverage, enhancing its quality, and improving the administrative efficiency of insurance systems. This grant will fund a senior program officer to support the program and expand its influence at a time when reform of the health insurance system is high on the nation's agenda. Expanding the staff of the Program on the Future of Health Insurance—a core component of the Commission on a High Performance Health System—will also help the Commission raise its visibility in the health insurance arena. The responsibilities of the new staff member will include: preparation of policy reports and issue briefs; tracking of emerging coverage, access, and policy issues; and project development, grants management, and oversight of grant-supported publications.

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Center for Studying Health System Change

$188,147
Trends in the Financial Burden of Medical Care Costs and the Effects on People with Chronic Conditions

According to Commonwealth Fund-supported research by Peter Cunningham and colleagues, out-of-pocket health care expenses as a share of income are on the rise among American families, with much of the increase accounted for by people with individual insurance and lower incomes. This trend is especially alarming, as evidence shows that people with high burdens are more likely to avoid needed health care and medications. This project will produce new estimates of out-of-pocket expenditures, which will be incorporated into the Commission on a High Performance Health System's revised National Scorecard. The project will also provide new data on the scope and duration of medical bill problems from 2003-2007, the role of health care providers in assisting patients with their medical costs, and the extent and consequences of high medical cost burdens for people with chronic health conditions.

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Trustees of Columbia University in the City of New York

$188,772
Lessons for Health Insurance Reform: Learning from States and from Health Systems Abroad

Over the next year, Columbia University's Sherry Glied and her colleagues will address the unfolding debate over strategies to expand and improve coverage and control cost growth by examining the experience of industrialized countries that have universal coverage. Since most U.S. health reform proposals rely on a mix of private and public insurance, the research team will examine the experience of those countries that achieve universal coverage with both public and private forms of insurance. In addition, Glied and her team will examine the supply, regulation, and pricing of physician services across major industrialized countries to see what lessons such approaches hold for U.S. policy. Additional work will build on the findings of the Commission on a High Performance Health System's State Scorecard by examining the relationship between state-level changes in coverage and the scorecard's access and quality measures. As in the past, the researchers will provide programming, data, and analytic support for Fund and Commission staff.

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Education & Research Fund of the Employee Benefit Research Institute

$160,256
EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2007

The EBRI/Commonwealth Fund Consumerism in Health Care Survey has garnered a national reputation as an unbiased source of information on high-deductible health insur-

ance plans with health savings accounts—collectively referred to as consumer-driven health plans. The 2007 survey will provide an update on Americans' experiences with consumer-driven health care and explore new issues, including: the extent to which the plans' incentives affect the use of preventive and chronic care services, the availability and use of information about providers and services, and Americans' views of new policy proposals that affect the tax deductibility of other health savings tools.

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President and Fellows of Harvard College

$219,288
Assessing the Long-Term Implications of Uninsured Adults to Medicare, Phase 2

Phase 1 of this project found that after gaining Medicare coverage at age 65, previously uninsured adults reported consistently greater use of health services, improved health, and higher total medical expenditures than previously insured adults. The findings suggest that expanding insurance coverage to older adults may not only improve their health but may also reduce their annual use of health care and medical costs after age 65. In phase 2, the project will examine whether Medicare also reduces racial, ethnic, and socioeconomic disparities in health status, control of chronic health conditions, and mortality. In addition, the research team will assess whether the Medicare program spends more on adults who were uninsured prior to enrolling in Medicare than it does on those who were insured.

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National Opinion Research Center

$228,151
Financial Protection and Value of Individual and Employer-Sponsored Health Insurance: A National Perspective

As the United States considers comprehensive health care reform, a critical challenge facing policymakers is defining what constitutes affordable health coverage. Measuring the affordability of health plans based only on premiums fails to take into account deductible size and covered services, which can dramatically affect a family's overall out-of-pocket costs during the year. This project will document the comparative affordability of small-group, large-group, and individual market insurance plans, taking into account both premiums and out-of-pocket medical expenses. In addition, the researchers will examine the benefit structure of plans available in individual markets in 10 states, and compare the expected out-of-pocket expenses for people enrolled in individual and group plans.

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Small Grants—Program on the Future of Health Insurance

AcademyHealth

$10,000
2008 National Health Policy Forum

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Economic Policy Institute

$44,204
Tracking Transitions: Health Insurance Coverage Across Time

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Education & Research Fund of the Employee Benefit Research Institute

$36,000
2008 Membership and Annual Health Confidence Survey

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Harbage Consulting

$45,000
The 2009 Health Policy Debate: Getting to the Details

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Health Policy R&D

$44,000
Drafting a Report on Proposed Federal Health Care Legislation

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National Opinion Research Center

$50,000
Comparing Financial Protection for a Medicare Benefit Package with Employer-Based Coverage

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Medicare's Future

AcademyHealth

$440,073
Medicare's Future: Support for Program Direction

Medicare has made major changes in the past few years: it has added prescription drug coverage and expanded the role of private insurers by authorizing new types of plans and increasing their payment rates. While enhancing the benefits available under Medicare, these changes also raise questions about the cost-effectiveness of the additional payments and how the most vulnerable beneficiaries will be affected. Medicare also is seeking to encourage quality improvement, foster greater coordination of care, promote the use of preventive services, and increase providers' efficiency. The Fund's Program on Medicare's Future is focused on analyzing these changes and developing information and options for improving Medicare. This grant supports strategic direction for the program and the development of new projects, coordination of ongoing work, and dissemination of findings.

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The George Washington University

$267,511
Medicare Advantage Private Plans: Assessing the Value for Elderly and Disabled Beneficiaries

Under Medicare Advantage, private plans in every U.S. county are paid more than what their enrollees would be expected to cost in traditional fee-for-service Medicare. Questions have been raised about what the Medicare program and its enrollees get for these extra payments, which are estimated to total more than $7 billion in 2007. This project will examine Medicare Advantage policies, including those that produce the extra payments to private plans, to determine what additional benefits, if any, those plans provide and to whom they accrue, and what the implications are for beneficiaries and the future of the Medicare program.

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Kaiser Foundation Research Institute

$334,511

Implications of Benefit Design in Medicare Prescription Drug Plans

There has been considerable controversy surrounding the basic Medicare Part D prescription drug benefit, particularly the use of cost-sharing in private drug plans and its impact on Medicare beneficiaries' costs and clinical outcomes. To date, there has been no scientific analysis of beneficiaries' actual experiences under Part D to assess these impacts. Using 2006 data from both standalone Part D plans and Medicare Advantage plans, this project will examine these issues and produce empirical evidence of the impact of Part D coverage, highlight important areas for further research, and inform efforts to improve the prescription drug benefit.

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Mathematica Policy Research, Inc.

$134,799

Analyzing Gaps in Health Coverage for the Recently Disabled

For Americans who have recently become disabled, gaining access to health insurance coverage, including Medicare, remains an uphill battle. This study will use new data on individuals applying for Social Security Disability Insurance (SSDI) to assess the strengths, limitations, and costs of eliminating Medicare's two-year waiting period. It will also consider possible reforms that could help the disabled obtain affordable coverage and access to care. The project team will analyze coverage, access, health care utilization, and mortality rates among SSDI applicants in the following periods: before they apply for benefits, during the disability determination process, and after the application is allowed or denied. The findings will also focus on the status of SSDI applicants whose applications are denied but are nonetheless unable to work and who frequently fall through the cracks of the health care safety net.

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Mount Sinai School of Medicine

$291,428

How Organization of Care Affects Health Outcomes and Costs for Elderly Patients with Chronic Conditions

Medicare's health delivery and financing system was originally designed to address acute care needs. Today's Medicare beneficiaries, however, are more likely to require care for chronic health conditions—and more likely to receive their care from multiple providers, with little or no coordination among them. This project will examine and compare patterns of care provided to three groups of elderly veterans with selected chronic conditions: those treated exclusively in the Veterans Health Administration (VHA) system, those getting care through both the VHA and Medicare, and those getting care exclusively through Medicare. The results will shed light on how continuity of care, costs, and outcomes in a coordinated care environment like the VHA compare with those in a more fragmented environment like fee-for-service Medicare. The findings will also indicate areas of care that Medicare may wish to target for improvement.

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The Urban Institute

$299,948

Developing and Evaluating Policy Options for Improving Medicare's Performance

Medicare enjoys widespread support, but its effectiveness in protecting the population it serves—particularly those individuals who are most vulnerable—can be improved. This project will examine a range of issues that policymakers might consider over the next few years, including: 1) increasing access to the Medicare Savings Programs, which are intended to provide additional protection against health care costs for low-income beneficiaries; 2) improving the structure of Medicare benefits; 3) expanding health insurance options for people approaching Medicare eligibility; and 4) addressing changes in retiree coverage. Policymakers will be able to use results from these studies to develop new financing options, target spending on beneficiaries who are most in need, and coordinate program policies with changes taking place elsewhere in the health system.

