The Commonwealth Fund

2004 ANNUAL REPORT

THE COMMONWEALTH FUND

2004 Annual Report

For the Fiscal Year Ended June 30, 2004

CONTENTS

President's Message
Transformational Change:
A Ten-Point Strategy to Achieve
Better Health Care for All 2

The Fund's Mission, Goals,
and Strategy 22

Improving Health Insurance
Coverage and Access to Care 27

Improving the Quality of
Health Care Services 46

International Program in
Health Policy and Practice 73

Executive Vice President–COO's Report
Regulating Foundations:
A Delicate Balance 88

Treasurer's Report 111

Financial Statements 116

Directors and Staff 126

Grants Approved, 2003–2004 134

The Fund's Founders
and Benefactors 189

MISSION STATEMENT

The Commonwealth Fund is a private foundation established in 1918 by Anna M. Harkness with the broad charge to enhance the common good. The Fund carries out this mandate by supporting efforts that help people live healthy and productive lives, and by assisting specific groups with serious and neglected problems. The Fund supports independent research on health and social issues and makes grants to improve health care practice and policy.

The Fund's two national program areas are improving health insurance coverage and access to care and improving the quality of health care services. The Fund is dedicated to helping people become more informed about their health care, and improving care for vulnerable populations such as children, elderly people, low-income families, minority Americans, and the uninsured. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries. In its own community, New York City, the Fund also makes grants to improve health care.

Library of Congress Number ISSN 0149-4457

Karen Davis
President

President's Message
2004 Annual Report

Transformational Change: A Ten-Point Strategy to Achieve Better Health Care for All

One of the keys to providing more effective health care, particularly for an increasingly diverse U.S. population, is improving communication between clinicians and patients. At All Children's Hospital in St. Petersburg, Florida, researchers working with Commonwealth Fund suppport are seeking to identify the communication problems that affect the quality and safety of care for Hispanic children and develop tools to enable hospitals to improve parent–provider communication.

The United States spends more than any other nation on health care—well over twice the per capita average among industrialized nations.[1] Health expenditures have grown from $1.3 trillion in 2000 to $1.7 trillion in 2003, and the portion of gross domestic product consumed by the health sector over that period has increased from 13.3 percent to 15.3 percent.[2,3] Yet it is increasingly clear that our money is not buying the best achievable care.

The U.S. health care system excels in some areas, but on many basic measures of quality it delivers poor-to-middling results, according to a recent study of five English-speaking countries by a Commonwealth Fund international working group.[4] Lack of health insurance continues to be a very significant problem: between 2000 and 2003, the number of uninsured Americans grew from 39.8 million to 45.0 million, a 14 percent increase that fell hardest on working adults.[5] Health insurance premiums rose at double-digit rates each year over the same period.[6] Many Americans, especially those with low

incomes or poor health, are unable to get access to affordable health care when they need it.[7]

What Americans want—and, indeed, what our high spending ought to buy—is the best health care in the world. Achieving that goal will require that we transform the health system to achieve better care for all. In a global economy, the United States needs to be competitive—not just in the goods we produce, but in the services we provide to our citizens.

Transformational change is not the same as radical restructuring. We do not need to replace the current system with a single-payer, all-government system or eliminate fee-for-service methods of payment; nor do we need to eliminate public insurance or convert Medicare into competing systems of private insurers. But we do need to make sure that we are achieving commensurate value for what we spend on health care.

To begin, we will need to take an unflinching look at the performance of our existing system, put aside outdated practices and ideological assumptions, and learn from what is currently working well in the United States and internationally, both in health care financing and in improving the quality of health care services. Most important, the process will have to engage the commitment and creativity of those dedicated to change, in both private and public sectors, inside and outside the health care system.

Work by The Commonwealth Fund and others suggests a 10-point strategy as a framework for change. The first point, "Agree on shared values and goals," is a place to start the work. The nine points that follow highlight strategies that could help our nation achieve those goals, address our most difficult challenges, and, at the same time, preserve the best aspects of our existing health care system.

TEN POINTS FOR TRANSFORMING THE U.S. HEALTH CARE SYSTEM

1. Agree on shared values and goals.
2. Organize care and information around the patient.
3. Expand the use of information technology.
4. Enhance the quality and value of care.
5. Reward performance.
6. Simplify and standardize.
7. Expand health insurance and make coverage automatic.
8. Guarantee affordability.
9. Share responsibility for health care financing.
10. Encourage collaboration.

1. Agree on shared values and goals.

As a nation, we have the capacity to shape a health care system that enhances our national competitiveness and quality of life by delivering the best care for all our citizens. Our aspirations should be nothing short of a health care system dedicated to ensuring safe, effective, patient-responsive, timely, efficient, and equitable care for all.[8] Today, however, we tolerate a system that fails too many of our people, compromising the health of our workforce, straining our economy, and depriving too many Americans of a healthy and secure retirement.

To forge consensus on directions for change, we need to embark on a national discussion about our shared values and goals for health care. We have the talent and resources to achieve a high-performance health system, but first we must identify what we want as a society from our health care system and what we hope to achieve over time.

The process could begin with the creation of a set of performance goals and interim targets. Establishing goals and targets would certainly involve debates over spending. Whatever the outcome, we should begin to give as much

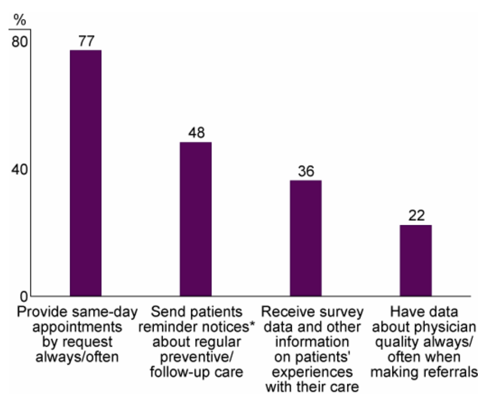
emphasis to the possibility of achieving savings through administrative simplification and elimination of waste as we give to improving access and quality, increasing responsiveness to patients, and reducing medical errors. The national discussion on health care priorities should be framed, as well, by a clear vision of the practical challenges we face and the attributes of the current system we value most highly.

2. Organize care and information around the patient.

To get access to the health care system, each patient needs a "medical home," a personal clinician or primary care practice that delivers routine care and manages chronic conditions. People with ready access to primary care use emergency rooms less and know where to turn when they are in pain or worried about a medical problem. Continuity of care with the same physician over time has also been associated with better care, increased trust, and patient adherence to recommended care.

Organizing care around the patient means sharing information and ensuring convenient access to needed services. It also means making sure doctors have the information they need to provide the best possible care.

Percent of primary care physicians who:



* Computerized or manual reminder notices.
The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care.

Ideally, a patient's medical home would maintain up-to-date information on all care received by the patient, including emergency room services, medications, lab tests, and preventive care. It would not necessarily serve as a "gatekeeper" to other services but would be responsible for coordinating care, ensuring preventive care, and helping patients navigate the system. Its clinicians would be expected to meet quality standards in key areas, such as ensuring that patients get access to the care they need, supporting them in making decisions about their own and their children's care, coordinating care among providers, collecting patient feedback through surveys and other means, and providing information on physicians and services that meet physician directory standards recommended by the National Committee for Quality Assurance.[9]

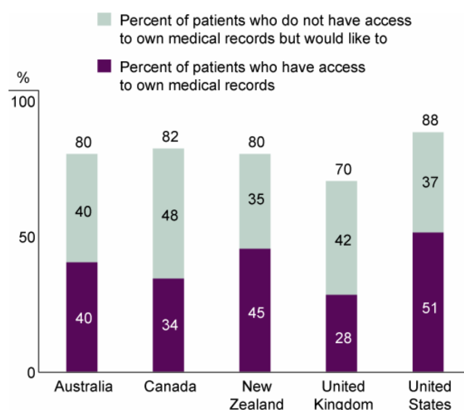
Implementing the medical-home approach to primary care would almost certainly require the development of a new

payment system. The blended per-patient panel fee and fee-for-service system in use in Denmark is one potential model.[10]

3. Expand the use of information technology.

As Donald Berwick, M.D., president of the Institute for Healthcare Improvement, has said, "Information is care."[11] Physician visits, specialized procedures, and stays in the hospital are important, but so is information that enables patients to be active and engaged partners in their care. Patients want information on their health conditions and treatment options.[12] They want to know which health care providers get the best results for patients with their kinds of conditions. Many would like access to laboratory and diagnostic test results and specialty consultation reports, or regular reminders about preventive and follow-up care. Information is also important for ensuring safety; patients need to know, for example, what medications they should be taking and when to act on an abnormal lab result.

The vast majority of Americans want information about their health and the care they receive. Improved technology could improve their access to medical records and other data.



The Commonwealth Fund 2004 International Health Policy Survey.

Modern information systems are a boon to both patients and physicians. Patient registries, for instance, can track whether people with conditions like diabetes or asthma are getting recommended follow-up care or if their conditions are well controlled. Decision-support systems can help physicians make diagnostic and treatment decisions, in some cases bringing patients into critical medical decisions. Information systems can also improve the efficiency of care, improve appointment scheduling, facilitate medication refills, and eliminate duplication of tests.

The health sector has been very slow to embrace information technology, despite wide recognition that it is very difficult to provide safe, high-quality, responsive care without ready access to good information. The greatest barrier to adoption has been cost—and unless financial incentives are provided, progress is likely to continue to be slow.

To encourage speedier implementation, private insurers may need to establish differential payments for providers with and without appropriate technology. Public programs could also use their leverage to accelerate change—as happened in 2003, for example, when the Medicare program implemented a new requirement that almost all doctors submit their claims electronically.

4. Enhance the quality and value of care.

The quality and cost of health care vary widely from place to place, both within the United States and internationally.[13,14] These disparities suggest that, by examining the distribution of health expenditures, identifying best practices, and spreading those models more broadly, we could make many significant improvements. It is well known, for example, that 10 percent of patients account for 70 percent of health care costs.[15] This ratio has been strikingly stable over several decades, yet few attempts to improve efficiency have focused on improving care for the sickest patients.

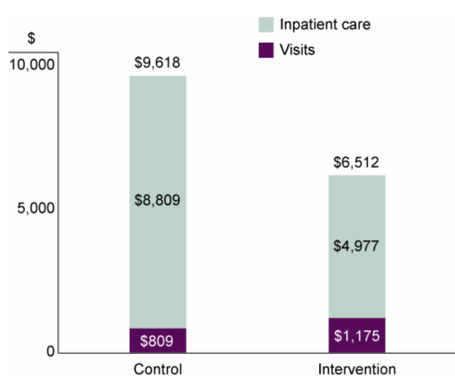
Two current Fund-supported projects are showing results in managing high-cost conditions. In one, advanced practice nurses are providing post-hospital care, including home visits, to congestive heart failure patients enrolled in private Medicare managed care plans. Randomized control trials have demonstrated that the technique reduces re-hospitalization, and thus annual care costs, by one-third.[16] The other is evaluating a home device called "Asthma Buddy" that monitors the daily condition of children with asthma. Pilot tests have demonstrated markedly reduced use of emergency rooms and hospitalization.[17]

Fund-supported evaluation of "business cases" for quality improvements suggest other new approaches, from pharmaceutical monitoring of cholesterol-reducing drugs[18] to redesigning primary care to make it more accessible to low-

income patients.[19] Hospitals and nursing homes have also implemented innovations that help retain nursing staff.[20] Other strategies include hospital self-assessment of medication safety,[21] prospective medication review of nursing home patients,[22] physician participation in risk management training,[23] and error reporting in a blame-free environment.[24] Many of the most promising techniques involve team-based approaches to care, in which physicians and other professionals coordinate tasks to get the job done efficiently and effectively.

Improving the management of high-cost conditions could yield significant savings and better care. In one project, visits from "advanced practice" nurses helped reduce congestive heart failure patients' use of inpatient services, thus reducing total costs.

Average cost per patient with congestive heart failure



Mary Naylor, "Making the Bridge from Hospital to Home: Grantee Spotlight," *The Commonwealth Fund Quarterly,* Fall 2003.

Another factor that makes the U.S. health system so costly is our far greater use of specialist procedures, such as radiological imaging and cardiac procedures. Regional cost variations are mainly associated with use of discretionary, or "supply-sensitive" services.[25] Many patients undoubtedly benefit from those services and enjoy better health outcomes and quality of life, yet it is a serious shortcoming in our system that we have developed no agreed-upon criteria for when those services are appropriate, and for which patients.[26] Both the United Kingdom and Australia have established national institutes to develop criteria for utilization of specialized procedures and pharmaceuticals;[27] we need to pursue a similar strategy.

Tapping the potential to improve quality and enhance value will require investment in the infrastructure required for widespread change. The Medicare program supports state Quality Improvement Organizations, which are dedicated to improving care for Medicare patients. Their mandate could be expanded to cover quality of care for all patients. The federal government supports learning collaboratives to improve primary care and disease management in community health centers. The approach could be extended to all safety net providers, including public hospitals and low-income primary care clinics. The Agency for Healthcare Research and Quality

(AHRQ) currently supports research on quality improvement, but an expanded mandate and budget could support much more extensive research on cost-effectiveness, elimination of waste, efficient practices, and team approaches to care. A three-year fellowship program at AHRQ could train a new cadre of quality improvement and patient safety officers, analogous to the epidemiological intelligence and surveillance officers at the Centers for Disease Control and Prevention.

5. Reward performance.

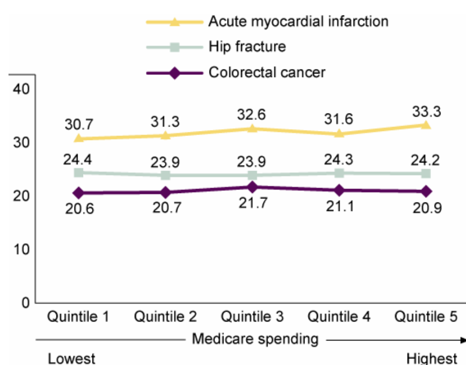
Paul Batalden, M.D., first coined the phrase, “Every system is perfectly designed to get the results it gets.” If we want fundamentally different results in health care, we need to be prepared to change the way health care providers are rewarded. Reforming payment methods is particularly critical. Indeed, there is widespread consensus that current methods of payment are “misaligned,” not only failing to reward quality improvement but actually creating perverse incentives to avoid sicker and more vulnerable patients.

Rewarding organizations for providing good care to a patient over the course of an illness or over time is the most difficult challenge. The current system typically pays hospitals on a per-case, per-diem, or charge basis; individual physicians on a fee-for-service basis; and integrated health care delivery systems on a capitation basis. Under those terms, hospitals may be penalized if they reduce hospitalization rates or shorten hospital stays, and physicians may be penalized if they keep chronic conditions well controlled. Only integrated health care delivery systems are rewarded for efficiency gains, but they are not rewarded for achieving higher quality.

One step might be to create a new type of group practice, perhaps called “accountable physician practices,” that would be responsible for meeting quality and efficiency targets. Payment could be made through a blended system of fixed monthly fees

Higher spending does not necessarily produce better outcomes. Mortality rates for three conditions, for example, are roughly the same for Medicare enrollees living in the lowest spending regions of the country (quintile 1) and the highest (quintile 5).

Mortality rates for selected conditions



Elliott Fisher et al., "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* (February 18, 2003).

for enrolled patients, fee-for-service (with rates adjusted to reflect additional revenue from other bases of payment), and bonuses for high performance. For hospitals, payment could be based on diagnosis—the method currently used by Medicare—with bonuses for meeting quality targets.

All providers could be required to report information on quality and efficiency for the patients under their care. In a mixed public–private system of insurance, this could be facilitated through a new multi-payer claims data system, which could also serve as an information base on provider performance.

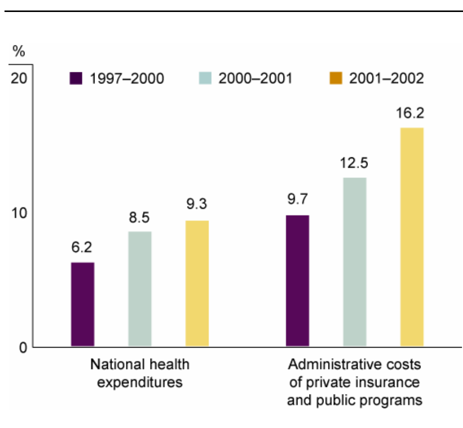
Payment differentials among insurers should be eliminated or greatly narrowed. Currently, for example, Medicaid tends to pay at a much lower rate than other sources of insurance, and Medicare typically pays less than commercial insurers. It might also be helpful to establish levels of covered benefits, with the first level composed of "high-value" benefits, such as preventive care and management of chronic conditions; a second level of "effective" benefits, such as treatment of acute conditions; and a third level of "patient-preference or supply-sensitive" benefits, which involve greater discretion.[28] Patient cost-sharing could vary across the three levels of benefits: no cost for high-value benefits, modest or minimal cost-sharing for effective benefits, and standard cost-sharing for patient-preference or supply-sensitive benefits. Classification should be scientifically driven, and benefits found not to improve health outcomes or patient quality of life should not be covered.

6. Simplify and standardize.

Health care administrative costs are far higher in the United States than in other countries and are the most rapidly rising component of national health expenditures.[29] This is partly explained by the major role of private insurers, whose

Expenditures for health care have surged in the United States over the past few years. Growth has been especially steep in the administrative costs of health insurance.

Percent growth in annual health expenditures



Katharine Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004).

premiums cover advertising, sales commissions, reserves, and profits. Instability of coverage, and high costs associated with enrolling and disenrolling many millions of people each year from private and public health plans, is another factor. The proliferation of insurance products, each with its own complex benefit design and payment methods, also inflicts high administrative costs on hospitals, physicians, and other providers. Plus, in a relatively new development, business associations like the Leapfrog Group have begun to set quality standards, which require even more reporting from health care providers.[30]

The diversity of the health care system brings with it the advantages of innovation and choice. Disadvantages include high administrative costs, complexity and confusion among options, burdensome reporting requirements, and delays and uncertainties regarding payment. The proliferation of options also reflects the wide range of health plan strategies to enroll the most "profitable" enrollees and discourage the enrollment of sicker patients. Since 10 percent of patients account for 70 percent of health care outlays, insurers have tremendous incentives to employ market segmentation techniques to achieve favorable selection. This is particularly a problem in the individual and small group markets, but it can also occur when multiple insurers are offered by an employer.

To simplify the health system, dominant players may have to give up their preferential treatment. Today, for example, large employers receive better insurance benefits than small businesses for the same premium, hospitals with larger market shares negotiate higher payment rates than smaller hospitals, and Medicare and Medicaid pay less than commercial insurers do. Standardizing practice in five areas—payment methods, benefits, claims administration, provider credentialing, and quality standards—would preserve

innovation and choice while improving efficiency, effectiveness, and equity.

7. Expand health insurance and make coverage automatic. The greatest problem in the U.S. health care system—the one that sets the United States apart from every other industrialized nation—is its failure to provide health insurance coverage for all. Forty-five million Americans are uninsured, and one-fourth of adults under age 65 are uninsured at some point during a given year.[31] The Institute of Medicine has estimated that 18,000 lives are lost each year in the United States as a direct result of gaps in insurance coverage,[32] at an economic cost between $65 billion and $130 billion annually from premature death, preventable disability, early retirement, and reduced economic output.

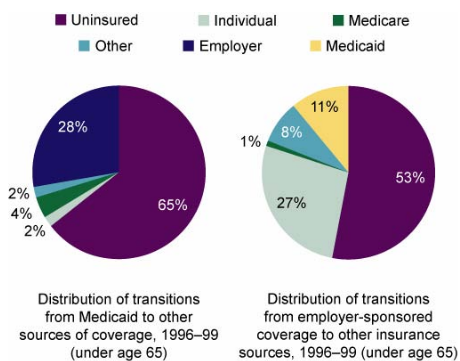
The United States has considered proposals to achieve universal coverage for almost a century.[33] Other countries have achieved that goal by covering their citizens under some form of automatic coverage, either through public programs or a mix of public and private insurance. Their citizens do not move in and out of coverage or experience gaps in coverage, and administrative costs are therefore markedly lower.[34] More important, no one is denied access to essential health services because of an inability to afford care.

A bold strategy for change would be to establish the capacity to enroll all Americans automatically in some form of health insurance. The general principle would be to cover everyone under one of four private or public group insurance options: a new pool modeled on the Federal Employees Health Benefits Program (FEHBP), employer coverage, Medicare, or the Children's Health Insurance Program (CHIP). Individuals would have a choice of coverage, and default criteria would assign those not exercising an active choice to a plan best fitting their circumstances. Enrollment could be checked

through the federal income tax system[35] or by state-level clearinghouses when people seek medical care.[36]

A new insurance pool for uninsured individuals and small businesses could be modeled on plans participating in FEHBP. A large pool, coupled with reinsurance, would enable small businesses to obtain lower premiums and provide their employees with a wider range of insurance options. For individuals, tax credits could subsidize premiums in excess of a given percent of income.

When people under age 65 leave their Medicaid or employer-sponsored health insurance, some shift to other sources of coverage—but more than half become uninsured.



Pamela Farley Short et al., *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem,* The Commonwealth Fund, November 2003.

For people covered under employer-sponsored plans, changing jobs is a major cause of insurance loss. Of those leaving employer coverage, 53 percent become uninsured.[37] Attempts to provide advanceable tax credits for workers displaced by international trade have reached only a tiny fraction of eligible workers.[38] A better strategy would be to cover all unemployed workers automatically through their former employers under so-called COBRA plans, with premium assistance to ensure affordability. Two small steps to increase continuity of coverage would be to require employers to cover former workers for at least two months following termination, and to require employers to enroll newly hired employees automatically within two months.

Medicare already provides automatic, permanent coverage for most elderly and disabled Americans. Stable coverage—coverage that does not change and is easy to understand—is one reason why beneficiaries tend to be very satisfied with Medicare, and one reason for the program's low administrative costs.[39] By expanding Medicare in two major ways—enabling older adults to become eligible earlier, and eliminating the two-year waiting period for people who become disabled[40]—important gaps in coverage could be closed. Spouses of disabled or elderly beneficiaries who are not currently eligible could also be given the option to buy in to Medicare, with premiums varying according to income.

The CHIP program provides coverage to low-income children, but many more could be covered if enrollment were made automatic and extended to their parents. CHIP could also be used to cover all uninsured school children. Medicaid, rather than disenrolling young adults on their 19th birthday, could continue their coverage until they get a job and qualify for their own benefits.[41] College students could be enrolled automatically in either their university health plans or CHIP.

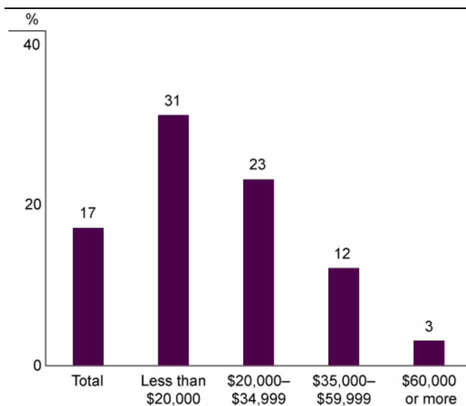
CHIP might also be used to extend coverage to low-wage workers, either through premium assistance to allow employees to receive coverage under their own employers' health plans, or by giving employers the option of purchasing employee coverage through CHIP.

Another strategy for reducing the number of people without insurance is to prevent loss of Medicaid/CHIP coverage. Of the one million people who go off Medicaid each month, 65 percent become uninsured.[42] A study in New York showed that most people who lose Medicaid coverage continue to be eligible but are unable to overcome the administrative barriers to reenrollment.[43] Rather than require people to reenroll, a simpler strategy would be to sustain their coverage under Medicaid or CHIP until other coverage—such as employer-sponsored insurance—kicks in. CHIP beneficiaries could be assessed a premium through the income tax system, thus ensuring that people whose incomes rise make appropriate contributions toward their coverage.

Helping people hold onto their coverage would go a long way toward solving the uninsured problem. A Fund-supported study estimates that guaranteeing coverage for even one year would reduce the uninsured rates for low-income children by 40 percent and for low-income adults by about 30 percent.[44]

People with low and moderate incomes are very likely to spend a significant portion of their income on health care costs.

Adults ages 19-64 who spent 5 percent or more of income on out-of-pocket health care costs



Income groups based on 2002 household income.
Author's analysis of the Commonwealth Fund Biennial Health Insurance Survey (2003).

8. Guarantee affordability.

The recent rise in health care costs makes affordability a key concern to everyone who contributes to health care financing. Uninsured families are particularly vulnerable, but increases in deductibles and other cost-sharing requirements have made paying medical bills more difficult for all working families. Findings from the 2003 Commonwealth Fund Health Insurance Survey indicate that over 71 million Americans under age 65 have medical bill problems or accumulated medical debt.[45] Sixty-two percent of people who reported those problems said they were insured at the time their bills were incurred.[46] Overall, 17 percent of adults ages 19 to 64 reported out-of-pocket expenses in excess of 5 percent of income.[47]

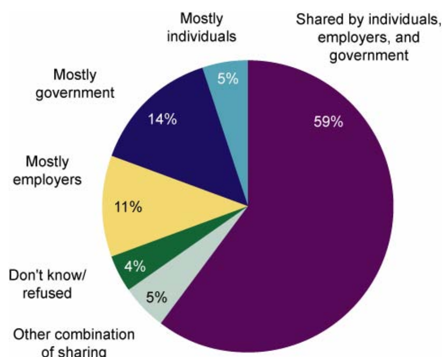
Those financial burdens could be relieved by establishing ceilings on out-of-pocket liability for individuals, using mechanisms that would effectively ensure that no American is required to spend more than 10 percent of income on health care. Setting a floor on coverage—for example, by extending CHIP coverage to anyone earning below 150 percent of poverty—would be a practical way to guarantee that the most vulnerable do not fall through the cracks in our mixed private–public system of financing.

9. Share responsibility for health care financing.

Even more difficult than restructuring public programs is determining employers' responsibility for financing the health benefits of their employees. Finding the right balance is important, since most Americans—59 percent, according to a recent Commonwealth Fund survey[48]—think that responsibility for health care financing should be shared among individuals, employers, and government. Interestingly, a survey of employers supported by the Fund also found that 59 percent of employers believe that it is very important that

When asked "Who should pay for health insurance?" most Americans say the responsibility should be shared by individuals, employers, and government.

Distribution of views on who should pay for health insurance



Percentages do not add to 100 percent because of rounding.
Sara R. Collins et al., *The Affordability Crisis in U.S. Health Care: Findings from The Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund, March 2004.

employers provide health coverage to their employees or contribute to the cost.[49]

The percentage of workers receiving coverage through their own employers has been slowly eroding for several decades, a trend that appears to have accelerated during the recent economic slowdown.[50] When employers do not cover their own employees, the cost is borne by other employers, government programs, and individuals. An analysis by the Fund indicates, for example, that companies spend roughly $31 billion to provide coverage for dependents who are actually employed by other firms,[51] an inequity that creates a very uneven competitive environment. There is also a risk that if public insurance programs or tax credits were to make other forms of coverage more affordable for workers, employer coverage would erode even more rapidly, with significant budgetary implications for government.

A good strategy here would be to develop a mix of incentives and disincentives to encourage all employers to help finance health coverage for their workers. Employers purchasing qualified coverage for all employees could be eligible for "reinsurance," with the federal government picking up most of the cost for employees with health expenses over a given threshold. Certain tax benefits could be conditional on contributing a minimum amount toward health insurance coverage for employees, and small businesses could be given an opportunity to purchase coverage through a group pool in order to eliminate the premium differential that currently favors large firms.[52]

10. Encourage collaboration.

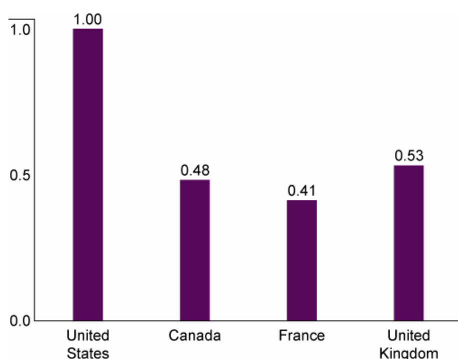
All the changes described so far would be much easier to accomplish in a climate of cooperation, both between the public sector and private insurers and employers and among health care providers. The goal would be to work together to

improve the performance of the health system and eliminate duplication or complexity, drawing on the strengths of each party. Real collaboration would enable us to preserve patient choice—among physicians, health plans, and benefit packages—and in fact make those choices far more meaningful with better information and some degree of standardization.

Possible areas for public–private collaboration include the establishment of common payment methods, performance rewards, and benefit packages. The public sector should probably take the lead in funding research on cost-effectiveness and improving quality and efficiency, creating a national institute on clinical excellence and efficiency, and establishing information technology standards. The private sector should probably take the lead in promoting professionalism in health care and incorporating quality improvement processes in organizational accreditation and certification of health care professionals.

Some governments negotiate with pharmaceutical companies to obtain better prices. A similar policy could produce significant savings in the United States—enough to finance a comprehensive Medicare drug benefit, according to one study.

Relative price of 30 pharmaceuticals, 2003



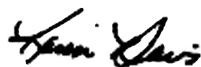
Relative prices assume no U.S. discount. Gerard F. Anderson et al., "Doughnut Holes and Price Controls," *Health Affairs* Web Exclusive (July 21, 2004).

The most controversial determinations would involve insurance, and specifically whether insurance should be offered by private insurance companies, public programs, or both. It is worth remembering that the United States has long relied on a mixed private–public health insurance system. Medicare offers a self-insured option, as well as the opportunity for private insurance plans to participate. In most states, Medicaid offers self-insured public coverage and widespread participation by private managed care plans. The Federal Employees Health Benefits Program includes private managed care plans, but its preferred provider organization plans are at financial risk for administrative but not medical expenses.[53] Retaining public insurance options as well as private managed care plans would give people enrolled in public programs the opportunity for choice.

Another major issue would be whether to use the purchasing clout of public programs, or a public–private

consortium of payers, to negotiate prices for pharmaceuticals and health care services. Other countries use the power of government to obtain lower prices—a difference that in large part explains the higher cost of health care in the United States.[54] Recent Fund-supported work, for example, shows that a comprehensive prescription drug benefit could be financed from the savings that would result if Medicare were to negotiate pharmaceutical prices comparable to those paid in other major industrialized countries.[55] The downside might be reduced investment in pharmaceutical research and development. This represents a major policy choice—but, at a minimum, differentials in prices across payers should be narrowed.

The Commonwealth Fund seeks to be a catalyst for transformational change by identifying promising practices in the United States and internationally and by contributing to solutions that could help us achieve such a vision. The Fund's role is to help establish a base of scientific evidence on what works, mobilize talented people to transform health care organizations, and collaborate with organizations that share its concerns. Our communications efforts, including a redesigned website at www.cmwf.org, enable us to spread the word, share knowledge and experience, and urge the agenda forward. At this critical juncture, we hope our work will contribute toward achieving a 2020 vision for American health care with better access, improved quality, and greater efficiency.[56]



REFERENCES

[1] U. E. Reinhardt, P. S. Hussey and G. F. Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs* 23 (May/June 2004): 10–25.

[2] K. Levit, C. Smith, C. Cowan et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23 (Jan./Feb. 2004): 147–59.

[3] S. Hefler, S. Smith, S. Keehan et al., "Health Spending Projections Through 2013," *Health Affairs* Web Exclusive (Feb. 11, 2004): W4-79–W4-93.

[4] The Commonwealth Fund International Working Group on Quality Indicators, *First Report and Recommendations of the Commonwealth Fund's International Working Group on Quality Indicators: A Report to Health Ministers of Australia, Canada, New Zealand, the United Kingdom, and the United States* (New York: The Commonwealth Fund, June 2004).

[5] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2003* (Washington D.C.: U.S. Government Printing Office, 2004).

[6] J. Gabel, G. Claxton, I. Gil et al., "Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage," *Health Affairs* 23 (Sept./Oct. 2004): 200–09.

[7] S. R. Collins, M. M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from The Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Mar. 2004).

[8] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academies Press, 2001).

[9] L. Shelton, L. Aiuppa, and P. Torda, *Recommendations for Improving the Quality of Physician Directory Information on the Internet* (New York: The Commonwealth Fund, Aug. 2004).

[10] K. Davis, "The Danish Health System Through an American Lens," *Health Policy* 59 (Feb. 2002): 119–32.

[11] D. M. Berwick, *Escape Fire: Lessons for the Future of Health Care* (New York: The Commonwealth Fund, Nov. 2002).

[12] C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, K. Davis, K. Zapert, and J. Peugh, "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs* Web Exclusive (Oct. 28, 2004): W4-487–W4-503.

[13] K. Davis et al., *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care Through the Patient's Lens* (New York: The Commonwealth Fund, Jan. 2004).

[14] E. S. Fisher, D. E. Wennberg, T. A. Stukel et al., "The Implications of Regional Variations in Medicare Spending: Part I. The Context, Quality, and Accessibility of Care," *Annals of Internal Medicine* 138 (Feb. 18, 2003): 273–87.

[15] K. Davis, *Will Consumer-Directed Health Care Improve System Performance?* (New York: The Commonwealth Fund, Aug. 2004).

[16] M. Naylor, "Making the Bridge from Hospital to Home: Grantee Spotlight," *The Commonwealth Fund Quarterly* (Fall 2003): 2.

[17] A. Saperstein, *Better Management of Asthma Through Improved Monitoring and Communication,* Commonwealth Fund Clinical Tool, Aug. 2004.

[18] H. Smits, B. Zarowitz, V. K. Sahney et al., *The Business Case for Pharmaceutical Management: A Case Study of Henry Ford Health System* (New York: The Commonwealth Fund, Apr. 2003).

[19] P. Gordon and M. Chin, *Achieving a New Standard in Primary Care for Low-Income Populations: Case Studies of Redesign and Change Tthrough a Learning Collaborative* (New York: The Commonwealth Fund, Aug. 2004).

[20] J. A. Meyer, S. Silow-Carroll, T. Kutyla et al., *Hospital Quality: Ingredients for Success—Overview and Lessons Learned* (New York: The Commonwealth Fund, July 2004).

[21] J. L. Smetzer, A. J. Vaida, M. R. Cohen et al., "Findings from the ISMP Medication Safety Self-Assessment for Hospitals Patient Safety," *Joint Commission Journal on Quality and Safety* 29 (Nov. 2003): 586–97.

[22] K. LaPane, *Evaluating Drug Regimens Before Problems Occur,* Commonwealth Fund Clinical Tool, Aug. 2004.

[23] S. C. Schoenbaum and R. R. Bovbjerg, "Malpractice Reform Must Include Steps to Prevent Medical Injury," *Annals of Internal Medicine* 140 (Jan. 6, 2004): 51–53.

[24] National Academy for State Health Policy, *State-Based Mandatory Reporting of Medical Errors: An Analysis of the Legal and Policy Issues* (Portland, Maine: NASHP, Mar. 2001).

[25] Fisher, "Implications of Regional Variations," 2003.

[26] "Overuse as a Quality Problem," The Commonwealth Fund Quality Improvement Leaders Network Monthly Email Update, Feb. 12, 2004.

[27] S. C. Schoenbaum, A.-M. J. Audet, and K. Davis, "Obtaining Greater Value from Health Care: The Roles of the U.S. Government," *Health Affairs* 22 (Nov./Dec. 2003): 183–90.

[28] Fisher, "Implications of Regional Variations," 2003.

[29] K. Davis, *Making Health Care Affordable for All Americans* (New York: The Commonwealth Fund, Jan. 2004).

[30] Leapfrog Group, *Incentive and Reward Compendium,* June 30, 2004.

[31] Collins, *Affordability Crisis,* 2004.

[32] Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (Washington, D.C.: National Academies Press, Jan. 2004).

[33] K. Davis, *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (New York: The Commonwealth Fund, Dec. 2001).

[34] K. Davis and Barbara S. Cooper, *American Health Care: Why So Costly?* (New York: The Commonwealth Fund, June 2003).

[35] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (Apr. 23, 2003): W3-199–W3-211.

[36] Institute of Medicine, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* (Washington, D.C.: National Academies Press, Nov. 2002).

[37] P. F. Short, D. R. Graefe, and C. Schoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem* (New York: The Commonwealth Fund, Nov. 2003).

[38] S. Dorn and T. Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002* (New York: The Commonwealth Fund, Apr. 2004).

[39] K. Davis, C. Schoen, M. M. Doty, and Katie Tenney, "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive (Oct. 9, 2002): W311–W324.

[40] S. B. Dale and J. M. Verdier, *Elimination of Medicare's Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs* (New York: The Commonwealth Fund, July 2003).

[41] S. R. Collins, C. Schoen, K. Tenney, M. M. Doty, and A. Ho, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, May 2004).

[42] Short, *Churn, Churn, Churn,* 2003.

[43] K. Lipson, E. Fishman, P. Boozang et al., *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs* (New York: The Commonwealth Fund, Aug. 2003).

[44] L. Ku and D. Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families* (New York: The Commonwealth Fund, Dec. 2002).

[45] K. Davis, *Hospital Pricing Behavior and Patient Financial Risk* (New York: The Commonwealth Fund, June 2004).

[46] S. R. Collins, *Health Care Costs and Instability of Insurance: Impact on Patients' Experiences with Care and Medical Bills* (New York: The Commonwealth Fund, June 2004).

[47] Collins, *Affordability Crisis,* 2004.

[48] Ibid.

[49] S. R. Collins, C. Schoen, M. M. Doty, and A. L. Holmgren, J*ob-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (New York: The Commonwealth Fund, Mar. 2004).

[50] J. L. Medoff, H.B. Shapiro, M. Calabrese et al., *How the New Labor Market Is Squeezing Workforce Health Benefits* (New York: The Commonwealth Fund, June 2001).

[51] S. R. Collins, K. Davis, and A. Ho, "A Shared Responsibility: U.S. Companies and the Provision of Health Insurance to Employees," forthcoming.

[52] J. R. Gabel and J. D. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees* (New York: The Commonwealth Fund, Apr. 2004).

[53] K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003).

[54] G. F Anderson, U. E Reinhardt, P. S Hussey et al., "It's the Prices Stupid: Why the U.S. Is So Different from Other Countries," *Health Affairs* 22 (May/June 2003): 89–105.

[55] G. F. Anderson, D. G. Shea, and P. S. Hussey, "Doughnut Holes and Price Controls," *Health Affairs* Web Exclusive (July 21, 2004): W4-396–W4-404.

[56] K. Davis, C. Schoen, and S. C. Schoenbaum, "A 2020 Vision of American Health Care," *Archives of Internal Medicine* 160 (Dec. 11–25, 2000): 3357–62.

Samuel O. Thier, M.D.
Chairman, Board of Directors

2004 Annual Report

The Fund's Mission, Goals, and Strategy

The Fund's board of directors plays a vital role in deciding where and how the foundation should strive to make an impact, given its limited resources. At a recent meeting, Fund assistant vice president Edward L. Schor, M.D., (left) and Errol R. Alden, M.D., executive director of the American Academy of Pediatrics, spoke to the Board about the importance of supporting efforts to improve preventive care services for young children.

The Fund carries out its broad charge of advancing the common good by supporting efforts that help people live healthy and productive lives and by assisting specific groups with serious and neglected problems. To that end, it supports independent research on health and social issues and makes grants to improve health care practice and policy.

The foundation's current goals—which express the Fund's long-term mission and its assessment of how it can best address certain pressing social issues—are threefold:

- **Improve health insurance coverage and access to care for all Americans**
- **Improve the quality of health care services and stimulate innovation in health care delivery**
- **Promote international exchange on health care policy and practice.**

The Fund's programs are organized in pursuit of those goals, following a well-defined set of principal strategies:

Goal: Improve health insurance coverage and access to care for all Americans

- Help develop a health insurance system that meets the needs of a 21st century population
- Focus national attention on the uninsured and emerging insurance issues
- Identify, support, and assess promising state and other initiatives to expand or improve coverage
- Develop and assess policy options to expand and stabilize health insurance
- Help preserve and strengthen the ability of Medicare to guarantee access to health services for the nation's current and future elderly and disabled beneficiaries
- Reduce the number of uninsured in New York City and connect low-income New Yorkers with better-quality primary care.

Goal: Improve the quality of health care services and stimulate innovation in health care delivery

- Increase the availability and accessibility of reliable information on the quality of health care and performance of providers that can be trusted by both physicians and patients
- Examine incentives—financial and non-financial, including policies, regulations, liability, accreditation, credentialing, and others—to foster quality
- Help build organizational and systemic capacity for change to improve quality
- Improve quality and reduce disparities in health care for low-income and racial or ethnic minority patients by identifying problems in health care quality and their causes, developing or identifying and evaluating new approaches to addressing disparities, and encouraging the

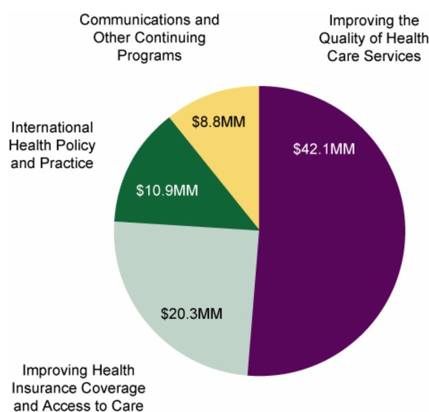
replication and dissemination of new approaches and practices

- Remedy the shortfall of minority physician leaders who are well trained in clinical medicine, health policy, public health, and health management
- Ensure that appropriate developmental and preventive child health services are available to all families, especially those with young children and low income
- Improve the quality of care and quality of life for people living in nursing homes.

Goal: Promote international exchange on health care policy and practice

- Develop an international network of policy-oriented health care researchers and practitioners
- Help keep policymakers in the United States informed of developments in, and transferable lessons from, other industrialized countries
- Foster the development of international collaborative programs to improve care.

Planned extramural grants spending: $82.1 million, fiscal years 2004-05 through 2008-09



In addition to grants programs pursuing those strategies, the Fund conducts programs in communications and in research, evaluation, and health policy that advance its objectives.

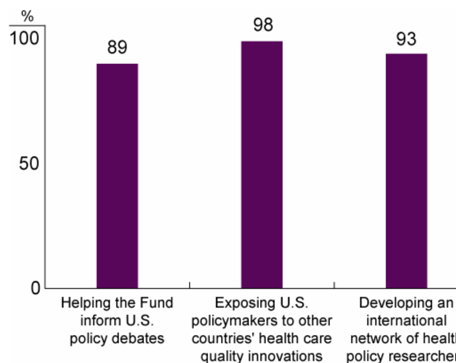
The Fund's total programmatic spending over the five-year period 2004–08 is expected to be $134.5 million. Of that amount, it is anticipated that 62 percent, or $82 million, will be spent as grants, allocated across program areas as follows: 32 percent to improving the quality of health care services, 15 percent to improving health insurance coverage and access to care, 8 percent to international health policy and practice, and 7 percent to other continuing programs. Reflecting the foundation's value-added approach to grantmaking, 38 percent

of the total budget will be devoted to intramural units engaged in program development and management, research, collaborations with grantees, and dissemination. This allocation includes $9.0 million to communicate the results of Fund-sponsored work and funds to operate programs directly managed by the foundation: the Task Force on the Future of Health Insurance; Research, Evaluation, and Health Policy; and International Health Policy, including Harkness Fellows in Health Policy. The foundation expects to spend approximately 5 percent of its extramural program budget on surveys, which have proven to be useful in informing policy debates and developing programs.

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 regularly reviews its major programs and activities to assess their effectiveness and reexamine their strategies. In 2004, the Fund carried out a review of its international health policy program, a major aspect of which was an international survey of the program's target audiences, Harkness Fellows in Health Care Policy returned to their home countries, and mentors of Harkness Fellows over the last six years. The survey and program review, conducted by David Blumenthal, M.D., Director of the Institute for Health Policy at Massachusetts General Hospital/Partners HealthCare System, provided strong endorsement of the foundation's investment in

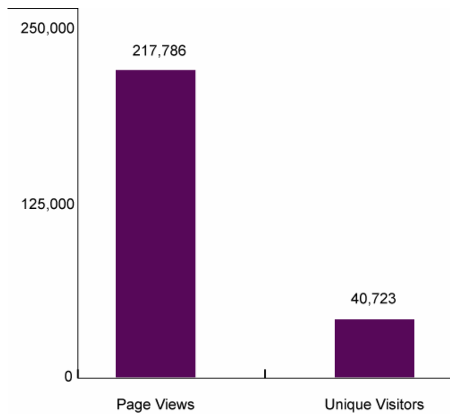
Audiences indicate that the Fund's International Program in Health Policy and Practice is achieving its objectives



international health policy and practice exchange. It cited particularly the strong role that the program is playing in disseminating promising quality improvement innovations among industrialized countries and the contributions of Harkness Fellows to improved policies both in their home countries and in the U.S. The review recommended steps to increase the impact of the program in the United States, through further engagement of policy officials.

The Fund's continuing commitment to communicating the results of its work to influential audiences was evidenced in 2004 by a major overhaul of its Web site, cmwf.org. Through numerous new features increasing its functionality, the new site makes it easier to find reports and program information, tailors information for key audiences such as journalists and those interested in emerging tools and innovations to improve care, and more accurately reflects the breadth and depth of Fund-supported work. With nearly 41,000 unique visitors and 218,000 Web page views each month, the site is proving to be a highly efficient and productive vehicle for distributing and publicizing the some 100 publications—Fund reports, chartbooks, issue briefs, and peer-journal articles—produced by the foundation's grantees and staff each year. It is also increasingly useful for communicating through webcasts important Fund-sponsored events—as they happen—to influential audiences and providing such services as "Washington Health Policy Week in Review" to Fund audiences.

The Fund's Web site has nearly 41,000 monthly visitors, who access a wide range of new information on health policy and practice



Cathy Schoen
Vice President

2004 Annual Report

Improving Health Insurance Coverage and Access to Care

Identifying ways to make the nation's health insurance system better meet the needs of American families is central to the mission of the Fund's Program on Improving Health Insurance Coverage and Access to Care.

Access to adequate, affordable, and secure health insurance is essential to the U.S. health care system and the nation's economy. Without it, the doors to high-quality medical care will remain closed for many American families, and the possibility of catastrophic medical bills will continue to threaten their economic security.

Despite efforts by the states to expand health coverage incrementally and maintain funding for public insurance programs, the number of uninsured Americans has continued to grow. Forty-five million were without health coverage in 2003, an increase of 5.2 million from 2000. Millions more face the periodic loss of insurance, with as many as one of four Americans under age 65 experiencing a time without coverage during the course of a year. Within the insured population, the ongoing erosion in the quality of coverage—as evidenced by rising deductibles and patient cost-sharing—has led to new concerns about people's ability to pay for needed care even with insurance.

Spurred by growing public concern about the future, comprehensive health reform is once again on the nation's

agenda. Restructuring the nation's health insurance system to better meet the needs of American workers and families is central to the mission of The Commonwealth Fund. Three Fund programs focus on improving coverage and access to care:

- **The Task Force on the Future of Health Insurance** seeks ways to expand rates of coverage and improve the quality and stability of coverage for the under-65, working-age population.
- **The Health Care in New York City Program** strives to reduce the high rate of uninsured among city residents and improve access to care for low-income and other vulnerable groups.
- **The Program on Medicare's Future** works to preserve and strengthen the current and future ability of Medicare to guarantee access to health care for elderly and disabled beneficiaries.

Task Force on the Future of Health Insurance

One of the priorities of the Fund's Task Force on the Future of Health Insurance is identifying and promoting replication of successful strategies to provide at-risk Americans with access to affordable coverage and care. In a growing number of communities, local leaders and providers are combining case management with innovative financing mechanisms to furnish free or discounted health care services to people who lack access to affordable coverage.

The Fund's Task Force on the Future of Health Insurance is an independent, nonpartisan forum created to explore strategies for expanding and improving health insurance coverage for the under-65 population. Its members, drawn from the health care, business, labor, government, and policy research communities, collaborate to develop policy options, assess promising models for insurance expansion, and address the effects of market and policy changes on the stability, quality, and affordability of health insurance. James J. Mongan, M.D., president and CEO of Partners HealthCare System, Inc., chairs the Task Force, which meets twice a year.

Health care reform is near the top of the nation's policy agenda for the first time in over a decade, driven by turmoil in the private insurance markets and state public insurance

programs. Reform strategies were proposed by nearly all of this year's presidential candidates as well as Democratic and Republican members of Congress, private sector groups, and leading academics. The Task Force helped inform the debate by offering policy options for achieving universal coverage and strategies to control health care costs.

Sara R. Collins
Senior Program Officer

The universal coverage framework offered by Fund president Karen Davis and vice president Cathy Schoen in their 2003 *Health Affairs* article, "Creating Consensus on Coverage Options,"[1] proved useful to candidates in shaping their platforms. The "Creating Consensus" framework, which builds on existing group insurance options such as the Federal Employees Health Benefits Program, is intended to help bridge differences between public and private approaches to health insurance reform. The Task Force also made an impact with its examination of the presidential candidates' reform plans, which included a comparison of coverage and cost estimates.[2] The study, which was updated at key junctures throughout the campaign, became an important resource for the public and the press; in fact, report downloads from the Fund's Web site exceeded 40,000.

Task Force member
George Halvorson
Chairman and CEO
Kaiser Foundation Health Plan

In the post-election era, the Task Force will continue to inform and advance the debate over health insurance reform. Timely analyses of initiatives recently implemented or championed by the Administration and Congress will provide crucial information about their ability to reduce the uninsured rate, enhance access to affordable care, or reduce insurance costs to workers and businesses. One such initiative is the health coverage tax credit program enacted as part of the 2002 Trade Act. The program, designed to help workers who have been displaced by globalization buy health insurance, has been the focus of recent work undertaken by Fund grantee Stan

Dorn of the Economic and Social Research Institute. At an April 2004 congressional briefing, Dorn reported that despite technical achievements in issuing the credits, enrollment in the program has been lower than expected, primarily because health plan premiums are too costly for many unemployed workers.[3] Both the Administration and Congress have relied on Dorn's research findings to explore ways to expand the tax credit's impact. The Task Force is now supporting Dorn's evaluation of the program's second year of operation.

Association health plans, which are offered by some professional and trade associations, have also been advanced as a way for small employers to purchase affordable health insurance coverage. Some proposals would allow these plans to bypass state insurance regulations, including reserve requirements. In her work, Task Force grantee Mila Kofman of Georgetown University revealed the pitfalls of such plans. Kofman found that the bankruptcies of unauthorized health plans, including association plans, have left nearly 100,000 people with approximately $85 million in medical debt since 2001.[4] In invited testimony before a hearing held by Senator Charles Grassley, Kofman called for stronger criminal penalties against such insurance scams.

Mila Kofman
Assistant Research Professor
Georgetown University

In related work, Kofman documented the insolvency risks with association health plans and similar insurance arrangements and recounted the experience of some states that have tried to regulate these plans.[5] Kofman's new work will focus on the financial protection provided by insurance discount cards.

Many employers are coping with rising premium costs by offering new insurance products that shift more financial risk to employees. This trend may accelerate with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act and its provision to create Health Savings Accounts (HSAs). These accounts can be used in combination

with high-deductible health plans (for example, a plan with a deductible of $1,000 or more for individuals). According to research led by the Health Research and Educational Trust's Jon Gabel, in the next two years up to 30 percent of employees will have a choice of a high-deductible or other type of "consumer-driven" health plan.[6]

The Task Force has tried to clarify what can and cannot be expected from such plans. In September 2003, for instance, the Task Force co-sponsored a conference with the Robert Wood Johnson Foundation at which Karen Davis warned that consumers may skimp on both needed and unneeded care, with low-income patients particularly at risk. Meanwhile, Columbia University researcher and Task Force grantee Sherry Glied is examining the potential of HSAs and high-deductible plans to cover more of the uninsured and their likely impact on group insurance markets.

The Task Force is also training its sights on reform options at the state level. With many states poised to emerge from troubled fiscal times, Task Force members, staff, and grantees are playing an active role in advancing states' coverage expansion initiatives. In a report co-sponsored by the Fund and Robert Wood Johnson Foundation, for example, the National Academy for State Health Policy detailed the development and early achievements of Maine's Dirigo Health Plan.[7,8] The plan aims to make quality, affordable health care available to every state resident within five years while initiating new processes for containing costs and improving health care quality. In the year ahead, the Task Force will be keeping close tabs on the progress of Maine's ambitious undertaking.

In February, Karen Davis was invited to attend a health summit sponsored by Governor Kathleen Blanco of Louisiana. The summit resulted in the formation of a health reform panel that was charged with developing a plan to cover the state's

800,000 uninsured residents; the Task Force is supporting the participation of George Washington University's Jeanne Lambrew as a technical expert on the panel. In Kansas, Governor Kathleen Sebelius hopes to develop a new health insurance coverage option for small businesses and their employees in 2005. The Task Force is providing a grant to researchers at the University of Kansas, the Massachusetts Institute of Technology, and Columbia University to help the state of Kansas determine the impact of different combinations of employee subsidies and employer tax credits on the total number of uninsured workers who could be covered through the new option.

Tracking trends in health insurance coverage is another mission of the Task Force. In late 2003, it conducted the latest Commonwealth Fund Biennial Health Insurance Survey, a nationally representative study of more than 4,000 adults that assesses trends in the extent of insurance coverage, the quality of insurance, and public sentiment regarding policies to expand coverage. Findings from the survey—which the Task Force is continuing to analyze—provide ample evidence of an "affordability crisis" in American health care.[9] Instability in insurance coverage appears to be growing, particularly among people with low incomes and minorities, while the quality of benefits for those with coverage is eroding. Large shares of uninsured and insured Americans alike reported not getting needed health care because of costs.

Paying medical bills is a problem as well. According to the biennial survey, two of five adults ages 19 to 64—more than 70 million people—had problems with medical bills in the past 12 months or were paying off medical debt accrued over the past three years. Medical bill problems were most common among those who experienced a period without coverage, with around 60 percent reporting that they had problems with bills or were currently paying off debt. But even those who were

continuously insured cited difficulties, particularly those with annual incomes less than $35,000. Given these results, it is perhaps unsurprising that most of those surveyed are in favor of federal efforts to extend health insurance coverage, and believe that the financing of care should continue to be a responsibility shared among individuals, employers, and the government.

Medical bill problems and medical debt are of increasing concern to policymakers. Newspaper reports have documented how some hospitals charge uninsured patients at rates higher than those negotiated with insurance companies. Other hospitals also charge high interest rates on debts owed by patients, have collection agencies harass them, or place liens on their homes.

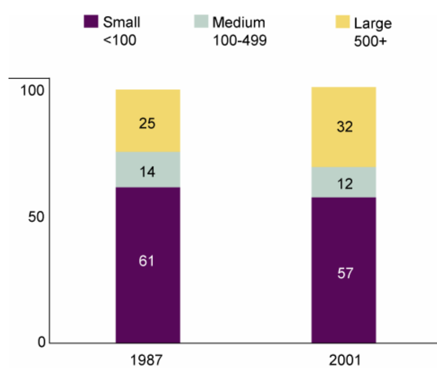
Spurred in part by Fund-supported work by the Access Project, the U.S. Department of Health and Human Services in February 2004 issued a clarification of its rules regarding hospital billing and collection practices, stating unambiguously that hospitals are free to waive the collection of fees to any patient or provide discounted care to uninsured patients who cannot afford to pay their bills.[10] Later, in June, Karen Davis and Sara Collins were invited to testify in two separate congressional hearings on pricing and debt collection practices of hospitals.[11,12] New Fund-supported work by Jeffrey Prottas of Brandeis University will further examine hospital billing practices and insurance coverage characteristics that may also contribute to medical debt.

The hospital pricing and collection practices described above are symptoms of a safety net system under tremendous strain. Task Force–supported research by Gerry Fairbrother and colleagues at the New York Academy of Medicine shows that community health centers find it difficult or impossible to arrange off-site care for their uninsured patients. The researchers also found that internists report difficulties

referring their uninsured patients for laboratory tests, diagnostic procedures such as mammograms and colonoscopies, and prescription drugs.[13] Sherry Glied documented that patients without health insurance do not have the same access to innovative treatments that insured patients do for three medical conditions—heart attack, cataracts, and depression. This omission costs the U.S. health system and the economy an estimated $1.1 billion in higher morbidity and mortality.[14]

Another focus of Task Force tracking and analysis is employer-sponsored health coverage—the backbone of the U.S. system of health insurance. In recent years, double-digit annual increases in insurance premiums have forced many employers to shift more of their health care costs to employees. According to Fund-supported work by Jon Gabel, small businesses have been particularly hard hit because they face greater costs compared with large employers and higher financial risks from providing benefits to small pools of workers.[15] As a result, workers in small businesses are more likely than their counterparts in larger firms to be uninsured, pay more of their premium costs, and face higher deductibles.

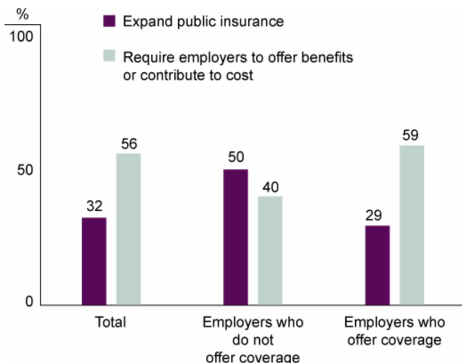
Proportion of uninsured workers by firm size, 1987-2001



S. Glied, S. Little, and J.M. Lambrew, *The Growing Share of Uninsured Workers Employed by Large Firms,* The Commonwealth Fund, October 2003.

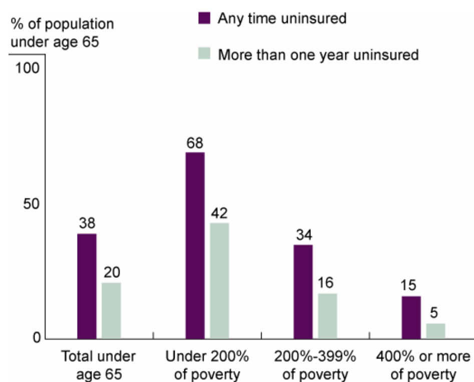
While workers in small firms face more coverage risk, new research supported by the Task Force shows there are growing numbers of uninsured workers at large firms. Columbia University's Sherry Glied and Sarah Little, along with George Washington University's Jeanne Lambrew, have found that the long-term shift away from manufacturing in the U.S. economy, coupled with a declining rate of unionization in the workforce, has led to an increase in the share of uninsured workers employed at large firms. From 1987 to 2001, the proportion of uninsured workers employed by firms with more that 500 employees grew from 25 percent to 32 percent.[16] New work by Peter Fisher and David West of the Iowa Policy Project and the Center for a Changing Workforce is examining the

Employer preferences among policy options to cover uninsured workers



S. R. Collins, et al., *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,* The Commonwealth Fund, March 2004.

38 percent of nonelderly people were uninsured over the period, 1996-99



P. F. Short, D. Graefe, and C. Schoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem,* The Commonwealth Fund, November 2003.

insurance coverage of temporary, part-time, and contingent workers at both small and large firms.

Even so, both small and large employers feel it is important for companies to offer health benefits to their workers, according to a Commonwealth Fund Supplement to the 2003 National Organizations Study.[17] Most employers said they would support a variety of policy options that would expand health insurance coverage and make it more affordable, including requiring employers to offer coverage.

Additional research by the Task Force has broken ground in understanding the dynamics of insurance coverage, in particular showing that insurance coverage is far from static in the U.S. population. While many people remain uninsured for long periods, others cycle on and off coverage. People with gaps in insurance coverage are much more likely to experience health care access problems and difficulty paying medical bills than those with uninterrupted coverage. Task Force–supported research by Pamela Farley Short finds that 85 million Americans were without health insurance at some point between 1996 and 1999. This is more than double the number of uninsured individuals at any point or in any one year during this period.[18,19] Fund-supported projects will be examining the effect of this "churning" on access to health care and documenting its cost to public insurance programs across the country.

Hispanics are at particularly high risk of experiencing gaps in their coverage or undergoing long periods without coverage. Task Force staff members Michelle Doty and Alyssa Holmgren found that 37 percent of Hispanic workers with incomes under 200 percent of poverty who had been employed full-time between 1996 and 2000 were uninsured for the entire four years.[20] Through a grant to the National Alliance for Hispanic Health, the Task Force supported a working meeting to mobilize Hispanic community leaders in support of

expanding insurance coverage for Hispanics and generating agreement on specific ways to tailor major insurance coverage initiatives to the needs of this population.

Young adults also often find themselves in an insurance coverage "limbo." Research by Task Force staff found that substantial churning in young adults' insurance coverage is a result of eligibility changes in both public and private programs as well as leaving high school and college. Policy recommendations presented in the Task Force brief, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help,* formed the basis of a bill introduced by Representative Vic Snyder to give states the option to increase the Medicaid and CHIP age limit from age 18 to 23.[21]

Older adults who are nearing retirement but still too young for Medicare are likewise at heightened risk of losing their insurance coverage. In 2005, the Task Force will be examining the insurance experience of older Americans with a new survey of people ages 50 to 70. The survey will shed light on the new Medicare prescription drug discount cards, retiree health benefits, financial security in the later years, and new coverage options for people approaching retirement.

Health Care in New York City Program

As many as one of four New York City residents lacks health insurance.[22] Without health coverage, uninsured New Yorkers—mostly low-income, working adults—are much less likely to get important check-ups, screenings, and other needed medical care.[23] To improve health coverage and services for the city's most vulnerable residents, the Fund's Health Care in New York City Program supports research on insurance issues and promotes adoption of promising practices that can lead to better-quality care.

The Fund is currently supporting a project with the New York City mayor's office to find ways to cover uninsured schoolchildren and connect those most in need with a "medical home." As part of the effort, a school-based health access team of parents, school nurses, primary care providers, and health plan case managers will monitor the health of at-risk students.

Jennifer Edwards
Senior Program Officer

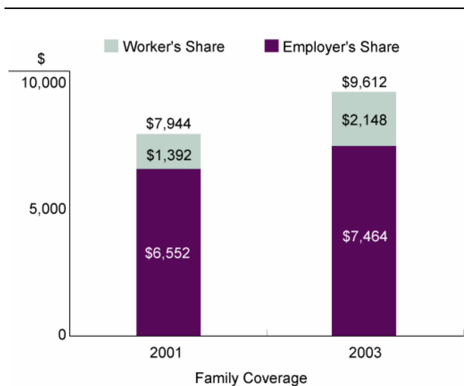
As part of a national campaign to raise awareness about the uninsured, program officer Jennifer Edwards joined city leaders in May to speak about the declining quality of employer-sponsored health insurance and the resulting impact on New York's families. Edwards cited a Fund survey of New York employers, conducted by the Health Research and Educational Trust, findings of which showed that in order to manage rising health costs, employers are increasing the share of health plan costs borne by workers and their families. Employee contributions for family health benefits rose by more than 50 percent from 2001 to 2003, from $1,392 to $2,148, and fewer workers opted for family coverage.

Moreover, two of five employers reported they are likely to increase the amount their workers pay in the next year, raising concerns that even more low-wage workers will be unable to afford coverage. Many employers expressed interest in helping lower-wage workers get coverage through public programs for which they may be eligible.[24]

With private coverage becoming less affordable, the ability of low-income families to obtain and keep their coverage in the state's various health insurance programs is more important than ever. A Fund-supported study conducted by Karen Lipson and colleagues from Manatt, Phelps and Phillips, LLP, found that many children are dropped from the rolls of Child Health Plus B—a program that provides health benefits to low-income children whose family income exceeds Medicaid limits—even though they are eligible to continue receiving coverage. According to the study, 93 percent of children who lost coverage were still eligible at the time of recertification, based on family size and income. The researchers recommend eliminating administrative barriers to retaining coverage as well as lengthening the period of

New York employers are increasing the share of the insurance premium that their workers' pay, delaying the start of benefits, and increasing cost-sharing at the point of service.

Share of health insurance premiums paid by New York employers and their workers



Edwards et al., *Employer-Sponsored Health Insurance in New York: Findings from the 2003 Commonwealth Fund/HRET Survey,* The Commonwealth Fund, May 2004.

eligibility for low-income children.[25] The Fund is supporting new work to explore the administrative and human costs of "churning," or repeated disenrollment and re-enrollment, in coverage programs.

Other Fund-supported work has investigated barriers to enrollment in public programs. Lake Snell Perry, an opinion research firm that focuses on social policy issues, has explored the reasons why many city residents failed to make the transition to Medicaid after their enrollment ended in a temporary program created in the wake of the September 11 terrorist attacks. Out of the 342,000 New Yorkers who signed up for Disaster Relief Medicaid, only 38 percent later applied for standard Medicaid benefits. Focus groups suggested that many people were confused by poor communication and deterred by negative perceptions of the Medicaid application experience.[26] Similarly, a study of workers in Chinatown, a neighborhood that was economically devastated by the attacks, found that a lack of accurate or easily accessible information hindered participation in a free, one-year coverage program.[27]

New York's Facilitated Enrollment Program was originally conceived as an interim solution to the complex enrollment requirements and procedures of state-subsidized programs. Now in its fifth year, the program, which enlists the help of volunteers based at nearly 50 community-based organizations, works with low-income families to navigate the confusing maze of rules and processes. The enrollers explain requirements to clients, help them locate documentation and fill out applications, and follow up with the Medicaid office and insurers. A Fund-sponsored study of enrollers documented the need for continuing this program.[28]

Connecting New Yorkers to sources of care, regardless of their health insurance status, is another key component of the Health Care in New York City Program. In the spring of 2004, Thomas Frieden, M.D., commissioner of the city's Department

of Health and Mental Hygiene, launched "Take Care New York," a campaign to achieve 10 health improvement goals—among them ensuring that every resident has a regular health care provider. The Department estimates that 1.4 million New Yorkers do not have a personal doctor, along with the benefits associated with continuous, coordinated care.[29]

Marjorie A. Cadogan
Executive Director
New York City Mayor's Office of Health Insurance Access

Concurrently, the Fund's program has expanded its scope to include improving linkages to primary care. A new project is helping to connect schoolchildren and their families with insurance and health care providers in disadvantaged neighborhoods, starting with elementary schools in Manhattan's East Harlem and the East New York/Bushwick section of Brooklyn. With Fund support, school nurses are working with the city health department, the Mayor's office, and local providers to identify and refer children in need to health care and coverage.

A second project focused on primary care access is testing a handheld computer called "Asthma Buddy," which is designed to help children monitor their asthma and communicate with nurses and doctors at hospitals. In a pilot study, the intervention significantly reduced hospital and emergency department (ED) admissions. The Fund is now supporting an evaluation to see if the improvements can be replicated in five hospitals across the city.[30]

Building on previous Fund-supported work conducted by John Billings of New York University,[31] a new initiative is testing innovative strategies to improve access to primary care and reduce ED use for nonemergency care. Billings' analysis has demonstrated that over three-quarters of ED visits in the city were for care that could have been provided in primary care settings. In launching this project, the Fund seeks to identify and evaluate innovations that connect ED users—many of whom are uninsured and low-income—with a regular source of primary care that is both acceptable and convenient.

Program on Medicare's Future

To help qualified beneficiaries sign up for the new Medicare prescription drug discount card as well as other assistance they may need, the Fund is supporting a multisite demonstration of a promising service called BenefitsCheckUp. More than 1 million seniors so far have used this Internet-based application to check their eligibility for various benefits. Outreach and hands-on assistance from local organizations are expected to enhance its effectiveness.

Since 1995, the Program on Medicare's Future has worked to advance the goals of the Medicare program in meeting the health needs of the nation's elderly and disabled populations. Over the past several years, the Fund has contributed significantly to the debate over fulfilling one of those needs—affordable prescription drugs. That debate culminated in the December 2003 passage of the largest benefit expansion in program history: the Medicare Prescription Drug, Improvement, and Modernization Act (MMA).

The new prescription drug benefit will provide significant subsidies for low-income beneficiaries by paying nearly all their drug costs, but it does not go into effect until 2006. In the meantime, low-income seniors can sign up to receive a drug discount card that will provide them with $600 toward their yearly drug costs. Following the enactment of MMA, the Fund announced that one of its top priorities was seeing most of the nation's low-income beneficiaries enrolled in the discount card program.

Research has shown, however, that only about 1.5 million of 7 million low-income eligible Medicare beneficiaries are signed up to receive other subsidies designed to assist them with their prescription drug costs.[32] Consequently, many of the Fund's current efforts are dedicated to increasing enrollment. For example, the National Academy of Social Insurance is exploring administrative and legislative options to improve enrollment in all Medicare low-income subsidy programs. In addition, the National Council on the Aging is testing a community-based approach to reaching low-income seniors with BenefitsCheckUp, a Web-based tool, and the state of Minnesota is using Fund support to provide one-on-one assistance to help seniors fill out enrollment forms.

While the Medicare drug benefit is of great assistance to the very poor, it contains significant gaps in coverage for the "near poor"—those whose incomes are low, but not quite low enough to receive the maximum benefit. During the MMA debate, Dennis Shea of the University of Pennsylvania teamed with Bruce Stuart and colleagues at the University of Maryland to show that even with the drug benefit, the near-poor would still devote between 12 percent and 15 percent of their incomes to prescription drugs in 2006.[33]

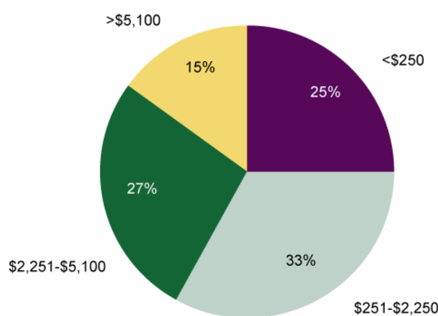
Bruce Stuart
Professor
University of Maryland School of Pharmacy

This situation will only worsen as beneficiaries' expenses rise with drug costs but incomes fail to keep up. The researchers will continue to examine the impact of the drug benefit design on the near-poor in future years.

Americans with chronic conditions and persistent high annual drug costs are also at risk, as illustrated by Marilyn Moon in a June 2004 Fund issue brief.[34] The drug benefit contains a deductible of $250 and provides no coverage for costs between $2,250 and $5,100. Beneficiaries with annual drug costs of $5,000, for example, will only receive $1,500 in drug assistance from the benefit and will be personally responsible for the remaining $3,500. Stuart and others are examining the "rollercoaster" created by fluctuations in out-of-pocket drug costs as people with persistent high drug costs move in and out of coverage each calendar quarter.

Forty-two percent of Medicare beneficiaries are expected to have annual prescription drug expenses of more than $2,250 in 2006—largely attributable to multiple chronic health conditions.

Level of prescription drug spending by the Medicare population, 2006



M. Moon, *How Beneficiaries Fare Under the New Medicare Drug Bill,* The Commonwealth Fund, June 2004. Based on Congressional Budget Office estimates.

The Fund is studying ways to close the gap in drug coverage and reduce other out-of-pocket costs for beneficiaries. One method is incorporating drug and Medigap-type coverage into the traditional Medicare program and offering it as an elective, comprehensive, high-option benefit. This kind of package would have a low deductible, low cost-sharing, and no coverage gap, while offering catastrophic protection. It also would cost beneficiaries far less than the typical premiums for Medigap policies and the forthcoming drug benefit.

To further improve the financial security of seniors, the Fund plans to explore the feasibility of providing current and future beneficiaries with the opportunity to "pre-fund" supplemental benefits. Beneficiaries would be able to start accumulating contributions at age 50 by deducting pre-tax dollars from earnings and investing them in individual Medicare savings accounts. The funds could be available for long-term care expenses, prescription drugs, or other services, or they could be used to buy into Medicare before age 65.