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Small Grants—Medicare's Future

AcademyHealth
$39,960
Reducing Hospital Readmissions
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Center for Health Care Strategies, Inc.
$33,770
Developing a Plan for Facilitating Integrated Care for Dual Eligibles
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Center for Medicare Advocacy, Inc.
$43,633
Medicare Advantage Special Needs Plans: A Beneficiary Perspective
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The George Washington University
$40,466
Medicare Advantage Payments and Enrollment Growth: Implications for the Future
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National Academy of Sciences
$25,000
Learning What Works: Infrastructure Required to Learn What Care is Best
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National Senior Citizens Law Center
$25,000
Forgotten Americans: The Future of Support for Older Low-Income Adults
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University of Maryland, Baltimore
$12,250
Coordinating Care Between State Medicaid Programs and Medicare Special Needs Plans Serving Dual Eligibles
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University of Maryland, Baltimore
$49,931
Assessing Potential Medicare Savings from Increased Use of Medications for Secondary Prevention in Beneficiaries with Complex Chronic Disease: A Pilot Study
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University of Texas at Austin
$26,139
LBJ Centennial Medicare Conference: Looking Back and Looking Forward

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Health Care Quality Improvement and Efficiency

Trustees of Boston University
$348,441
Examining Quality, Efficiency, and Patients' Experiences in U.S. Hospitals, Phase 2

In 2006, Boston University researchers, working under a Fund grant, surveyed hospital chief quality officers and front-line clinicians to assess quality improvement activities and perceptions of quality. In the second phase of the project, the project team will examine the relationship of this rich data-set to measures of cost, patient readmissions, mortality, and patient experience. In addition to quantitative analysis, the project team will conduct case studies of eight hospitals to determine in greater detail the characteristics that allow hospitals to perform well across multiple domains of quality and efficiency. This research will then be translated into practical guides to assist hospitals in their own performance improvement efforts.

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Regents of the University of California
$298,432
Assessing the Impact of Personal Health Records on Underserved Patients with Chronic Illness

Electronic medical records have been shown to help providers deliver better, safer care to patients. Electronic personal health records (PHRs) offer additional benefits: by providing patients with direct access to their personal medical information and the ability to input their own notes, they engage patients in managing their condition. Focusing on a large HIV/AIDS outpatient clinic at San Francisco General Hospital, a safety net facility that already has an established electronic medical record system, this project will evaluate the usefulness of PHRs accessed through the 'convergent technologies' of broadband Internet, cellular technology, and telemedicine. The investigative team will assess the impact PHRs have on patients' adherence to treatment guidelines, disease progression, clinical outcomes, and use of health services. The findings will help providers and policymakers understand how PHRs can help these patients manage their chronic illness.

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Regents of the University of California
$298,806
Using Electronic Health Records for Quality Improvement in Community Health Centers
Frances Cooke Macgregor Grant

Community health centers (CHCs), like other health care providers, may benefit from the implementation of electronic health record (EHR) systems. Because EHR systems are likely to produce only limited financial benefits to CHCs, spending scarce resources on an EHR system can only be justified if it leads to rapid, significant improvement in health care quality. This project seeks to understand the factors that can facilitate rapid quality improvement through EHR adoption. The investigators will study five CHC networks that provide EHR services as well as 15 affiliated CHCs that are using EHRs. Not only will the study findings help CHCs seeking to implement EHR systems, but the results will also inform policymakers in allocating grant funds to health centers to assist with EHR adoption.

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Regents of the University of California
$250,801
Understanding Why Some Physician Organizations Excel at Chronic Disease Management

The Fund previously supported a national study of large physician organizations to learn about their implementation and use of preventive services and care management processes for chronic illnesses. The findings showed that adoption rates for such tools and services as disease registries and patient reminders are low, but that external incentive programs and information technology are associated with higher use. The next step is to determine how medical groups that have implemented care management processes were able to do so. Researchers will visit 12 physician organizations, varying in type and level of performance, to determine the factors that help and hinder implementation. The dissemination of these findings will help providers improve the care they deliver to patients with chronic illness and help payers and policymakers create an environment that fosters quality improvement.

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Center for Studying Health System Change
$175,371
The Role of Information Technology in Facilitating Care Coordination

The U.S. health system generally does a poor job of ensuring that patient care is properly coordinated. Health information technology, particularly electronic medical records (EMRs), may enable providers to coordinate care better by improving the flow of information among a patient's various health care providers and sites of care. Still, not much research has been done to examine providers' use of EMR systems to improve care coordination. To learn how EMRs are being used to coordinate care, how they might be enhanced to facilitate coordination, and what else is required for proper care coordination, the project team will conduct interviews with physician practices that are using EMRs, with EMR vendors, and with health care experts. The findings will help providers and policymakers optimize EMRs for care coordination.

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President and Fellows of Harvard College
$284,079
Analyzing the Interrelationship of Patient Experience, Quality and Cost of Hospital Care, Phase 3

Since April 2005, the Hospital Quality Alliance (HQA), a public-private collaboration to improve the quality of care provided by the nation's hospitals, has been publicly reporting information on the quality of hospital care. The project team, under two prior Fund grants, demonstrated a large variation in quality across hospitals and medical conditions, an inverse relationship between performance on HQA measures and risk-adjusted mortality, and potential tradeoffs between quality and costs. In this third project, the team will incorporate an analysis of new patient experience measures added to the HQA database in spring 2008. The investigators will study performance on these new measures, analyze the relationship with measures of quality and cost, examine if and how measures of care coordination are associated with hospital readmissions, and describe changes in hospital performance since the HQA was launched.

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President and Fellows of Harvard College
$166,788
Evaluating the Impact of a Novel Pay-for-Performance Program in a Medicaid Managed Care Plan

The mixed results that pay-for-performance programs have produced so far signal the need for better payment incentive designs. Hudson Health Plan, a Medicaid managed care plan in New York State, has implemented a novel design that matches rewards not with the care provided to a population of patients, but rather with the care provided to each individual patient. To improve childhood immunization rates, the plan gives providers a fixed-dollar bonus for each child receiving timely immunizations. For this project, the investigators will evaluate the program's effectiveness in improving overall quality of care by examining plan data from 2002 to 2007 and by surveying providers. The project team will also determine if the incentive program has had any impact on

racial/ethnic disparities in immunization rates, and on the safety net providers who care for minority patients.

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Health Management Associates, Inc.

$351,421
Case Studies of Innovation and High Performance

Under the revised Five-Year Program Plan Budget approved by the Executive and Finance Committee, the Fund will develop a Web site, www.whynotthebest.org, to enable health care organizations to compare their performance with established benchmarks and to aid them in improving that performance. This effort will be strengthened with the development and dissemination of case studies of high performance and innovation. Toward that end, project staff will produce 84 case studies of high-performing, innovative providers, including hospitals, physician practices, nursing homes, delivery systems, public-private collaboratives, and state or local innovations.

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Institute for Healthcare Improvement

$499,816
Reducing Rehospitalizations, Phase I

Hospitalizations consume nearly one-third of the $2 trillion spent on health care in the United States. At the same time, there is ample evidence that many hospitalizations—especially rehospitalizations—are preventable through a variety of means, from comprehensive hospital discharge planning and post-discharge support, to multidisciplinary disease management, patient education, and enhanced support in the home. This project is the first phase of a planned five-year demonstration project to reduce preventable rehospitalizations in three to five states or regions. In phase 1, the project team will: 1) identify and develop processes, protocols, and other tools to assist statewide initiatives in reducing rehospitalizations; 2) select the states or regions that will participate in the demonstration; and 3) map out a strategy for implementation.

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University of Iowa

$458,939
Improving Hospital Quality Through Leadership Assessment and Intervention

Hospital leadership—including governing boards, chief executive officers, and senior management—can have strong influence on organizational performance. Soon, hospitals will have a new validated instrument to formally assess the effectiveness of their leadership in improving quality of care—the Hospital Leadership and Quality Assessment Tool. This project will use the new tool to collect baseline information on hospital leadership performance, and then work with the Medicare Quality Improvement Organizations (QIOs) to develop and implement a technical assistance protocol for improving leadership at low-performing hospitals. An evaluation will determine whether hospitals implementing the protocol improved their performance on the leadership assessment as well as on quality-of-care measures. The QIOs will help disseminate the assessment tool and implement the intervention protocol to hospitals nationwide.

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National Committee for Quality Assurance

$499,998
Pursuing Efficiency: Assessing Health Plan Characteristics and Practices That Affect Performance

Although the National Committee for Quality Assurance (NCQA) has been measuring health plan quality for more than a decade, consistent measures of cost have only recently been developed. In 2006, NCQA introduced new measures of health care resource utilization for six chronic conditions treated in various care settings. This project will look at more than 500 health plans to examine the relationship between the new cost measures and quality of care, as well as patients' experiences. The investigators will identify the factors associ-

ated with high performance, using existing data sources as well as new survey data on plan characteristics and operational processes. In addition, the project team will conduct case studies of five plans to explore additional factors that may contribute to high performance.