In addition to the financial difficulties associated with high out-of-pocket costs, beneficiaries face the anxiety of trying to navigate our complex health care system. In an October 2003 issue brief,[35] Moon and colleagues reported that more than one-third of Medicare beneficiaries have four or more chronic conditions and more than one-half of beneficiaries see two to three physicians in one year. All beneficiaries—especially those with multiple chronic conditions—must grapple with health care decisions: which types of clinicians to see, when to visit providers, what kind of care is best, and what they can do to help manage their conditions. Individuals could be better served by clinicians who would oversee all their care, help them navigate the health care system, provide information on self-care, and serve as advocates. To this end, the Fund will be exploring a medical home benefit that offers each beneficiary a patient-centered care practice. The Fund is also investigating how to provide a post-hospital care coordination benefit for those high-cost, high-risk beneficiaries who spend time in hospitals.

The benefits of a medical home, prescription drug coverage, and other services are important developments. But, in order to receive optimal care, the Medicare program and its beneficiaries still must identify the top-performing health care providers—those furnishing the highest quality care at relatively low cost. The Fund is planning to sponsor research to

advance state-of-the art performance measurement that will provide information to improve care and efficiency for Medicare beneficiaries.

REFERENCES

[1] K. Davis and C. Schoen, "Creating Consensus on Coverage Options," *Health Affairs* Web Exclusive (Apr. 23, 2003).

[2] S. R. Collins, K. Davis, J. M. Lambrew, *Health Care Reform Returns to the National Agenda: 2004 Presidential Candidates' Proposals,* The Commonwealth Fund, Sept. 2003 (last updated Oct. 8, 2004).

[3] S. Dorn and T. Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002,* The Commonwealth Fund, Apr. 2004.

[4] M. Kofman, K. Lucia, and E. Bangit, *Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed,* The Commonwealth Fund, Aug. 2003.

[5] M. Kofman, E. Bangit, and K. Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges,* The Commonwealth Fund, March 2004.

[6] J. R. Gabel, H. Whitmore, T. Rice et al., "Employers' Contradictory Views about Consumer-Driven Health Care: Results from a National Survey," *Health Affairs* Web Exclusive, Apr. 21, 2004.

[7] J. Rosenthal and C. Pernice, *Designing Maine's DirigoChoice Benefit Plan,* The Commonwealth Fund, December 2004.

[8] J. Rosenthal and C. Pernice, *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine,* The Commonwealth Fund, June 2004.

[9] S. R. Collins, M. M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund, March 2004.

[10] C. Pryor, R. Seifert et al., *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt,* The Commonwealth Fund, June 2003; also see June 2004 update.

[11] K. Davis, *Hospital Pricing Behavior and Patient Financial Risk,* Invited Testimony, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Hearing on "Pricing Practices of Hospitals," June 22, 2004.

[12] S. R. Collins, *Health Care Costs and Instability of Insurance: Impact on Patients' Experiences with Care and Medical Bills,* Invited Testimony, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives, Hearing on "A Review of Hospital Billing and Collection Practices," June 24, 2004.

[13] G. Fairbrother, M. Gusmano, H. Park et al., "Care for the Uninsured in General Internists' Private Offices," *Health Affairs* 22 (Nov./Dec. 2003).

[14] S. Glied, "The Uninsured and the Benefits of Medical Progress," *Health Affairs* 22 (July/Aug. 2003).

[15] J. Gabel and J. D. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees,* The Commonwealth Fund, Apr. 2004.

[16] S. Glied, J. M. Lambrew, and S. Little, *The Growing Share of Uninsured Workers Employed by Large Firms,* The Commonwealth Fund, Oct. 2003.

[17] S. R. Collins, C. Schoen, M. M. Doty, and A. L. Holmgren, *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,* The Commonwealth Fund, Mar. 2004.

[18] P. F. Short and D. Graefe, "Battery Powered Health Insurance?: Stability and Instability in Coverage of the Uninsured Over Time," *Health Affairs* 22 (Nov./Dec. 2003).

[19] P. F. Sbort, D. R. Graefe, and C. Schoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem,* The Commonwealth Fund, Nov. 2003.

[20] M. M. Doty and A. L. Holmgren, *Unequal Access: Insurance Instability Among Low-Income Workers and Minorities,* The Commonwealth Fund, Apr. 2004.

[21] S. R. Collins, C. Schoen, K. Tenney, M. M. Doty, and A. Ho, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help,* The Commonwealth Fund, (updated May 21, 2004); H.R. 3192, Medicaid/SCHIP Optional Coverage for Young Adults Act of 2003.

[22] D. Holahan et al., *Health Insurance Coverage in New York, 2002,* United Hospital Fund, May 2004.

[23] M. J. Crawford et al., "New Yorkers Without Health Care Coverage Are Not Getting the Care They Need," *NYC Vital Signs* 2004 3(1).

[24] J. Edwards et al., *Employer-Sponsored Health Insurance in New York: Findings from the 2003 Commonwealth Fund/HRET Survey,* The Commonwealth Fund, May 2004.

[25] K. Lipson et al., *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs,* The Commonwealth Fund, August 2003.

[26] E. LeCouteur, *New York's Disaster Relief Medicaid: What Happened When It Ended?* The Commonwealth Fund, July 2004.

[27] S.-C. Sim and C. Peng, *Lessons Learned from a Program to Sustain Health Coverage After September 11 in New York City's Chinatown,* The Commonwealth Fund, July 2004.

[28] E. Ward, *Report from the Field: New York's Facilitated Enrollers Speak,* Statewide Youth Advocacy, Inc., December 2003.

[29] M. J. Crawford et al., "New Yorkers Without Health Care Coverage Are Not Getting the Care They Need," *NYC Vital Signs* 2004: 3(1).

[30] " 'Asthma Buddy' May Help Kids Breathe Easier, Stay in School," *The Commonwealth Fund Quarterly,* Fall 2003.

[31] J. Billings, "Barriers to Timely and Effective Care: Looking Beyond Issues of Insurance Coverage," presentation to The Commonwealth Fund, February 2004.

[32] K. Davis, *Top Ten Health Policy Stories of 2004*, The Commonwealth Fund, December 2004.

[33] D. Shea, B. Stuart, and B. Briesacher, *Caught in Between: Prescription Drug Coverage of Medicare Beneficiaries Near Poverty,* The Commonwealth Fund, August 2003.

[34] M. Moon, *How Beneficiaries Fare Under the New Medicare Drug Bill,* The Commonwealth Fund, June 2004.

[35] C. Boccuti, M. Moon, and K. Dowling, *Chronic Conditions and Disabilities: Trends and Issues for Private Drug Plans,* The Commonwealth Fund, October 2003.

Stephen C. Schoenbaum, M.D.
Executive Vice President for Programs

2004 Annual Report

Improving the Quality of Health Care Services

Support for learning collaboratives and other proven, team-based approaches to improving care figures prominently in the work of the Health Care Quality Improvement Program. One such collaborative designed by New York City's Primary Care Development Corporation was instrumental in helping the Jerome Belson Health Center in the Bronx provide better, more efficient care to its patients, most of whom have developmental and physical disabilities. Following a redesign of its physical layout and an upgrade of its systems, the clinic was able to reduce waits as well as serve a greater number of patients each day.

The U.S. health care system produces enormous benefits for the patients it serves. Nonetheless, in each of the six dimensions of health care—safety, effectiveness, patient-centeredness, timeliness, equity, and efficiency—there is much room for improvement, both on an absolute basis and, in some instances, relative to the care that residents of other countries receive.

More people in health care today are talking about improving patient safety than they were five years ago when the Institute of Medicine released its seminal report, *To Err Is Human.* But it is not possible to say whether fewer people are dying or being harmed by medical error. Physician-recommended health care services are still not being delivered to millions of patients. Communication, an essential component of good, patient-centered care, could be improved for all patients, but particularly for minorities and those whose with limited English proficiency. Americans are less likely to be able to get same-day appointments with their primary care physicians than residents of many other industrialized nations. Disparities in the care received by minorities and low-income

patients are more the rule than the exception. And there is growing evidence that in many instances, it is possible to deliver more effective care with fewer resources.

The Commonwealth Fund is addressing the challenges of improving health care quality through four distinct programs:

- **Health Care Quality Improvement** focuses on developing information about quality, aligning financial incentives to stimulate quality improvement, and building the capacity of the health care system to achieve and sustain quality improvements.
- **Quality of Care for Underserved Populations** works to improve quality and reduce disparities in health care for low-income and minority patients by raising awareness of problems, identifying and developing methods to improve care, and evaluating the effectiveness of quality improvement programs.
- **Child Development and Preventive Care** is working to encourage, support, and sustain improvements in the way preventive care is provided to young children—especially those services dealing with cognitive, emotional, and social development.
- **Quality of Care for Frail Elders** strives to improve care for nursing home residents by helping to change the prevailing culture in facilities from one that is institutionally centered to one that is resident-centered.

Health Care Quality Improvement Program

Lucian L. Leape, M.D., adjunct professor of health policy, Department of Health Policy and Management, Harvard School of Public Health. An internationally recognized leader of the patient safety movement, Dr. Leape was one of a group of experts who met at the Fund's November 2004 Quality Improvement Colloquium to assess progress made and discuss the necessary next steps. Seated next to him are Dennis S. O'Leary, M.D. (center), president of the Joint Commission on Accreditation of Healthcare Organizations, and James Conway, executive vice president and chief operating officer of the Dana-Farber Cancer Institute.

The philosophy behind the Fund's Health Care Quality Improvement Program is that change is most likely to occur when a problem is understood and publicly recognized, when appropriate incentives are put in place, and when stakeholders have the capacity to initiate and sustain change. Consistent with this philosophy, the program continues to fund projects aimed at: 1) providing reliable information about quality of care to the public and the health care industry; 2) making a business case for improving quality of care; 3) improving coordination of care and teamwork among health care professionals; and 4) facilitating the exchange of information between physicians and patients.

In this past year, Fund staff published a paper in *Health Affairs* arguing that the problems experienced by the U.S. health care system are unlikely to be solved without strong leadership from the federal government.[1] Noting that U.S. health care costs, already highest in the world, continue to rise and that strategies to shift and minimize costs have not worked, authors Stephen Schoenbaum, M.D., Karen Davis, and Anne-Marie Audet, M.D., argued for a greater federal role in establishing an agenda to set national priorities, develop guidelines for health care, and help implement measures to track provider performance. The paper was the subject of a lively Fund-sponsored debate, shown live via webcast, that featured four of the nation's leading health care quality experts. Since the article's publication, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued a position paper calling for establishment of a new federal office for quality within the Department of Health and Human Services. In addition, members of Congress are

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

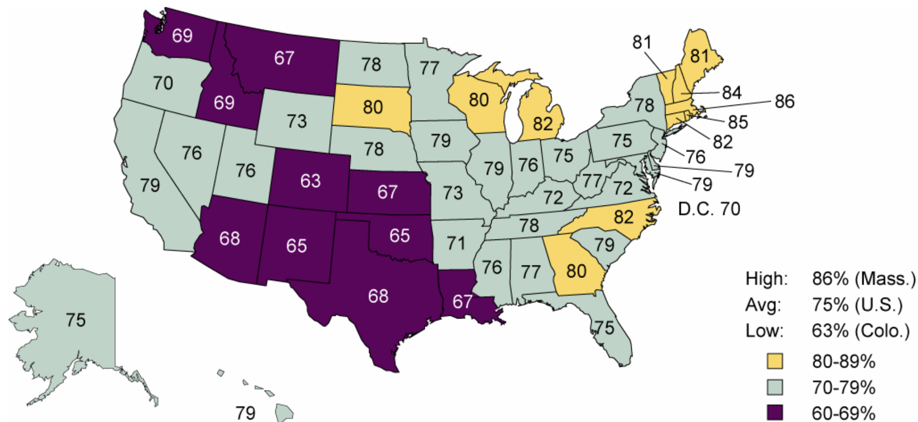
working on legislation to institute some of the government functions advocated in the article, including the setting of national priorities for quality.

Another report by Fund researchers, *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care Through the Patient's Lens,*[2] examined how the health system works from the perspective of patients. Its findings confirmed what several other recent studies have shown: that the U.S. performs worse than its peer nations on several dimensions of quality.

The quality of children's health care is the focus of the newest entry in the Fund's well-received and much-downloaded series of chartbooks on health care quality. Produced by Sheila Leatherman, research professor at the University of North Carolina at Chapel Hill, and Douglas McCarthy, president of Issues Research, Inc., this comprehensive resource provides easy-to-use information distilled from some 500 studies on preventive care, treatment of chronic conditions, mental health, and other areas of health

The Fund-supported *Quality of Health Care for Children and Adolescents: A Chartbook* identified gaps in the quality of pediatric care, such as the fact that only three-quarters of young children in the U.S. were up to date on their immunizations in 2002.

Percentage of children (ages 19-35 months) who received all recommended doses of five key vaccines in 2002*



*4:3:1:3:3 series = 4+ doses of diphtheria and tetanus toxoids and pertussis vaccine or diphtheria and tetanus toxoids only, 3+ doses of poliovirus vaccine, 1+ dose of a measles-containing vaccine, 3+ doses of *Haemophilus influenzae* type b vaccine, and 3+ does of hepatitis B vaccine.

National Center for Health Statistics, 2002 National Immunization Survey (N=30,000+ households), as reported by the CDC (2003b).

care. In the chartbook, Leatherman and McCarthy report that while a number of advances in children's care have been made, many serious problems persist. One-third of children with asthma fail to receive appropriate medications, for example, and three-fourths of children with severe mental health problems are not evaluated or treated. The Fund partnered with a number of organizations to disseminate the chartbook, including the National Initiative for Children's Healthcare Quality, the American Academy of Pediatrics, and others. The chartbook has also received attention in the United Kingdom: Leatherman was invited to meet with advisors to Prime Minister Tony Blair to discuss the implications of the chartbook's findings for the U.K.

Sheila Leatherman
Research Professor
School of Public Health
University of North Carolina at Chapel Hill

Leatherman and McCarthy are now at work on a third chartbook that will focus specifically on the elderly. The team will also launch a new series of "quality snapshots," to be published twice a year, that will maintain a spotlight on key quality-of-care issues.

The Fund-sponsored series of Colloquia on Quality Improvement, chaired by David Blumenthal, M.D., continues to foster action and influence policy by examining salient quality-of-care topics. In attracting leaders from both the public and private sectors, the series of meetings is helping to facilitate exchange of knowledge and expertise, as well as collaboration on projects to address challenges. The June 2004 colloquium focused on the 2003 Medicare reform law, exploring how specific provisions of that legislation could be leveraged to improve beneficiaries' care.

Responding to growing interest nationally in assessing the performance of individual physicians, another Fund colloquium focused on physician clinical performance assessment. Three dozen leaders representing health care purchasers, insurers, researchers, and providers, as well as the American Medical Association and Massachusetts Medical

Society, explored why physician clinical performance measurement is important, how to measure quality at the physician level, and what some key challenges are in implementing performance measurement. Dana Safran of the New England Medical Center presented the results of Fund-supported work she conducted with the Massachusetts Health Quality Partnership to validate measures of patients' experience with care at the individual physician level. Safran's project also validated the Ambulatory Care Experience Survey (ACES), which has been adapted for use by the Pacific Business Group on Health, the Centers for Medicare and Medicaid Services' Doctor Office Quality Project, and General Electric's Bridges to Excellence project.

A number of methodological challenges remain to measuring physician performance by valid means. With Fund support, the National Committee for Quality Assurance (NCQA) has formed the National Forum on Performance Benchmarking of Provider Offices and Organizations, a collaboration of health plans nationwide whose mission is to improve the quality of care in provider offices by advancing the methods and practice of provider-level measurement and reporting.

Many sources of information about physicians and their training, affiliations, and quality are already available to the public, particularly through the Internet. But there are significant gaps in the accuracy and completeness of many of these physician directories.[3] With a small grant from the Fund, NCQA convened a national advisory group to recommend a set of standards for directories, which were later published by the Fund and NCQA in June 2004.[4] Fund support to the Midwest Business Group on Health, meanwhile, is testing the application of these standards in the Chicago area in partnership with several large health plans and the Chicago Medical Society.

Aligning provider payments with quality has received a lot of attention lately as efforts are undertaken in both the public and private sectors to provide a business reason for physicians and hospitals to improve quality. With Fund support, the Leapfrog Group developed a compendium that catalogues 78 of these "pay-for-performance" programs nationwide.[5] But while the number of financial incentive programs is growing, very little is known about their effectiveness and impact on quality. With Fund support, Meredith Rosenthal at the Harvard School of Public Health is conducting an evaluation of the pay-for-performance program implemented by PacifiCare in 2003 in more than 200 California group practices. The study will examine whether aligning payment with standards of care can improve mean performance for 10 quality measures, reduce variation in quality among physician groups, and have a spillover effect on other measures of quality not directly linked to financial incentives.

Payment policies often discourage health care providers from investing in quality-enhancing interventions.[6] To quantify the financial gap that must be closed to make quality-enhancing interventions feasible, Kerry Kilpatrick, based at the University of North Carolina School of Public Health, will team up with Sheila Leatherman to conduct in-depth financial analyses of Medicaid managed care organizations and state primary care case management programs. Their goal is to devise a robust method for analyzing the business case for quality improvement and to develop recommendations for eliminating barriers to improvement in care to Medicaid patients.

Kerry Kilpatrick
Professor and Associate Dean, University of North Carolina School of Public Health

Chronic health conditions afflict an estimated 100 million Americans and account for as much as one-quarter of U.S. national health care expenditures. Yet the management of chronic illnesses has lagged behind advances in technology and

medicine, with quality and effectiveness compromised by poor communication and a general lack of coordination among the clinicians caring for individual patients. Researchers Stephen Ross, M.D., and C.T. Lin, M.D., of the University of Colorado Health Sciences Center, have been studying the effects of giving patients with congestive heart disease access to their own electronic medical record and letting them communicate with their physicians through e-mail.[7,8] For his work on this project, C.T. Lin was named one of nine National IT Innovators of the Year for 2003.

The Fund is also supporting a project led by John Wiecha, M.D., at Boston Medical Center to evaluate the impact on care of an interactive Web site that helps patients participate in the management of their illness. The project will be exploring how such Internet-based technology can be used to create a "virtual" interdisciplinary team, foster teamwork, and even improve clinical outcomes. If successful, this work could serve as a model for management of other chronic conditions.

Another model for improving care—this one targeting high-risk older patients making the difficult transition from hospital to home—has already been successfully tested in controlled trials and is now ready for implementation within a major health insurance plan. Developed by a multidisciplinary research team headed by Mary Naylor at the University of Pennsylvania School of Nursing, the model relies on the care coordination efforts of advanced practice nurses. The Fund-supported project will be evaluating its effectiveness and economic feasibility.

The Fund will also continue to foster adoption of a national infrastructure for health information technology. In May 2004, a Fund-supported Alliance for Health Reform briefing in Washington, D.C., drew more than 250 people from Capitol Hill to hear from experts about promising new

developments toward achieving this goal—including the announcement by the Department of Health and Human Services of over 20 IT standards, the doubling of the budget allotted to AHRQ for research and demonstrations, and the appointment of the first "national health information technology coordinator." While this progress is encouraging, barriers still exist to widespread adoption of IT by health care professionals. Currently, the Fund is supporting research at the University of California, San Francisco, to determine the costs and the benefits of implementing electronic medical records in solo or small group physician practices.

Quality of Care for Underserved Populations

Communication, in its various forms, plays a central role in encounters between health care providers and patients. Over the coming year, projects sponsored by the Fund's Program on Quality of Care for Underserved Populations will focus on establishing national standards for interpreters in health care, understanding adverse medical events for minority patients with limited English proficiency, and improving language services in small physician practices, among other areas.

The Commonwealth Fund's Program on Quality of Care for Underserved Populations focuses on improving heath care for minority and low-income patients—groups whose health may be compromised by a lack of care that is responsive to their needs, concerns, and cultures. The program's primary goals are to improve quality of care and to reduce disparities related to race, ethnicity, and income by:

- promoting awareness and understanding of health and health care disparities for underserved populations
- identifying methods to improve care for the underserved
- evaluating the effectiveness of quality improvement efforts
- using results of research to improve physician practices and inform development of better public and private policies for delivering care to the underserved.

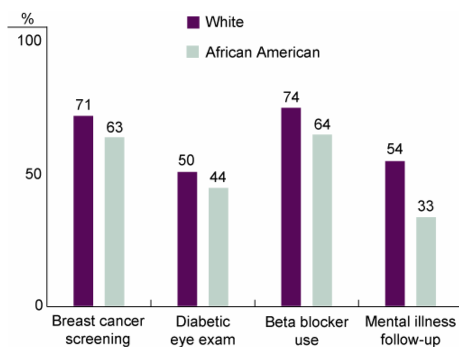
Recent national reports released by the Institute of Medicine (IOM)[9] and the Agency for Healthcare Research and Quality (AHRQ)[10] make clear that health care disparities are pervasive. Moreover, Senator Ted Kennedy (D-Mass.) and Senator Bill Frist (R.-Tenn.) each introduced a health care disparities bill to address the problem. In the past, the Fund has supported seminal work to identify the race and ethnicity

of patients and link this information to quality-of-care indicators. The first of these studies, conducted by David Nerenz of Michigan State University, identified disparities in care within managed care plans, which subsequently led to the development of quality improvement programs.

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

On several measures of preventive care, chronic disease management, and acute care, African Americans and other racial/ethnic minority groups do not fare as well as whites.

Racial disparities in the quality of clinical care



E. C. Schneider, A. M. Zaslavsky, and A. M. Epstein, "Racial Disparities in Quality of Care for Enrollees in Medicare Managed Care," *Journal of the American Medical Association* 287 (March 13, 2002): 1288-94.

Nerenz is now replicating his earlier work by partnering with the Health Resources and Services Administration on a project involving six state Medicaid programs and 12 health plans. The plans are using data on patients' race/ethnicity to pinpoint disparities revealed by HEDIS quality indicators and then implementing quality improvement projects to reduce or eliminate these disparities. This system for identifying and addressing disparities evidently has broader appeal: the state of Michigan is now planning to adopt it as part of its regular contractual requirements for Medicaid managed care plans. Building on the work of David Nerenz, the Center for Health Care Strategies recently announced that it will be working with up to 12 Medicaid plans in a Best Clinical and Administrative Practices (BCAP) collaborative to "improve health care quality for racially and ethnically diverse populations in Medicaid managed care." This large-scale initiative to eliminate disparities for publicly insured individuals is being supported by the Fund and the Robert Wood Johnson Foundation.

The Fund understands the importance of ensuring the accuracy of racial and ethnic data, as well as setting standards for how those data should be collected in clinical settings, who should be collecting the data, and in which categories they should be collected. In 2004, Romana Hasnain-Wynia and colleagues at the Health Research and Educational Trust (HRET) completed a project to develop a uniform framework for collecting data on patient race, ethnicity, and primary

Romana Hasnain-Wynia
Senior Director of Research and Evaluation
Health Research and Educational Trust

language in six leading hospitals and health systems.[11] In the next phase of work, the researchers will work with private hospitals within the University Healthsystem Consortium to collect and analyze performance data, stratified by race, ethnicity, and primary language, on 10 hospital quality measures used by the Centers for Medicare and Medicaid Services (CMS). Meanwhile, George Washington University's Bruce Siegel, M.D., will head up an effort to assess the feasibility of using the CMS hospital quality indicators, also stratified by race and ethnicity, in major safety net hospitals that treat large numbers of minority patients.

Recognizing that quality improvement programs targeting disparities need to be conducted in settings where underserved patients receive their care, the Bureau of Primary Health Care initiated the Health Disparities Collaboratives in 1998 to address disparities in care delivered to poor, minority, and other underserved populations in community health centers. The Fund is now cosponsoring, with AHRQ, a study of the Health Disparities Collaboratives on the quality of care for patients with hypertension, diabetes, and asthma. The results will determine whether the collaboratives have been effective in reducing care disparities for these patients. In another project supported by the Fund and AHRQ, investigators will examine the widespread underuse of effective medical services in New York City's East Harlem neighborhood and will test interventions to improve treatment for breast cancer, recurrent stroke, hypertension, and premature birth.

Patients who have limited proficiency in English or difficulty comprehending physician instructions and health information also experience difficulties accessing care. Many also receive lower-quality care or underutilize appropriate health services.[12,13,14,15] For a project focused on the needs of diabetes patients with limited English proficiency and low

Dean Schillinger, M.D.
Associate Professor
University of California, San Francisco

health literacy, Dean Schillinger, M.D., and colleagues at the University of California, San Francisco (UCSF), are implementing and comparing two types of patient self-management support—automated telephone-based management and group medical visits. In its *2004 Report on Health Literacy,* the IOM featured the UCSF project as a promising model for addressing health literacy; the study is also highlighted in a new American Medical Association (AMA) textbook on the subject.[16]

In this past year, the Fund's Quality of Care for Underserved Populations Program announced a call for research proposals related to communication and quality of care for vulnerable patients. The strong interest in this field is evident in the more than 500 proposals received in response. After careful review, the program selected five projects, among them efforts to establish national standards of practice for interpreters in health care, understand adverse medical events for minority patients with limited English proficiency, and improve language services in small physician practices and health care benefit offices. The projects, which will be completed in the coming year, are expected to help raise awareness of the challenges faced by these patients and, more importantly, point to potential solutions.

Being able to communicate in a patient's primary language is an important component of health care providers' "cultural competency," but there is more to it than that. Cultural competency really involves responsiveness to all aspects of a patient's culture, enabling providers to promote greater engagement of patients in managing their medical conditions. However, in a Fund-supported survey of medical residents, Joel Weissman and colleagues at Harvard University found that medical residents reported a lack of confidence in being able to address many aspects of culturally competent care.[17]

To help medical schools determine what sort of cultural competency training is included in their curricula, the Fund provided support to the Association of American Medical Colleges (AAMC) for the development of a self assessment instrument—the Tool for Assessing Cultural Competency Training (TACCT). The project has generated considerable interest in the academic community. Several medical schools and residency programs have requested the instrument for pilot-testing. Members of AAMC's Group on Student Affairs, Minority Affairs Section, meanwhile, have indicated that they will serve as advisors and "champions" for TACCT as it is used at each medical school. The tool is now being used on a trial basis at a number of medical schools, and the New York Academy of Medicine, Affiliated Medical Schools of New York, and AAMC will be testing TACCT at all New York State medical schools.

A prelude to eliminating disparities is raising awareness of the issue and identifying effective methods for improving care for underserved patients. A project led by John McDonough, executive director of Health Care For All, a Massachusetts consumer organization, highlighted disparity-reduction efforts planned or under way at the state level.[18] After learning about McDonough's work, the New England Coalition for Health Equity announced it will sponsor a symposium, built around his findings, to develop priorities for development of the infrastructure and capacity necessary to address health disparities in each of the six New England states. At the national level, Ruth Perot of the Summit Health Institute for Research and Education convened a meeting of minority health experts from around the country and developed a national policy agenda for eliminating health disparities in communities of color; the agenda will serve as the basis for a planned congressional briefing.

A scene from the film *Worlds Apart.*

The Fund also supported the production of *Worlds Apart,* a film that follows four patients of different cultural backgrounds as they interact with the medical system.[19] The film, by Maren Grainger-Monsen, M.D., and Julia Haslett, has exerted a powerful influence on medical training and minority health care since its release in February 2004. A winner of several prestigious awards, the film and its powerful lessons are now being used by 24 medical schools, 31 residency programs and medical centers, and 86 colleges and universities, as well as libraries and other health-related educational institutions nationwide. The Joint Committee on Accreditation of Healthcare Organizations also is using *Worlds Apart* for internal staff training on cultural competency issues. And, after viewing *Worlds Apart* and studying disparities data, the United Network of Organ Sharing's board of directors voted to increase minority access to kidney transplants by revising allocation priority for tissue matching—an extraordinary policy change that will allow more than 200 additional kidney transplants annually for minority patients.

2004 Fellowship in Minority Health Policy

Improving the capacity of the health care system to address the health needs of minority and disadvantaged populations is the goal of the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy. Established in 1996, the program offers a one-year, full-time program of study to future physician-leaders who intend to pursue careers in minority health and health policy. The program is directed by Joan Reede, M.D., dean for diversity and community partnership at Harvard Medical School. The fellowship combines an intensive year of training in health policy, public health, and management with special program activities focused on minority health issues. Participants in the program complete academic work for a master's degree in public health or public

administration. The program usually awards five fellowships per year.

Since completing their fellowship, the 40 alumni physician fellows have become actively engaged in health policy, research, and service delivery to minority communities. Most fellows hold appointments at schools of public health or medicine, and several have assumed leadership roles in departments of public health or community health centers. Alumni fellows also serve on numerous local and national advisory committees related to minority health.

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

The 2004 Minority Health Policy Fellows are:

- **Alexy Arauz, M.D.,** Clinical Fellow in Pediatrics at Massachusetts General Hospital for Children, Boston, Mass. Dr. Arauz's research interests focus on health disparities of minorities, effective access, and utilization of care. She is particularly interested in becoming a better health care advocate for all children. Most recently, she conducted research for the MGH Center for Child and Adolescent Health Policy and spent time at the Washington office of the American Academy of Pediatrics working on several initiatives.

- **Christian Arbelaez, M.D.,** Chief Resident for Emergency Medicine, Rhode Island Hospital, Brown University. Already recognized as a teacher and speaker in his community, Dr. Arbelaez is committed to overcoming patient language barriers to health care access as well as recruiting underrepresented minority students into the

medical profession. He has mentored students in the Medical School Familiarization Program in Galveston, Texas, and he initiated translation services at Rhode Island Hospital.

- **Jacqueline Grant, M.D., M.P.H.,** Associate Professor and Medical Director of Obstetrics/Gynecology, University of Missouri. With a medical interest in obstetrics and gynecology and a policy interest in maternal and child health, Dr. Grant is committed to advancing women's and minority health issues. An established clinician, instructor, and researcher, she received the 2003–04 Best Doctors in America Award for her impressive record of service and advocacy of minority health issues.

- **Lenny Lopez, M.D.,** Resident Physician, Internal Medicine, Brigham and Women's Hospital, Boston, Mass. A member of the Brigham and Women's Ethics Committee, Dr. Lopez is interested in linking clinical effectiveness to policy issues in order to improve medical access and provide effective care to underserved minorities. Recently, he worked on a multicenter pediatric asthma disparity study for Latino communities in New York City. Dr. Lopez plans a career as an academic and cardiologist specializing in health issues related to the U.S. Latino population.

- **Ivette Motola, M.D.,** Emergency Medicine Resident at Massachusetts General Hospital/Brigham and Women's Hospital, Boston, Mass. First working in hospital emergency rooms as a volunteer technician and now as a medical doctor, Dr. Motola has adopted as her personal and professional ideal "health care 24 hours a day regardless of economic access." She is dedicated to improving quality and access to care for uninsured, underserved, and non-English-speaking patients.

- **Nwando Onyejekwe, M.D.,** Chief Resident, Department of Family Medicine, Columbia University College of Physicians and Surgeons, New York, N.Y. Dr. Onyejekwe has undertaken leadership and advocacy roles in her schools and communities to provide recruitment services and support for minority health professionals. Awarded a research fellowship at the Harvard AIDS Institute, she designed a pilot HIV/AIDS education and training program for high-risk adolescent females, G.I.R.L.T.A.L.K., now a successful nonprofit corporation. Dr. Onyejekwe is the recipient of a 2004–05 Harvard Presidential Scholarship.

Program on Child Development and Preventive Care

Gordon Glade, M.D., a Utah pediatrician, is one of the few physicians in the country who regularly conducts well child visits with multiple families. Such group visits are not only an efficient way to provide certain preventive services, but they offer the opportunity for parents to share and learn from each others' experiences in raising their children. Utah is one of the states participating in the Fund's Assuring Better Child Health and Development (ABCD) initiative.

The Commonwealth Fund's Child Development and Preventive Care Program is helping to create the professional and policy infrastructure necessary for substantive reform of the current approach to pediatric preventive care. The program is working to encourage, support, and sustain improvements in the way preventive care is provided to young children—especially those services dealing with cognitive, emotional, and social development. The program pursues three principal strategies: (1) promoting the establishment of standards and their use in quality measurement; (2) identifying and disseminating models of pediatric practice that enhance efficiency and effectiveness; and (3) encouraging adoption of public policies that remove barriers to quality and align incentives with desired clinical practices.

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

What gets measured is what gets done, and to this point there has not been sufficient measurement of the quality of preventive child health care. But progress is being made. For example, the Promoting Healthy Development Survey

(PHDS),[20] developed with Fund support by Christina Bethell at the Oregon Health & Science University, is becoming the leading global measure of preventive child health care quality, and its use by pediatric practices, health plans, and state Medicaid programs is steadily increasing. Work conducted by Henry Ireys at Mathematica Policy Research, meanwhile, focused on ways to exploit the potential of external quality review and improvement organizations to champion more detailed quality measurement, especially for child developmental services provided through publicly funded care; future Fund-sponsored projects will be exploring this area further.

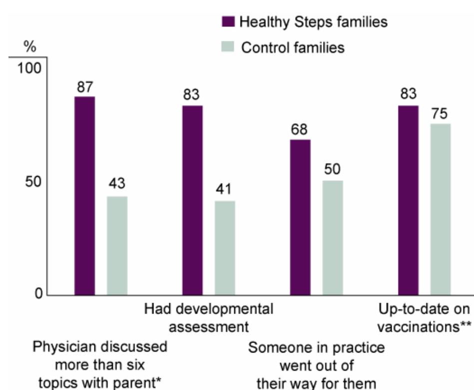
Melinda K. Abrams
Senior Program Officer

Other projects will help establish standards for organizing and managing efficient pediatric practices, providing the individual elements of preventive care, formulating recommendations for preventive services, and scheduling children and families for care at those ages that are especially important developmentally. To facilitate measurement of progress, the Fund also is involved in benchmarking the quality of developmental services, through the National Survey of Early Childhood Health, as well as children's developmental status, in partnership with Child Trends.[21]

Although the Child Development and Preventive Care Program does not support clinical research, it has been very involved in evaluating various systems and models of care, most notably the Healthy Steps for Young Children Program. The Healthy Steps model, in addition to the Fund's work with practices in North Carolina through the Assuring Better Child Health and Development (ABCD) initiative, has clearly demonstrated that the quality and use of screening and other

Healthy Steps, in the nation's first, large clinical trial designed to improve delivery of developmental and behavioral services to young children, improved the quality of care, enhanced communication between pediatricians and parents, and helped children receive appropriate preventive services.

Measuring Healthy Steps by selected quality-of-care outcomes



* Topics included: importance of regular routines, sleep problems, discipline, language development, toilet training, sibling rivalry, home safety, child's development, child's temperament, ways of helping child learn.

** All vaccines due by 24 months of age.

C. S. Minkovitz et al., "A Practice-Based Intervention to Enhance Quality of Care in the First 3 Years of Life," *Journal of the American Medical Association* 290 (Dec. 17, 2003).

developmental services in real-world practices can be improved.[22,23]

There is also growing interest in developing linkages between physician practices and community-based services, the need for which is identified during preventive care visits. For example, the Fund is supporting the evaluation of a statewide referral system in Connecticut called Help Me Grow that connects at-risk children under age 5 with needed services through a toll-free telephone hotline.[24] Earlier support to the Association of Maternal and Child Health Programs allowed researchers to study the states' toll-free parenting helplines, which can assist parents in accessing and coordinating high-quality, early childhood services.[25] Through additional support, the Fund also expects to help identify promising "linkage models" for individual practices, health plans, and communities.

To help ensure that effective approaches to care are disseminated and adopted, the Fund has established a strong, working partnership with the American Academy of Pediatrics. Similarly, the Fund has joined forces with pediatric nurse practitioner programs across the country to improve the skills of these essential child health care providers. This project, which is being led by Bernadette Mazurek Melnyk of Arizona State University, will develop, implement, and evaluate a new prevention curriculum for child development and behavior.