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Yale University

$260,793
Identifying Strategies for Diffusion of Improvements in Hospital Care for Heart Attack Patients

Although hospitals have been collaborating on efforts to encourage the widespread adoption of best clinical practices, it is not clear what the most successful methods are for doing so. For this project, researchers at Yale University will study a national program sponsored by the American College of Cardiology to reduce the time it takes for patients who have suffered certain types of heart attack to get the life-saving intervention of balloon angioplasty. Drawing from survey data and case studies, the project team will examine how the program diffuses improvements in clinical process and which hospital characteristics facilitate adoption of these improvements. One of the project's key products will be a blueprint detailing the best ways to spread quality improvement interventions throughout the nation's hospitals.

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Small Grants—Health Care Quality Improvement and Efficiency

University of Alabama at Birmingham

$22,000
Improving the Evidence Base for Invasive Therapeutic Procedures: Background Information

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American Medical Informatics Association

$50,000
Clinical Decision Support Systems in Electronic Health Records

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Brandeis University

$39,467
Examining Cardiac Surgery Efficiency Using Data Envelopment Analysis

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Center for Studying Health System Change

$49,869
Use of Retail Health Clinics: A Household Survey Analysis

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Health Tech Strategies, LLC
$12,500
Capitol Hill 'Steering Committee on Telehealth and Healthcare Informatics' Series

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The Hastings Center, Inc.
$24,988
Examining Policy Options for Ensuring the Ethical Conduct of Health Care Quality Improvement Activities

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The Urban Institute
$49,954
Organizational Models for Birth Care: A Cross-Case Analysis

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Yale University
$35,000
Spill Over Effects of Quality Collaborative Efforts

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Patient-Centered Primary Care Initiative

American College of Physicians
$224,995
What Does a Patient-Centered Medical Home Cost?

There is considerable enthusiasm among physicians and payers for the patient-centered medical home (PCMH) as a model of primary care that can provide better quality of care, improve the patient experience, prevent avoidable emergency room use and hospitalizations, and reduce total costs of care. But little is known about how much it costs physician practices to implement and sustain components of the medical home. This project will define incremental costs and payment options associated with the implementation and operation of a PCMH. With this information, physicians, insurers, and policymakers will be in a better position to make key decisions with regard to implementing the medical home model, compensating providers for their comprehensive services, and recognizing and promoting the PCMH as the new standard of primary care.

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Center for Health Policy Development
$150,157
Advancing Patient-Centered Medical Homes in Medicaid Programs

One of the most successful instances of the patient-centered medical home (PCMH) in practice comes from North Carolina's Medicaid program, which has achieved improved quality and considerable cost savings since it implemented its PCMH initiative. In recent months, several states have considered or passed new legislation or regulations to promote the PCMH in publicly funded programs like Medicaid and the State Children's Health Insurance Program. To encourage further adoption of the PCMH model and to assist states with implementation, the National Academy for State Health Policy will work collaboratively with state Medicaid officials to: 1) inform state policymakers, through webcasts and policy briefs, of the benefits of PCMHs and strategies for promoting their adoption; 2) develop financing and policy options for implementing the PCMH model in publicly funded programs; and 3) support and track states' implementation efforts by convening a meeting with state officials and providing technical assistance as needed.

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University of Connecticut

$458,987
Evaluating a Medical Home Demonstration in Two Health Plans

A patient-centered medical home provides coordinated care and enhanced access to physicians (e.g., by phone or e-mail, or after regular hours), makes use of clinical decision support tools and health information technology, engages patients in their care, and undertakes performance measurement and quality improvement activities. Two large health plans in New York are conducting a demonstration to promote medical homes by helping physician practices redesign their offices and revising the way they are reimbursed for patient services. The project team will evaluate this demonstration to determine if it is feasible to transform practices into medical homes and to assess the impact such a change has on quality of care, patients' care experiences, and the total costs of care.

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International Communications Research, Inc.

$300,000
Evaluating Medical Homes in New Orleans: A Survey of Patients, Phase 1

More than two years after the devastation of Hurricane Katrina, many New Orleans residents are uninsured, in poor health, and without a regular source of care. To stabilize and strengthen primary care in the New Orleans area, the federal government awarded Louisiana a $100 million grant for the restoration and transformation of neighborhood primary care clinics into medical homes. This project will survey clinic patients and neighborhood residents about the accessibility and coordination of care to help determine whether this investment is increasing access and improving quality. The results will be compared with those of the Kaiser Family Foundation's population survey of New Orleans, as well as findings from a future Fund-supported survey of clinic directors that will seek information about the development of medical homes at the clinic and community level.

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President and Fellows of Harvard College

$491,640
Building Patient-Centered Medical Homes: An Evaluation of a Multipayer Demonstration in Rhode Island

While certain components of the medical home model have been shown to improve health care and reduce costs, few evaluations have been done to demonstrate the benefits of the model overall—and none have involved the majority of the payers in a given state. This project will evaluate the impact of a public-private, multipayer medical home demonstration in Rhode Island, under which public and private health plans serving the majority of the state's insured population have agreed to support core services of the patient-centered medical home. Five large physician practices will receive assistance in providing this enhanced care, as well as a monthly supplemental case rate payment per patient. The project team will determine whether the Rhode Island model is effective in transforming these practices into medical homes, and whether it improves the quality of care, patients' care experiences, and total costs.

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National Committee for Quality Assurance

$296,847
Expanding Measurement Approaches for Evaluating the Patient-Centered Medical Home, Phase 2

The nation's four primary care specialty societies have issued a joint statement describing the principles of a patient-centered medical home (PCMH). With Fund support, the National Committee for Quality Assurance worked with the professional societies to translate those principles into practical criteria that payers can use to certify physician practices as PCMHs—for example, a practice must have

written standards for patient access and communication, follow evidence-based guidelines, and have a referral tracking system. In phase 2, project staff will: 1) disseminate the measures nationally and advise organizations on their use; 2) further develop and test measures related to the quality of patient-physician communication, family and community involvement in care, and care coordination; and 3) analyze the relationship between the systems used in PCMHs and care efficiency-information needed to reform payment for primary care services.

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Qualis Health

$699,997
Transforming Safety-Net Clinics into Patient-Centered Medical Homes, Phase 1

The patient-centered medical home is a model of primary care in which patients receive well-coordinated services and enhanced access to a clinical team, and clinicians use decision support tools, measure their performance, and conduct quality improvement activities to meet patients' needs. The model holds promise not only for improving clinical quality and patients' experiences, but also for reducing health system costs. Fund research demonstrates, moreover, that most racial disparities in health care vanish when patients have a medical home. The Commonwealth Fund is launching a new, five-year demonstration to help 50 safety-net primary care clinics become patient-centered medical homes that achieve benchmark levels of quality, efficiency, and patient experience. In the initiative's first year, project staff will develop the curriculum for improvement, engage national stakeholders, develop a request for proposals, and select the regions and clinics that will participate.

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Small Grants—Patient-Centered Primary Care Initiative

International Society for Quality in Health Care, Inc.

$6,300
International Society for Quality in Health Care (ISQua) 2007 Conference: Commonwealth Fund Sessions

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Louisiana Public Health Institute

$46,750
Strategic Planning Grant to Assist New Orleans with Implementation of Medical Home System of Care

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Society of General Internal Medicine

$25,000
Establishing a Policy Relevant Research Agenda for the Patient-Centered Medical Home: A Multi-Disciplinary Approach

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The Urban Institute

$49,952
Analysis and Dissemination of Results from Community Care of North Carolina

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State Innovations

AcademyHealth

$302,088
State Innovations: Support for Program Direction

Guided by the attributes of effective performance identified by the Commission on a High Performance Health System, the Fund's State Innovations program aims to improve the performance of the health care system by stimulating, supporting, and spreading innovative initiatives at the state level. This grant will provide strategic direction for the program, develop new projects, coordinate ongoing work, and direct efforts to disseminate findings to policymakers and the public. The program director also will participate in the critical review of grantee reports and other Commission-related papers submitted for Fund publication, prepare issue briefs and other materials, represent the Fund in public forums, and contribute more generally to the activities of the Commission.

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AcademyHealth

$444,246
The State Quality Institute: Advancing Health Care Quality Improvement Through Technical Assistance

While some states have implemented programs in recent years to improve the quality of care and overall health system performance, many find themselves under-resourced and ill-equipped to address these issues on their own. Building on findings from the Commission on a High Performance Health System's State Scorecard, the proposed State Quality Institute will assist eight state teams in developing and implementing sustainable quality improvement action plans centered around value-based purchasing, quality reporting, care coordination, or chronic care management. The Institute will enable state teams to consult in person with experts in each of these areas and receive additional technical assistance through site visits, Web-based conferences, and other means. State teams will share their experiences with one another and report on their progress. AcademyHealth will disseminate results to state health policymakers through reports and issue briefs.