Bernadette Mazurek Melnyk
Dean, Arizona State University College of Nursing

Medicaid is the dominant health care program serving low-income children, and its standards and protocols affect the care of not only children covered by publicly funded programs but also many children whose care is financed through private insurance. The Fund's success with its first ABCD initiative, a Medicaid-focused program managed by the National Academy for State Health Policy, has led to a second phase involving five state Medicaid programs—California, Iowa, Minnesota, Utah, and Illinois (with funding from the Michael Reese Health Trust

and Chicago Community Trust). While ABCD I tested new models for delivering and financing child health and developmental services for low-income families, ABCD II is focusing on promoting healthy mental development of young children. Additional, continuing Fund-sponsored efforts to improve children's health through Medicaid include activities by the Center for Health Care Strategies to identify barriers to improving developmental services through the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), and policy research led by Sara Rosenbaum of George Washington University, to analyze how contract specifications with managed care organizations influence provider reimbursement and the provision of developmental services to children.

Creative reform of health care policy and systems is likely to occur first among states. At the state level, partnerships within government and between public and private entities appear critical to formulating and implementing new health policies. In an effort to identify additional ways to engage states in quality improvement efforts on behalf of children, the Fund recently convened a cross-section of state government leaders. We also expect to expand our work with national organizations representing state government to develop collaborative activities toward improving child developmental services.

The Child Development and Preventive Care Program will also be seeking ways to address the persistent problem of financing care. Due in part to the fragmented system of health care for children in the United States, predictable and equitable reimbursement for preventive care and developmental services remains a continuing dilemma.

Quality of Care for Frail Elders Program

One of the Fund's goals is to help bring resident-centered care to the nation's nursing homes. The Green House Project is one of a few highly promising models of noninstitutional long-term care. Shown here are a resident and young guests at the Green House in Tupelo, Mississippi, where residents live in a homelike environment and are free to make their own choices regarding daily living activities.

In hospitals, good care is paramount. But in nursing homes, good care is only half the picture: equally important is providing a good place to live. In traditionally run nursing homes, consideration of quality of life is often neglected at the expense of efficiently delivered clinical services.

The Picker/Commonwealth Program on Quality of Care for Frail Elders focuses on improving quality in nursing homes by working to change the prevailing culture in facilities from one that is institutionally centered to one that is resident-centered. The Fund does this by making strategic grants to organizations or supporting projects that can influence the industry to become more resident-centered, or that provide a platform to disseminate practices or models that embody that conviction.

Wellspring is one model of resident-centered care. Nursing homes that join together in a Wellspring "alliance"[26] become part of an ongoing quality improvement collaborative that has been shown to improve nursing home performance without increasing costs.[27]

One of the vital questions nursing home leaders must ask themselves before joining a Wellspring alliance is, What does our current culture look like? To help answer this question, Leslie Grant of the University of Minnesota's Carlson School of Management developed a "culture/climate" survey, which enables nursing homes to perform a self-assessment before beginning the Wellspring process[28] and to monitor their progress during the journey. The survey asks, for example, whether the facility is committed to supporting resident-directed care; whether leadership staff encourages all employees to participate in resident-directed

Mary Jane Koren, M.D.
Senior Program Officer

LaVrene Norton
Executive Director,
Action Pact, Inc.

care; and whether staff have the opportunity to participate in decision-making. Coupled with a leadership module that Grant and culture change expert LaVrene Norton of Action Pact developed jointly, this tool has provided critical information for nursing homes in new alliances, and could be useful to institutions outside Wellspring.

In addition, the Fund supported several projects to improve specific elements of the original model. One of these elements is Wellspring's system for sharing data to improve quality—a key strength of the program. Work undertaken by David Zimmerman of the University of Wisconsin enhanced Wellspring's data system, which now allows member nursing homes not only to calculate clinical outcome prevalence rates but to help identify those residents who are at high risk for a problem, such as pressure ulcers, before it develops.

The Wellspring model also addresses a shortcoming common to many programs that seek to educate staff: that giving people better, or more, information may be insufficient to change practice. Recognizing that the clinical care teams were having difficulty implementing what they had been taught, Barbara Bowers, a professor at the University of Wisconsin–Madison School of Nursing, developed with Fund support an implementation package for "just-in-time learning" that is intended for nursing assistants and other frontline staff. Individual sections of the package are distributed to staff to complement particular training sessions.

Over the past year, the Fund also supported work to ready the infrastructure of Wellspring Innovative Solutions (WIS), the entity formed to disseminate the model, for active marketing and outreach efforts. In 2004, a new nursing home alliance in Maryland was inaugurated and an alliance of homes in North and South Carolina should be ready to start in early 2005. Groups of nursing homes in California and elsewhere have contacted Wellspring for information about forming

alliances, indicating that many nursing homes are eager for tested ways to achieve better performance.

There are nursing homes, however, that wish to provide resident-centered care but for whom joining an alliance of nursing homes is not feasible or desirable. For many of these facilities, the Pioneer Network is an invaluable ally. A diverse group of providers, researchers, and practitioners, the Pioneers began to promote culture change in nursing homes in 1996. Its new Web site, www.Pioneernetwork.net, which was updated with support from the Fund, helps to achieve one of the network's major goals: to serve as a resource clearinghouse and link people and organizations interested in culture change. A new book, *Getting Started: A Pioneering Approach to Culture Change in Long-Term Care Organizations,*[29] which was written with partial Fund support and is featured on the site, should help them on their way.

Many nursing home providers require more comprehensive and in-depth operational guidance in enacting culture change. A Fund-sponsored project led by Steven Shields, one of the leading proponents of resident-centered care and the CEO of Meadowlark Hills, a long-term care complex in Kansas, will provide actual tools for nursing home administrators seeking assistance with their own cultural transformation. These will include a leadership manual, "Tips for Administrators," policy and procedure manuals, human resource management systems, and a quality improvement process that reinforces the core philosophy of resident-centered care.

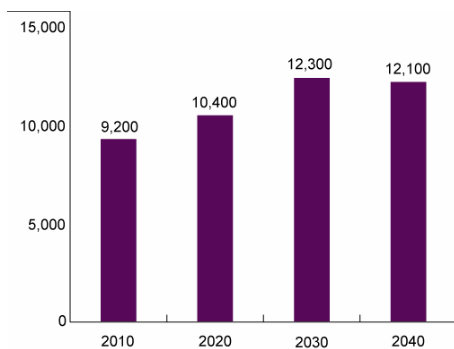
While most of the nursing homes that are embracing culture change come from the not-for-profit sector, the for-profit side of the industry is beginning to take notice. Beverly Enterprises, the largest for-profit chain in the United States, is working with a consultant to introduce resident-centered care in a small cohort of their facilities. A Fund-supported

evaluation of this initiative has already demonstrated to Beverly's top management the potential for this new way of doing business. Staff turnover, an endemic problem in the industry as a whole, has dropped and far fewer agency workers are needed to cover vacant positions. At one of the homes, staff reported they would quit rather than be expected to work under the old system again. In light of this compelling evidence, Beverly will be expanding the initiative into 10 more of its homes in the coming year.

States are increasingly feeling the impact of an aging America on their budgets. Long-term care, in fact, was chosen by the National Governors Association (NGA) as the priority topic for 2004 and made the focus of a Fund-sponsored NGA Policy Forum and Task Force Meeting held in May in Chicago. Senior state officials from 30 states attended the event, which featured a panel of speakers including Josefina Carbonell, U.S. Assistant Secretary for Aging, James Marks, M.D., senior vice president, Robert Wood Johnson Foundation, and Rick Surpin, founder of the Paraprofessional Healthcare Institute. Workgroups met following the sessions to craft action plans to take back with them to their respective states.

The need for long-term care will increase in coming decades as the U.S. population grows older.

Projected number (in thousands) of people age 65 and older who will need long-term care



Congressional Budget Office, *Projections of Expenditures for Long-Term Care Services for the Elderly*, 1999, as reported in R. B. Friedland and L. Summer, *Demography Is Not Destiny, Revisited,* The Commonwealth Fund (forthcoming).

In June 2004, AcademyHealth held what is hoped to be a series of Fund-sponsored colloquia on long-term care to increase attention to long-term care and cultivate a network of interested policymakers, providers, and researchers. Held in conjunction with AcademyHealth's Annual Research Meeting, the initial colloquium stimulated lively discussions on a number of long-term care issues, including the use of information to improve long-term care quality. Fund president Karen Davis, in her keynote address, discussed the demographic changes that are bringing long-term care to the forefront, the cost implications of those changes, and a policy framework for a possible Medicare long-term care benefit.

Follow-up activities are planned to keep the momentum going between meetings and cement relationships among attendees.

Consumers are not often invited to participate in discussions of nursing home quality, although when well organized they can be extremely effective in promoting change. A small Fund grant to the Friends and Relatives of the Institutionalized Aging (FRIA), a consumer group based in New York City, will enable the organization to compile and produce a set of materials to help families of nursing home residents form family councils. The family council guide, which will be distributed on the FRIA Web site,[30] will also become part of a package of materials, including a video on family councils, being developed by the National Citizens Coalition for Nursing Home Reform.[31]

Many nursing home residents are not fortunate enough to have an actively involved family. Recognizing the need to give these individuals a voice, the Older Americans Act authorizes and partially supports the Nursing Home Ombudsman Program. Under the direction of Carroll Estes, a study being conducted in New York and California is learning how the local ombudsman programs can be made more effective. A national advisory committee has worked with the project team, which is being supported by the Fund and the Archstone Foundation, to develop the survey. Interest in participating is keen in other states, including Georgia, Illinois, Ohio, and Wisconsin.

REFERENCES

[1] S. C. Schoenbaum, A.-M. J. Audet, and K. Davis, "Obtaining Greater Value from Health Care: The Roles of the U.S. Government" *Health Affairs* 22 (November/December 2003).

[2] K. Davis, C. Schoen, S. C. Schoenbaum, A.-M. J. Audet, M. M. Doty, and K. Tenney, *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care Through the Patient's Lens,* The Commonwealth Fund, January 2004.

[3] E. Stone, J. Heinold, L. Ewing, and S. Schoenbaum, *Accessing Physician Information on the Internet,* The Commonwealth Fund, January 2002.

[4] L. Shelton, L. Aiuppa, and P. Torda, *Recommendations for Improving the Quality of Physician Directory Information on the Internet,* The Commonwealth Fund, June 2004.

[5] See "Issue of the Month: The Leapfrog Compendium," *Quality Matters,* October 2004 Update, The Commonwealth Fund.

[6] S. Leatherman, D. Berwick, D. Iles et al., "The Business Case for Quality: Case Studies of a National Survey," *Health Affairs* 22 (March/April 2003): 17–30.

[7] S. E. Ross and C.T. Lin, "The Effects of Promoting Patient Access to Medical Records: A Review," *Journal of the American Medical Informatics Association* 10(2003): 129–138.

[8] M. A. Earnest, S. E. Ross, L. A. Moore et al., "Use of a Patient-Accessible Medical Record in a Practice for Congestive Heart Failure: Patient and Physician Experiences," *Journal of the American Medical Informatics Association* (in press).

[9] B. D. Smedley, A. Y. Stith, and A. R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* The Institute of Medicine, 2002.

[10] *National Healthcare Disparities Report,* Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2003.

[11] R. Hasnain-Wynia, D. Pierce, and M. A. Pittman, *Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals,* The Commonwealth Fund, May 2004.

[12] E. A. Jacobs, N. Agger-Gupta, A. H. Chen et al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature,* The California Endowment.

[13] D. Schillinger and A. H. Chen, "Literacy and Language: Disentangling Measures of Access, Utilization, and Quality," *Journal of General Internal Medicine,* 19 (March 2004): 288–90.

[14] A. Fernandez, D. Schillinger, K. Grumbach et al., "Physician Language Ability and Cultural Competence: An Exploratory Study of Communication with Spanish-Speaking Patients," *Journal of General Internal Medincine* 19 (February 2004): 167–74.

[15] A. John-Baptiste, G. Naglie, G. Tomlinson et al., "The Effect of English Language Proficiency on Length of Stay and In-Hospital Mortality," *Journal of General Internal Medicine* 19 (March 2004): 221–28.

[16] J. G. Schwartzberg, J. B. VanGeest, C. C. Wang, eds., *Understanding Health Literacy,* American Medical Association, December 2004.

[17] Presented at Policy Forum and Technical Advisory Panel for "Assessing Residents' Preparedness to Care for Diverse Patient Populations," Washington, D.C., June 10, 2004.

[18] J. E. McDonough, B. K. Gibbs, and J. L. Scott-Harris et al., *A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities,* The Commonwealth Fund, June 2004.

[19] Clips from the film can be accessed at http://www.cmwf.org/topics/topics_show.htm?doc_id=228596.

[20] C. Bethell, C. Peck, M. Abrams, et al., *Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid,* The Commonwealth Fund, September 2002.

[21] B. Brown, M. Weitzman et al., *Early Child Development in Social Context: A Chartbook,* The Commonwealth Fund/Child Trends, September 2004.

[22] See, for example, C. S. Minkovitz, N. Hughart, D. Strobino, et al., "A Practice-Based Intervention to Enhance Quality of Care in the First 3 Years of Life," *Journal of the American Medical Association* 290 (December 2003): 3081–3091.

[23] H. Pelletier and M. Abrams, *The North Carolina ABCD Project: A New Approach for Providing Development Services in Primary Care Practice,* The Commonwealth Fund, August 2002.

[24] See "Grantee Spotlight: Paul Dworkin," *The Commonwealth Fund Quarterly,* Summer 2004, p. 2.

[25] See M. Booth, T. Brown, and M. Richmond-Crum, *Dialing for Help: State Telephone Hotlines as Vital Resources for Parents of Young Children,* The Commonwealth Fund, November 2004.

[26] There are currently five Wellspring alliances with approximately 50 nursing home members.

[27] R. I. Stone, S. C. Reinhard et al., *Evaluation of the Wellspring Model for Improving Nursing Home Quality,* The Commonwealth Fund, August 2002.

[28] L. Grant, "Leadership Profiles for Mid-Atlantic Wellspring Alliance Facilities at Baseline 2004" (working paper), 2004.

[29] S. Misiorski, *Getting Started: A Pioneering Approach to Culture Change in Long-Term Care Organizations,* The Pioneer Network, August 2004.

[30] http://www.fria.org/iindex.shtml.

[31] http://www.nccnhr.org/.

Robin Osborn
Vice President

2004 Annual Report

International Program in Health Policy and Practice

The Fund's annual international symposium provides an important forum for exploring health system issues of common concern to the world's industrialized nations. At the 2004 symposium, John Hutton MP, England's Minister of State for Health (flanked by Ian Shugart, Assistant Deputy Minister, Health Canada, and John Iglehart, founding editor of *Health Affairs*) commented on findings of the Fund's international survey of public views on primary care and discussed reforms under way in his country.

The Fund's International Program in Health Policy and Practice is dedicated to building an international network of policy-oriented health care researchers and encouraging cross-national comparisons of health care systems' performance and policy approaches. As part of that work, the program conducts high-level policy forums for international exchange, which foster creative thinking about health care problems common to the U.S. and other industrialized countries and highlight innovative policy solutions.

Six-Year Board Review

The International Program in Health Policy and Practice (IHP), directed since 1997 by Fund vice president Robin Osborn, had its six-year review by the Commonwealth Fund Board of Directors in April 2004. As part of the review, Harvard University's David Blumenthal, M.D., conducted an independent evaluation, for which he surveyed 128 key informants, Harkness Fellows, and mentors.

The survey respondents were nearly unanimous in their endorsement of IHP and their agreement that the Fund should

continue sponsoring an international program. Ninety-three percent of respondents agreed that IHP is making progress in developing a network of health policy and health services researchers. Nearly all respondents rated IHP as very or moderately effective in promoting high-level exchanges between industrialized countries, and nine of 10 respondents felt that the program was enhancing the Fund's ability to inform the U.S. policy debate and expanding the audience for all of the Fund's work. In addition, more than four of five found the products produced by IHP to be useful in their work and agreed that the program enabled the Fund to draw on other countries' innovations in developing its U.S. programs. Key program components of IHP were all rated very highly, with the Harkness Fellowships receiving the strongest endorsement of all program activities. While the policy issues addressed by the program over the first six years received broad support, there were suggestions for further emphasis, including quality improvement initiatives, information technology, and innovative health care delivery models.

In their discussions regarding the review, Board members expressed support for expansion of the group of five countries on which IHP activities are focused, citing Germany and other European countries as the priority. The review also called for efforts to increase IHP's impact on U.S. policy thinking, as well as the program's profile in Washington, D.C.

2004 International Symposium

For the past seven years, the Fund has hosted an annual international symposium in health care policy on a topic of common concern to the U.S. and other industrialized nations. This year's symposium, held in Washington, D.C., in October 2004, brought together leading policy thinkers around the theme of primary health care innovation and reform. Participants included health ministers, or their designates,

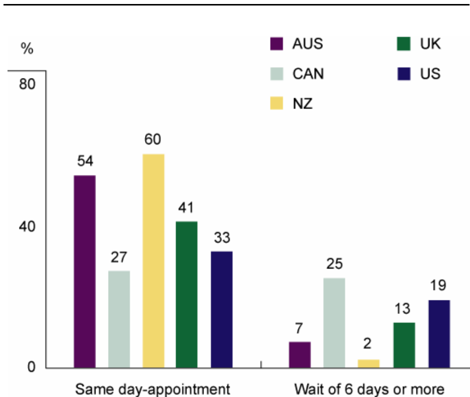
from Australia, Canada, Mexico, New Zealand, the United Kingdom, and the U.S., as well as senior government officials and leading researchers from each country. In addition, experts from Germany, the Netherlands, and Sweden shared experiences on innovations in their countries.

U.S. Secretary of Health and Human Services Tommy G. Thompson co-hosted the opening dinner and emphasized the value of forums, such as the international symposium, for cross-national learning. In sharing his vision for transforming the U.S. health care system, the Secretary talked about the need to harness the potential of information technology, shift the focus from curative medicine to prevention, and give consumers more choice as a key to better quality and lower costs. Looking beyond America's borders, he was passionate in his call for using health care as a bridge to peace between countries.

Drawing on many of the themes introduced by Secretary Thompson, Franz Knieps, director-general for health care provision and long-term care insurance for the German Ministry of Health and Social Security, presented an ambitious agenda for reforming his nation's health care system to improve quality, efficiency, and choice while ensuring its sustainability. Among the innovations he described were Germany's newly established Institute for Quality and Efficiency in Health Care, which develops evidence-based guidelines and assesses the cost-effectiveness of new pharmaceuticals; financial incentives for patients to use primary care doctors as their point of entry into the system; and an electronic health card. A further highlight of the meeting was the third John M. Eisenberg, M.D., International Lecture, delivered by Mark McClellan, M.D., administrator of the Centers for Medicare and Medicaid Services.

C-SPAN and the Kaiser Network broadcast live the release of the results of the Fund's 2004 International Health

Access to doctor when sick or need medical attention



2004 Commonwealth Fund International Health Policy Survey.

Policy Survey and the Ministers' Policy Roundtable. Fund vice presidents Cathy Schoen and Robin Osborn presented the 2004 survey findings, which were simultaneously published by *Health Affairs* as a "Web Exclusive."[1] The survey elicited the views of 1,400 adults in Australia, Canada, New Zealand, and the U.S., as well as an expanded U.K. sample of 3,000 adults (funded by The Health Foundation), on their experiences with primary and preventive care.

In all five countries, the survey found shortfalls in the delivery of safe, effective, timely, patient-centered, efficient and equitable care, with substantial variation among the nations. Patients in each country experienced problems accessing care when sick, with U.S. and Canadian adults the least likely to be able to see a doctor the same day and the most likely to use emergency rooms for non-emergency care. Up to 15 percent of patients who had a lab test in the past two years reported getting incorrect test results or a delay in receiving abnormal test results. On issues of doctor–patient communication, one of three or more respondents across the countries said their doctor does not tell them about treatment choices or ask for their opinion. U.S. patients were the most likely to have high out-of-pocket costs and to forgo care because of costs.

In reacting to the findings, Andrew Bindman, M.D., of the University of California, San Francisco, emphasized the critical role of a strong primary care infrastructure in underpinning a high-performing health care system.

In a policy roundtable discussion, health ministers or their designates from Australia, Canada, Germany, Mexico, New Zealand, the U.K., and the U.S. had a candid exchange of views on such issues as health care quality, health system sustainability, and priorities. Senior policymakers and scholars then introduced national approaches to redesigning and improving the delivery of primary health care, ensuring same-

day appointments, coordinating care for chronically ill patients through learning collaboratives, and implementing electronic health records.

The last day of the symposium—which focused on opportunities for the U.S. to learn from international innovations—was held on Capitol Hill, with the cooperation of the Alliance for Health Reform. As panel reactors, congressional staff commented on the relevance and potential transferability of Germany's disease management program, New Zealand's no-fault medical malpractice system, and the U.K.'s use of financial incentives to improve quality of care.

Commissioned papers presented at the symposium will be submitted for consideration as part of a series of *Health Affairs* international Web Exclusive articles. The symposium is cosponsored by the journal in collaboration with founding editor John K. Iglehart.

U.S.–U.K. Meeting on Health Care Quality

In July 2004, the Fund and the London-based Nuffield Trust cosponsored "Improving Quality of Health Care in the United States and United Kingdom: Strategies for Change and Action, 2004," the sixth in a series of meetings for senior U.S. and U.K. policymakers and quality experts. The gathering was further enriched by representatives from Australia and New Zealand. Held in New York City, the meeting addressed four topics: the use of contractual agreements and incentives to improve quality and efficiency, patient engagement and decision making, implementation of electronic medical records, and the role of professionalism in quality improvement.

The impressive results obtained by U.S., U.K., and Australian quality improvement collaboratives targeting diabetes, cancer, and depression provided a starting point for a dynamic and provocative cross-national exchange on the sustainability and spread of quality improvement efforts.

During the conference, Carolyn Clancy, M.D., director of the U.S. Agency for Healthcare Research and Quality (AHRQ), and Sir Liam Donaldson, M.D., chief medical officer of the U.K. Department of Health, reported on the progress of the 2001 bilateral agreement between the U.S. and U.K. for collaboration on quality improvement and proposed an agenda for future efforts.

International Working Group on Quality Indicators

Since 1999, Gerard Anderson at Johns Hopkins University and the Fund's Robin Osborn have co-directed the International Working Group on Quality Indicators, a unique collaboration among government officials from Australia, Canada, New Zealand, the U.K., and the U.S.; leading quality experts; the Organization for Economic Cooperation and Development (OECD); the Nuffield Trust; the Institute of Medicine; and the Canadian Council of Health Services Accreditation. Chaired by Arnold Epstein, M.D., of the Harvard School of Public Health, the project has produced the first-ever set of 30 quality indicators for benchmarking and comparing health care system performance across countries. The findings, published in the May/June 2004 issue of *Health Affairs,* attracted wide media coverage, including the *Washington Post*, *Wall Street Journal*, *Newsday*, National Public Radio, CNN, ABC, CBS, Fox News, *The Economist*, *Canadian Globe and Mail*, *Toronto Star*, *Independent*, and *Sydney Morning Herald*. The working group's report, published in June 2004, had 10,000 downloads from the Fund's Web site in the first week.[2]

In a collaboration with the Fund, the OECD is building on the Fund's work through its International Health Care Quality Indicators Project, also chaired by Dr. Epstein. OECD has expanded the project to include 21 countries and is further developing the scope and depth of the indicator set. This project was endorsed by health ministers at the OECD May

2004 ministerial meeting; the OECD is now securing the necessary funding to enable it to institutionalize the collection of international quality data.

Harkness Fellows in Health Care Policy

Aimed at developing promising health care policy researchers and practitioners in the U.K., Australia, and New Zealand, the Harkness Fellowships provide a unique opportunity to spend up to 12 months in the U.S., conduct a policy-oriented research study, gain firsthand exposure to managed care and other models of health care delivery, enhance methodological skills, and work with leading health policy experts. Selection committees in each country interview candidates and recommend fellows. Nicole Lurie, M.D., senior natural scientist and Paul O'Neill Alcoa Professor of Health Policy at the RAND Corporation, serves as the Fund's senior fellowships advisor.

Harkness Fellows in Health Care Policy continue to generate articles based on their fellowship work. For example, U.K. Harkness Fellow Kieran Walshe (2000–01) co-authored a *Health Affairs* study with his U.S. mentor, Stephen M. Shortell of the University of California, Berkeley, that compared national systems for reporting and investigating major failures in health care organizations that result in harm to patients. Another article, by Canadian Harkness Associate Steven G. Morgan (2001–02) and colleagues, described British Columbia's experience with its evidence-based approach to drug coverage. U.K. Fellow Ronald Gray (2002–03) published an article in *Pediatrics* with his U.S. mentor, Marie McCormick, M.D., that discussed findings from a longitudinal study on behavioral problems in low-birth-weight children. Malcolm Battersby, M.D., Australian Fellow (2003–04) published a report for the South Australian government on collaboratives for chronic illness. And 2003–04 Canadian Harkness Associate Alexandre Sirois's interview on

pharmaceutical costs with Princeton University economist Uwe Reinhardt, who chairs the Fund's international coordinating committee, was published in Quebec's *La Presse*.

Fellows who have returned to their home countries continue to receive national recognition and assume influential posts in health care policy. In the U.K., Carmel Hughes (1998–99) was promoted to professor at the School of Pharmacy, Queen's University, while Ciaran O'Neill (2001–02) was promoted to professor of health economics and policy at the University of Ulster. Raymond Moynihan (1998–99), a reporter for the *Australian Financial Review*, served as guest editor for the *British Medical Journal,* and Alan Cass was made director of the policy and practice division of the George Institute for International Health in Sydney. In New Zealand, 2002–03 fellow Ngaire Kerse was promoted to associate professor of general practice and primary health care at the University of Auckland. Among Canadian Harkness Associates, Jennifer Zelmer (2002–03) was promoted to vice president for research and analysis at the Canadian Institute for Health Information, and Steven G. Morgan (2001–02) received the prestigious Canadian Institutes of Health Research New Investigator Career Award.

The sixth class of fellows (2003–04) completed a productive year, ending with a final reporting seminar in San Diego in June 2004. The year included several opportunities for fellows to meet with leading U.S. and international policy experts. In October, fellows attended the Fund's International Symposium on Health Care Policy and participated in a visit to AHRQ. A Washington policy briefing in February gave the fellows exposure to the political process and the views of a wide range of senior policymakers and stakeholders. Joining the Harkness fellows was a U.S. journalist from the Kaiser Media Fellowships in Health.

In May, the fellows traveled to Toronto and Ottawa for

briefings with senior government officials and health care leaders and a closer look at the Canadian health care system. Two Canadian Harkness Associates, selected in collaboration with the Canadian Health Services Research Foundation, participated in the fellowship seminars, adding a valuable Canadian perspective.

The 2004–05 Harkness Fellows arrived in the U.S. beginning in August. With the support of The Health Foundation, the fellowships were expanded to include two U.K. Harkness/Health Foundation Fellows. Geared toward health care practitioners and senior civil servants involved directly in health policy, the Harkness/Health Foundation Fellowships aim to enrich health policy development and leadership in the U.K. The 2004–05 Harkness Fellows will undertake research projects under the guidance of a distinguished roster of U.S. and home country mentors. A publishable paper or report for senior policymakers is expected to result from each fellowship.

The 2004–05 Harkness Fellows are:

- **Jean-Marie Berthelot** (Canada)
  Head and Senior Researcher, Statistics Canada
  Project Title: *Health Services Use and Health Disparities: A U.S.–Canada Comparative Analysis*
  Placement: Statistics Canada

- **Marie Bismark, M.B.Ch.B., LLB, MBHL** (New Zealand)
  Legal Advisor and Researcher, Health and Disability Commissioner
  Project Title: *Analysis of Hospital Adverse Events, Complaints and Compensation in New Zealand: Opportunities for U.S. Learning*
  Placement: Harvard School of Public Health
  Mentors: Troyen Brennan, M.D., J.D., Ph.D., and David Studdert, L.L.B., Sc.D., M.P.H.

- **Jane Burns, Ph.D.** (Australia)
  Senior Program Manager, *beyondblue*: the national depression initiative
  Project Title: *Prevention or Treatment in Adolescent Mental Health? A Comparison of U.S. and Australian Strategies and Approaches*

Placement: University of California, San Francisco
Mentors: Charles E. Irwin, Jr., M.D., and Claire Brindis, Dr.P.H.

- **Elana Taipapaki Curtis, M.B.Ch.B., Dip PH, M.P.H.** (New Zealand)
  Public Health Medicine Specialist, National Screening Unit, Public Health Directorate, Ministry of Health
  Project Title: *Ethnic Disparities in Breast Cancer Mortality and Survival: Understanding the Role of Access and Quality of Care*
  Placement: University of California, San Francisco
  Mentor: Andrew Bindman, M.D., and Rebecca Smith-Bindman, M.D.

- **Rhiannon Tudor Edwards, D.Phil., M.A.** (United Kingdom)
  Director, Centre for the Economics of Health, and Senior Research Fellow, Institute of Medical and Social Care Research, University of Wales, Bangor
  Project Title: *The Economics of Prevention in Health Care: The Business Case for Quality*
  Placement: Group Health Cooperative of Puget Sound
  Mentors: Edward Wagner, M.D., M.P.H., and Eric Larson, M.D., M.P.H.

- **Rachel Elliott, Ph.D., B.Pharm.** (United Kingdom)
  Clinical Senior Lecturer, School of Pharmacy and Pharmaceutical Sciences, University of Manchester
  Project Title: *What Factors Influence Patients' Decisions to Adhere to Medicine and Are They Taken Account of in Health Policy?*
  Placement: Harvard Medical School
  Mentors: Stephen Soumerai, Sc.D., and Dana Safran, Sc.D.

- **Dominic Ford, M.A.** (United Kingdom)
  Mental Health Operational Development Manager, Healthcare Commission
  Project Title: *Performance Assessment in Mental Health Services: a User Perspective*
  Placement: RAND Corporation
  Mentors: Elizabeth McGlynn, Ph.D., and Kenneth Wells, M.D., M.P.H.

- **Stephen Monaghan, M.B.Ch.B., M.P.H., LLM** (United Kingdom)
  Public Health Director, Cardiff Local Health Board, National Public Health Service (Wales)
  Project Title: *How Well Do Incentives for Quality Work?*
  Placement: RAND Corporation
  Mentor: Paul Shekelle, M.D., Ph.D.

- **Nadeem Qureshi, M.B.B.S., M.Sc.** (United Kingdom)
  Clincal Lecturer/General Practitioner, School of Community Health Sciences, University of Nottingham
  Project Title: *Anticipating and Preventing Inequalities in Genetic Health Care Provision for Vulnerable Minority Populations*
  Placement: Centers for Disease Control and Prevention
  Mentor: Muin J. Khoury, M.D., Ph.D.

- **Kathryn Rowan, D.Phil.** (United Kingdom)
  Director, Intensive Care National Audit and Research Center
  Project Title: *A Comparison of Quality Initiatives in the U.K. and the U.S.*
  Placement: Agency for Healthcare Research and Quality
  Mentor: Carolyn Clancy, M.D., and Dan Stryer, M.D.

- **Richard E. Scott, Ph.D.** (Canada)
  Associate Professor, Department of Community Health Sciences, University of Calgary
  Project Title: *Assessing Issues and Solutions for E-Health Policy Development in Six Countries*
  Placement: Department of Community Health Sciences, University of Calgary

- **Peter Sprivulis, M.B.B.S., Ph.D.** (Australia)
  Clinical Director, Acute Demand Management Unit, Department of Health, Government of Western Australia
  Project Title: *The Business Case for Investment in Quality: How Much Should We Spend on Clinical Decision Support Systems?*
  Placement: Brigham and Women's Hospital
  Mentor: David W. Bates, M.D., M.Sc., and Donald Berwick, M.D.

- **Claire Stebbing, M.B.B.S., M.A.** (United Kingdom)
  Senior House Officer, Department of Paediatrics, Guys' and St. Thomas' NHS Trust
  Project Title: *Medication Errors in Children and an Assessment of Strategies for Their Prevention*
  Placement: Brigham and Women's Hospital
  Mentor: David W. Bates, M.D., M.Sc.

Packer Policy Fellowships, an Australian–American Health Policy Fellowship Program

The "reverse" Harkness Fellowship program established in 2002 by the Australian Department of Health and Ageing in collaboration with the Fund, was renamed the Packer Policy Fellowships in honor of Kerry Packer, chairman of Consolidated Press Holdings, Ltd. The Packer Policy Fellowships program is 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 October 2004 and selected the second round of fellows:

- **Kristen Testa,** director of programs to increase health insurance coverage for children and families at The Children's Partnership in California.

- **Keith McInnes,** project director of Cancer Care, a pilot project based at Harvard Medical School that uses electronic health records and information technology to improve the quality of care for cancer patients.

Partnerships with International Foundations

The Fund continues to seek and nurture partnerships with international foundations in order to expand and enrich its programs. In addition to the recent expansion of the Harkness Fellowships, the Fund's partnership with The Health Foundation includes other areas of collaboration. Beginning with the 2004 International Health Policy Survey, The Health Foundation supports an expanded U.K. survey sample, making possible statistically significant comparisons between England, Scotland, Wales, and Northern Ireland. The foundation will also host a U.K. health policy symposium, modeled after the Fund's own International Symposium, to bring together health

ministers and senior government officials from the four countries and to release the U.K. survey findings.

In the fall of 2002, the Fund joined the Bertelsmann International Network for Health Policy and Reform in a collaboration among 15 countries to share information on policy reforms, innovations, and best practices. Composed of independent experts from foundations and research institutions based in Asia, Australia, Europe, and North America, the network analyzes health sector reforms and trends in industrialized nations on a "real-time" basis. Reports are produced twice a year and disseminated to policymakers and, through the Internet, to a worldwide policy audience. The third meeting of the collaboration was held in Berlin in July 2004. In December 2004, the Bertelsmann Foundation partnered with the Fund and AcademyHealth to convene a meeting of senior U.S. and German government officials and leading policy experts to share innovative health care delivery and financing models for the coordination of care for people with chronic illnesses.

An ongoing collaboration between the Fund and the Canadian Health Services Research Foundation enables two Canadian Harkness Associates to participate in the fellowships program each year. In addition, the Fund continues to build on its longest-standing international partnership with the Nuffield Trust, with which the Fund has cosponsored the annual U.S.–U.K. Meeting on Health Care Quality since 1999.

Ian Axford Fellows, 2005

A further dimension of IHP is the Fund's administration of the Ian Axford Fellowships in Public Policy. Established by the New Zealand government in conjunction with the private sector, the program provides opportunities for outstanding U.S. professionals working in a range of public policy areas—including health care, education, welfare reform, criminal

justice, employment, race relations, the environment, science and technology, and tax policy—to take six-month policy sabbaticals in New Zealand. Complementing the Harkness Fellowships, the program strengthens a growing network of international exchange on health and social policy issues. The Ian Axford Fellowships selection committee, chaired by Robert D. Reischauer, president of the Urban Institute, met in May and selected three 2005 fellows, who will begin their tenure in New Zealand in January 2005:

- **Nicholas Johnson,** director of the State Fiscal Project at the Center on Budget and Policy Priorities

- **John O'Brien,** director of health policy studies in the Center for Health Program Development and Management at the University of Maryland, Baltimore County

- **Dena Ringold,** senior economist at the World Bank.

Research Projects and Other Activities

Through its Small Grants Program, the Fund supports efforts to learn from other countries' innovations. One of the 2004–05 grants supported international sessions at the 2004 AcademyHealth Annual Research Meeting, at which presentations were made on the Fund's International Working Group on Quality Indicators and OECD Quality Indicators project, lessons from abroad concerning the use of quality-improvement incentives, and results of the Fund's 2003 International Health Policy Survey of hospital executives. Small Grant support also enabled publication of the lead article in the May/June 2004 issue of *Health Affairs,* "U.S. Health

Care Spending in an International Context," by Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson. The study examined factors explaining high U.S. health care spending relative to other countries with much older populations, including disproportionately high administrative costs and the fragmented nature of the U.S. health system. Published in the same issue was an analysis of trends in international nurse migration, prepared by the University of Pennsylvania's Linda Aiken and colleagues.

REFERENCES

1 C. Schoen, R. Osborn, P. T. Huynh, M. Doty, K. Davis, K. Zapert, and J. Peugh, "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs* Web Exclusive (October 28, 2004).

2 First Report and Recommendations of the Commonwealth Fund's International Working Group on Quality Indicators, The Commonwealth Fund, June 2004.

John E. Craig, Jr.
Executive Vice President—COO

Executive Vice President—COO's Report
2004 Annual Report

Regulating Foundations: A Delicate Balance

The Commonwealth Fund board of directors is responsible for the foundation's governance. A policy-setting board, its members serve on Executive and Finance, Audit and Compliance, Governance and Nominating, and Investment committees whose work ensures strong oversight of the institution's management, program strategies, and endowment. Members include William R. Brody, M.D., president of Johns Hopkins University; Robert C. Pozen, chairman of MFS Investment Management; and Jane E. Henney, M.D., senior vice president and provost for health affairs at the University of Cincinnati.

Foundations have been the subject of much scrutiny over the last year on Capitol Hill, in the offices of state attorneys general, and in the media. Amidst numerous calls for increased regulation of the sector, leaders of the foundation community have attempted to respond to the challenges posed. Yet, so far, relatively little of the attention has focused on the positive role most foundations play in society—and how to avoid damage to strongly performing institutions while ensuring accountability throughout the sector. Many people, both inside and outside philanthropy, believe that a closer, more comprehensive, and much more thoughtful examination of the regulatory structure governing foundations is warranted.

The Challenge: Foundations Under Heightened Scrutiny

Many forces account for the increased scrutiny foundations are encountering today. These include the well-documented misbehavior of some nonprofits and private foundations;[1] inadequate understanding of the varying operating practices of private foundations; heightened attention to the accountability

of all governing boards following the Enron and other corporate scandals; preference in some quarters for higher foundation spending rates to meet immediate social and cultural needs; and dissatisfaction of some observers with the programs foundations choose to sponsor.

Those factors contributed to the 2003 passage of the Charitable Giving Act (H.R. 7) by the House of Representatives. As originally drafted, the bill would have prohibited foundations from counting most intramural spending toward their federally required annual payout. Such a change would have substantially increased the payout requirement for many foundations, leading to major erosion in the purchasing power of their endowments over the next 20 years.

Prior to the bill's passage, however, the House leadership worked closely with foundation representatives to rethink the handling of internal expenses. Reflecting the compromise reached, the version passed by the House in September 2003 permitted the allocation of certain internal expenses and the administrative costs associated with them—for research, program development, and communications, for example—toward the payout requirement. The Senate and House were ultimately unable to reconcile their respective legislation on charitable giving in 2003, and the bill did not become law. Nevertheless, the compromise was an important step toward better congressional understanding of foundations and the nature of their work.

In 2004, the Senate Finance Committee (SFC) returned to the issue of nonprofit and foundation governance. In anticipation of a new round of legislation, committee staff produced a discussion draft, which served as the basis for hearings held on June 22, 2004, and a follow-up Charitable Governance Roundtable.

The SFC discussion draft proposed an unprecedented role for the federal government in the management and regulation of the nonprofit and philanthropic sector. Its provisions included:

- review of each organization's tax-exempt status every five years, with voluminous filing requirements;
- defining as an "administrative expense" any foundation expenditure that is not an extramural grant;
- detailed review of intramural expenses greater than 10 percent of a foundation's total expenses, with determination by the Internal Revenue Service (IRS) of the appropriateness of counting those expenses toward the required annual payout;
- disallowance of any intramural spending greater than 35 percent of the total as part of the qualifying distribution for meeting the annual payout requirement;
- for highly paid managers, substantial documentation and public disclosure of information regarding compensation;
- limits on expenses for travel, meals, and accommodation;
- incentives for foundations to increase their payout to 12 percent, from the current minimum of 5 percent;
- detailed requirements for institutional oversight and management by boards of directors, with confirmation of compliance provided on organizations' IRS tax returns (the 990 for nonprofits, and the 990-PF for private foundations);
- a requirement that all organizations change their auditors every five years;
- a requirement that boards of directors haveno fewer than three members, and no more than 15;
- IRS authority to remove, with cause, any board member of an organization;
- prohibition or severe limits on compensation of foundation trustees;

- publication on an organization's Web site of all documents required to be filed with regulators;
- additional fees to be paid to the IRS for numerous new required filings;
- federal support of accrediting agencies for charities and subgroups, such as foundations, with accreditation fees to be paid by organizations and the IRS able to base charitable status on accreditation; and
- a requirement that tax returns for organizations include detailed descriptions of annual performance goals and measures.

Many of the governance measures contemplated in the SFC draft originated in the Sarbanes–Oxley Act of 2002, which concerned corporate accountability. Some measures, however, go well beyond those required even in the corporate context—for example, the proposal that organizations change their independent auditors at least every five years.

Some measures proposed in the discussion draft, especially those intended to address problematic areas like inappropriate tax shelters, were favorably received at the June 22 hearings. Yet the broader proposals to expand federal involvement in the activities of nonprofits and private foundations were severely criticized, both then and in subsequent discourse, as too intrusive and micromanaging, unmindful of the regulatory burdens already borne by nonprofit organizations, inadequately appreciative of the diligence exercised by most nonprofit boards, and underestimating the merits of self-regulation in a heterogeneous and overwhelmingly public-spirited sector. For example:

- Most of the information to be submitted by foundations for five-year reviews of their tax-exempt status is already submitted in annual IRS tax returns. Moreover, the IRS clearly lacks the resources to review five-year filings from

the nearly 1.4 million nonprofit organizations in the United States.

- Attempting to codify in detail the responsibilities of nonprofit boards underestimates the responsible behavior of the great majority of nonprofit boards. Doing so could also undermine their effectiveness by concentrating efforts on code requirements instead of the broader needs of the organization, and would almost certainly discourage board service by able individuals, given the increased liability concerns arising from detailed codification of responsibilities.
- Mandated five-year terms for auditors of all organizations regardless of size, purpose, or geographic setting ignores the importance of continuity and experience in the auditing exercise. Such a limit would be especially burdensome for small organizations in localities with a limited number of qualified auditors.
- The proposed maximum of 15 board members for an organization does not take into account the need of universities, hospitals, and other large organizations for larger boards with a wide range of competencies, which are exercised through board committee structures.
- Federally sponsored accrediting agencies pose the risk of political influence in the missions and management of nonprofits.

Finance Committee Chairman Senator Charles Grassley has indicated the need for caution regarding comprehensive legislation and has stated that any legislation in the near term will likely focus on tackling specific abuses. The outcome of ongoing activity by the committee remains uncertain, however, and the issues at stake for foundations and nonprofits generally are momentous.

Foundations have also received attention from state officials. Incorporated under state law, foundations are held

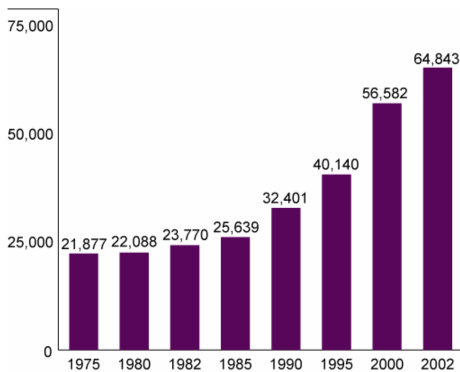
accountable by states for certain standards of behavior.[2] Using the Sarbanes–Oxley legislation as their springboard, attorneys general in several states—including California, Connecticut, Hawaii, Massachusetts, and New York—have introduced legislation that would tighten state regulation of the nonprofit and foundation sectors. With varying degrees of success, nonprofit organizations in each of those states have worked to help ensure that any new legislation promotes best practices by governing boards, while neither undermining the ability of nonprofits to attract able board members nor adding burdensome new regulations.

Foundations have also been the subject of considerable negative press recently. Major newspapers, the *Boston Globe* in particular, have devoted substantial coverage to questionable practices in the nonprofit sector, including foundations. Although the *Wall Street Journal* ran an insightful story on how health care foundations like The Commonwealth Fund are stimulating quality improvement in health care—and the media sometimes report the results of foundation programs—the focus of the press has generally been on foundations' expenses, particularly trustee and executive compensation, and examples of misconduct.

The Facts: A Changing Foundation Sector

The oversight and watchdog functions performed by Congress, the IRS, offices of state attorneys general, and the media are beneficial, in that they can lead to corrective action in cases of real misbehavior. Their effectiveness is weakened, however, by misperceptions or inadequate understanding of key aspects of the foundation sector: its recent growth, its structure and heterogeneity, the operating styles of different foundations, and information available on foundations' activities.

The number of U.S. foundations grew by 173 percent between 1982 and 2002.



The Foundation Center, 2003.

Recent Dynamic Growth

The economic stagflation of the 1970s, combined with 1969 federal regulations that established disincentives for the formation of foundations and mandated annual payout rates exceeding market returns, produced an essentially stagnant foundation sector. As a result, the number of organizations remained stable at roughly 22,000 from 1975 until 1980. The long bull stock market of 1982–2000, the large number of new fortunes created in the same period by the technology revolution and economic growth, and a more favorable federal regulatory environment from 1980 onward produced a major new wave of foundation formation: the number of foundations grew from 23,770 in 1982 to nearly 65,000 in 2002. Today, almost half of foundations with assets of $1 million or more were formed after 1989 (more than 10,000 institutions).

Two features of the recent growth in the foundation sector have significant implications for an appropriate regulatory apparatus for the sector. First, foundation formation is no longer the preserve of the super-rich, as it largely was in earlier eras. Foundations are now established by individuals of comparatively modest wealth, with a resulting explosion in the number of foundations with assets under $5 million, and even $1 million.

Second, even as the sector has been “democratized” with respect to the relative wealth of founders, it has also become far more diversified geographically. The share of foundations in the Northeast, for example, fell from 38 percent in 1982 to 31 percent in 2002, and the Midwest, from 27 percent to 25 percent, while the share in the South rose from 22 percent to 26 percent, and the West, from 13 percent to 17 percent. Among the seven states with the most foundations, Florida replaced Massachusetts between 1980 and 2002, joining New York, California, Illinois, Texas, Pennsylvania, and Ohio. Even within the seven states accounting for 50 percent of all

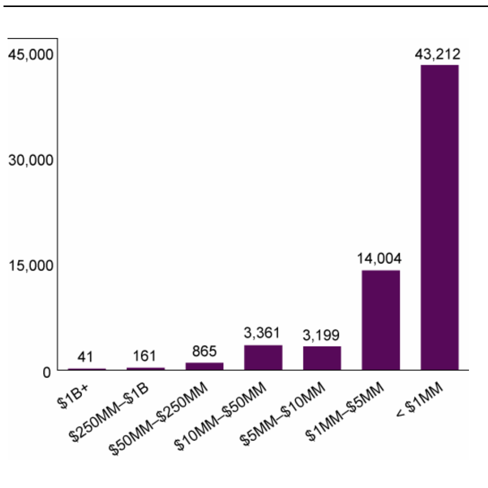
foundations, growth differentials over the 22-year period were marked: California's growth rate was highest, at 226 percent, and New York's was lowest, at 91 percent.

A "Small Firm" Sector

A peculiar feature of the foundation sector is the extent to which assets are concentrated in a small group of institutions: 41 foundations with assets exceeding $1 billion account for 32 percent of all foundation wealth, and 161 foundations with assets between $250 million and $1 billion account for another 17 percent.

By contrast, small foundations (those with assets between $1 million and $5 million) and very small organizations (with assets less than $1 million) hold only 7 percent and 3 percent, respectively, of the sector's wealth. They are, however, extremely numerous. Small foundations number 14,004, and very small foundations, 43,212. The average endowment assets of small foundations is $2.2 million and of very small foundations $270,000. The high annual payout rates of these foundations (14 percent and 28 percent, respectively) reflects the fact that many of them are "pass-through" entities used as charitable giving conduits in the donor's lifetime. Some of these small institutions are destined to become very large as the result of donor bequests, but the very limited number of foundations currently with assets of $250 million or more indicates that most small and very small foundations will remain so.

Only 202 U.S. foundations have assets of $250 million or more, while 43,212 have assets of less than $1 million.



The Foundation Center, 2003.

A Range of Operating Styles

The earliest foundations, including The Commonwealth Fund, have pursued a "value-added" style of grantmaking. From the beginning, they employed professional staffs charged with the responsibility for developing grantmaking strategies, working with grantees to develop projects, monitoring the progress of

grantees' work, taking corrective action when needed, and disseminating the results of the work of grantees. Value-added foundations have also mounted their own intramural research programs and taken responsibility for managing programs or projects directly when skilled external grantees were not available, or when direct management by the foundation was expected to be a more productive strategy. Run essentially as nonprofit businesses, value-added foundations have enhanced the impact of their programs by connecting grantees with each other to build synergies among projects. In addition, they have created opportunities for grantees to present their work to influential audiences, and developed communications programs whose activities include co-authoring papers with grantees, operating sophisticated Web sites, and testifying before Congress. Not surprisingly, foundations with a value-added operating style have also emphasized the assessment of performance relative to goals, not only for grantees but for their own work.

The value-added approach of the early foundations, with its many requirements and pressures, proved more challenging than most donors were willing or could afford to attempt. As a result, for many years the great majority of foundations operated purely as grantmakers, focusing on basic due diligence with regard to proposals and the work of grantees. In contrast with value-added foundations, these "low-engagement" foundations do not need substantial intramural staff and therefore have low internal operating budgets.

Over the last 25 years, however, a growing number of foundations—particularly large, newer ones—have chosen to adopt the value-added model. In fields such as health care, they have been stimulated to do so by the example of established institutions like The Commonwealth Fund, which provide evidence that devoting substantial resources to intramural activities over an extended period pays off

handsomely in terms of the productivity of grantees and the foundation's overall performance.[3] Other circumstances contributing to the return to favor of the high-engagement, value-added model are the proclivities of entrepreneurial founders, who tend to apply to their philanthropic efforts the same energy and hands-on direction that made them successful in creating major new businesses. Additionally, a growing body of literature by researchers such as Michael E. Porter at Harvard Business School supports the pursuit of value-added strategies.[4]

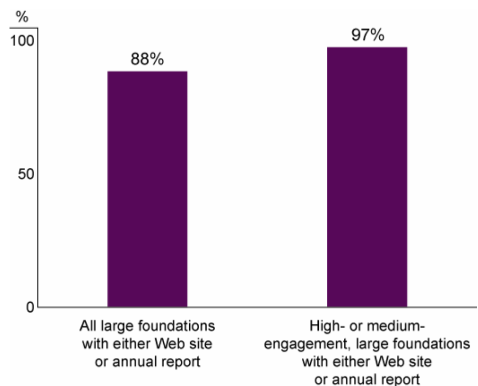
Thus, the operating styles of private foundations today range along a spectrum from low engagement to high engagement. An understanding of a foundation's operating style is essential for understanding its spending practices.[5] Regrettably, few observers outside the field seem to appreciate this, with the result that some observers label all intramural spending as questionable, while the press often describes intramural outlays by foundations as "expenditures on themselves."

Extensive Reporting of Information

Among the ironies of the proposals for increased regulation is the call for more information from foundations, a group of institutions that already voluntarily supplies a great deal of information or is required to do so by existing regulations. Foundations currently use several mechanisms to report on their activities:

- All private foundations must file annually the IRS 990-PF tax return, which in addition to soliciting data on revenues, expenses, assets, and regulatory issues also requires detailed information on grants, programs, and endowment investments. The inadequacies of the 990-PF as an information source and regulatory device are discussed below, but the huge volume of information it solicits is

The great majority of U.S. foundations with $250 million or more in assets maintain Web sites and publish annual reports that provide a great deal of information on their activities.



The Commonwealth Fund 2004 Survey of Large Foundation Web Sites.

nonetheless available to all—since 2000 on Guidestar.com, in the offices of the Foundation Center, or from the foundations themselves.

- The Foundation Center, supported principally with grants from foundations and with regional offices and collections around the country, collects data on all foundations; maintains a searchable Internet database on all known grantmakers (including private, community, corporate, and operating foundations); publishes reports tracking foundation trends; maintains a user-friendly Web site designed to assist would-be grantees, researchers, and regulators; and provides training on the use of its services.
- Most large and many smaller foundations publish annual reports or, increasingly, maintain Web sites designed to communicate their purposes and giving strategies and disseminate the results of their work. Of the top 200 private foundations (accounting for 45 percent of all foundation assets) in 2002, for example, 88 percent either published a detailed annual report or maintained a Web site disclosing a substantial amount of information on their activities. This percentage rises to 97 percent when low-engagement foundations that devote their resources to a few local or regional institutions are omitted.
- Most state attorneys general require annual submission of reports from foundations.

The Regulatory Dilemma

This sketch of the foundation sector gives some indication of the challenge facing regulators and watchdogs in monitoring foundations' activities and identifying misconduct. Those with oversight responsibilities face a rapidly growing, highly diverse, and dynamic sector whose modes of operation are changing in response to societal needs.

The distribution of foundation assets poses a particular problem for regulators and anyone seeking to monitor the activities of the sector. Large foundations—few in number—are relatively easy to monitor and can afford, within reason, the resources needed to comply with regulatory requirements for information and pursue best practices. Further, the size of these institutions and the number of internal and external stakeholders in their affairs promote an institutional ethic of accountability. Because of these factors and the visibility of foundations, instances of misconduct tend to be self-corrected quickly. Not surprisingly, a 1984 IRS study of large foundations found this segment of the sector to be well run—a finding that weighed significantly in the IRS's decision to devote fewer resources to oversight of the sector.

But small foundations—extremely large in number—are much more difficult to track. As a group, small and very small foundations are the organizations that warrant particular attention because of the recent formation of many, their limited visibility and scarcity of stakeholders in their affairs, their varying knowledge of and ability to implement best practices, and the heterogeneity of their purposes and missions. Paradoxically, small foundations are also least able to afford significant regulatory burdens, particularly when the opportunity cost of such burdens is taken into account.

Monitoring the activities of some 57,000 small and very small foundations is made all the more difficult by the paucity of regulatory resources. When the 2 percent excise tax on foundations' net investment income was enacted in 1969, experts advised that a substantial portion of the revenues raised be dedicated to funding regulation of the sector by the IRS. That step was not taken, with the result that the IRS lacks the capacity to perform the oversight function most observers regard as necessary. Further, the nonprofit nature of the foundation sector, and the likely concentration of misconduct

in small and very small institutions, results in comparatively little financial payoff from time spent by field agents in the sector.[6]

State attorneys general have a wide range of responsibilities, and the resources available to them are stretched very thin. Few have the capacity to analyze the voluminous reports submitted to them by foundations each year, with the result that virtually all rely on "whistleblower" reports from individuals or the media as a trigger for looking into a foundation's affairs. Regulatory shortcomings are further compounded by confidentiality considerations, which by law prevent the routine sharing between the IRS and state attorneys generals of much information on foundations.

Perhaps the greatest obstacle to appropriate regulation of the foundation sector, however, is the 990-PF itself—the primary instrument used by the IRS to collect information on foundations, and one on which state attorneys general, the media, and researchers rely. The faults of the 990-PF can be summarized as follows:

- Little altered in format since at least 1969, its underlying premise is that most foundations are exclusively grantmakers, when in fact foundations have become increasingly diverse in their operating styles. The bifurcation of expense data requested on the 990-PF between "Operating and Administrative Expenses" and "Contributions, Gifts, Grants Paid" encourages the presumption that all intramural expenses are for general administration, when for high- and medium-engagement foundations this is unlikely to be the case.
- Because of the detailed information requested on foundations' endowment assets and investment activity (purchases and sales), the 990-PF return for a foundation like The Commonwealth Fund is typically 500 to 600 pages in length. Most of the information requested on

individual investments and thousands of financial transactions is unmanageable and of little use for regulatory purposes. Yet the mass of information solicited poses a major obstacle to electronic submission of the return and electronic analyses of this potentially important database.

- Most data collected on foundations' revenues and expenses and assets/liabilities are geared to the calculation of the required qualifying distribution and annual excise tax—not to presenting a picture of the foundation's expense structure in the context of its operating style, nor to shedding light on the investment performance of its endowment. As a result, the presentation of the data on the 990-PF is, at best, confusing to researchers and the media and, at worst, misleading.
- The 990-PF lacks clear definitions of the categories of expenses that foundations are required to report; consequently, considerable inconsistency arises as foundations attempt to interpret IRS instructions and classify their expenditures.
- The relevance in the foundation context of a fair amount of information collected on the 990-PF is questionable—for example, interest expense, inventories for sale or use, and mortgage loan investments as an assets category.
- Information on potentially controversial areas, such as trustee compensation, is not solicited in formats that make it readily identifiable.

Given all these faults, databases constructed from the 990-PF are seriously flawed, as are many of the analyses that regulators, researchers, and the media base on them.

Toward More Effective Regulation of the Foundation Sector

A number of steps could be taken to improve the federal

government's oversight of the foundation sector and make the regulatory process more modern, simple, and efficient.

A Major Overhaul of the 990-PF

The Foundation Financial Officers Group (FFOG), an association of the chief financial officers of a wide range of foundations, including most large entities, is currently testing a proposed new set of Financial Reporting Standards, with the hope that those standards might ultimately be incorporated into a revised 990-PF.

The major innovation of the FFOG proposal would be to ask foundations to allocate their expenses across four categories:

- Direct Public Benefit Activities, including external grants and programs directly operated by the foundation, such as fellowships, intramural research and evaluation, communications, grantee forums and joint work with grantees, technical assistance to governmental bodies, social services, arts performances, historic preservation, museums, and other programs with significance beyond the foundation's grants programs;
- Grantmaking Activities, including resources dedicated to selecting grantees, monitoring the progress of projects, evaluating programs, and meeting regulatory requirements regarding grants;
- General and Administrative Activities, including the overall operation of the foundation and work not directly connected to any of the other three categories; and
- Investment Management Activities, representing the costs of internal investment staff and other expenses associated with management of the foundation's endowment.

In addition to providing helpful guidelines for those allocations, the FFOG proposal would also define expense elements more clearly than does the current 990-PF, make needed corrections in requested expense elements, and ask

foundations to identify their operating style as low engagement, medium engagement, or high engagement.

A recent test of the proposed FFOG format by 34 foundations, including The Commonwealth Fund, indicates that this innovation provides a much clearer, more accurate picture of how foundations allocate resources to accomplish their missions than does the existing 990-PF format (see adjacent figure).[7] It is to be hoped that, after a period of testing, the IRS will move rapidly to adopt this modernized approach to data collection.

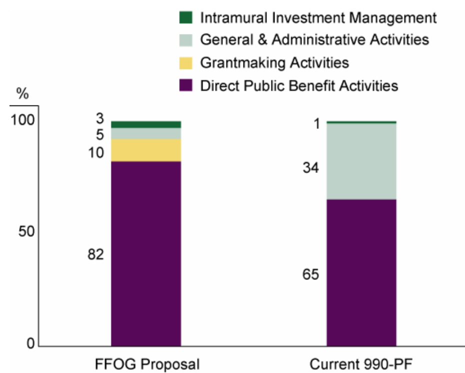
As suggested by Betsy Buchalter Adler, chair of the Exempt Organizations Committee of the American Bar Association's Section of Taxation, a redesigned 990-PF could also address, in question form, most of the governance and management concerns raised by the recent SFC discussion draft. Questions could easily cover such topics as whether or not a foundation has a conflict-of-interest policy (and if not, why not), internal governance practices, and a process for determining executive compensation. This approach would put pressure on institutions to develop appropriate policies and implement best practices. It would also help the IRS and state attorneys general to target their audit resources—without slipping into micromanagement of individual institutions.

Electronic Filing and Database Creation

No less important than revising the expense reporting framework would be simplifying the 990-PF to enable electronic filing. The 990 for nonprofits can already be filed electronically, and the barriers to electronic filing by foundations should be few once the unnecessary investments information requirement noted above is eliminated.[8] Electronic filing would greatly improve the accuracy and completeness of foundation tax returns, as electronic systems require all key data fields to be filled and check automatically

The proposed FFOG expense reporting format presents a far more accurate picture of the expenditures of value-added foundations like The Commonwealth Fund than does the current 990-PF format.

Distribution of value-added foundation expenditures



The Commonwealth Fund, 2004.

for errors. Electronic filing would also promote information-sharing between regulators.

These steps would allow foundation 990-PFs to be assembled into a researchable database, which in turn would allow for the development of benchmarks for expense allocations according to foundation operating style. Benchmarks would have to be used carefully, given the heterogeneity of the sector even within operating styles, but they would be a major resource to guide the activities of regulators and watchdogs.[9]

The collection of better information through a revised 990-PF and the creation of an electronic database to make that information available would facilitate the development of improved algorithms for targeting audits, thereby promoting better use of scarce regulatory resources.

Increased Regulatory Resources and Information-Sharing

Clearly, additional IRS resources would be needed to develop more sophisticated regulatory approaches, implement e-filing of tax returns, analyze the improved database on foundations, develop algorithms for targeting audits, and train additional field staff. At least some portion of revenues raised by the excise tax on foundations should be set aside for such purposes, with some allocation to state regulators.

Given governmental fiscal constraints and the foundation sector's commitment to improved self-regulation, a group of leading foundations would undoubtedly underwrite a public-private collaboration with the IRS to overhaul the 990-PF as outlined above. Such a group could well be the source of voluntary funding for other initiatives to improve the regulatory structure. As Marion R. Fremont-Smith observes, "with adequate funding and personnel, the Internal Revenue Service would have been able to prevent most of the abuses [the Senate Finance Committee] is addressing. It is not the

code provisions that are inadequate; rather it has been the inability of the Service to adequately police the sector."[10]

Further, there is near-universal agreement that the IRS and state attorneys general should be encouraged to share information on foundations involved in questionable practices, and that most existing legal obstacles to such coordination should be removed. Coordination across jurisdictions would not address all the problems arising from the inadequacy of current regulatory resources, but information-sharing would help target regulatory efforts on the trouble spots.

Reexamining the Place of Small and Very Small Foundations

Very few foundations with assets of less than $5 million can afford the professional staff necessary to add value to the work of their grantees. There can be little justification, therefore, for substantial intramural expenses, except when the foundation is operating programs directly. At the same time, small foundations face significant challenges in handling their affairs well, including substantial startup costs, diseconomies of scale, attracting conscientious board members, and avoiding the temptations of using the foundation for nonphilanthropic ends (such as inappropriate compensation of family members). The available evidence suggests that regulators should focus their attention on this extremely large "small firm" segment of the foundation community. Yet, no amount of regulatory resources or requirements can fully address the potential for misconduct in a sector that has grown as rapidly as has the small foundation community in recent years.

Thus, the foundation community, researchers, and regulators should reexamine the rationale for encouraging the creation of foundations with assets of less than $5 million, especially given the alternative of donor-advised funds

managed by community foundations or large mutual fund companies.[11]

The Foundation Sector's Responsibilities

Study of the foundation sector and the regulatory challenges it presents leads inescapably to the conclusion that the sector itself must take a more active role in defining best practices, encouraging their adoption, and working with individual foundations and regulators to identify and correct abuses.

This work is already under way. In 2004, the Foundation Executives Group issued *Governance Principles for Large Foundations* (www.cof.org), thus adding to the recommended standards introduced in the Council on Foundations' 2002 *Principles and Practices for Effective Grantmaking,* and more recent *Stewardship Principles and Best Practices for Family Foundations* and *Stewardship Principles and Best Practices for Corporate Grantmakers.*

Yet publishing guidelines and books on proper stewardship and good management may not be enough. Foundation sector organizations—the Council on Foundations and regional associations of foundations—may well need to go further in their efforts to promote best practices. Foundation membership organizations should consider establishing proactive committees to which individuals concerned about particular foundations' practices might turn. Properly staffed and charged with well-defined mandates, state or regional voluntary "foundation stewardship" committees could help thwart abuses and, equally important, use information available to them as sector leaders to help regulators use their resources more efficiently—for example, by advising on the level of investigatory response appropriate to a media report of foundation abuse.

The performance of any foundation, of course, depends ultimately on the quality of its governing board, the body with

legal fiduciary responsibility for its operations. Recent attention to governance issues has spurred many foundations to review their governance structure and processes and to identify and address potential weaknesses. As an example, The Commonwealth Fund's recently revised code of ethics, conflict-of-interest policy, and board committee charters are posted on the foundation's Web site.

Do No Harm

Given the number and diversity of foundations, neither the IRS nor state regulators can hope to manage them directly. The public must rely on strong governing boards to ensure the accountability and performance of foundations. As New York State, Attorney General Eliot Spitzer has said "I think we need to educate [nonprofit boards] about what the laws require, and what their obligations are: to ask questions about financials, to inquire about salaries, to inquire about self-dealing...."[12] Yet several of the witnesses who addressed or submitted comments to the SFC at its June 2004 hearings observed that the proposed federal regulatory measures threatened to discourage board service by precisely the kind of people needed by foundations.

In his testimony before the Senate Finance Committee, Derek Bok, former president of Harvard University and now faculty chair of Harvard's Hauser Center for Non-Profit Organizations, cautioned that "there is danger that in enacting rules in response to a few particularly flagrant, widely publicized abuses, regulators will impose burdens of paperwork, record-keeping, and other costs on all nonprofits that will more than equal any benefits achieved by government intervention."[13]

Jonathan Small, president of the Nonprofit Coordinating Committee of New York, encouraged the committee to

> keep in mind as you review federal regulation of nonprofits the Hippocratic oath taken by doctors: 'Do no harm.' There are already many laws and regulations governing the operation of nonprofits, as well as a number of watchdog organizations monitoring them. We believe that the vast majority of abuse and misconduct is already covered by existing rules; therefore, what is needed most is enforcement of those rules at the federal and state levels. Also, each new rule that prevents misbehavior or catches a bad actor can impose additional costs on tens of thousands of organizations that are behaving properly.[14]

This advice is well taken. If we in the foundation community hope to see it heeded, we need to step up our own efforts to ensure strong performance and accountability throughout the sector.

REFERENCES

[1] Specific areas of abuse include credit counseling organizations claiming tax exemption but actually used to market financial products; auto and similar donation programs; tax shelters; and failure to file accurate and timely tax returns (990 and 990-PF). Additionally, instances of excessive payment of board members and members of donors' families as staff, as well as apparently inappropriate reimbursement for travel and other expenses of such individuals have been identified.

[2] In fact, according to Marion R. Fremont-Smith of Harvard's Hauser Center for Nonprofit Organizations, relatively few states devote attention to this responsibility. She reported in a September/October 2004 *Foundation News & Commentary* interview that "the extent of enforcement of fiduciary duties in the states ranges from almost nonexistent in the majority to active in six or seven states."

[3] John E. Craig, Jr., "An Undervalued Species: Private Value-Added Foundations," *The Commonwealth Fund Annual Report 2003;* John E. Craig, Jr., "The Value-Added Foundation: Grantees' Views on the Fund's Performance," *The Commonwealth Fund Annual Report, 2002;* and John E. Craig, Jr., "The Fund's Performance as a Grantmaker," *The Commonwealth Fund Annual Report 2000.*

[4] Michael E. Porter and Mark R. Kramer, "Philanthropy's New Agenda: Creating Value," *Harvard Business Review,* November 1999.

[5] Very large foundations, for example, are less able to pursue a full value-added "high-engagement" strategy because of the sheer volume of grants that must be made to meet the annual federal distribution requirement. Such foundations can be classified as "medium-engagement" foundations, reflecting their varied pursuit of a value-added strategy.

[6] IRS veterans have observed that while an audit of a for-profit corporation almost invariably produces substantial tax revenues, audits of foundations and other nonprofits seldom produce revenues.

[7] The marked differences in the two presentations of the Fund's expenses are due principally to the fact that the 990-PF encourages treatment of all non-grant expenses as "general and administration" expenses, regardless of their purpose. In the FFOG proposal, the Fund's non-grant expenses are functionally allocated as follows: those supporting intramural programs such as research and evaluation, communications, fellowships, and joint work with grantees—which are included along with external grants in the "Direct Public Benefit Activities" category; non-grant expenses arising from the development, selection, oversight, and management of grants—which are identified as a distinct legitimate business cost, "Grantmaking Activities"; and intramural endowment management and true general administration costs—which are more clearly defined under the FFOG format than under the current 990-PF.

[8] The motivation for collecting detailed information on foundations' investments originated in concerns about diversification. Those concerns can be addressed more usefully with a simple reporting format that asks foundations to show the allocation of their endowment portfolios across major asset classes, the rank-order share of the endowment in the largest 10 positions, and, if that share is greater than a threshold (such as 20 percent), an explanation for it. Foundations should be prepared to defend the calculation of their annual net investment income and the excise tax payable on it, but the vast underlying detail should be provided on an as-needed basis.

[9] FFOG and regulators need to give further attention to the development of metrics for identifying foundations' operating styles (low-, medium-, or high-engagement), rather than relying solely on self-declaration by each foundation.

[10] Paper submitted for the July 22, 2004, Roundtable on Charitable Governance, following the June 22, 2004, hearing "Charity Oversight and Reform: Keeping Bad Things from Happening to Good Charities," before the United States Senate Committee on Finance.

[11] Many small foundations are established as the precursor to large bequests on the death of the donor. It should be possible to continue to allow the creation of such entities, provided there is adequate evidence of a clear, long-term plan for funding a sizeable endowment of, say, $10 million or more.

A donor-advised fund is a separately identified account maintained and operated by a community foundation, a charitable gifts division of a mutual fund company, or nonprofits such as educational, social service, health care, cultural, or religious organizations. While the donor may advise on the distribution of funds from the account and the investing of its assets, the manager must be free to accept or reject the

donor's recommendations. Donor-advised funds now number over 81,000, reflecting the tax advantages they have over private foundations, their lower cost and ease of establishment compared to foundations, and their lack of regulation. The SFC discussion draft cited the potential for abuses of donor-advised funds, such as the absence of annual payout and activity requirements, grants producing a private benefit to the donor, tax deductions for gifts of illiquid property (e.g,, real estate or stock in privately held companies) producing little or no income for charitable distribution, and the valuation of such gifts. The leadership of the community foundation and mutual fund communities are working with legislators toward appropriate regulation of these vehicles.

[12] *The Legislative Gazette,* November 22, 2004 (Matt Peppe reporting on Attorney General Spitzer's interview with radio station WAMC).

[13] Testimony by Derek Bok at the June 22, 2004, hearing "Charity Oversight and Reform: Keeping Bad Things from Happening to Good Charities," before the United States Senate Committee on Finance.

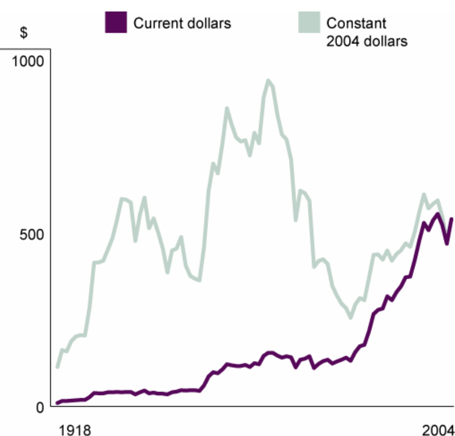
[14] Jonathan A. Small, Nonprofit Coordinating Committee of New York, Inc., "Comments on Senate Finance Committee Staff Discussion Draft Concerning Tax-Exempt Organizations," July 14, 2004.

2004 Annual Report

Treasurer's Report

The investment committee of the Fund's board of directors is responsible for the effective and prudent investment of the endowment, a task essential to assuring 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 policy questions to be addressed by the committee. The committee meets at least twice a year with the Fund's principal external investment managers, at which time it also deliberates investment issues affecting the management of the endowment and considers new undertakings.