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Center for Health Care Strategies, Inc.

$199,429
The Business Case for Quality, Phase 2

In the first phase, the investigators worked with 10 Medicaid managed care organizations to launch quality improvement interventions and determine whether the investment could generate net financial savings. Initial findings indicate that the strongest potential for a short-term return on investment lies in those interventions that focus on patients who use the most services and on conditions that account for a high share of hospital claims. For this next phase, five state-based teams will be chosen to design and implement larger-scale, evidence-based quality improvement initiatives that target high-cost, high-risk patients (asthma or congestive heart failure) and would be applicable to commercially insured populations. The results will aid policymakers in developing reforms that align financial incentives with high-quality care across multiple stakeholders.

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Center for Health Policy Development

$208,425
State Partnerships to Improve Quality: Understanding Critical Factors in Their Success

According to the State Scorecard released by the Commission on a High Performance Health System, the quality of health care varies widely across the United States—with significant room for improvement in every state. Several of the top-performing states have formed interagency quality partnerships, many involving the private sector. Understanding how these partnerships work could offer insights for other states. This project will: 1) analyze the key components, policies, and practices that contribute to the formation and success of quality improvement structures; and 2) disseminate this information nationally to assist other states seeking to form quality improvement partnerships, as well as to provide a way for leading states to learn from each other as they refine and

advance their efforts. Project staff will convene leading states for a 'quality summit,' maintain a listserv of interested state officials, and lead a session at the National Academy for State Health Policy's annual meeting.

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Health Management Associates, Inc.

$109,680
States in Action Newsletter: Six Issues for 2008-09

To help stretch their limited health care dollars, states have developed a broad range of innovative strategies to improve health system performance. Among them are collaborations between public and private stakeholders to improve quality, programs that reward providers for quality and efficiency, and efforts to improve access to affordable insurance coverage and health services. The Fund's e-newsletter, *States in Action: A Bimonthly Look at Innovations in Health Policy*, has been tracking noteworthy state efforts since 2005. An editorial advisory board, formed in November 2007, informs the selection of innovations and reviews each issue. With a circulation surpassing 10,000 subscribers, *States in Action* is a valuable tool for updating local, state, and federal policymakers, researchers, program administrators, and grantmakers on activities and promising initiatives across the nation.

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The Urban Institute

$145,717
Monitoring the Impact of Health Care Reform in Massachusetts, Phase 2

This study will evaluate the impact of Massachusetts's recently enacted health care reform legislation. With Fund support, a survey was completed last year, before the reform was initiated, to collect baseline information on coverage, health care access, utilization of services, and out-of-pocket costs. Of particular note, the 18-to-25 age group is estimated to account for approximately 42 percent of the uninsured in Massachusetts—a finding that supports the state's targeting of young adults. In phase 2, the project team will collect data through a follow-up survey to assess the reform's first-year impact on insurance status, access to and use of health services, and out-of-pocket spending, particularly among the uninsured and individuals with low and moderate income. Additional survey questions will address areas related to the new coverage programs and health insurance purchasing mechanisms available under the law. A subsequent follow-up survey in 2008 will gather similar information to support a pre/post analysis.

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Small Grants—State Innovations

AcademyHealth

$25,000
Support for the State Health Research and Policy Interest Group Meetings

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AcademyHealth

$25,833
Enhancing and Expanding the State Quality Improvement Institute

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California State University

$50,000
Health Coverage Expansion Efforts in Critical States: Issue of Policy, Politics, and Governance

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Massachusetts Health Data Consortium, Inc.
$18,025
Support for State Travel and Meeting Summary Report at National All-Payer Claims Database Conference

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National Conference of State Legislatures
$49,985
NCSL Health Reform Seminar for Legislators and Legislative Staff

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Tides Center
$40,000
Assessing Equity Elements of Selected State Health Law and Proposed Legislation

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Special Populations

Health Care Disparities

Brandeis University
$317,285
High-Performing Community Health Centers: What It Takes

Federally funded community health centers (CHCs) are an integral part of the health care safety net for disadvantaged communities. Not much is known, however, about how costs and quality vary among CHCs, or how the performance and fiscal health of these vital facilities could be strengthened. For this project, researchers will determine the extent to which health centers in three states with large low-income, minority populations (California, Massachusetts, and Texas) provide cost-effective care, identify health centers that provide high-quality care at reasonable cost, and pinpoint the factors that contribute to the success of high-performing CHCs.

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Regents of the University of California
$129,248
Examining the Link Between Diabetes Outcomes and Patient Experiences Within Vulnerable Populations

With Fund support, a survey instrument developed to capture the care experiences of minority and low-income patients—the Patient Assessments of Cultural Competency (PACC)—is currently undergoing testing with a sample of health plan enrollees. This project will expand the scope of an already funded study of diabetes patients at large safety net hospitals in San Francisco and Chicago to test the validity of PACC with a more socioeconomically diverse population of both insured and uninsured patients. The investigators aim to determine how these patients' diabetes outcomes are affected by care experiences, and what the risk factors are for having substandard experiences.

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Harris Interactive, Inc.
$315,072
Assessing Community Health Centers' Capacity to Serve as Medical Homes

Federally qualified health centers (FQHCs) are important providers of care to low-income, uninsured, and minority patient populations. The Fund's 2006 Health Care Quality Survey found that Americans face challenges in accessing high-quality, patient-centered care, and that obstacles are particularly problematic for patients at these centers. A follow-up national survey of CEOs at 1,078 FQHCs in 2009 will examine the extent to which their organizations possess the systems and capacity needed to achieve high performance. Specifically, the survey will focus on medical home structures, engagement in quality improvement activities, and workforce capacity. To investigate the association between clinical performance and organizational measures of high performance,

the survey data will be linked to the Uniform Data System used by the Bureau of Primary Health Care.

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The Joint Commission

$347,450
Developing Hospital Standards to Advance Culturally Competent Patient-Centered Care

Findings from a major Joint Commission study indicate that hospitals need more robust guidance and incentives for adopting practices that promote culturally competent, patient-centered care. Building on this work, the Joint Commission will develop accreditation standards to promote, facilitate, and incentivize the provision of culturally competent, patient-centered care in health care organizations. Project staff will produce a standards implementation guide and an article for publication in the Joint Commission's official newsletter to introduce the new standards to the field and provide information about the implementation timeframe.

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National Public Health and Hospital Institute

$271,060
Safety Net Hospitals and Emergency Department Throughput: Best Practices from High Performers

Public hospitals in the United States receive nearly three times as many emergency department (ED) visits as private hospitals. One of the most serious problems facing these safety net hospitals is ED throughput—how efficiently patients can be seen, cared for, and discharged. A team from the National Public Health and Hospital Institute proposes to identify public hospitals that have made great strides in easing ED overcrowding and facilitating patient flow. After analyzing the strategies used by five high performers, project staff will develop an educational program for 15 hospitals that are struggling with ED throughput. Working collaboratively, these facilities will then develop initiatives to increase their efficiency and their ability to provide high-quality emergency care.

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National Quality Forum

$199,959
National Voluntary Consensus Standards for Culturally Competent Care

An important contributor to racial and ethnic health disparities is a lack of care that is 'culturally competent'—care that is responsive to the needs and preferences of underserved minority populations. Promoting cultural competency as a key ingredient of health care quality requires consensus on standards for measuring and reporting the quality of culturally competent care. From this consensus, experts can recommend preferred practices and develop performance measures. This project will produce a nationally endorsed set of voluntary consensus standards for measuring and reporting the quality of culturally competent care. At the end of phase 1, the project team expects to achieve an endorsement of critical competencies. If this expectation is met, the Fund would consider support for a second phase of work to develop performance measures based on this framework. The team will also identify areas of cultural competency requiring additional research or development.

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Small Grants—Health Care Disparities

AcademyHealth

$5,000
2008 Annual Research Meeting: Disparities Interest Group Meeting

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Child Trends, Inc
$50,000
Analytical Support for Staff in the Program for Quality of Care for Underserved Populations

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Drexel University
$25,000
The Sixth National Conference on Quality Health Care for Culturally Diverse Populations

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The George Washington University
$48,650
High Performing Safety Net Hospitals: Models for Improvement

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Fellowship in Minority Health Care

President and Fellows of Harvard College
$900,000
The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: Support for Program Direction and Fellowships, 2008-09

Addressing pervasive racial and ethnic disparities in health and health care requires trained, dedicated physicians who can lead efforts to improve minority Americans' access to quality medical services. The Fellowship in Minority Health Policy has played an important role in addressing these needs. During the year-long program, physicians undertake intensive study in health policy, public health, and management, all with an emphasis on minority health issues, at Harvard University. Fellows also participate in special program activities. Since 1996, a total of 73 fellows (including 14 supported by the California Endowment and three supported by Delta Dental) have successfully completed the program and received a master's degree in public health or public administration. In the coming year, program staff will select a 13th group of four fellows, provide current fellows with an enriched course of study and career development, and conduct ongoing evaluation activities.