The Commonwealth Fund's endowment, in millions, 1918-2004



The value of the endowment rose from $498.3 million on June 30, 2003, to $571.2 million on June 30, 2004, reflecting a return of 20.6 percent on the investment portfolio during the year combined with total spending (including programs, administration, investment management fees, and taxes) of $27.98 million. In that 12-month period, the return of the Wilshire 5000 index of U.S. stocks was 21.2 percent; the return of the Lehman Aggregate Bond index was .3 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 16.0 percent. The Fund's overall investment performance exceeded not only that of the weighted market benchmarks, but also the 13.0 percent produced by the median U.S. balanced manager during the fiscal year.

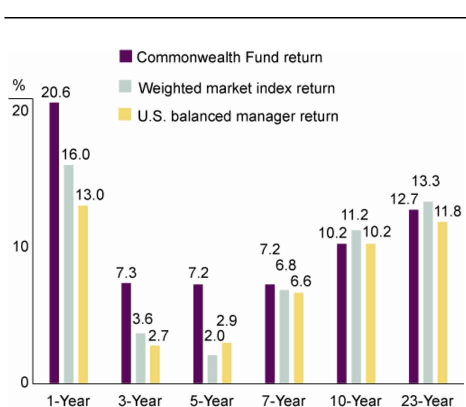
The Fund's team of marketable equity (U.S. and international) managers produced a combined 12-month return of 23.5 percent, well above the Wilshire 5000's 21.2 percent and the median U.S. equity manager's 21.6 percent. In a period of pronounced volatility in marketable equity markets, almost all of the foundation's equity managers produced very strong returns compared with their market benchmarks. The Fund's bond manager outperformed the Lehman Aggregate bond index (3.8 percent versus .3 percent), reflecting the ultimate payoff on an early bet on U.S. economic recovery. The foundation's private equities and real estate portfolios had particularly strong returns during the year, and its oil and gas portfolio benefited from the sale of Intrepid Energy North Sea, Ltd.—a holding which produced an average annual return of 20 percent over a seven-year investment period.

The Fund's investment returns in 2003–04 continued to benefit from the significant restructuring of the management of the endowment that the foundation's investment committee began in early 2000. The restructuring has been aimed at reducing the risk of performance significantly divergent from that of the overall market or peer institutions and at streamlining the management structure. The investment committee undertook further changes in the allocation of the endowment among asset classes during the year, principally by decreasing the U.S. marketable equities allocation from 35 percent to 30 percent, increasing the energy allocation to 5 percent of the endowment, and establishing a commodities allocation of 3 percent of the endowment.

The Commonwealth Fund's endowment management strategy

	Long-term target	Permissible range
Total endowment	100%	
Asset Class		
Total Equity	80%	65-85%
U.S. equity marketable securities	30%	25-45%
Non-U.S. equity marketable securities	15%	10-20%
Marketable alternative equity	10%	0-20%
Non-marketable altertnative equity	10%	0-10%
Inflation hedge	15%	5-15%
Fixed Income	20%	15-35%

The Commonwealth Fund endowment's average annual investment returns

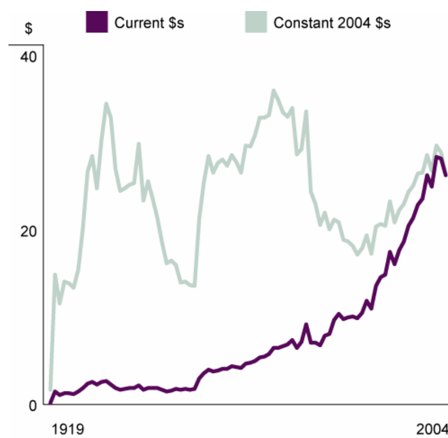


The salient features of the Fund's current investment strategy are summarized in the accompanying figure. Key among these are an overall target commitment of 80 percent of the portfolio to equities (publicly traded and private) and 20 percent to fixed income securities; a 30 percent commitment to publicly traded U.S. equities, paired with a 15 percent commitment to international equities, including a 5 percent allocation to emerging markets; allocation of approximately 10 percent of the endowment to a passive S&P 500 index fund, to help control investment costs and assure adequate tracking of the market; satellite U.S. active large and small capitalization value and growth stock managers, with mandates to outperform their respective market bogeys; assignment of responsibility for 10 percent of the endowment to marketable alternative equity (hedge fund) managers; a 10 percent commitment to non-marketable alternative equities (venture capital and private equities); and a 15 percent allocation to inflation hedges, including real estate, oil and gas, and TIPS.

The investment 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 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 over the three-, five-, and seven-year periods ending June 30, 2004. For the last 10 years and over the almost 23 years since the foundation adopted a multiple manager system, the portfolio's average annual return has equaled or exceeded that of the median U.S. balanced manager but fallen just short of the weighted benchmark index return.

The Commonwealth Fund's annual spending, in millions, 1919-2004: Total spending of $650.8 million over 85 years, or $2.05 billion in constant 2004 dollars



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. While the Fund's endowment has performed comparatively well in the severe equities bear market that began in early 2000, the average annual return on the endowment during this downturn has been 5.4 percent annually. At the same time, the foundation's spending rate has exceeded 5.5 percent annually, and inflation has taken an additional 2.4 percent from the endowment's purchasing power each year. Most market seers predict continued low average investment returns for at least the next five years, as the market corrects for the excesses that occurred in the final stages of the 1982–2000 bull market in stocks.

Like most other institutions whose sole source of income is their endowment, the Fund has found it necessary to reduce its spending plans to adjust to the current market realities. After a reduction of 10 percent in 2003–04, it expects to maintain an essentially flat budget over the next five years. The Fund is fortunate in being able to maintain this level of spending, which allows continuation of all major grants programs.

In a constrained fiscal environment, the Fund remained extraordinarily productive over the last year, while achieving intramural cost savings that enabled staying well within the policy guideline set by the Board of Directors for the ratio of extramural (60 percent minimum) to intramural spending (40 percent maximum). The Fund's shift from mail/paper to electronic distribution of the results of its work and that of grantees and a major upgrade of its Web site accounted for

much of the savings achieved on intramural costs. The foundation's ability to maintain all grants programs and the intramural capacities that assure their effectiveness will enable it to continue to fulfill a unique and highly productive role in American society.

INDEPENDENT AUDITORS' REPORT

We have audited the accompanying statement of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2004 and the related statements of activities and of cash flows for the year then ended. The financial statements of The Commonwealth Fund as of June 30, 2003 and for the year then ended were audited by other auditors whose report dated September 19, 2003 expressed an unqualified opinion on those statements. 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 audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit 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 audit provides 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, 2004 and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

September 30, 2004

THE COMMONWEALTH FUND

STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2004 AND 2003

	2004	2003
ASSETS		
CASH	$ 477,521	$ 29,138
INVESTMENTS - At fair value (Notes 1 and 2)	572,128,427	498,148,956
INTEREST AND DIVIDENDS RECEIVABLE	157,031	561,423
PREPAID TAXES - Net (Note 5)	-	131,218
PREPAID INSURANCE AND OTHER ASSETS	183,687	153,769
RECOVERABLE GRANTS	350,000	350,000
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 $1,571,924 at June 30, 2004 and $1,581,112 at June 30, 2003 (Note 1)	4,471,000	4,602,389
TOTAL ASSETS	$ 578,042,666	$ 504,251,893
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable and accrued expenses	$ 1,027,586	$ 1,464,577
Taxes payable - net	875,221	-
Securities transactions payable - net	205,443	372,508
Program authorizations payable (Note 3)	17,573,288	18,751,005
Accrued postretirement benefits (Note 4)	1,925,002	1,765,517
Deferred tax liability (Note 5)	1,531,576	475,528
Total liabilities	23,138,116	22,829,135
NET ASSETS:		
Unrestricted	554,687,761	481,020,758
Temporarily restricted (Note 7)	216,789	402,000
Total net assets	554,904,550	481,422,758
TOTAL LIABILITIES AND NET ASSETS	$ 578,042,666	$ 504,251,893

See notes to financial statements.

THE COMMONWEALTH FUND

STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2004 AND 2003

	2004	2003
REVENUES AND SUPPORT:		
Interest and dividends	$ 25,501,155	$ 17,319,543
Contribution and other revenue (Note 7)	4,266	32,177
Net assets released from restrictions (Note 7)	285,211	150,000
Total revenues and support	25,790,632	17,501,720
EXPENSES:		
Program authorizations and operating program	21,215,335	25,010,993
General administration	2,578,849	2,543,103
Investment management	3,005,826	2,629,145
Taxes (Note 5)	2,168,405	935,711
Unfunded retirement and other postretirement (Note 4)	367,862	130,953
Total expenses	29,336,277	31,249,905
EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS	(3,545,645)	(13,748,185)
NET INVESTMENT GAINS:		
Net realized gains (losses) on investments	24,314,863	(27,151,744)
Change in unrealized appreciation of investments	52,897,785	37,445,762
Total net investment gains	77,212,648	10,294,018
CHANGES IN UNRESTRICTED NET ASSETS	73,667,003	(3,454,167)
TEMPORARILY RESTRICTED CONTRIBUTION FROM BEQUEST (Note 7)	100,000	-
NET ASSETS RELEASED FROM RESTRICTIONS (Note 7)	(285,211)	(150,000)
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS	(185,211)	(150,000)
CHANGES IN NET ASSETS:	73,481,792	(3,604,167)
Net assets, beginning of year	481,422,758	485,026,925
Net assets, end of year	$ 554,904,550	$ 481,422,758

See notes to financial statements.

THE COMMONWEALTH FUND

STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2004 AND 2003

	2004	2003
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets:	$ 73,481,792	$ (3,604,167)
Net investment gains	(77,212,648)	(10,294,018)
Depreciation expense	347,871	406,680
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Decrease in interest and dividends receivable	404,392	537,158
Decrease in prepaid taxes - net	131,218	146,700
Decrease in deferred tax asset	-	285,942
(Increase) decrease in prepaid insurance and other assets	(29,918)	56,856
Decrease in accounts payable and accrued expenses	(436,991)	(847,194)
Increase in taxes payable - net	875,221	-
(Decrease) increase in program authorizations payable	(1,177,717)	480,123
Increase (decrease) in accrued postretirement benefits	159,485	(286,493)
Decrease in securities transactions payable - net	(167,065)	(5,280,815)
Increase in deferred tax liability	1,056,048	475,528
Net cash used in operating activities	(2,568,312)	(17,923,700)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of furniture, equipment, and building improvements - net	(217,057)	(1,089,107)
Purchase of investments	(427,900,969)	(484,934,895)
Proceeds from the sale of investments	431,134,721	503,959,169
Net cash provided by investing activities	3,016,695	17,935,167
NET INCREASE IN CASH	448,383	11,467
CASH, BEGINNING OF YEAR	29,138	17,671
CASH, END OF YEAR	$ 477,521	$ 29,138
SUPPLEMENTAL INFORMATION -		
Taxes paid	$ 105,918	$ 49,500

See notes to financial statements.

NOTES TO FINANCIAL STATEMENTS
Years Ended June 30, 2004 and 2003

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 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.

2. INVESTMENTS

Investments at June 30, 2004 and 2003 comprised the following:

	2004		2003	
	Fair Value	Cost	Fair Value	Cost
U.S. Equities	$ 222,120,398	$ 199,573,796	$ 204,406,869	$ 214,896,635
Non - U.S. Equities	115,787,460	85,420,609	100,628,294	92,578,688
Fixed income	68,882,700	68,427,970	79,075,285	77,792,969
Short-term	24,156,609	24,156,609	13,957,645	14,019,919
Marketable alternative equity	65,567,269	42,140,486	59,670,856	29,560,194
Nonmarketable alternative equity	11,017,563	14,857,943	10,200,114	18,172,907
Inflation hedge	64,596,428	60,972,222	30,209,893	27,351,262
	$ 572,128,427	$ 495,549,635	$ 498,148,956	$ 474,372,574

At June 30, 2004, the Fund had total unexpended commitments of approximately $32.8 million in various limited partnership 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, 2004, the Fund had no outstanding derivative positions. The table below summarizes the Fund's outstanding positions in futures and forward contracts at June 30, 2003:

	2003	
Contract type	Number of Long (Short) Contracts	Notional Amount
30-year Treasury Bond futures	45	4,500,000
10-year Treasury Note futures	74	7,400,000
5-year Treasury Note futures	(78)	7,800,000
2-year Treasury Note futures	(30)	6,000,000

Included in short-term investments at June 30, 2003 is a variation amount receivable of approximately $33,000, which represents funds due from brokers for excess amounts on

deposit. Also included in short term investments at June 30, 2003 are unrealized losses on open futures contracts of approximately $69,000.

3. PROGRAM AUTHORIZATIONS PAYABLE

At June 30, 2004, program authorizations scheduled for payment at later dates were as follows:

July 1, 2004 through June 30, 2005	$	14,005,290
July 1, 2005 through June 30, 2006		3,560,293
Thereafter		114,401
Gross program authorizations scheduled for payment at a later date		17,679,984
Less adjustment to present value		106,696
Program authorizations payable	$	17,573,288

A discount rate of 2.09% was used to determine the present value of the program authorizations payable at June 30, 2004.

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 19% and 20% of the participants' compensation for the years ended June 30, 2004 and 2003, respectively. Pension expense under this plan approximated $878,000 and $938,000 for the years ended June 30, 2004 and 2003, 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. This pension expense approximated $60,000 and $93,000 for the years ended June 30, 2004 and 2003, respectively. In addition, the Fund provides health and life insurance to certain former employees.

Effective July 1, 1998, the Fund entered into deferred compensation agreements with certain senior executives that provides for unfunded deferred compensation computed as a percentage of salary. There were no deferred compensation contributions for the year ended June 30, 2004.

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 following data is for the Fund's postretirement medical plan for the years ended June 30, 2004 and 2003:

	2004	2003
Benefit obligation at June 30	$ 1,754,507	$ 1,492,410
Fair value of plan assets at June 30	-	-
Funded status	1,754,507	1,492,410
Actuarial loss	170,495	273,107
Accrued benefit cost recognized	$ 1,925,002	$ 1,765,517
Net periodic expense (benefit)	262,097	(197,025)
Employer contribution	102,612	89,468

Significant assumptions related to postretirement benefits as of June 30 were as follows:

	2004	2003
Discount rate	5.33%	5.90%
Health care cost trend rates—Initial	7.10	10.00
Health care cost trend rates—Ultimate	7.20	5.00

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% Federal excise tax, if certain criteria are met, on net investment income. For the years ended June 30, 2004 and 2003, that excise tax rate was 2% and 1%, 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, 2004, distributions approximating $200,000 are required to be made by June 30, 2005 to satisfy the minimum requirements of approximately $25.9 million for the year ended June 30, 2004.

In the Statements of Financial Position, the deferred tax liability of $1,531,576 and $475,528 at June 30, 2004 and 2003, respectively, resulted from Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2004 and 2003, the tax provision was as follows:

	2004	2003
Excise taxes - current	$ 1,023,977	$ 129,680
Excise taxes - deferred	1,056,048	761,470
Unrelated business income taxes - current	88,380	44,561
	$ 2,168,405	$ 935,711

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, 2004 and 2003, Picker program grants totaled approximately $1,350,000 and $1,370,000, 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. In keeping with this bequest, an initial amount of $552,000 was recorded as a temporarily restricted net asset as of and for the year ended June 30, 2002.

During the years ended June 30, 2004 and 2003, net assets released from donor restrictions were $285,211 and $150,000, respectively.

2004 Annual Report

DIRECTORS AND STAFF

Lawrence S. Huntington

Following 15 years of service to The Commonwealth Fund's Board of Directors—14 of them as chair of the Investment Committee—Lawrence S. Huntington retired from the Fund's Board on November 9, 2004. Throughout his terms on the Board, Mr. Huntington also served on the Audit and Nominating Committees.

Under Mr. Huntington's skillful guidance, the value of the endowment rose from $297 million in 1989 to $590 million at the end of 2004, while at the same time the Fund spent $313 million to advance its goals. His leadership was especially crucial in steering the foundation through the burst of the technology stock market bubble in 2000: in contrast with many foundations, the Fund has not had to reduce its spending substantially in recent years.

Mr. Huntington's influence on the Fund's work went well beyond the management of the endowment. His firsthand experience in the challenges that academic health care systems face in achieving their multiple missions contributed to the Board's decision to launch the Task Force on Academic Health Centers in 1995. He encouraged the foundation to undertake as much action-oriented work as its resources allow, and was particularly insightful in the vetting of proposals for backing health care delivery innovations. At the same time, Mr. Huntington never took his eye off the policy compass,

encouraging the Fund to undertake work that would improve public and private policies affecting insurance coverage, access to care, and incentives for health care providers to deliver high-quality care.

Mr. Huntington took a particularly keen interest in the foundation's efforts to improve health care and quality of life in New York City. He also paid close attention to the governance and management of the Fund and encouraged assessment of the foundation's performance—not only the performance of the endowment, but also that of the foundations' grants. Altogether, his is a record of exemplary board service to a private foundation, and his mark on the Fund's goals, strategies, and performance will be enduring.

William Y. Yun became a member of the Fund's Board of Directors and chairman of the Investment Committee on November 9, 2004. As president of Fiduciary Trust, a subsidiary of Franklin Templeton Investments, he has overall responsibility for all investment management and research activities and oversees Fiduciary's international offices. He is a member of the Board of Directors of Fiduciary Trust, serving on the company's Management, Global Investment, and Investment Policy Committees. Prior to his election as Fiduciary president in 2000, Mr. Yun served as an executive vice president and oversaw the firm's global equity division. Before joining Fiduciary in 1992, he had both asset management and investment banking experience at Blyth Eastman Paine Webber, First Boston, and CB Commercial Holdings. Mr. Yun serves as chair of the Christ Church Day School in New York and is a trustee of the city's South Street Seaport Museum. He brings experience and expertise that will help advance the Fund's commitment to improving health care access and quality, as well as ensure the availability of the resources needed for achieving the foundation's objectives.

BOARD OF DIRECTORS

Samuel O. Thier, M.D.
Chairman

Walter E. Massey

William R. Brody, M.D.

Robert C. Pozen

Benjamin K. Chu, M.D.

Cristine Russell
Vice Chairman

Karen Davis

James R. Tallon, Jr.

Samuel C. Fleming

William Y. Yun

Jane E. Henney, M.D.

INVESTMENT COMMITTEE

William Y. Yun, *Chairman*
William R. Brody, M.D.
Karen Davis
Samuel C. Fleming
Robert C. Pozen
Samuel O. Thier, M.D.

AUDIT AND COMPLIANCE COMMITTEE

Samuel C. Fleming, *Chairman*
Jane E. Henney, M.D.
James R. Tallon, Jr.
William Y. Yun

HONORARY DIRECTORS

Harriet B. Belin
Lewis M. Branscomb
C. Sims Farr
Lawrence S. Huntington
Margaret E. Mahoney
Robert M. O'Neil
Calvin H. Plimpton, M.D.
Alfred R. Stern
Lewis W. Bernard
Frank A. Daniels, Jr.
Robert J. Glaser, M.D.
Helene L. Kaplan
William H. Moore
Roswell B. Perkins
Robert L. Sproull
Blenda J. Wilson

OFFICE OF THE PRESIDENT

Karen Davis
President

Rose A. Capasso, *Executive Assistant*

Alice M. Ho, *Research Associate*

OFFICE OF THE EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER

John E. Craig, Jr.
Executive Vice President and Chief Operating Officer

Diana Davenport
Director of Administration

Gary M. Stehr
Controller

Andrea C. Landes
Director of Grants Management

Nino DePaola, *Executive Assistant*

Hope Lyons, *Grants Manager*

Jeannine M. Croslin, *Grants Assistant*

Leslie K. Knapp, *Financial Assistant*

STAFF

Office of the Executive Vice President for Programs

Stephen C. Schoenbaum, M.D.
Executive Vice President for Programs

Cathy A. Schoen
Vice President for Health Policy, Research & Evaluation

Clare Churchouse, *Executive Assistant*

Robin I. Osborn
Vice President and Director, International Program in Health Policy and Practice

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

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

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

Jennifer N. Edwards
Senior Program Officer and Deputy Director, Task Force on the Future of Health Insurance

Mary Jane Koren, M.D.
Senior Program Officer

Melinda K. Abrams
Senior Program Officer

Sara R. Collins
Senior Program Officer

Phuong Trang Huynh
Program Officer

Michelle M. Doty
Senior Analyst

Sabrina K. H. How, *Program Associate*

Jamil K. Shamasdin, *Program Associate*

Jonathan Wittenberg, *Program Associate*

Alyssa Holmgren, *Program Assistant*

Jolene N. Saul, *Program Assistant*

Brigitta Spaeth-Rublee, *Program Assistant*

Communications Office

William M. Silberg
Vice President for Communications and Publishing

Christopher A. Hollander
Associate Communications Director

Martha A. Hostetter
Web Editor

Mary C. Mahon
Public Information Officer

Deborah Lorber, *Associate Editor*

Paul D. Frame, *Production Editor*

Ned C. Butikofer, *Web Production Associate*

Office and Building Administration

Sean T. Montague, *Director, Information Technology*

Tamara A. Ziccardi, *Manager of Administration*

Ingrid D. Caldwell, *Receptionist*

Dane N. Dillah, *Office Services Coordinator*

Matthew E. Johnson, *Dining Room Manager*

Edwin A. Burke, *Assistant Dining Room Manager*

James McKinney, *Building Manager*

Shelford G. Thompson, *Assistant Building Manager*

Senior Advisors

Jo Ivey Boufford, M.D., *Senior Program Advisor*

Anne Mackinnon, *Senior Program Reviewer*

White & Case, *Counsel*

2004 Annual Report

GRANTS APPROVED, 2003 – 2004

For more information about a Fund-supported project listed here, please contact the grantee organization.

IMPROVING HEALTH INSURANCE COVERAGE AND ACCESS TO CARE

TASK FORCE ON THE FUTURE OF HEALTH INSURANCE

Actors' Fund of America

$208,201

Creating Web-Based Information on Health Insurance and Policy Initiatives

In 2000, The Commonwealth Fund supported the redesign of the Actors' Fund of America's health insurance website to make it more complete and more useful to all people-not just entertainment professionals-seeking insurance information. About 700 visitors use the site each day. Information is currently most comprehensive in the two markets where the majority of entertainment professionals live, New York and California. Detailed information needs to be provided for the other 48 states, however, where workers without health insurance face many of the same barriers as these professionals do. This project will enable the Actors' Fund to engage six graduate students and their mentors, each based at a different U.S. university, to compile information on private and public health insurance options for eight states in their respective geographic regions. The students and mentors will also help raise awareness about the uninsured and the resources available through the website by holding campus forums and writing articles for their student newspapers and for online outlets. The website will be renamed to signal that it serves a broader audience. Cofunding is being sought from local foundations in the communities where the universities are located.

James Brown
Managing Director, Artists' Health Insurance Resource Center
729 Seventh Avenue, 10th Floor
New York, NY 10019
Tel: (212) 221-7300 ext. 166
jbrown@actorsfund.org

Center for Health Policy Development
$159,857
Support for Implementation of Maine's Dirigo Health Plan
Maine recently enacted comprehensive health reform that addresses insurance coverage, health care costs, and quality of care in the state. The goal of this initiative is to achieve universal access to health care within five years through the creation of the Dirigo Health Plan. The legislation includes a series of steps in the first year that will require new information and guidance for the state's Office of Health Policy and Finance, which is charged with implementing the initiative. This grant will fund essential analysis to help the state move from legislation to action. In addition, it will help set the stage for an evaluation that will determine if Maine's efforts could be a model for the country. Maine has received funding from the U.S. Health Resources and Services Administration and is seeking cofunding from two other foundations.

Cynthia Pernice
Project Manager
National Academy for State Health Policy
50 Monument Square, Suite 502
Portland, ME 04101
Tel: (207) 874-6524
cpernice@nashp.org

Center for Health Policy Development
$219,654
Using Evidence-Based Medicine to Control Pharmaceutical Program costs, Phase 1 of 2
By making better use of available scientific evidence regarding the relative efficacy of prescription drugs, some states believe they can save money on their pharmaceutical assistance programs while ensuring the quality of care provided to enrollees. The Drug Effectiveness Review Project, a multistate collaborative effort initiated by former Oregon state officials, is attempting to use evidence-based research to help states design their pharmaceutical programs. In Phase 1 of this two-phase project, investigators will examine how participating states incorporate evidence-based research into their drug purchasing strategies and measure the preliminary impact on costs and utilization. If the first phase is successful, in the second phase the project team will examine the impact of a full

year of evidence-based purchasing on costs, drug utilization, and quality of care. Project findings will inform all states about the benefits and challenges of using evidence-based research to control the costs of their prescription drug benefits.

Neva Kaye
Interim Co-Executive Director/Program Director
National Academy for State Health Policy
50 Monument Square, Suite 502
Portland, ME 04101
Tel: (207) 874-6545
nkaye@nashp.org

Columbia University
$197,393
Commonwealth Fund Task Force on the Future of Health Insurance: Data Analysis and Technical Assistance
The Fund's Task Force on the Future of Health Insurance is exploring ways to extend health insurance coverage to uninsured working Americans and their families. This core grant to Columbia University funds analysis of data and policy options, as well as technical support for Task Force staff and grantees. In the past year, the Columbia team, led by Sherry Glied, has examined trends in insurance coverage related to income level and employer size and analyzed policy options for insuring Hispanics and young adults. In the year ahead, the team will assess the impact of policy options across states and continue to track coverage trends, with a focus on the erosion and instability of coverage for middle-income families. The grant also will support analysis for Task Force staff and grantees. Together, these activities will yield new information for policymakers about the future course of health coverage in the United States.

Sherry Glied, Ph.D.
Professor
Joseph L. Mailman School of Public Health
Department of Health Policy and Management
600 West 168th Street, Room 611
New York, NY 10032
Tel: (212) 305-0295
sag1@columbia.edu

Economic and Social Research Institute
$149,015
Leveraging State Dollars to Strengthen Health Coverage in an Economic Downturn
States that have implemented health insurance coverage expansions over the past few years have developed creative strategies for using a portion of state money to leverage private, federal, and additional state dollars to cover the uninsured. While these are smart strategies for any economy, they are critical now that states are cutting programs to help

close deficits. This project will examine lessons gained from these innovations, with the goal of helping states stretch limited dollars in order to maintain or expand coverage, or to enhance the cost-effectiveness of care. Three categories of innovation will be studied: 1) new state premium assistance programs that help low-wage workers buy into job-based or Medicaid coverage; 2) the use of uncompensated care funds, for example, to enable patients to visit primary care doctors rather than rely on emergency rooms; and 3) new state purchasing and care delivery strategies to foster cost-effective delivery of high-quality services. Project staff will develop up to 10 state profiles and four in-depth case studies that will provide state and federal policymakers with ideas about viable models of coverage as they weather the economic downturn.

Sharon Silow-Carroll, MBA, MSW
Senior Vice President
2100 M Street, NW, Suite 605
Washington, DC 20037
Tel: (202) 833-8877
silow@optonline.net

Economic and Social Research Institute
$107,156
Trade Act Health Coverage Project
Some policymakers have proposed federal income tax credits to help uninsured workers purchase health coverage. Analysis of such proposals can now benefit from real-world experience following enactment of the Trade Act of 2002, which created a tax credit to pay 65 percent of health insurance premiums for roughly 300,000 early retirees and unemployed workers. For this project, the Economic and Social Research Institute will: 1) describe early state plans for implementing Trade Act coverage; 2) identify key concerns with initial federal implementation; and 3) identify and assess Trade Act issues that are relevant to broader coverage expansions. In addition to producing three state case studies, project staff will prepare a policy report to articulate findings pertinent to future decisions about the use of tax credits to cover large numbers of uninsured workers and their families. Cofunding is expected to be provided by the Nathan Cummings Foundation.

Stan Dorn, JD
Senior Policy Analyst
2100 M Street, NW, Suite 605
Washington, DC 20037
Tel: (202) 833-8877 ext. 14
sdorn@esresearch.org

Georgia State University Research Foundation, Inc.
$146,088
Assessing the Strategic Role of Community Safety Net Networks

In dozens of U.S. localities, community leaders and health care providers have organized a system of free or discounted health care services for people who cannot get private coverage because they are too sick or work for an employer that does not offer it, or because their modest incomes disqualify them from public programs. A key feature of these safety net initiatives is that they enroll people in case management programs and reduce future need for urgent care. For this grant, the investigators will examine: 1) the importance of leveraging state or federal funding in sustaining such community efforts, and 2) community approaches to delivering cost-effective care on tight budgets. The project team will conduct case studies in three communities where financing-whether through Medicaid disproportionate share hospital payments, employer contributions, or a reinsurance mechanism-has been most innovative. The findings will be disseminated to the hundreds of health care access projects around the country to help them achieve sustainability, as well as to states and localities that may, over the longer term, find these programs beneficial for covering more of the uninsured.

Karen Minyard
Executive Director, Georgia Health Policy Center
One Park Place South, Suite 660
Atlanta, GA 30303
Tel: (404) 651-3104
Fax: (404) 651-3147
kminyard@gsu.edu

Health Research and Educational Trust
$172,802
Assessing the Implications of Patient Cost-Sharing and Care Patterns for Benefit Design, Phase 1
With the retreat from managed care, employers and health insurance plans are turning more and more to patient cost-sharing as a way to control rising health care expenses. In some cases, patients are put at such financial risk that it may be limiting their ability to adhere to recommended care. For this project, the investigators will examine the claims database of a large private health insurance carrier to assess the impact of various cost-sharing models, focusing on patients who have high-cost chronic conditions or low income. The grant, which will cofund the first 15 months of a two-year project, will help inform the design of public and private health insurance that meets the financial needs of vulnerable populations.

Jon R. Gabel
Vice President, Health System Studies
325 7th Street, N.W., Suite 700
Washington, DC 20004
Tel: (202) 626-2688
jgabel@aha.org

New York Academy of Medicine
$71,384
Investigation of the Extent of Churning and the Costs of Re-enrollment
For this project, a research team at the New York Academy of Medicine will analyze data from selected states on the cycling of children on and off Medicaid coverage. The investigation will focus on the frequency and duration of gaps in coverage and the amount spent by states and health plans to reenroll families who lost coverage due to administrative barriers. Differences among states' coverage eligibility rules will enable project staff to compare the effects of various policies, such as income verification and six-month versus 12-month eligibility periods. This project complements a Georgetown University grant (see above) to analyze the causes and consequences of churning and develop solutions.

Gerry Fairbrother, Ph.D.
Senior Research Associate
1216 Fifth Avenue
New York, NY 10029-5293
Tel: (212) 822-7287
gfairbro@nyam.org

The President and Directors of Georgetown College
$128,648
Examining the Causes and Consequences if Unstable Insurance Coverage and Identifying Solutions
Instability in health insurance coverage is a chronic concern for low-income families and often creates problems for the providers trying to serve them. Many states have attempted to help families and individuals remain enrolled in coverage for which they qualify by ensuring continuous coverage for children, simplifying eligibility renewal processes, and other reforms. State budget pressures, however, have stalled or reversed progress in many cases. This project, together with a complementary study by the New York Academy of Medicine (see below), seeks to gain a better understanding of how turnover, or churning, in insurance coverage affects families and health systems. Using data obtained from program administrators, health plans, and providers, Georgetown University researchers will analyze the causes and consequences of churning in public programs serving low-income families with children. These data, along with findings from interviews, roundtables, and site visits, will help project staff develop a set of policy recommendations for state and federal policymakers to help stabilize public coverage.

Cindy Mann, J.D.
Research Professor
2233 Wisconsin Avenue, NW, Suite 525
Washington, DC 20007

Tel: (202) 687-0880
crm32@georgetown.edu

Small Grants—Task Force on the Future of Health Insurance

AcademyHealth
$5,000
2004 National Health Policy Conference
Wendy Valentine, M.H.A.
Vice President
1801 K Street, Suite 701-L
Washington, DC 20006
Tel: (202) 292-6700
wendy.valentine@academyhealth.org

Economic and Social Research Institute
$28,272
Updating State Planning Grant Report
Sharon Silow-Carroll, MBA, MSW
Senior Vice President
2100 M Street, NW, Suite 605
Washington, DC 20037
Tel: (202) 833-8877
silow@optonline.net

Employee Benefit Research Institute Education and Research Fund
$7,000
2004 Health Confidence Survey
Paul Fronstin, Ph.D.
Director, Health Security and Quality Research Program
2121 K Street, N.W., Suite 600
Washington, DC 20037-1896
Tel: (202) 775-6352
fronstin@ebri.org

Employee Benefit Research Institute Education and Research Fund
$28,500
Sustaining Membership for The Commonwealth Fund at The Employee Benefit Research Institute
Dallas L. Salisbury
President and Chief Executive Officer
2121 K Street, N.W., Suite 600
Washington, DC 20037-1896
Tel: (202) 775-6322
salisbury@ebri.org

The President and Directors of Georgetown College
$46,369
Discount Health Plans: A Recent Development In Health 'Coverage'

Mila Kofman, J.D.
Georgetown University
2223 Wisconsin Avenue, NW, Suite 525
Washington, DC 20007
Tel: (202) 784-4580
mk262@georgetown.edu

Universal Health Care Action Network
$25,615
State Perspectives on Federal Initiatives to Promote Universal Coverage

Ken Frisof, M.D.
National Director
2800 Euclid Avenue, #520
Cleveland, OH 44115-2418
Tel: (216) 241-8422 ext. 16
frisof@uhcan.org

HEALTH CARE IN NEW YORK CITY

Fund for the City of New York
$221,110
Using Community Surveys to Identify Health and Access Disparities in New York City
In 2002 and 2003, the New York City Department of Health and Mental Hygiene collected data on residents' health behaviors, health conditions, and service use through their annual Community Health Surveys. The surveys, which allow comparison of results across 32 neighborhoods, help city officials establish more effective public health policies and programs while supporting the decision-making of private organizations concerned about health disparities. Through two small grants, the Fund supported production of a chartbook on health disparities from the 2002 survey, as well as the addition of questions on health care access to the 2003 survey. This new project will disseminate findings from the 2003 survey by producing two additional chartbooks, one on access to care and coverage and a second on women's health. Project staff also will supplement the 2004 survey by including questions about New Yorkers' access to primary care services and producing a third chartbook describing primary care access across New York's neighborhoods and racial/ethnic groups. Survey findings will help the Fund as it adds a new area of focus to the Health Care in New York City program. Findings also will aid city officials as they develop programs for underserved communities. The Department of Health and Mental Hygiene will provide cofunding.

Farzad Mostashari, M.D., M.S.P.H.
Assistant Commissioner for the Bureau of Epidemiology Services
125 Worth Street, N-6
New York, NY 10032
Tel: (212) 788-5384
fmostashari@health.nyc.gov

Mayor's Fund to Advance New York City

$231,338

Increasing Access to Health Coverage and Care for New York City Students Commonwealth / Health Services Improvement Fund Grant

In 2001, about 246,000 children in New York City were eligible for, but not enrolled in, one of the public insurance programs offered by New York State. The Mayor's Office of Health Insurance Access and the Office of School Health will conduct a demonstration project in 23 schools to develop systems for covering uninsured children and connecting those most in need with a medical home. These schools, located in the city's poorest neighborhoods, are the sites for implementation of a new automated school health record that will allow the city to track information about student's insurance and overall health status. The project has three parts: 1) creating systems to track children's insurance and health status; 2) conducting outreach activities, enrolling children in coverage, connecting children with a medical home, and following up to see that needs are met; and 3) evaluating findings for possible citywide rollout. If successful, these new systems could improve the health of underserved schoolchildren in New York City.

Marjorie A. Cadogan
Executive Director
51 Chambers Street, 1st floor, Room 100
New York, NY 10007
Tel: (212) 788-8267
mcadogan@cityhall.nyc.gov

MetroPlus Health Plan, Inc.