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Child Development and Preventive Care

Ambulatory Pediatric Association
$141,518
Young Investigator Awards for Research in Child Development and Preventive Care

Improvement in the quality of child development and preventive care has been hindered by the small number of investigators working in the field and the consequent dearth of research. The Ambulatory Pediatric Association (APA), which has experience with supporting and mentoring young investigators, proposes to create a cadre of researchers dedicated to improving developmental services. The APA will recruit and, in collaboration with the Fund, select six young investigators for an award program. Those chosen will receive mentoring, networking opportunities, and a forum to present their research and receive feedback. Providing such strategic support early in academic careers could yield useful research in the short term, while influencing the focus of work over the long term.

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Boston Medical Center Corporation

$149,385

Communicating with Parents About Developmental Screening in Primary Care

One of the obstacles to the adoption of structured developmental screening by pediatric practices is the difficulty physicians have in communicating screening results to parents and in referring families to appropriate intervention services. This project will develop, evaluate, and disseminate communication guidelines for pediatricians, including specific language and key messages. Such guidelines would provide doctors with the comfort and confidence needed to discuss screening results, and their implications, with parents. By reducing physicians' apprehension regarding the use of structured screening, rates for early detection and intervention should increase and, ultimately, long-term outcomes for children with developmental delays should improve.

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Center for Health Policy Development

$176,333

Improving Early Childhood Health and Developmental Services Through EPSDT Policy

The quality of each state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program rests heavily on the decisions made by the program's coordinator, an administrator within the state Medicaid program. EPSDT coordinators rarely share experiences and approaches to their work. Providing these coordinators with the opportunity to learn about children's health and developmental needs, best clinical practices, and innovative policies could significantly improve the quality of children's preventive and developmental services. Through a series of facilitated teleconferences, this project will provide coordinators with the means to communicate and collaborate with one another in order to make the EPSDT program more effective in promoting children's health and development.

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Center for Health Policy Development

$220,414

Planning for ABCD III: Building State Capacity for Care Coordination

The previous Assuring Better Child Health and Development (ABCD) initiatives have helped 25 states launch projects to promote structured developmental screening through policy and practice change. As practitioners step up their identification of young children with developmental concerns, however, they are presented with a new challenge: effectively referring families to appropriate intervention services and coordinating their care with other developmental service providers. This complex problem, which requires cross-agency and public-private collaboration within each state, is the proposed focus for the next ABCD initiative led by the National Academy for State Health Policy (NASHP). The project team will begin background work by surveying states' care coordination policies and practices, fostering dialogue across states, and undertaking planning efforts. Concurrently, NASHP will continue to support states' efforts to sustain their achievements in expanding developmental screening.

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University of Chicago

$99,995

Cost-Benefit Analyses of Early Childhood Health Care Interventions

Early life experiences are believed to be a strong influence on the trajectory of children's personal development and health. This argues for investment in services for young children. But the social and economic consequences of early health and health care experiences remain relatively unexplored, and evidence is not readily available. Drawing from evaluations of multiple child health interventions conducted over the years, this project will fill that gap by analyzing the early origins and lifetime consequences of disparities in health across socioeconomic groups, with an eye toward prevention and remediation.

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Connecticut Children's Medical Center

$340,709

National Dissemination of Comprehensive, Coordinated Systems of Early Identification and Referral of Children at Risk for Developmental or Behavioral Problems, Phase 2

Obtaining appropriate services for children identified with or at risk for developmental problems is often quite difficult. Connecticut's solution has been to provide care coordination through Help Me Grow, a live toll-free telephone service that utilizes a statewide database of community services. As a result of the program's success, many other states and communities, as well as some national organizations, have a keen interest in replicating it. Although a toolkit on the Fund's Web site has helped others to begin the replication process, further progress will require hands-on technical assistance. This project will allow Help Me Grow staff to help at least five jurisdictions create similar centralized care coordination systems for child development services and to create and revise resources for a national audience.

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The George Washington University

$137,550

A Policy Leadership Forum in Early Childhood Health and Development

The debate over reauthorization of the State Children's Health Insurance Program has focused rare national attention on policy related to children's access to health care and the quality of services they receive. For this project, experts in child health policy will convene key congressional and federal executive branch staff on a regular basis to learn about children's needs for early preventive and developmental services and to discuss how policy improvements could better address those needs. The off-the-record meetings, which will take place six to eight times a year, will help equip staff to recommend and design policy and program reforms, now and in the future, that will promote child health and development.

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Illinois Chapter of American Academy of Pediatrics

$312,438

Overcoming Barriers to Referral and Care Coordination for Children Eligible for Early Intervention Services

Screening young children for developmental delay is of limited value when families lack ready access to early intervention services. When such services are available, information about them must be incorporated into the child's care plan if they are to be of any use. In many communities, this collaboration between child health care practices and early intervention programs is missing. The Illinois Chapter of the American Academy of Pediatrics proposes to identify barriers on both sides of the referral process that contribute to poor care coordination for children with developmental problems. Drawing from its findings, the project team will develop and test an approach for overcoming these obstacles. To prepare for statewide and, later, national dissemination of the tested approach, staff also will design training modules and a variety of educational materials.

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Kaiser Foundation Health Plan of Colorado

$179,679

Implementing and Evaluating a High-Performing System of Well-Child Care in a Large HMO, Phase 3

Fund-supported researchers previously identified feasible changes in pediatric practice that could improve the provision of well-child care, including the adoption of 'electronic visits' and the introduction of tiered care, whereby visits are individualized based on identified risks and families' service needs. Leadership at Kaiser Permanente of Colorado and Denver Community Health Services, which serves a lower-income population, have tested and will soon begin implementing these changes in their respective systems. This grant will support an evaluation of their implementation programs and will help disseminate findings to other health care organizations.

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National Committee for Quality Assurance

$204,088

The Quality of Child Health Care: Expanding the Scope and Flexibility of Measurement Approaches

The Commonwealth Fund has supported a number of projects to develop and test measures of the quality of developmental services in primary care settings. Much more work needs to be done, however, to ensure the implementation and use of these measures by payers and national organizations. A significant barrier to widespread adoption of such measures is their use of nonadministrative data sources, and the perceived difficulty and cost associated with them. Under this grant, the National Committee for Quality Assurance (NCQA) will explore options for overcoming barriers to the use of these more robust measures. The NCQA team will assess new strategies for making nonadministrative data collection feasible and flexible for states and commercial payers. This work will pave the way for states and other payers to recognize or reward providers that deliver high-quality developmental services.

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National Conference of State Legislatures

$140,062

Educating State Legislators About Child Development

State legislators can be instrumental in promoting the healthy development of young children. Yet most are relatively uninformed about child development and opportunities to improve the content of health insurance coverage through legislated policy changes. This project will seek to educate state legislators about the importance of early prevention and developmental services and about the policy options available to them for promoting the health and development of young children in their state. Project staff will prepare educational materials, develop policy options, and convene a group of influential legislators to assist them and their colleagues in taking effective action.

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Pennsylvania Health Law Project

$201,661

Spreading and Sustaining Developmental Screening in Pennsylvania

With support from the William Penn Foundation, the Pennsylvania Health Law Project (PHLP), a nationally recognized advocate for child health policy reform, is helping to promote the use of developmental screening by Philadelphia-area pediatric practices. PHLP's efforts closely resemble those of states currently participating in the Fund's ABCD Screening Academy. The Fund will now engage the PHLP team to help advance wider adoption of structured developmental screening in Pennsylvania and beyond. Project staff will: work with six diverse child health care practices throughout the state to expand their use of screening tools; design a comprehensive curricular training package for national dissemination; and develop a set of recommendations to overcome administrative, budgetary, and policy-related barriers to statewide adoption of screening.

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Small Grants—Child Development and Preventive Care

American Academy of Pediatrics, Inc.

$22,243

Promoting the Open Forum Concept: Grants to AAP Chapters

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Arizona State University
$27,243
Assessing Lessons Learned: Implementing a New Curriculum for Pediatric Nurse Practitioners

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Center for Health Policy Development
$36,306
Enhancing and Expanding the ABCD Screening Academy

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Child and Family Policy Center
$25,200
Beyond SCHIP Reauthorization: State and Federal Advocacy to Ensure Children's Healthy Development

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Child Health and Development Institute of Connecticut, Inc.
$25,000
Design and Development of a Comprehensive Child Health Services Component of Connecticut's Early Childhood Plan

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Connecticut Children's Medical Center
$49,210
Developing Care Coordination as a Critical Component of a High Performance Pediatric Health Care System

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Grantmakers for Children, Youth, and Families, Inc.
$4,000
Pre-Meeting Institute on Partnerships to Promote Children's Healthy Development: GYCF Annual Meeting

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Health Management Associates, Inc.
$50,000
A Study of State Medicaid Programs' Efforts to Improve Quality of Child Health Care

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Keene Mill Consulting, LLC
$8,000
Successful Community Integration of Early Child Health and Development

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National Initiative for Children's Healthcare Quality
$7,500
7th Annual Forum for Improving Children's Healthcare Quality

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Oregon Health & Science University
$19,133
Enhanced Technical Assistance to the ABCD Screening Academy States to Improve Measurement and Evaluation

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SG Associates Consulting, LLC
$25,430
Experience with Co-Locating Services to Improve Primary Care Access and Care Coordination

Susanna Ginsburg
President
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Society for Developmental and Behavioral Pediatrics
$15,000
Workshop on Training Residents in Developmental-Behavioral Pediatrics

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Professor and Vice-Chair of Pediatrics
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Tufts-New England Medical Center
$22,940
Commonwealth Instrument for Child Screening and Surveillance

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Picker/Commonwealth Program on Quality of Care for Frail Elders

AcademyHealth
$185,693
The Commonwealth Fund/AcademyHealth Long-Term Care Colloquium, Year 5
Picker Program Grant

AcademyHealth's successful Long-Term Care Colloquium series has brought together policymakers, providers, and researchers to ensure that long-term care research responds to the issues facing those in the field, and that study results reach those in a position to take action. Participants in the 2007 meeting rated their experience very highly, and many reported they intend to use what they learned to inform policymakers and others in their home state about key long-term care concerns. To reach a wider audience of state policymakers, the fifth colloquium will expand activities beyond the daylong meeting preceding AcademyHealth's Annual Research Meeting and the half-day policy seminar in Washington to include a presence at a national conference, such as the annual meeting of the National Academy for State Health Policy. Possible topics include pay-for-performance demonstrations and international models of long-term care.

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American Association of Homes and Services for the Aging

$354,936
Advancing Excellence in America's Nursing Homes: Working to Achieve Lasting Improvement in Quality
Picker Program Grant

Advancing Excellence in America's Nursing Homes is a two-year campaign led by a national, broad-based coalition of organizations with a stake in the quality of nursing home care. It is supported by 47 local field networks that raise awareness of the campaign; recruit providers, consumers, and workers; lend technical assistance; and convene meetings to share best practices. This grant will support Advancing Excellence by: 1) funding a national field network coordinator; 2) developing written materials to inform providers, policymakers, and others about progress made and lessons learned; and 3) ensuring that network members are able to attend campaign events, including a symposium and a workshop.

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National Senior Citizens Law Center

$167,153
Medicaid Funding for Assisted-Living Care: How State Policies Affect Residents
Picker Program Grant

A significant number of frail elders with Medicaid coverage can choose to live in an assisted-living facility as an alternative to a nursing home. This study will review the laws and policies in the 41 states whose Medicaid programs cover assisted-living services, in an effort to help state officials and legislators understand the human impact of their policies. The project team will select five states for closer study to gauge the effect their policies and programs have on Medicaid beneficiaries' eligibility for assisted-living services and their access to providers, among other concerns. Results will be shared with state legislators and Medicaid officials, as well as consumers, to promote the development of policies ensuring that frail elders who opt for assisted-living enjoy access to quality services.

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Trustees of the University of Pennsylvania

$168,850
The Business Case for Health Information Technology in Nursing Homes
Picker Program Grant
Health Services Improvement Fund Grant

Nursing homes are evincing interest in new health information technologies (HIT) to improve the quality of services, achieve operational efficiencies, and realize a positive financial return. This project will explore the business case for adopting HIT, focusing on 15 nursing homes in New York that are currently implementing HIT systems as part of a state-funded demonstration project. If the analysis finds that these facilities have achieved a favorable return on investment, other nursing home providers could be encouraged to invest in HIT. Alternatively, if the evidence is inconclusive, nursing homes may require external support if they are to adopt HIT and reap its benefits.

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Pioneer Network

$227,317
The Pioneer Network Initiative: Moving into the Second Decade
Picker Program Grant

Over the last decade, the Pioneer Network has grown into a respected leader of the movement to transform U.S. nursing homes. Its challenge now is to promote culture change among the majority of nursing homes that have yet to adopt the principles of resident-centered care. This project will support Pioneer as it seeks to: 1) define core competencies of resident-centered care-the skills, knowledge, and behaviors that are necessary to provide such care in nursing homes; 2) collaborate with the Centers for Medicare and Medicaid Services (CMS) to explore creative ways by which traditional facilities can be made to look and feel more like a home; and 3) enlist new partners in the effort to spread resident-centered practices.

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University of Pittsburgh
$252,644
A Web-Based Staffing and Quality Simulation Tool to Improve Nursing Home Care
Picker Program Grant

A nursing home resident's experience depends, in large measure, on the facility's staff. Certain staffing characteristics in particular have been shown to affect overall quality: staffing levels, turnover and long-term retention, and use of agency staff. Drawing from several large data sets, a research team from the University of Pittsburgh and RAND will examine how quality of nursing home care changes as different aspects of staffing are altered, either singly or in combination. From these results, the team will then create and test the usefulness of a set of tables and a Web-based simulation tool that will allow nursing home administrators to see how manipulating different staffing characteristics affects quality measures. The investigators will present their findings to providers through trade association conferences, industry newsletters, and the Web sites of the Nursing Home Quality Campaign and the Pioneer Network.

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$346,229
Availability and Use of Health Information Technology in Nursing Homes
Picker Program Grant

To determine the prevalence and use of health information technology (HIT) in U.S. nursing homes, the research team will undertake a national survey of nursing home administrators and professional staff. In preparation for the survey, they will identify care processes that clinical and administrative leaders in nursing homes believe would benefit from integration into an HIT system. The team will also determine what clinical applications are included in the current software packages used by providers. The survey questions will focus on the extent to which HIT is already in use in nursing homes and whether providers are taking full advantage of their HIT systems. Information gleaned from this study will enable the team to identify activities and policies that could hasten nursing homes' adoption of HIT and improve its utilization.

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Small Grants—Picker/Commonwealth Program on Quality of Care for Frail Elders

American College of Health Care Administrators
$35,000
Achieving Staff Stability and Improving Performance: A Nursing Home Leaders Guide
Picker Program Grant

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Cornell University
$49,210
Linking Technology Implementation to Culture Change and Resident Centered Care: Phase 2
Picker Program Grant

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Massachusetts Long Term Care Foundation
$29,617
Changing LANES: How Can Local Area Networks for Excellence (LANES) Overcome Data Entry Barriers for Nursing Homes in the Advancing Excellence Campaign?
Picker Program Grant

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New York University
$40,000
Nurses' Involvement in Culture Change: Opportunity for Improving Resident Quality of Care and Quality of Life
Picker Program Grant

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International Health Care Policy and Practice

The Commonwealth Fund
$300,000
International Symposium on Health Care Policy, Fall 2008

The Fund's 11th annual International Symposium on Health Care Policy will focus on nations' best practices for achieving value throughout the health care system—how to deliver high-quality, accessible care that is affordable and sustainable. In bringing together leading policymakers and researchers from Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States, the symposium will highlight for U.S. policymakers the strategies that other health systems have employed to achieve greater efficiency and better outcomes at lower costs. To reach the Washington, D.C., policy audience, the Fund and the Alliance for Health Reform will cosponsor a pre-symposium briefing on Capitol Hill to showcase examples of innovative international approaches to health care policy and delivery. Insights gained from these alternative models will inform the work of the Fund's Commission on a High Performance Health System. The journal *Health Affairs* will consider online publication of papers commissioned for the symposium.

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The Commonwealth Fund
$130,000
Enhancing International Program Communications and Publications Capacity

To strengthen the impact of the International Program in Health Policy and Practice (IHP) and raise the Fund's profile as a source of cross-national analysis, two external contractors will work with IHP and Communications staff to: 1) increase the number of publications produced from IHP-sponsored work; and 2) develop a strategy for disseminating findings and analysis to policymakers, researchers, and journalists. The contractors will author articles for *Health Affairs* submission as well as Fund issue briefs and reports; prepare cross-national policy syntheses for the Fund's Web site; and provide quality control for papers commissioned for the International Symposium and international quality improvement meetings. In so doing, they will enhance the Fund's capacity to bring innovations and lessons from abroad to the attention of U.S. audiences.

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The Commonwealth Fund
$75,000
Commonwealth Fund/Nuffield Trust International Conference on Health Care Quality Improvement, 2008

The annual health care quality improvement symposia sponsored by the Fund and the Nuffield Trust since 1999 have brought together senior government officials, leading health researchers, and practitioners from the United States and the United Kingdom to exchange ideas and strategies for quality improvement. At the 2007 meeting, U.S. and U.K. experts explored the challenges of delivering high-quality, efficient acute care for people with chronic illness, and resolved to collaborate further on developing strategies for changing policy and practice. The 2008 conference, to be held in Boston, will carry that work forward. Among the topics to be explored are: system reforms that promote the medical home model; shared accountability resulting from shifts to multidisciplinary care teams; and payment incentives that foster better

care coordination. Project staff will explore opportunities for collaboration on specific improvement activities.