$166,682

Improving Asthma Management for Children in New York City: Evaluation of the Asthma Buddy Program

Asthma continues to be the leading cause of emergency department visits and hospitalizations for children and places serious limitations on normal childhood activities, including school attendance. With evidence showing that improved patient self-management is critical to better health outcomes, experts have devised a handheld computer that prompts patients to answer a series of questions and then reports this information to the doctor who helps manage their care. This new 'Asthma Buddy' technology was used recently to reduce

emergency visits and hospitalizations for a small group of children with asthma seen at Coney Island Hospital. For this project, the Asthma Buddy will be tested more widely for a sample of children seen in five hospitals run by the city's Health and Hospitals Corporation (HHC). MetroPlus Health Plan, HHC's managed care plan that primarily serves publicly insured New Yorkers, will conduct a scientific study to measure changes in health care use, asthma knowledge, symptoms, and quality of life, as well as the intervention's cost-effectiveness. These findings will help determine if systemwide implementation is warranted.

Arnold Saperstein, M.D.
Chief Medical Officer
160 Water Street, 12th Floor
New York, NY 10038
Tel: (212) 597-8940
sapera@nychhc.org

Small Grants—Health Care in New York City

Coleman Associates
$22,950
Medicaid Enrollment Process Redesign Project, Final Phase

Roger Coleman
Chief Executive Officer
224 Spruce Street
Santa Fe, NM 87501
Tel: (505) 995-1073
rcole9519@aol.com

Greater New York Hospital Association
$1,000
GNYHA -UHF Symposium Planning Committee

Tim Johnson
Executive Director
555 West 57th Street, 15th Floor
New York, NY 10019
Tel: (212) 506-5420
tjohnson@gnyha.org

Joan and Sanford I. Weill Medical College of Cornell University
$15,000
David Rogers Health Policy Colloquium

Oliver Fein, M.D.
Associate Dean
445 East 69 Street, Suite 420
New York, NY 10021
Tel: (212) 746-4837
ofein@med.cornell.edu

Primary Care Development Corporation
$20,000
Learning Collaborative Planning Project

Patricia Simino-Boyce, Ph.D., RN
Director, Clinical Initiatives
22 Cortlandt Street, 12th Floor
New York, NY 10007
Tel: (212) 693-1850 ext. 125
psboyce@pcdcny.org

MEDICARE'S FUTURE

International Communications Research
$173,550
2004 Survey of Health Insurance Experiences of Older Adults Before and After Enrolling in Medicare
In late 1999, the Fund conducted a survey of older Americans, ages 50 to 70, to examine their health insurance experiences before and after enrolling in Medicare. A number of events have occurred since that survey: the economy has weakened, health care costs have risen, physicians have threatened to drop or not enroll new Medicare patients, and employer-based health insurance and retiree coverage have eroded. In the meantime, the absence of a Medicare prescription drug benefit remains a concern. A new survey will examine changes that have occurred since the earlier survey and explore emerging areas of policy concern. This information will inform legislative debate over the future of health insurance coverage for older Americans.

Melissa J. Herrmann
Vice President
53 West Baltimore Pike
Media, PA 19063
Tel: (484) 840-4300
MHerrmann@icrsurvey.com

National Academy of Social Insurance
$199,978
Medicare/Medicaid Dual Eligibles: Reaching All Who Qualify
Most low-income Medicare beneficiaries are entitled to help from Medicaid or from Medicaid-administered Medicare Savings Programs to pay for some or all of their uncovered health care expenses. Despite their need for such assistance, only about 60 percent of eligible beneficiaries are enrolled. For this project, the National Academy of Social Insurance will examine options for strengthening the federal role in the identification and enrollment of eligible people in these programs. Possibilities include: 1) simplification of eligibility, for example, by implementing presumptive eligibility or removing asset tests; 2) increasing federal operating responsibility, such as requiring the Social Security

Administration to enroll eligible beneficiaries; and 3) increasing federal financing, for example, by making federal government fully responsible for Medicare Savings Programs. An advisory panel will assist project staff in identifying the issues, commissioning papers on the options, synthesizing conclusions, and evaluating their implications and feasibility.

Kathleen King
Director, Health Security Policy
1776 Massachusetts Avenue, N.W., Suite 615
Washington, DC 20036
Tel: (202) 452-8097
kking@nasi.org

The National Council on the Aging, Inc.
$250,041
BenefitsCheckUp: Helping Low-Income Seniors Receive Health Benefits, Phase 3
BenefitsCheckUp is a breakthrough Internet application that screens seniors for their eligibility for 1,200 public benefit programs, including those that help pay medical and prescription drug expenses. A multisite demonstration launched in 2001 by the National Council on the Aging (NCOA) is testing whether community-based groups can enhance the Web tool's usefulness by assisting the most vulnerable seniors with eligibility screening and follow-through to ensure enrollment. In the third and final project phase, the model communities will conduct an extensive outreach campaign to sign up as many seniors as possible for the new Medicare drug discount card. The effort's focus will be those low-income beneficiaries who are eligible for the $600 Medicare drug subsidy. Through surveys and database analysis, project staff also will determine whether this community-based approach is more effective than the Web site alone in enrolling eligible people in public programs. Project cofunding will be provided by the U.S. Department of Commerce, Atlantic Philanthropies, and local foundations.

James P. Firman, Ed.D
President and Chief Executive Officer
409 Third Street, S.W., Suite 200
Washington, DC 20024-3204
Tel: (202) 479-6601
james.firman@ncoa.org

The President and Directors of Georgetown College
$307,711
Program Direction Grant for The Commonwealth Fund's Program on Medicare's Future
Changes to Medicare now under consideration could fundamentally alter the program's future role in insuring and financing the health care needs of the nation's elderly and disabled populations. While much of the discussion is focused

on federal or state budget costs, the Fund's Program on Medicare's Future provides independent analysis of reforms from the perspective of beneficiaries, particularly those who are vulnerable because of low income or poor health. Under the leadership of Barbara S. Cooper, this program direction grant will provide overall strategic direction, develop new projects, coordinate ongoing work, and direct efforts to disseminate findings of program-supported work to policy leaders and the public. The program director will also participate in the critical review of reports considered for Fund publication, prepare issue briefs and summaries of Fund work, and represent the program in public forums.

Cathy Schoen
Vice President
The Commonwealth Fund
1 East 75th Street
New York, NY 10021
Tel: (212) 606-3864
cs@cmwf.org

The Urban Institute
$86,400
Fostering Medicare-Private Collaboration in Value Based Purchasing
Medicare and private purchasers have both adopted innovations to constrain costs and ensure they are receiving good value for their health care dollar. Medicare, the nation's largest health care purchaser, uses electronic claims processing and prospective payment systems for most types of health care providers. Many private purchasers, meanwhile, have implemented disease and care management programs. But the two sectors have rarely tried to work together, learn from each other, and leverage one another's efforts. This project seeks to identify and foster value-based purchasing activities that could be implemented by Medicare and private purchasers. In advisory group meetings and interviews with a variety of experts, the investigators will focus primarily on three approaches: 1) provider-based information technology, to manage administrative and clinical information; 2) multipayer claims databases, to identify efficient, high-quality providers; and 3) paying for performance.

Robert Berenson, M.D.
Senior Fellow in Health Policy
2100 M Street, N.W.
Washington, DC 20037
Tel: (202) 261-5886
rberenso@ui.urban.org

University of Maryland
$278,757
Evaluation of the Effect of Medicare Drug Policy Decisions on Vulnerable Seniors

Whatever the outcome of Medicare prescription drug legislation in Congress, policymakers will want to know what the impact of the proposed benefit will be, particularly with respect to the poorest and sickest beneficiaries, as well as the pros and cons of alternative benefit designs. For this project, Bruce Stuart and colleagues at the University of Maryland School of Pharmacy will update their benefit impact simulation model and develop quick-response analyses as policy questions arise. They also will explore the role of improved drug formulary management in lowering costs and improving outcomes and examine the experiences of long-term care residents. The project team will assess the possible impact of alternative benefit designs on use and on out-of-pocket expenses, as well as the likely impact on vulnerable beneficiaries.

Bruce Stuart, Ph.D.
Professor and Executive Director of the Peter Lamy Center on Drug Therapy and Aging
School of Pharmacy
515 W. Lombard Street, 1st Floor
Baltimore, MD 21201
Tel: (410) 706-5389
bstuart@rx.umaryland.edu

Small Grants—Medicare's Future

ARC of the United States
$26,700
Advancing Policy Reforms That Can Improve the Health and Independence of Americans Living with Paralysis

Henry Claypool
Co-Director
1875 Eye Street, NW, 12 Floor
Washington, DC 20006
Tel: (202) 429-6810
hclaypool@halftheplanet.org

Medstat Group
$49,816
Analysis of Employer-Sponsored Preferred Provider Organizations

William D. Marder, PhD
Senior Vice President and General Manager
125 Cambridge Park Drive
Cambridge, MA 02140
Tel: (617) 492-9329
bill.marder@medstat.com

Rutgers, The State University of New Jersey
$14,715
Conference on Evidence-based State Pharmacy Benefit Management and the Transition to a New Medicare Drug Benefit

Kimberley Fox, M.P.A.
Senior Policy Analyst
317 George Street, Suite 400
New Brunswick, NJ 08901-2008
(732) 932-3105 ext 235
kfox@cshp.rutgers.edu

University of Texas at Austin
$7,500
A Symposium on Big Choices: The Future of Health Care for Older Americans
Kenneth S. Apfel
Sid Richardson Chair in Public Affairs
LBJ School of Public Affairs
P.O. Box Y
Austin, TX 78713-8925
Tel: (512) 471-6267
kapfel@mail.utexas.edu

The Urban Institute
$42,246
Assessing the Potential Impact of the Medicare Prescription Drug and Improvement Act of 2003 on Beneficiary Choices and Expenditures.
Robert Berenson, M.D.
Senior Fellow in Health Policy
2100 M Street, N.W.
Washington, DC 20037
Tel: (202) 261-5886
rberenso@ui.urban.org

Small Grants—Health Policy, Research, and Evaluation

Office for Oregon Health Policy & Research
$40,000
Analyzing the Impact of Program Changes on Health Care for the Oregon Health Plan Standard Population
Jeanene Smith, MD MPH
Deputy Administrator
225 Capitol Street NE, 5th Floor
Salem, OR 97301
Tel: (503) 378-2422 ext. 420
jeanene.smith@state.or.us

IMPROVING THE QUALITY OF HEALTH CARE SERVICES

HEALTH CARE QUALITY IMPROVEMENT

A.A.R.P.
$149,366
Feasibility of Developing a Model Physician Directory for Medicare Beneficiaries
AARP, in collaboration with the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA), will test the feasibility of assembling a physician directory that meets the standards recommended by a Fund-supported, NCQA-convened panel of experts. The directory will include information about physicians within a single market who care for Medicare beneficiaries in that community, whether through a Medicare preferred provider organization, health maintenance organization, or other setting. NCQA will provide technical assistance for the development and maintenance of the directory and a user guide, as well as conduct consumer testing. The AARP team will promote and disseminate the model directory. To create a blueprint for others to follow, the costs and process of developing and maintaining the online directory will be documented. CMS and AARP will supply cofunding for the project.

Joyce Dubow, MUP
Senior Policy Advisor
601 E Street, NW, B6-451
Washington, DC 20049
Tel: (202) 434-3901
jdubow@aarp.org

Institute for Safe Medication Practices
$285,211
Assessing Improvements in Medication Safety: A Follow-Up Survey of Safe Medication Practices in U.S. Hospitals
Frances Cooke Macgregor Grant
In 2000, the Institute for Safe Medication Practices, the Health Research and Educational Trust (HRET), and the American Hospital Association conducted a survey of medication safety practices among U.S. hospitals. Most of the nearly 1,500 responding organizations achieved a score of less than 50 percent on the use of nationally recommended safe practices for drug storage and distribution, medication labeling, communication of medication orders, and patient education. In the three intervening years, patient safety has been at the forefront of public debate about health care reform, and a Fund-supported HRET project developed tools to assist hospitals in improving medication safety. This project will re-survey U.S. hospitals and evaluate the current status of

medication safety practices. Results will indicate where and how progress has occurred, providing lessons and examples of activities required to realize further gains. Cofunding will be provided by HRET.

Allen J. Vaida, Pharm.D.
Executive Director
1800 Byberry Road, Suite 810
Huntingdon Valley, PA 19006-3520
Tel: 215-947-7797
avaida@ismp.org

Massachusetts General Hospital
$302,552
The Commonwealth Fund Quality Improvement Colloquia, Series II
In 2002, The Commonwealth Fund began funding a series of Quality Improvement Colloquia to: 1) synthesize the work of Fund grantees and others on strategies for improving the quality of health care; 2) develop recommendations for public policy changes, institutional improvement strategies, and a future research agenda; and 3) establish a network of private and public sector leaders who would disseminate this work within their own professional circles and advise the Fund about program priorities. The first grant supported two colloquia, one in November 2002, 'The Business Case for Quality,' and another in May 2003, 'Accelerating the Adoption of Information Technology.' This second grant will support follow-up activities from the first two colloquia, a fall 2003 colloquium centered on overuse of health care services and the business case for quality, and a spring 2004 colloquium on the promises and pitfalls associated with the collection and use of performance data.

David Blumenthal, M.D., M.P.P.
Director, Institute for Health Policy
50 Staniford Street, 9th Floor
Boston, MA 02114
Tel: 617-726-5212
dblumenthal@partners.org

Midwest Business Group on Health
$91,599
Improving Online Physician Directories in Chicago
Thousands of physician directory websites have been developed by hospitals, physician groups, health plans, state medical boards, and other organizations. Previous Fund-supported work showed that most of these websites have missing or out-of-date information, as well as severely limited search capabilities. Recent Fund support enabled the National Committee for Quality Assurance (NCQA) to convene an advisory group to create standards for physician directories. Based on the advisors' recommendations, the Midwest

Business Group on Health will conduct a demonstration project in which a group of Chicago-based health plans, hospitals, and physician organizations will implement the recommended standards and evaluate the cost and value of doing so. This work should yield a blueprint for creating physician directories that meet NCQA-recommended standards.

Larry S. Boress, CAE
Vice President
35 E. Wacker Drive, Suite 1910
Chicago, IL 60601
Tel: 312) 372-9090
lboress@mbgh.org

President and Fellows of Harvard College
$252,844
Determining Whether Pay-for-Performance Incentives Improve Health Care Quality in Medical Groups
There is little empirical information to support the assumption that pay-for-performance incentives will lead to improved quality of care. This project will evaluate the impact of the PacifiCare Health System's Pay-for-Performance program, which was launched in January 2003 in more than 200 group practices in California. The study will examine whether aligning payment with standards of care can: 1) improve mean performance for 10 quality measures; 2) reduce variation in quality among physician groups; and 3) have a spillover effect on other measures of quality not directly linked to financial incentives. Project staff will compare changes in the performance of group practices in California with practices in Oregon and Washington that are not exposed to such incentives.

Meredith B. Rosenthal, Ph.D.
Assistant Professor of Health Economics and Policy
Harvard Center for Risk Analysis
718 Huntington Avenue
Boston, MA 02115
Tel: (617) 432-3418
mrosenth@hsph.harvard.edu

The Regents of the University of California
$278,019
Costs and Benefits of Implementing Electronic Medical Records in Solo/Small Group Practices
Electronic medical records (EMRs) can enhance the quality of patient care by minimizing errors and improving efficiency and coordination. Physicians' adoption of this technology has been slow, however, in part because the benefits and costs that doctors can expect should they invest in it have not been well documented. In visits to 15 doctors' offices across the country, project staff will document how EMRs affect workflow and

collect empirical data on their costs and benefits. The team will analyze accounting and other administrative data to estimate the overall financial impact, including the expenses of acquiring and maintaining EMRs and the revenue derived from changes in productivity. Barriers and facilitators to implementation will also be described. By addressing physicians' most frequent questions and concerns about EMRs, this study could contribute to the broader diffusion of a technology with great potential.

Robert H. Miller, Ph.D.
Associate Professor of Health Economics in Residence
University of California, San Francisco, Institute for Health & Aging
3333 California Street, Suite 340
San Francisco, CA 94118
Tel: (415) 476 8568
millerr@itsa.ucsf.edu

Trustees of Dartmouth College
$81,158
Disseminating a Community-Based Strategy to Improve Health and Health Care

Through its Small Grants Fund, the Fund has supported the Dartmouth COOP Clinical Improvement System in the development and validation of How's Your Health, a community-based approach to improving health. The model, which uses results from a patient-completed online survey to address specific health issues within a single city or region, is now ready to be implemented and diffused. This project will bring together five communities in a collaborative effort to implement How's Your Health. Each participant will commit to: 1) conducting a community assessment using the survey; 2) analyzing the results of the assessment; 3) conducting health interventions as appropriate; and 4) reporting on their impact through biweekly conference calls and online progress reports. Project staff will provide technical assistance to the communities, organize and moderate conference calls, and oversee online communications. A final report will describe the diffusion effort and its impact within the participating communities.

John H. Wasson, M.D.
Professor of Community & Family Medicine
7265 Butler Building
Hanover, NH 03755
Tel: (603) 646-3007
john.h.wasson@dartmouth.edu

Trustees of the University of Pennsylvania
$275,627
Coordinating Care Between Hospital and Home: Translating Research into Practice, Phase 1

Discontinuity in care for patients discharged from hospitals significantly compromises quality of care. Elderly patients with multiple chronic conditions are particularly vulnerable. A multidisciplinary research team based at the University of Pennsylvania School of Nursing has developed and tested in controlled trials an innovative model of care coordination delivered by advanced practice nurses to high-risk older adults who are making the difficult transition from hospital to home. This project will translate the research into practice at a major health care insurer, Aetna. During Phase 1, the investigators will: 1) convert assessment tools and intervention protocols into Web-based modules that could be used by any insurer, including Medicare, to implement the model; 2) develop clinical information systems, marketing tools, and educational materials for insurers and providers; and 3) test and evaluate the model's effectiveness and economic feasibility in preparation for large-scale implementation in Phase 2. If the model is successful, it would generate cost savings for providers and insurers and enhance quality through better coordination of care.

Mary D. Naylor, Ph.D., R.N., F.A.A.N.
Professor of Gerontology
School of Nursing
420 Guardian Drive, Room NEB364
Philadelphia, PA 19104-6096
Tel: (215) 898-6088
naylor@nursing.upenn.edu

University of Colorado Health Sciences Center
$299,067
Improving Transitions in the Care of Older, Hospitalized Patients
Improving the coordination of post-hospital care for elderly, chronically ill patients has proved difficult. A major reason is the dearth of quality-of-care measures to help pinpoint problems that occur during the transition from one site of care to another. This project will refine and test the Care Transitions Measure, a tool that assesses problems in care coordination from the patient's perspective so that hospital systems can develop targeted solutions. An advisory committee representing organizations involved in furthering quality improvement at the health system and policy levels will provide guidance in the refinement and testing processes, and later will promote the measure's use by health care providers.

Eric A. Coleman, M.D.
Associate Professor of Medicine, Division of Health Care Policy and Research
Division of Health Care Policy and Research
13611 E. Colfax Avenue, Suite 100
Aurora, CO 80011
Tel: (303) 724-2456
eric.coleman@uchsc.edu

University of North Carolina at Chapel Hill
$101,418
Identifying Payment Policies to Improve the Business Case for Quality, Phase 1
A previous Fund-supported project showed that although quality-enhancing interventions may save health care dollars over the long run, from the providers' perspective the business case for these efforts is weak or nonexistent. In the first phase of this project, investigators will develop a process to identify categories of improvements undertaken by hospitals or health systems that are likely to yield financial payoffs for insurers, employers, or health care providers. They will also identify payment reforms, such as 'gain-sharing,' that could help eliminate barriers to adoption. If this work proceeds satisfactorily, support for a second phase of work would help project staff quantify the financial gap that must be closed to make it feasible for a health care delivery system to invest in the selected interventions. Phase 1 will yield a robust method for analyzing the business case for quality improvements, as well as a set of interventions appropriate for in-depth financial analyses in Phase 2.

Kerry Kilpatrick, Ph.D., M.B.A.
Professor and Associate Dean for Academic Affairs
1103 D McGavran-Greenberg
Chapel Hill, NC 27599-7440
Tel: (919) 966-7352
kerry_kilpatrick@unc.edu

University of North Carolina at Chapel Hill
$396,415
Investigating the Business Case for Quality in Medicaid, Phase 2
Payment policies often discourage health care providers from investing in quality-enhancing interventions. For this project, investigators will conduct in-depth financial analyses of six to eight Medicaid managed care organizations or state primary care case management programs to quantify the financial gap that must be closed to make certain health care interventions feasible. Project staff will select interventions that have been scientifically proven to be effective and are likely to yield financial payoffs for at least one party-the provider, the plan, or the state. This work will yield a robust method for analyzing the business case for quality improvement generally, as well as recommendations specifically for eliminating barriers to improvement in Medicaid.

Kerry Kilpatrick, Ph.D., M.B.A.
Professor and Associate Dean for Academic Affairs
1103 D McGavran-Greenberg
Chapel Hill, NC 27599-7440
Tel: (919) 966-7352
kerry_kilpatrick@unc.edu

AcademyHealth
$40,000
Experiences and Challenges in the Coordination of Chronic Care in the U.S. and Germany
Patricia Pittman
Senior Manager for International Projects
1801 K Street, Suite 701-L
Washington, DC 20006
Tel: 202-292-6712
patricia.pittman@academyhealth.org

Bailit Health Purchasing, LLC
$12,000
Beyond ROI: A Framework for Establishing a Business Case for Quality
Michael H. Bailit
President
120 Cedar Street
Wellesley, MA 02481
Tel: 781-237-5111
mbailit@bailit-health.com

Bridges to Excellence
$50,000
Developing Valid Measures of Hospital Efficiency
Francois de Brantes
President
3135 Easton Turnpike, W2A
Fairfield, CT 06828
Tel: (203) 373-2352
francois.dbrantes@corporate.ge.com

Brigham and Women's Hospital
$44,367
The Cost of a National Health Information Infrastructure
Rainu Kaushal, M.D., MPH
Instructor in Medicine
Division of Internal Medicine
1620 Tremont Street
Boston, MA 02120
Tel: (617) 732-4814
rkaushal@partners.org

President and Fellows of Harvard College
$14,427
Legal Implications of Individual Physician Clinical Performance Measurement
David M. Studdert, LL.B, ScD, MPH
Associate Professor of Law & Public Health

677 Huntington Avenue, #408
Boston, MA 02115
Tel: (617) 432-5209
studdert@hsph.harvard.edu

President and Fellows of Harvard College
$15,000
Building Consensus to Develop, Test and Report Outpatient Measures of Quality - A Meeting of Key Stakeholders
Leonard J. Marcus
Director, Program for Health Care Negotiation and Conflict Resolution
1552 Tremont Street
Boston, MA 02120
Tel: (617) 696-0865
ljmarcus@hsph.harvard.edu

Health Tech Strategies, LLC
$7,500
2004 Capitol Hill Steering Committee on Telehealth and Healthcare Informatics
Neal Neuberger
President
6612 Brawner Street
McLean, VA 22101
Tel: (703) 790-4933
nealn@hlthtech.com

Harris Interactive, Inc.
$10,000
Strategic Health Perspectives
Humphrey Taylor
Chairman
111 5th Avenue, 8th Floor
New York, NY 10003
Tel: (212) 539-9657
Fax: (212) 539-9669
htaylor@harrisinteractive.com

The Massachusetts Health Quality Partners, Inc.
$19,568
Achieving Effective Public Release of Health Quality Information in Massachusetts: A Conference to Understand the Issues and Build Consensus and Establish a Roadmap
Melinda Karp
Director of Programs
705 Mt. Auburn Street, 705-3E
Watertown, MA 02471
Tel: (617) 972-9056
mkarp@mhqp.org

National Committee for Quality Assurance
$48,220
Performance Benchmarking of Physician Offices: Establishing the Foundations

Joachim Roski, Ph.D.
Vice President, Quality Measurement
2000 L Street, N.W., Suite 500
Washington, DC 20036
Tel: (202)955-5139
roski@ncqa.org

Pacific Business Group on Health
$39,785
Exploring the State-of-the-Art in Measuring an Improving Phusician Quality and Efficiency

David S.P. Hopkins, Ph.D.
Director, Quality Measurement and Improvement
221 Main Street Suite 1500
San Fransisco, CA 94105
Tel: (415) 615-6322
dhopkins@pbgh.org

QUALITY OF CARE FOR UNDERSERVED POPULATIONS

Joint Commission on Accreditation of Health Care Organizations
$124,955
Understanding Adverse Medical Events for Minority Patients with Limited English Proficiency
Adverse medical events related to miscommunication between patients and providers frequently occur in minority populations. This project seeks to determine the nature of communication-related errors experienced by minority patients with limited English proficiency. The investigators will: 1) describe and classify known process errors and preventable adverse events associated with communication problems in hospital settings; 2) analyze data collected from accredited hospitals in four different regions of the country to determine the relative rates of medical error in hospitals, patterns and predictors of error, and language factors associated with them; and 3) identify methods to prevent medical errors related to limited English proficiency. This work will aid in the development of strategies, standards, and policies intended to correct inequities in the provision of safe patient care to limited-English patients.

Jerod M. Loeb, Ph.D.
Executive Vice President-Division of Research
One Renaissance Blvd
Oakbrook Terrace, IL 60181
Tel: 708-916-5920
jloeb@jcaho.org

Medical College of Wisconsin
$169,046
Using Parent Mentors to Manage Asthma Care for Urban Minority Children, Phase 1
Asthma, the most prevalent chronic childhood illness, disproportionately affects minority children. This project will conduct a community-based trial to test whether minority parents trained as mentors could successfully coach other minority parents in managing their children's asthma. Activities in the first phase will include recruitment and training of parent mentors and recruitment of families. Funding for subsequent phases to evaluate outcomes and summarize the experiences of children, parents, mentors, and physicians would be requested if initial work proceeds satisfactorily. If this mentoring model is shown to be effective and is disseminated broadly, it could help to reduce hospitalizations and emergency room visits, lower costs for asthma care, reduce asthma morbidity, empower parents to manage their children's condition, and, ultimately, reduce racial and ethnic disparities in asthma care outcomes. The Medical College of Wisconsin and Robert Wood Johnson Foundation will provide cofunding for all project phases.

Glenn Flores, M.D.
Associate Professor of Pediatrics, Epidemiology and Health Policy
Department of Pediatrics, MS#756
8701 Watertown Plank Rd.
Milwaukee, WI 53226
Tel: (414) 456-4454
gflores@mail.mcw.edu

National Council on Interpreting in Health Care
$62,058
Establishing National Standards of Practice for Interpreters in Health Care
Lack of qualified interpreters is frequently cited as the greatest barrier to health care for patients who are not proficient in English. At present, there are no national standards defining the characteristics and competencies of a qualified medical interpreter. This project will implement a consensus-building process to develop a set of practice standards for interpreters working in health care settings. Project staff will: 1) examine other standards that have been developed in this country and abroad; 2) conduct focus groups with language interpreters to collect information on their roles; and 3) convene a committee of experts from the National Council on Interpreting in Health Care to review the data gathered and draft an initial set of standards. National standards will provide guideposts for improving the training of health care interpreters, which in turn could lead to a reduction in medical errors arising from miscommunication. The California Endowment will cofund this project.

Cynthia E. Roat, M.P.H.
Co-Chair of the Board
350 NW 189th Street
Shoreline, WA 98177
Tel: (206) 546-1194
c.roat@ncihc.org

National Health Law Program
$120,000
Improving Language Services in Small Physician Practices and Health Care Benefit Offices
An executive order issued in 2000 requires that federal agencies and entities that receive federal funding take ‘reasonable steps’ to ensure that clients with limited proficiency in English are able to access services. Building on its earlier Fund-supported work, the National Health Law Program (NHeLP) will identify and describe current models and best practices for providing patients with interpretation and other language assistance in a cost-effective manner. The effort will focus on solo or small group physician practices-where the majority of doctors practice and where language barriers are especially acute-as well as state and local enrollment offices for Medicaid and the State Children’s Health Insurance Program. To obtain this information, NHeLP will rely on its listservs and extensive network of advocacy organizations. At the project’s conclusion, health care providers will have a step-by-step framework to help them establish language assistance programs for their patients.
Mara Youdelman, J.D., L.L.M.
Staff Attorney
1100 14th Street, Suite 400
Washington, DC 90034
Tel: (212) 289-7661
youdelman@healthlaw.org

New York Academy of Medicine
$123,481
Examining Disparities in the Use of High-Volume Hospitals in New York City
For a number of medical procedures and conditions, patient outcomes are often better at hospitals that perform these procedures or treat these conditions at high rates. There is some evidence indicating that for certain procedures and conditions, white patients receive care at high-volume hospitals at greater rates than minority patients do. For this project, researchers will investigate the scope of these disparities and identify a range of policy solutions. The study will determine: 1) if racial disparities in the use of high-volume hospitals in fact exists; 2) whether such differences are lower among patients enrolled in managed care plans; 3) what the distinguishing characteristics of high-volume hospitals are;

and 4) whether disparities are less pronounced for those conditions for which designated 'centers of excellence' exist. The project team will share findings with patient advocates, hospital and managed care officials, purchasers, and others to encourage them to take action. This grant will supplement a new project being undertaken by the Agency for Healthcare Research and Quality.

Bradford H. Gray, Ph.D.
Director, Division of Health & Science Policy
1216 Fifth Avenue
New York, NY 10029-5293
Tel: (212) 822-7286
bgray@nyam.org

New York University
$235,089
Remote Simultaneous Medical Interpreting: Assessing Medical Outcomes, Phase 2
Recognizing that language barriers can seriously compromise the quality of patient care, health care providers and researchers are working to identify effective language interpretation practices. In Phase 1 of this project, the investigators initiated a trial to determine the comparative effectiveness and cost of remote simultaneous medical interpreting (RSMI), which allows doctors and their patients to communicate through wireless headsets. Preliminary results indicate that use of RSMI reduced interpreting errors by at least one-half compared with interpreting provided by family members, nurses, or office staff; its use also substantially reduced the length of physician visits. In Phase 2, the project team will compare the medical outcomes of patients provided with RSMI services to patients who relied on customary interpreting practices. The team will also complete a cost analysis of RSMI. Findings will be disseminated through the New York City Health and Hospitals Corporation. The California Endowment will provide cofunding.

Francesca M. Gany, M.D.
Executive Director, Center for Immigrant Health
School of Medicine
550 First Avenue, OBV CD 402
New York, NY 10016
Tel: (212) 263-8897
fg12@med.nyu.edu

Summit Health Institute for Research and Education, Inc.
$150,000
Informing Policymakers About Racial and Ethnic Disparities in Health Care
In the fall of 2003, the congressionally mandated National Healthcare Disparities Report will be published. For this

project, the Summit Health Institute for Research and Education, Inc., will inform key policymakers of the report's findings as well as findings from the Institute of Medicine's 2002 report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, which stimulated little public discussion of solutions. The project will include dissemination of highlights from the two reports, press conferences, and a congressional briefing. The Summit Health Institute will also provide information and technical assistance to national advocacy organizations-expected to include the National Black Caucus of State Legislators, National Native American AIDS Prevention Center, Asian and Pacific Islanders American Health Forum, and National Hispanic Medical Association-which promote policies that address health disparities. These efforts will contribute to the development of concrete policy recommendations for the reduction of health care disparities in the United States.

Ruth T. Perot
440 First Street, NW, Suite 430
Washington, DC 20001-2028
Tel: 202-371-0277
rperot@shireinc.org

The National Quality Forum
$125,000
Using Informed Consent to Improve the Safety of Care for Patients with Limited English Proficiency
To help ensure patients' safety and meaningful participation in health care decisions, it is critical that physicians obtain their fully informed consent. The National Quality Forum has recommended that health care providers ask patients to recount what they have agreed to as a way to confirm that informed consent has indeed been given. Implementing this practice is challenging, however, particularly for providers who serve patients with low literacy and limited English proficiency. Focusing on individuals undergoing invasive surgical procedures, this project will address obstacles to adoption of this practice and develop recommendations to surmount them. Activities will include: 1) self-assessments by providers who regularly obtain confirmation of informed consent, 2) interviews with providers who do not follow this practice; 3) a case study examining the experiences of providers following the practice; and 4) a workshop to discuss experiences of early adopters of the practice. Findings will be used to develop a guide to obtaining informed consent for dissemination to health plan administrators, hospital personnel, and outpatient surgery providers.

Robyn Y. Nishimi, Ph.D.
Chief Operating Officer
601 Thirteenth Street, NW, Ste 500 North
Washington, DC 20005

Tel: (202) 783-1300
rynishimi@qualityforum.org

University of South Florida Research Foundation
$124,999
Hospital Care for Hispanic Children: Improving Parent-Provider Communication
Research has shown that patients who are not proficient in English receive inferior health care. Most studies, however, have focused on adult patients. This project will enable children's hospitals to measure and improve the quality and safety of care they provide for Hispanic children whose parents have limited English proficiency. Through focus groups, project investigators will identify communication problems between parents and physicians and assess their impact on care. This information will be used to develop a health care quality survey for parents that will help assess language-related problems and needs. Survey results will help hospitals design programs and procedures to improve care for Hispanic children. The survey and a technical guide will be distributed through the Children's Hospital Accountability Initiative and the National Association of Children's Hospitals and Related Institutions.

Lisa Simpson, M.B., M.P.H., F.A.A.P.
Professor and Endowed Chair, Child Health Policy
601 4th Street, CRI 1008
St. Petersburg, Florida 33701
Tel: (727) 553-3672
lsimpso1@hsc.usf.edu

Small Grants—Quality of Care for Underserved Populations

American College of Physicians
$20,000
Third Annual National Health Communication Conference

John Tooker, M.D, M.B.A, F.A.C.P
Executive Vice President and Chief Executive Officer
190 North Independent Mall West
Philadelphia, PA 19106
Tel: (215) 351-2802
jtooker@acponline.org

American Public Health Association
$10,000
National Public Health Week 2004: Racial and Ethnic Disparities

Georges C. Benjamin, MD, FACP
Executive Director
800 I Street, NW
Washington, DC 20001-3710
Tel: (202) 777-2742
georges.benjamin@apha.org

Association for Health Center Affiliated Health Plans
$24,573
Recruiting and Retaining Specialty Physicians in Medicaid Managed Care and Community Health Centers, A Study of Challenges and Best Practices

Margaret A. Murray
Executive Director
2001 L Street, NW, 2nd Floor
Washington, DC 20036
Tel: (202) 331-4601
mmurray@ahcahp.org

Foundation for Informed Medical Decision Making
$24,868.79
Evaluation of a Decision Aid for Breast Cancer in an Underserved Population

Pamela Wescott
Senior Research Associate, Patient Perspectives and Program Evaluation
40 Court Street, Suite 200
Boston, MA 02108
(617) 367-2000
pwescott@fimdm.org

Research Foundation of State University of New York
$25,000
The Fourth National Conference on Quality Health Care for Culturally Diverse Populations: Integrating Community Needs Into the National Health Agenda

Dennis Andrulis, Ph.D.
Research Professor
Health Science Center at Brooklyn
Department of Preventive Medicine
450 Clarkson Avenue, Box 1240
Brooklyn, NY 11203
Tel: (718) 270-7736
dennis.andrulis@downstate.edu

FELLOWSHIP IN MINORITY HEALTH POLICY

President and Fellows of Harvard College
$800,000
The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: Support for Program Direction and Fellowships, 2004-05
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 medical services and quality of care. The Fellowship in Minority Health Policy has played an important role in addressing these needs. Under the direction of Joan Reede, M.D., the program has

provided young physicians with an intensive year of coursework in health policy, public health, and management at the Harvard School of Public Health or John F. Kennedy School of Government, as well as special program activities-all with an emphasis on minority health issues. Since 1996, a total of 35 fellows have successfully completed the program and received a master's degree in public health or public administration. In the coming year, the program will select a ninth group of four fellows while providing current fellows with an enriched course of study, career development, and program evaluation.