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The Commonwealth Fund

$1,630,500
Harkness Fellowships in Health Care Policy and Practice, 2009-10

Support for a 12th class of Harkness Fellows in Health Care Policy and Practice will allow the Fund to continue to develop promising policy researchers and practitioners from Australia, Canada, Germany, New Zealand, the United Kingdom, and, beginning in 2008, the Netherlands. A newly established partnership with the Dutch Ministry of Health, Welfare, and Sport will enable two Dutch fellows to be selected each year (one supported by the Fund and the other by the Dutch ministry), and through a partnership with the B. Braun Foundation, the program will support a third German fellow to strengthen leadership in nursing policy. To maintain the Harkness program's competitiveness, the Fund in 2007 increased the fellowship award, made a research and travel supplement available to Canadian Associates, and added to the curriculum a Leadership Skills Seminar Series.

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Harris Interactive, Inc.

$400,000
International Health Policy Survey, 2008

The 2008 International Health Policy Survey will assess health care system performance and responsiveness from the perspective of adults who have health problems. Conducted in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States, the survey will include questions about safety, waiting times, communication with providers, care coordination, administrative burden, and financial barriers to care. The findings, which will be released at the Fund's 2008 International Symposium and summarized in an article for *Health Affairs*, should generate substantial interest among health ministers, policymakers, researchers, and the media. They will also inform the work of the Commission on a High Performance Health System.

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Johns Hopkins University

$61,000
Cross-National Comparisons of Health Systems Quality Data, 2008

Comparisons between the U.S. health care system and the systems of other industrialized countries reveal striking differences in spending, availability and use of services, and health outcomes. This project will produce the 11th paper in a series of annual analyses of key health data for the 30 member nations of the Organization for Economic Cooperation and Development (OECD). The authors will provide an update of overall trends in health systems' performance, emphasizing those measures that reflect the core dimensions of a high performance health care system. Financing strategies, health insurance coverage, and the impact of various approaches to the public-private mix will be examined as a secondary theme. Findings will be presented at the Fund's 2008 International Symposium on Health Care Policy and submitted to the journal *Health Affairs* for Web publication. A chartpack containing core components of the OECD database, now available on the Fund's Web site, will be updated as a resource for journalists, policymakers, and researchers.

Gerard F. Anderson, Ph.D.
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London School of Economics and Political Science

$237,800
Learning from Other Nations About Universal Coverage and Cost-Containment

The 2008 U.S. presidential campaign presents a unique opportunity to bring to U.S. policymakers valuable lessons from other industrialized nations regarding their implementation of universal health insurance coverage and their mechanisms for controlling costs. Project staff will establish a European-U.S. Experts Advisory Group to

identify and compare best practices in Denmark, England, France, Germany, the Netherlands, Sweden, and Switzerland and gauge their transferability to the United States. A series of commissioned papers will provide the content for the 2008 International Symposium on Health Policy; these will later be submitted for consideration as *Health Affairs* Web Exclusives. To reach a broad Washington policy audience, the Fund and the Alliance for Health Reform will organize a Capitol Hill briefing.

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United Kingdom
+44 20 7955 7564
e.a.mossialos@lse.ac.uk

Scientific Institute for Quality of Healthcare

$136,530

Understanding Medical Homes: A Survey of Patients and Physicians in Primary Care Practices in Denmark, the Netherlands, and the United Kingdom

The medical home concept is gaining traction in the United States, and it has received strong endorsement from many policymakers. This project is intended to provide a more complex and nuanced understanding of how medical homes work by surveying physicians and patients in primary care practices in Denmark, the Netherlands, and the United Kingdom—all countries that have strong primary care infrastructures and that typically outperform the U.S. in international comparisons. Combined with findings from a parallel survey of U.S. primary care practices, the three-nation survey will help assess the interaction and relative importance of characteristics of primary care practices and health care delivery models in responding to patients' care preferences.

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The Netherlands
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Small Grants—International Health Care Policy and Practice

University of British Columbia

$34,325

Quality of Medicine Use in Seven Countries

Steven G. Morgan, Ph.D.
Assistant Professor, Health Care and Epidemiology
Centre for Health Services and Policy Research
429-2194 Health Sciences Mall
Vancouver, British Columbia V6T 1Z3
Canada
(604) 822 7012
morgan@chspr.ubc.ca

Regents of the University of California

$5,500

The Role of the Medical Home in Providing a Focus for Care and in Facilitating Coordination of Care for Chronically Ill Patients

Thomas Bodenheimer, M.D.
Professor of Family and Community Medicine
Center for Excellence in Primary Care
Department of Family and Community Medicine
University of California at San Francisco
San Francisco General Hospital
995 Protrero Avenue, Building 80-83
San Francisco, CA 94110
(415) 206-6348
tbodenheimer@fcm.ucsf.edu

Canadian Association for Health Services and Policy Research

$10,000

2008 Canadian Association for Health Services and Policy Research Conference

Kevin Barclay
Executive Director
56 Dallaire Crescent, Box 1091
Richmond, Ontario K0A 2Z0
Canada
(613) 235-7180
kbarclay@cahspr.ca

University of Cologne
$10,000
Population-Based Disease Management Programs in the German Health Care System: Are There Lessons to Be Learned?

Karl Wilhelm Lauterbach, M.D.
Professor, Institute for Health Economics and Clinical Epidemiology
Gleueler Straße 176-178
Koln 50935
Germany
+49 221 4679
karl.lauterbach@bundestag.de

Group Health Cooperative
$19,000
The Use of Patient/Provider Agreements to Improve Quality, Patient Engagement, and Coordination of Care for People with Chronic Conditions: U.S. and U.K. Perspectives

Edward H. Wagner, M.D.
Director
MacColl Institute for Healthcare Innovation
Center for Health Studies
Group Health Cooperative
1730 Minor Avenue, Suite 1600
Seattle, WA 98101
(206) 287-2877
wagner.e@ghc.org

Health Services Research Association of Australia & New Zealand
$17,000
5th Annual Australia-New Zealand Health Services and Policy Research Conference

Toni Ashton, Ph.D.
Associate Professor in Health Economics
Health Systems Section
School of Public Health
Private Bag 92019
Auckland
New Zealand
+64 9 3737599
t.ashton@auckland.ac.nz

National Institute for Health and Clinical Excellence
$50,000
Evidence-Based Policy Making in Healthcare: Structures, Values and Impact Based on Experience from the U.K., France, Germany, and Australia

Kalipso Chalkidou, M.D.
Associate Director, Research and Developmet
71 High Holborn, MidCity Place
London WC1V 6NA
United Kingdom
+44 20 7067 4933
kalipso.chalkidou@nice.org.uk

University of Oregon
$24,995
Physician Activation: Physician Attitudes, Beliefs and Behaviors Regarding Patient Self-Management

Judith H. Hibbard, Dr.P.H.
Professor
Department of Planning, Public Policy & Managment
1209 University of Oregon
Eugene, OR 97403-1209
(541) 346-3364
jhibbard@uoregon.edu

Scientific Institute for Quality of Healthcare
$25,000
Expansion of 2008 Commonwealth Fund International Health Policy Survey to Include the Netherlands

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Scientific Institute for Quality of Healthcare
$5,000
Dutch Harkness Fellowships Event in Collaboration with the Launch of the Scientific Institute for Quality in Health Care and 2008 Conference 'Improving Quality and Safety in Healthcare: What Does Work?'

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WGBH Educational Foundation
$50,000
PBS Frontline Documentary on Learning From Other Countries' Health Care Systems

Jon Palfreman
Founder, Palfreman Film Group, Inc.

24 Partridge Road
Lexington, MA 02420
(978) 376-6624
jpalfreman@pfgmedia.com

Communications

Project HOPE/The People-to-People Health Foundation, Inc.

$217,200
A Web Publishing Alliance with *Health Affairs*

The Fund has had an online publishing partnership with the policy journal *Health Affairs* since 2003, a collaboration that has provided opportunities to publish Fund-supported research more often and faster than traditional means allow, while raising the Fund's professional and public profile. This grant will provide *Health Affairs* with an additional year's funding, in support of a new series of published reports on topics related to high performance health care, and for enhancements to *Health Affairs*' Web operations.

Susan Dentzer
Editor-in-Chief, Health Affairs
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814
(301) 656-7401
sdentzer@projecthope.org

The Commonwealth Fund

$300,000
whynotthebest.org: A Commission Web Resource for Quality Improvement

Since August 2006, The Commonwealth Fund Commission on a High Performance Health System has issued several major reports in support of its mission to move the nation toward greater access, quality, equity, and efficiency in health care. To build on this work, the Fund proposes to develop a Commission Web resource—www.whynotthebest.org—to enable health care professionals and other stakeholders to compare their organizations' performance against a range of benchmarks, access case studies that document improvement activities, and interact with other organizations through moderated forums.

Barry A. Scholl
Vice President for Communications and Publishing
1 East 75th Street
New York, NY 10021
(212) 606-3841
bas@cmwf.org

Small Grants—Communications

American Society on Aging

$5,750
2008 Joint Conference of the American Society on Aging/ National Council on the Aging

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

Association of Health Care Journalists

$10,000
Association of Health Care Journalists Urban Workshop

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

Association of Health Care Journalists

$35,000
Association of Health Care Journalists Annual Conference and Luncheon Roundtable and Urban and Rural Health Workshops

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

Trustees of Columbia University in the City of New York

$29,500
2008 Educational Insert in Columbia Journalism Review

Louisa Daniels Kearney
Advertising Director
2950 Broadway
New York, NY 11050
(212) 883-2828
ldkpub@aol.com

Greater Washington Educational Telecommunications Association
$25,000
Special Program on the Presidential Candidates and Health Care

Lester M. Crystal
President
2700 South Quincy Street, Suite 250
Arlington, VA 22206
(703) 998-2101
lcrystal@newshour.org

Pear Tree Communications, Inc.
$45,675
whynotthebest.org: A Commission Web Resource for Quality Improvement, Planning Phase

Martha Hostetter
Partner
3035 Lincoln Boulevard
Cleveland Heights, OH 44118
(216) 220-4604
mh@cmwf.org

Society of American Business Editors and Writers, Inc.
$15,000
2008 Business Journalist Training

Carrie Paden
Executive Director
University of Missouri-Columbia
385 McReynolds Hall
Columbia, MO 65211
(573) 882-8985
padenc@missouri.edu

Organizations Working with Foundations

AcademyHealth
$15,000
General Support

W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

The Center for Effective Philanthropy
$5,000
General Support

Phil Buchanan
Executive Director
675 Massachusetts Avenue, 7th Floor
Cambridge, MA 02139
(617) 492-0800
philb@effectivephilanthropy.org

Foundation Center
$15,000
General Support

Sara L. Engelhardt
President
79 Fifth Avenue
New York, NY 10003
(212) 620-4230
sle@fdncenter.org

Grantmakers for Children, Youth, and Families, Inc.
$2,500
General Support

Stephanie McGencey, Ph.D.
Executive Director
8757 Georgia Avenue, Suite 540
Silver Springs, MD 20910
(301) 589-4293
smcgencey@gcyf.org

Grantmakers in Aging, Inc.
$6,500
General Support

Carol A. Farquhar
Executive Director
7333 Paragon Road, Suite 220
Dayton, OH 45459-4157
(937) 435-3156
cfarquhar@giaging.org

Grantmakers In Health
$15,000
General Support

Lauren J. LeRoy, Ph.D.
President and Chief Executive Officer
1100 Connecticut Avenue NW, Suite 1200
Washington, DC 20036
(202) 452-8331
lleroy@gih.org

Health Services Research Association of Australia & New Zealand
$1,500
General Support
Jackie Cumming
President
C/- CHERE
Faculty of Business, UTS
P.O. Box 123 Broadway
NSW 2007
Australia
+64 4 463 6567
jackie.cumming@vuw.ac.nz

Independent Sector
$12,500
General Support
Diana Aviv
President and Chief Executive Officer
1602 L Street NW, Suite 900
Washington, DC 20036
(202) 467-6100
diana@independentsector.org

International Society for Quality in Health Care, Inc.
$1,200
General Support
Roisin Boland
Chief Executive Officer
2 Parnell Square East
Dublin 1
Ireland
+353 1 871 7049
info@isqua.org

New York Regional Association of Grantmakers
$15,100
General Support
Ronna D. Brown, J.D.
President
79 Fifth Avenue, Fourth Floor
New York, NY 10003-3076
(212) 714-0699
rbrown@nyrag.org

Nonprofit Coordinating Committee of New York
$35,000
General Support
Michael E. Clark
President
1350 Broadway, Suite 1801
New York, NY 10018-7802
(212) 502-4191
mclark@npccny.org

Rockefeller University
$90,000
Transfer and Maintenance of The Commonwealth Fund's Archives, Part 12

This grant will support the transfer, processing, and storage of additional Commonwealth Fund materials at the Rockefeller Archive Center, which has housed the Fund's archives since 1985.
Erwin Levold, Ph.D.
Chief Archivist
Rockefeller Archive Center
15 Dayton Avenue
Sleepy Hollow, NY 10591-1598
(914) 631-4505
stapled@mail.rockarch.org

Other Continuing

The Commonwealth Fund
$30,000
Authorization to Support 2008 Audience and Grantee Surveys
Andrea C. Landes
Director of Grants Management
1 East 75th Street
New York, NY 10021
(212) 606-3844
acl@cmwf.org

President and Fellows of Harvard College
$15,000
The Academy Center for Teaching and Learning at Harvard Medical School
Jules Dienstag, M.D.
Dean for Medical Education
17 Quincy Street, Massachusetts Hall
Cambridge, MA 02138
(617) 432-6250
jules.dienstag@hms.harvard.edu

Health Care for All
$1,500
For the People: A Celebration of Health Care Leaders
John E. McDonough, D.Ph.
Executive Director
30 Winter Street, Suite 1010
Boston, MA 02108-4720
(617) 350-7279
mcdonough@hcfama.org

Massachusetts General Hospital
$17,000
Henry J. Kaiser Family Foundation Faculty Scholars in General Internal Medicine Reunion
Paul F. Griner, M.D.
Director, Mentoring Program, General Medicine Unit
50 Staniford Street, 9th Floor
Boston, MA 02114
(617) 724-4629
pfgriner@partners.org

Morehouse School of Medicine, Inc.
$10,000
The Satcher Health Leadership Institute at the Morehouse School of Medicine
Sally M. Davis
Vice President for Institutional Advancement
720 Westview Drive SW
Atlanta, GA 30310-1495
(404) 752-1730
sdavis@msm.edu

National Medical Fellowships
$7,500
National Medical Fellowships Annual Benefit Gala
Esther R. Dyer, D.L.S.
President and CEO
5 Hanover Square, 15th Floor
New York, NY 10004
(212) 483-8880
erdyer@nmfonline.org

New York Academy of Medicine
$6,600
New York Academy of Medicine 2008 Gala
Jo Ivey Boufford, M.D.
President
1216 Fifth Avenue
New York, NY 10029-5293
(212) 822-7201
jboufford@nyam.org

New York City Health and Hospitals Corporation
$28,580
Using Emergency Department Coordinators to Link Adults to Primary Care Clinics
Robert Hessler, M.D.
Assistant Director, Department of Emergency Medicine
Bellevue Hospital Medical Center
462 First Avenue Room, #345
New York, NY 10016
(212) 562-3346
rh33@med.nyu.edu

Primary Care Development Corporation
$6,000
Primary Care Development Corporation Spring Gala Dinner
Ronda Kotelchuck
Executive Director
22 Cortlandt Street, 12th Floor
New York, NY 10007
(212) 437-3917
rkotelchuck@pcdcny.org

United Hospital Fund of New York
$8,500
United Hospital Fund Gala, 2007
James R. Tallon, Jr.
President
Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10118
(212) 494-0700
jtallon@uhfnyc.org

SUMMATION OF PROGRAM AUTHORIZATIONS

Year ended June 30, 2008

	Major Program Grants	Small Grants Fund Grants	Total Authorizations
High Performance Health System	$13,235,762	$1,245,446	$14,481,208
Commission Activities	$2,426,582	$171,600	$2,598,182
Future of Health Insurance	$1,249,816	$229,204	$1,479,020
Medicare's Future	$1,633,471	$296,199	$1,929,670
Health Care Quality Improvement and Efficiency (see note 1)	$3,893,685	$302,698	$4,196,383
Patient-Centered Primary Care Initiative	$2,622,623	$128,002	$2,750,625
State Innovations	$1,409,585	$117,743	$1,527,328
Special Populations	$6,486,728	$566,706	$7,053,434
Health Care Disparities	$1,580,074	$78,650	$1,658,724
Commonwealth Fund/Harvard University Fellowships in Minority Health Policy	$900,000		$900,000
Child Development and Preventive Care	$2,303,832	$319,229	$2,623,061
Picker/Commonwealth Program on Quality of Care for Frail Elders (see notes 2 & 3)	$1,702,822	$168,827	$1,871,649
International Health Care Policy and Practice	$2,970,830	$236,026	$3,206,856
Communications	$517,200	$158,425	$675,625
Other Continuing Programs	$214,300	$128,680	$342,980
Total Program Grants Approved	$23,424,820	$2,335,283	$25,760,103
Grants Matching Gifts by Directors and Staff			$676,237
Program Authorizations Cancelled or Refunded and Royalties Received			($583,957)
Total Program Authorizations			**$25,852,383**

Notes:
1) Frances Cooke Macgregor Award of $298,806 in 2007–08.
2) Picker Program Grants totaled $1,871,649 in 2007–08.
3) Health Services Improvement Award of $168,850 in 2007–08.

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