Joan Y. Reede, M.D., M.P.H., M.S.
Dean for Diversity and Community Partnership
Minority Faculty Development
146 Longwood Avenue, Room 219
Boston, MA 02115
Tel: (617) 432-2413
joan_reede@hms.harvard.edu

CHILD DEVELOPMENT AND PREVENTIVE CARE

American Academy of Pediatrics, Inc.

$458,978

Training Office Staff to Improve Preventive and Developmental Services in Pediatric Practices

Improving the quality of preventive health care and developmental services for children will require substantial changes in how this care is provided, from revamped appointment systems to new screening procedures. To be successful, such an effort will require the involvement of the entire staff of pediatric practices, not only physicians. The American Academy of Pediatrics (AAP) has proposed a practice-based quality improvement program that will be developed and evaluated through a collaboration of teams of administrative and clinical staff from 12 practices within a single region. The program will use a modular curriculum and resource toolkit that is based on work completed by previous Fund grantees (e.g., the National Initiative for Children's Healthcare Quality). The final program, which will become part of the AAP's ongoing educational activities, will be widely disseminated through the federally funded, multidisciplinary Bright Futures initiative to promote a system of high-quality preventive care for children.

Darcy Steinberg, M.P.H.
Director, Division of Developmental Pediatrics and Preventive Services
141 Northwest Point Blvd.
Elk Grove Village, IL 60007
Tel: (847) 434-7935
dsteinberg@aap.org

Connecticut Children's Medical Center
$239,868
Strengthening the Developmental Surveillance and Referral Practices of Child Health Care Providers
Young children with developmental problems, and children at significant risk for those problems, are not being identified and referred as early as possible to intervention programs by their health care providers. Consequently, many children begin school with problems that could have been prevented or ameliorated. This project will develop a training program for child health care providers in developmental surveillance and in the use of a new centralized referral and case management system for children in need of services. The system will be in effect throughout Connecticut and accessible by a toll-free number. A national training model and materials for replication are expected to be a result of this work.

Paul H. Dworkin, MD
Physician In Chief
282 Washington Street
Hartford, CT 06106-1299
Tel: (860) 545-8566
pdworki@ccmkids.org

George Washington University
$199,996
Determining How States Invest in Early Child Development Under Medicaid and CHIP
The Fund's work with George Washington University has provided states with valuable guidance on maximizing the potential of Medicaid and the State Children's Health Insurance Program (CHIP) to deliver a full range of preventive care and developmental services to young children from low-income families. This project will provide states with further guidance by analyzing how program investment and design can affect the delivery of these services. The George Washington team will first compare key components of each state's Medicaid and CHIP programs, including provider network specifications, compensation arrangements for preventive services, medical necessity definitions, and standards of care. If this first stage proceeds satisfactorily, project staff will then undertake a more in-depth review of five states to gauge the impact of their program choices on the pediatric care provided to low-income families. State Medicaid and CHIP administrators will be able to draw from the successful approaches highlighted by this work in their efforts to improve delivery of child developmental services.

Sara Rosenbaum, JD
Chair, Department of Health Policy
2021 K Street, N.W., Suite 800
Washington, DC 20006
Tel: (202) 530-2343
sarar@gwu.edu

Mathematica Policy Research, Inc.
$202,133
Partnering with External Quality Improvement Organizations to Enhance Preventive and Developmental Care for Low-Income Children
All state Medicaid programs that employ risk-based managed care plans must contract with an outside entity to monitor the quality of health care provided by the plans. These entities, called external quality improvement organizations (EQIOs), play an increasingly important role in assessing and improving the quality of care provided to low-income individuals. This project will identify ways that state Medicaid agencies can work effectively with EQIOs to enhance the quality of preventive and developmental services provided to young Medicaid-enrolled children. Recent EQIO reports to state Medicaid agencies will be analyzed to measure the extent and quality of EQIO work in this area, while information obtained from interviews with Medicaid and EQIO staff in five states will locate exemplary EQIO contributions to improving preventive and developmental care.

Henry Ireys, Ph.D.
Senior Researcher
600 Maryland Ave., SW
Room 550
Washington, DC 20024
Tel: (202) 554-7536
hireys@mathematica-mpr.com

Oregon Health & Science University
$307,287
Developing a Performance Measurement Tool for Pediatric Practices, Phase 2
Recent studies point to a gap between the kinds of preventive and developmental services parents want for their young children and the care they actually receive from pediatric practices. To highlight and quantify this gap, the Fund previously supported creation of the Promoting Healthy Development Survey (PHDS), a validated measure of care quality based on parents' reports. In a recent project, Christina Bethell developed a version of the PHDS that could be used to measure the quality of care at individual practices. The instrument was successfully pilot-tested at two practices in Vermont. The proposed project will test the revised PHDS in 10 additional practices to confirm the measure's psychometric properties and to establish norms against which practices can assess their performance-both of which are critical for national dissemination. Project staff also will develop templates for reporting results to pediatricians and health plan administrators.

Christina Bethell, Ph.D., M.P.H., M.B.A.
Researcher

Department of Pediatrics, School of Medicine
707 SW Gaines Road, Mail Code CDRCP
Portland, OR 97239-2998
Tel: (503) 528-9312
bethell@ohsu.edu

Stanford University
$145,529
Achieving Consensus on Best Office Practices in Well Child Care
A number of unique approaches are available to improve particular aspects of well child care, but there is no comprehensive plan for providing developmental and other preventive services in an efficient and effective manner. This project will produce a practical, authoritative physician guide to best office practices in well child care, including research-based, technology-driven strategies to achieve them. The investigators will consolidate information on the latest health care innovations and consult with pediatric experts in order to generate key concepts and specific strategies. The resulting guide will be disseminated to pediatric practices through the meetings and publications of the American Academy of Pediatrics, the National Initiative for Child Health Quality, and other national organizations and agencies. Project staff also will collaborate with members of a national, practice-based pediatric research network to develop plans for implementing best practices in physician offices and testing their feasibility.
David A. Bergman, M.D.
Associate Professor
725 Welch Rd., Room 325
Stanford, CA 94305-5731
Tel: (650) 497-8994
david.bergman@stanford.edu

Trustees of Dartmouth College
$265,817
Addressing Maternal Depression: A Screening Project
Depression in mothers is associated with the occurrence of developmental problems in their young children, including impaired cognitive function, depression, and behavioral problems. Depression may also affect mothers' confidence and parenting skills. Addressing maternal depressive symptoms has been shown to improve behavioral outcomes for both mothers and children, and new guidelines emphasize that pediatricians should play a role in detecting depression. For this project, investigators will develop, implement, and evaluate the effectiveness of a model for screening and referral of mothers for depression in five primary pediatric practices. The feasibility and cost of implementation will also be assessed. If the evaluation demonstrates the model's value, project staff will prepare technical assistance materials for

providers and health plans to facilitate replication.

Ardis L. Olson, M.D.
Assistant Professor of Pediatrics
Dartmouth Hitchcock Medical Center
Department of Pediatrics
One Medical Center Drive
Lebanon, NH 03756
Tel: (603) 650-5473
ardis.l.olson@dartmouth.edu

University of Rochester
$63,836
Evaluating the Receipt and Quality of Anticipatory Guidance Provided to Parents of Young Children
Anticipatory guidance provided during well-child care visits helps promote parents' awareness of their young child's developmental milestones and needs. Such counseling can lead to better health outcomes while increasing parents' satisfaction with their pediatric providers. More information is needed, however, to determine which topics are brought up when pediatricians talk to parents and whether parents view these interactions positively. For this project, investigators will analyze a special supplement to the national Medical Expenditure Panel Survey that focuses on children's preventive care services. They will examine parents' experiences with their child's primary pediatric clinician, their receipt of anticipatory guidance, and the relationship between the two. Dissemination of the findings is expected to draw national attention to variations in the quality of children's preventive services and inform efforts to improve care.

Susanne Tanski, M.D.
Research Associate
American Academy of Pediatrics
Center for Child Health Research
1351 M. Hope Avenue, Suite 130
Rochester, NY 14620
Tel: (585) 275-1544
susanne_tanski@urmc.rochester.edu

ASSURING BETTER CHILD HEALTH AND DEVELOPMENT II (ABCD II)

Since March 2000, the Fund's Assuring Better Child Health and Development initiative has been implementing an ambitious strategy to help state Medicaid agencies promote and improve the delivery of developmental services for low-income children.The National Academy for State Health Policy launched a second consortium of four states, listed below, to enhance the healthy mental development of young low-income children. These grants were awarded during fiscal year 2003-04, with funds authorized during the prior fiscal year, 2002-03.

California Department of Health Services
$50,000
Best-PCP-Behavioral, Developmental, Emotional Screening and Treatment by Primary Provider in Medi-Cal Managed Care

Stan Rosenstein
Deputy Director, Medical Care Services
Medi-Cal Managed Care Division
MS 4404, PO Box 997413
Sacramento, CA 95899-7413
Tel: (916) 440-7800
srosenstein@dhs.ca.gov

Iowa Department of Human Services
$55,000
Iowa's Care for Kids Healthy Mental Development Initiative

Sally Nadolsky
ESPDT Policy Specialist
Hoover State Office Building
1305 E. Walnut
Des Moines, IA 50219-0114
Tel: (515) 281-5796
snadols@dhs.state.ia.us

Minnesota Department of Human Services
$55,000
Great Start Minnesota

Glanace Ecklund Edwall, Ph.D.
Director of Children's Mental Health
444 Lafayette Road
St. Paul, MN 55155

Tel: (651) 215-1382
glenace.edwall@state.mn.us

Utah Department of Health
$53,455.42
Enhancing Utah's Capacity to Support Children's Healthy Mental Development

Michael J. Deily
Director, Division of Health Care Financing
P.O. Box 143101
Salt Lake City, UT 84114-3101
Tel: (801) 538-6406
mdeily@utah.gov

Small Grants—Child Development and Preventive Care

AcademyHealth
$3,000
2004 Child Health Services Research Meeting

Wendy Valentine, M.H.A.

Vice President
1801 K Street, Suite 701-L
Washington, DC 20006
Tel: (202) 292-6700
wendy.valentine@academyhealth.org

Center for Health Care Strategies, Inc.
$22,367
Modernizing EPSDT: Developing an Operational Prototype for a 21st Century Medicaid Program
Stephen A. Somers, Ph.D.
President
1009 Lenox Drive, Suite 204
Lawrenceville, NJ 08648
Tel: (609) 895-8101
sasomers@chcs.org

Center for Health Care Strategies, Inc.
$10,000
Barriers and Solutions to Improve Developmental Services through Early and Periodic Screening Diagnosis and Treatment Program
Stephen A. Somers, Ph.D.
President
1009 Lenox Drive, Suite 204
Lawrenceville, NJ 08648
Tel: (609) 895-8101
sasomers@chcs.org

Center for Health Policy Development
$16,800
Pre-Conference on Quality in Children's Health at 17th Annual State Health Policy Conference
Neva Kaye
Interim Co-Executive Director/Program Director
National Academy for State Health Policy
50 Monument Square, Suite 502
Portland, ME 04101
Tel: (207) 874-6545
nkaye@nashp.org

Center for Health Policy Development
$20,132
Assuring Better Child Health and Development Initiative (ABCD II): Expanding the State Consortium to Include Illinois
Neva Kaye
Interim Co-Executive Director/Program Director
National Academy for State Health Policy
50 Monument Square, Suite 502
Portland, ME 04101
Tel: (207) 874-6545
nkaye@nashp.org

Health Management Associates
$36,400
State Opportunities to Improve Health Care Quality for Children

Vernon K. Smith, Ph.D.
Principal
120 North Washington Square
Suite 705
Lansing, MI 48933
Tel: 517-318-4819
vsmith@hlthmgt.com

Johns Hopkins University
$12,963
Incorporating a Child Developmental Focus in State Title V Needs Assessments

Holly Grason, M.A.
Director, WCHPC
Johns Hopkins Bloomberg School of Public Health
615 N Wolfe St. Rm.E4140
Baltimore, MD 21205
Tel: (410) 502-5443
hgrason@jhsph.edu

National Academy of Sciences
$13,615
Conceptualizing of Child Health and Its Implications for Services

Marie C. McCormick, M.D., Sc.D.
Professor and Chair
Department Maternal/Child Health
677 Huntington Ave
Boston, MA 02115

Tel: (617) 432-3759
mmccormick@hsph.harvard.edu

National Initiative for Children's Healthcare Quality
$7,500
3rd Annual Forum for Improving Children's Healthcare Quality

Charles Homer, M.D., M.P.H.
CFO
375 Longwood Ave, 3rd Floor
Boston, MA 02215
Tel: (617) 754-4807
chomer@nichq.org

Tufts-New England Medical Center
$49,181
Office-Based Prevention of Child Behavior Problems: An Urban Extension Project

Ellen C. Perrin, M.D.
Professor of Pediatrics
750 Washington Street, Box 334
Boston, MA 02111
Tel: (617) 636-8010
eperrin@tufts-nemc.org

PICKER/COMMONWEALTH PROGRAM ON QUALITY OF CARE FOR FRAIL ELDERS

AcademyHealth

$102,077

The Commonwealth Fund/AcademyHealth Long-Term Care Colloquium

Although demand for long-term care services continues to grow, this important health care sector has been a relatively low priority for both policymakers and health services researchers. In addition, meaningful communication between these groups and collaboration on work have been limited. This Picker Program Grant will plan the first in a series of colloquia on long-term care to be sponsored by the Fund and AcademyHealth over the next five years. The meetings' goals are to focus attention on critical long-term care issues and problems, foster discussion and consensus among state and local policymakers, practitioners, and researchers on potential solutions to those issues, and identify the information gaps and research needed to solve the problems. Proceedings, slides, and commissioned papers from the meetings will be posted on the AcademyHealth and Fund Web sites.

W. David Helms, Ph.D.
President and Chief Executive Officer
1801 K Street, Suite 701-L
Washington, DC 20006-1301
Tel: (202) 292-6700
david.helms@academyhealth.org

Consumers Union of United States, Inc.

$189,044

Drawing Lessons from the Nursing Home Watch List

With partial support from the Fund, Consumers Union published its Nursing Home Watch List in 2000, 2001, and 2002 to help consumers avoid the worst-performing facilities in their state. Many homes appeared on the list in more than one year, suggesting that the Centers for Medicare and Medicaid Services has not realized its goal of ensuring that facilities achieve compliance with federal quality standards. This Picker Program Grant will: 1) update the watch list; 2) investigate why some facilities appear on the list repeatedly; 3) examine the characteristics of poor-performing facilities and relate those findings to the state's use of the regulatory process; 4) sponsor a meeting with regulators to design strategies that states can use to help nursing homes achieve

and maintain better quality; and 5) determine whether low-performing homes on the watch list lose market share to high-performing homes. Findings and recommendations will be widely disseminated to consumers, policymakers, and regulators.

Trudy Lieberman
Director, Center for Consumer Health Choices
101 Truman Avenue
Yonkers, NY 10703-1057
Tel: (914) 378-2513
liebtr@consumer.org

Manhattan Retirement Foundation
$150,000
Developing Tools for Achieving Resident-Centered Care in Nursing Homes
Most nursing homes are regimented, medically oriented environments. To transform them into settings where the individual resident is the focus, nursing home executives and administrators need detailed guidance on creating and sustaining new clinical and management processes. This Picker Program Grant will develop a set of tools to effectuate change in nursing home culture. Employing a variety of information technology systems, they will include: a text on leadership development; specific operational policies, procedures, and programs; an integrated human resources system; and a comprehensive system of quality improvement. The tool set will be targeted to providers, administrators-in-training, nursing home consultants, and others seeking to improve the quality of life for residents in long-term care facilities. Cofunding will be provided by the Sunflower Foundation of Kansas and the Kansas Foundation for Medical Care; additional cofunding is being sought.

Stephen J. Shields
Executive Director
2121 Meadowlark Road
Manhattan, KS 66502
Tel: (785) 537-4610
steve.shields@meadowlark.org

Regents of the University of Minnesota
$259,997
Evaluation of Small Group Homes for Nursing Home Residents
The physical structures of virtually all of today's nursing homes will be obsolete by the time baby boomers start to turn 85 in 2032. Recognizing the need to move away from the institutional model that prevails today, the investigators on this Picker Program Grant will test the feasibility of establishing small group homes for the elderly that are designed to foster more resident-centered care. Focusing on

the Mississippi-based Green House Project, which has so far established four group homes of 10 residents each, the evaluation will examine the operational, financial, and regulatory issues associated with the small group design and assess its impact on staff and residents. Lessons learned from the evaluation will be used to enhance and refine the prototype, develop templates for replication and self-evaluation, and establish the business case for this new way of caring for frail elders.

Rosalie A. Kane, Ph.D.
Professor
School of Public Health
420 Delaware St SE
D-527, MMC 197
Minneapolis, MN 55455-0381
Tel: (612) 624-5171
kanex002@umn.edu

Spragens and Associates, LLC
$200,000
Wellspring Innovative Solutions: Replicating the Model
Many nursing homes are looking for evidence-based models to improve the care they provide to their frail elderly residents. Wellspring is one such model. But if replication of this model is to proceed, Wellspring Innovative Solutions will require support to build its capacity to recruit nursing homes and serve new and existing members. This Picker Program Grant will provide the crucial support needed to attract an able leader for the dissemination effort, develop professional education and training capabilities, establish a formal mentoring program for new alliance leaders, and develop marketing capacities. If the project is successful, a program-related investment will be contemplated for next year to help the organization reach a goal of 18 alliances, of about 10 nursing homes each, by 2005. This level of activity will enable Wellspring to function as a financially independent, nonprofit service business in the field of nursing home quality improvement. Cofunding is being sought.

Lynn Hill Spragens, MBA
President
5407 Pitney Bluff Court
Durham, NC 27705
(919) 740-1980
Lspragens@msn.com

The Regents of the University of California
$281,484
Enhancing Performance of the Long Term Care Ombudsman Program
The Long Term Care Ombudsman Program, authorized under the Older Americans Act, is charged with protecting and

representing the interests of nursing home residents. Ombudsmen visit nursing homes to resolve complaints and quality problems. In many cases, however, the program is not fulfilling its mandate. Focusing on local programs in California and New York, this Picker Program Grant will identify factors that affect program performance by interviewing ombudsmen, selected state officials, and federal experts, and by examining data from the National Ombudsman Reporting System. A set of recommendations and a toolkit for states will be developed and shared with state policymakers, local program officials, and other critical audiences to stimulate adoption of best practices.

Carroll L. Estes, Ph.D.
Professor
Institute For Health and Aging
Box 0646
3333 California Street, Laurel Heights 340
San Francisco, CA 94143
Tel: (415) 476-3236
cestes@itsa.ucsf.edu

University of North Texas
$167,654
Empowering in Nursing Home Staff: Measuring the Impact of Self-Managed Work Teams, Phase 2
Improving the quality of nursing home care is heavily dependent on raising the performance of nurses' aides, the employees who interact with residents most frequently. Self-managed work teams have emerged as a potential remedy for the rampant absenteeism and turnover plaguing nursing homes. This Picker Program Grant is the second phase of a project to measure the impact of staff empowerment on job satisfaction and retention. Self-managed work teams were implemented in five nursing homes in Phase 1. Continued data collection in the five experimental homes and in five other facilities where work teams are not in use will allow project staff to compare levels of employee satisfaction and retention. If the work teams are shown to have a positive effect on nursing home staff, project staff will develop training modules and a 'how-to' manual for dissemination to nursing home administrators and long-term care educators.

Dale E. Yeatts, Ph.D.
Professor and Chair, Dept. of Sociology
2001 Lariat Road
Denton, TX 76207
Tel: (940) 565-2238
yeatts@unt.edu

Small Grants—Picker/Commonwealth Program on Quality of Care for Frail Elders

American Association of Nurse Assessment Coordinators
$10,617
Scannable Resident Assessment Protocol (RAP) Survey of Nurse Assessment Coordinators

Diane Carter
President and CEO
1780 South Bellaire Street
Suite 150
Denver, CO 80222-4307
Tel: 303-758-7647
dcarter@aanac.org

American Health Quality Foundation
$25,000
Helping QIO Staff Facilitate Culture Change

Richard Deutsch, M.A.
Director of Communications
1155 21st Street NW, Suite 502
Washington, DC 20036
Tel: (202) 331-5790
rdeutsch@ahqa.org

Friends and Relatives of Institutionalized Aged, Inc.
$25,000
Family Council Manual Project 2003

Jessica Herold, MSW
Family Advocacy Coordinator
18 John Street, #905
New York, NY 10038-4009
Tel: (212) 732-5667
jherold@fria.org

Grantmakers in Aging, Inc.
$3,000
2003 GIA Annual Conference

Carol A. Farquhar
Executive Director
7333 Paragon Rd., Ste. 220
Dayton, OH 45459-4157
Tel: (937) 435-3156
cfarquhar@giaging.org

Regents of the University of Minnesota
$30,350
Optimizing Leadership to Achieve Resident-Directed Staff Behaviors: Linking Wellspring to Culture Change

Leslie A. Grant, Ph.D.
Associate Professor

Department of Healthcare Management
321 19th Avenue South
3-147 Carlson School of Management
Minneapolis, MN 55455
Tel: (612) 624-8844
grant004@umn.edu

National Governors Association
$36,278
National Public Forum: Confronting Long-Term Care Challenges in America
Diane Braunstein
Program Director, Long-Term Care and Aging
444 North Capital Street
Washington, DC 20001-1512
dbraunstein@nga.org

Yale University
$33,051
The Hospital Elder Life Program (HELP) Spreading Innovation Project
Sharon K. Inouye, M.D.
Professor of Medicine
333 Cedar Street (DC013K)
P.O. Box 208025
New Haven, CT 06520-8025
Tel: (203) 688-7302
sharon.inouye@yale.edu

INTERNATIONAL PROGAM IN HEALTH POLICY AND PRACTICE

Harris Interactive, Inc.
$344,000
The 2004 International Health Policy Survey
The 2004 International Health Policy Survey, the seventh in an annual series of surveys commissioned by the Fund, will assess health care system performance and responsiveness from the perspective of the consumer. Conducted in Australia, Canada, New Zealand, the United Kingdom, and the United States, the survey will explore the public's views on and experiences with their health care system, focusing on primary and preventive care. It will consider timeliness of health care access, medical errors, doctor-patient communication, patient involvement in decision-making, prescription drug use, and patient choice. Survey findings, which are scheduled for presentation at the Fund's 2004 International Symposium, will highlight the impact of different health care delivery system approaches, and should generate substantial interest among health ministers, policymakers, researchers, and the media. Project staff will submit a paper discussing survey results to the

journal Health Affairs for Web publication.

Kinga Zapert, Ph.D.
Vice President of Health Policy Research
111 Fifth Avenue, 8th Floor
New York, NY 10003
Tel: (212) 539-9751
kzapert@harrisinteractive.com

Johns Hopkins University
$75,000
Cross-National Comparisons of Health Systems Quality Data, 2004
Comparisons between the U.S. health care system and health systems of other industrialized countries reveal striking differences in spending, availability and use of services, and health outcomes. This project will prepare a seventh paper in an annual series of analyses of key health data for the 30 member countries of the Organization for Economic Cooperation and Development (OECD). It will provide an update of overall trends in health systems' performance, with an emphasis on spending, coverage, hospital capacity and utilization, pharmaceutical costs, use of technology, trends in the supply and incomes of health professionals, and quality of care. In comparing health system data, the study will illustrate the impact of different national policies on system efficiency. Findings will be presented at the Fund's 2004 International Symposium on Health Care Policy and submitted to the journal Health Affairs for Web publication. An accompanying chartpack with core components from the OECD database will be posted on the Fund's website and updated annually.

Gerard F. Anderson, Ph.D.
Professor Health Policy and Management
Center for Hospital Finance and Management
Bloomberg School of Public Health
624 North Broadway, Room 302 Hampton House
Baltimore, MD 21205
Tel: (410) 955-3241
ganderso@jhsph.edu

Johns Hopkins University
$126,861
International Working Group on Quality Indicators, 2004
The International Working Group on Quality Indicators, initially convened by the Fund in March 1999, aims to improve the measures available for cross-national comparisons of health care quality. In early 2004, the group will release a report to health ministers recommending a minimum set of quality indicators for collecting health system data in Australia, Canada, New Zealand, the United Kingdom, and the United States. Two additional meetings will be held in April and September 2004 to address operational issues related to

data collection and implementation in the five countries, and to expand the core set of indicators to include responsiveness and equity. Participation in the meetings by the Organization for Economic Cooperation and Development (OECD) has resulted in a Fund collaboration with the OECD to expand the number of industrialized countries in which quality data are collected to 19, as well as to widen the scope of the indicator set. The work conducted in this phase is expected to be completed by the end of 2004, when the project will be transferred to the OECD.

Gerard F. Anderson, Ph.D.
Professor Health Policy and Management
Center for Hospital Finance and Management
Bloomberg School of Public Health
624 North Broadway, Room 302 Hampton House
Baltimore, MD 21205
Tel: (410) 955-3241
ganderso@jhsph.edu

Massachusetts General Hospital
$54,000
Five-Year Evaluation of the Fund's International Program in Health Policy and Practice
Under the direction of David Blumenthal, M.D., the Institute for Health Policy at Massachusetts General Hospital will conduct an assessment of the Fund's International Program, last evaluated in 1996. The evaluation team will examine how well the program is meeting its mission, what its major accomplishments have been over the past five years, how it has evolved, and how the program and its individual components could be improved. Activities will include: a review of program activities, publications, and data supplied by the Fund; an online survey of 60 key individuals, supplemented by telephone interviews; and an online survey of Harkness Fellows and their U.S. mentors.

David Blumenthal, M.D., M.P.P.
Director, Institute for Health Policy
50 Staniford Street, 9th Floor
Boston, MA 02114
Tel: 617-726-5212
Fax: (617) 724-4738
dblumenthal@partners.org

The Nuffield Trust
$60,000
The Commonwealth/Nuffield Trust International Conference on Health Care Quality Improvement, 2004
Since 1999, the Fund and the Nuffield Trust have sponsored a series of annual symposia for U.S. and U.K. government officials, health researchers, and practitioners to promote the exchange of ideas on quality improvement policies and

strategies. These transatlantic meetings have focused on such critical issues as patient safety, changing physician and organizational behavior, use of information technology, disparities in health care, and public reporting of provider performance data. A product of the series is an agenda for U.S.-U.K. collaboration on efforts to improve quality, formalized in an agreement signed by the two countries in 2001. Participants at the sixth quality improvement conference, which has been expanded to include Australian representation, will: 1) review the progress of the collaboration and recommend an agenda for the coming year; 2) explore which quality improvement strategies work and which do not; and 3) compare case studies of learning collaboratives in different countries to gauge their impact and sustainability.

John Wyn Owen, C.B.
Secretary
59 New Cavendish Street
London W1G 7LP
United Kingdom
Tel: 020-7631-8450
jwo@nuffieldtrust.org.uk

The Commonwealth Fund
$207,000
International Symposium on Health Care Policy, Fall 2004
The Fund's seventh annual International Symposium on Health Care Policy will focus on improving health care from the patient's perspective, challenges in moving toward a patient-driven health care delivery system, and innovative approaches to addressing these challenges. In bringing together leading policymakers and researchers from Australia, Canada, New Zealand, the United Kingdom, the United States-and potentially additional G-8 countries-the symposium will highlight how other health systems are: improving responsiveness and access in health care delivery systems; redefining the doctor-patient relationship; incorporating patients' and families' experiences with care into quality improvement initiatives; facilitating patient involvement in treatment decisions; using performance data to give patients choice of providers; and promoting culturally competent care for increasingly diverse populations. Presenters will highlight innovative policies, incentive structures, and health care delivery models that support these changes and improve quality in health care. Commissioned papers from the symposium will be submitted for publication as Health Affairs Web Exclusive articles.

Robin Osborn
Vice President, International Health Policy and Practice
One East 75th Street
New York, NY 10021
Tel: (212) 606-3809
ro@cmwf.org

The Commonwealth Fund
$1,158,338
Harkness Fellowships in Health Care Policy, 2005-06
Support for an eighth class of Harkness Fellows in Health Care Policy will allow the Fund to continue developing promising policy researchers and practitioners from Australia, New Zealand, and the United Kingdom. In January 2004, the first two Harkness/Health Foundation Fellows were selected, a product of a new partnership between the Fund and the U.K.-based Health Foundation to build policy leadership capacity in the U.K. National Health Service and Department of Health. In October 2003, the first two Packer Fellows in Health Policy were selected, the inaugural appointments in a 'reverse Harkness' program that enables U.S. health policy experts to undertake policy research in Australia.

Robin Osborn
Vice President, International Health Policy and Practice
One East 75th Street
New York, NY 10021
Tel: (212) 606-3809
ro@cmwf.org

Small Grants—International Program in Health Policy and Practice

AcademyHealth
$10,000
5th Internationl Conference on the Scientific Basis of Health Services: Global Evidence for Local Decisions

Patricia Pittman
Senior Manager for International Projects
1801 K Street, Suite 701-L
Washington, DC 20006

Tel: 202-292-6712
patricia.pittman@academyhealth.org

Ben-Gurion University of The Negev
$44,000
The Emerging Paradigms in Health Systems

Dr. Dov Chernichovsky, Ph.D.
Research Associate
50 East 42nd Street, 17th Floor
New York, NY 10017-5405
Tel: (617) 868-3900

University of Bristol
$17,550
The Impact of PHARMAC

Bronwyn Croxson, Ph.D.
Research Affiliate
P.O. Box 3724

Wellington, New Zealand
Tel: (+644) 471 5165
b.croxson@paradise.net.nz

The Commonwealth Fund
$11,769
International Health Services Research Funders' Network Annual Meeting
Robin Osborn
Vice President, IHP
One East 75 Street
New York, NY 10021
Tel: (212) 606-3809
ro@cmwf.org

University of British Columbia
$31,992
International Approaches to Central Drug Review
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
Tel: 604- 822 7012
morgan@chspr.ubc.ca

COMMUNICATIONS

Alliance for Health Reform
$209,352
2004 Health Policy Seminars and Congressional Staff Retreat
Alliance for Health Reform briefings have served as a valuable resource for congressional staff and journalists seeking the latest information on key health policy issues. In the coming year, the Alliance will conduct eight briefings and roundtables and will host a retreat, to be cofunded by the Catholic Health Association of the United States, for senior congressional staff. Possible briefing topics include: the fifth anniversary of the Institute of Medicine's landmark study on medical errors; presidential candidates' health reform plans; nursing home care; results from the Fund's physician, health insurance, and prescription drug coverage surveys; and issues related to implementation of a Medicare drug benefit.
Edward F. Howard, J.D.
Executive Vice President
1444 Eye Street, NW, Suite 910
Washington, DC 20005-6573
Tel: (202) 789-2300
edhoward@allhealth.org

President and Fellows of Harvard College
$450,000
The Commonwealth Fund/John F. Kennedy School of Government Bipartisan Congressional Retreat, 2005
Each year since 1999, key members of Congress and other policy experts have met for three days in January under the auspices of the Fund and Harvard University's John F. Kennedy School of Government to discuss emerging issues in health care policy. These retreats provide an opportunity for lawmakers to spend time away from their day-to-day demands so they can openly discuss health policy issues in a private setting, obtain high-quality information and analysis on multiple facets of an issue, and enhance their ability to make the value and political judgments that lie ahead. In 2005, the sessions will most likely focus on topics related to Medicare, the uninsured, quality of care, and international health policy.

Julie Boatright Wilson, Ph.D.
Director, Malcolm Wiener Center
79 John F. Kennedy Street, Room T416
Cambridge, MA 02138
Tel: (617) 495-8302
julie_wilson@harvard.edu

Project HOPE/The People-to-People Health Foundation
$200,000
A Strategic Web Publishing Partnership with 'Health Affairs'
The World Wide Web plays an increasingly important role in scholarly communication, especially when subject matter is particularly time-sensitive or when target audiences can be reached more effectively online than through traditional means. Recognizing this, the Fund provided a grant in 2002 to support expanded Web publishing by Health Affairs, the leading peer-reviewed health policy journal. Continued support will enable Health Affairs to pursue new online features and provide more sophisticated tracking of the impact of its Web publishing on audiences of interest to the journal and the Fund. Although the Fund will no longer support the annual international print issue of Health Affairs, it will provide further support for its Web publishing program to ensure electronic publication of articles with an international focus.

John K. Iglehart
Founding Editor of Health Affairs
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814
Tel: (301) 656-7401 ext. 243
jiglehart@projecthope.org

Small Grants—Communications

Association of Health Care Journalists
$10,000
5th National Annual Conference: Politics Patients and Products: Hotspots in 2004
Melinda Voss, M.P.H.
Executive Director
Room 204 Murphy Hall
University of Minnesota
206 Church St. SE
Minneapolis, MN 55455-0418
Tel: 612 624-8877
ahcj@umn.edu

Harris Interactive, Inc.
$8,500
Health Care Opinion Leaders Project
Kinga Zapert, Ph.D.
Vice President of Health Policy Research
111 Fifth Avenue, 8th Floor
New York, NY 10003
Tel: (212) 539-9751
kzapert@harrisinteractive.com

Medscape Portals, Inc
$25,000
Early Childhood Development Online CME Program
Marc P. DesLauriers, Ph.D.
Associate CME Director
224 West 30th Street
New York, NY 10001
Tel: (212) 624-3799

National Public Radio
$50,000
National Public Radio News Health Care Coverage
Melissa Gill
Director of Developmetn
635 Massachusetts Avenue, NW
Washington, D.C. 20001
(202) 513-3261
mgill@npr.org

WGBH Educational Foundation
$45,000
Marketplace's Health Desk coverage
Marita Rivero
Vice President and General Manager for Radio

125 Western Avenue
Boston, MA 02134
(617) 300-2401
marita_rivero@wgbh.org

ORGANIZATIONS WORKING WITH FOUNDATION

AcademyHealth
$35,000
General Support
W. David Helms, Ph.D.
President and Chief Executive Officer
1801 K Street, Suite 701-L
Washington, DC 20006-1301
Tel: (202) 292-6700
david.helms@academyhealth.org

Grantmakers in Aging, Inc.
$6,000
General Support
Carol A. Farquhar
Executive Director
7333 Paragon Rd., Ste. 220
Dayton, OH 45459-4157
Tel: (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, N.W., Suite 1200
Washington, DC 20036
Tel: (202) 452-8331
lleroy@gih.org

Health Services Research Association of Australia & New Zealand
$1,000
General Support
Jane Hall
C/- CHERE
Faculty of Business
UTS
PO Box 123 Broadway NSW 2007
Sydney, Australia
Tel: (612)9351 0921
jane.hall@chere.uts.edu.au

New York Regional Association of Grantmakers
$11,500
General Support
Michael Seltzer
President
505 Eighth Avenue
Suite 1805
New York, NY 10018-6505
Tel: 212-714-0699
mseltzer@nyrag.org

Nonprofit Coordinating Committee of New York
$35,000
General Support
Jonathan Small
President
1350 Broadway, Suite 1801
New York, NY 10018-7802
Tel: (212) 502-4191 ext. 23
jsmall@npccny.org

Rockefeller University
$90,000
Transfer and Maintenance of The Commonwealth Fund's Archives, Part 8
Darwin H. Stapleton
Director
Rockefeller Archive Center
15 Dayton Avenue
Sleepy Hollow, NY 10591-1598
Tel: (914) 631-4505
stapled@mail.rockefeller.edu

Small Grants—Special Opportunities

Kaiser Family Foundation
$5,000
General Operating Support for the Barbara Jordan Conference Center
Larry Levitt, MPP
2400 Sand Hill Road
Menlo Park, CA 94025
Tel: 650/854-9400
llevitt@kff.org

Women's Prison Association and Home, Inc.
$3,500
2004 Gala
Ann L. Jacobs
110 Second Avenue
New York, NY 10003

Tel: (212) 674-1163
ajacobs@wpaonline.org

Alfred E. Smith Memorial Foundation, Inc.
$5,000
2003 Alfred E. Smith Memorial Foundation Dinner
His Eminence Edward M. Egan
Archbishop of New York
Archdiocese of New York
1011 First Avenue
New York, NY 10022-4134
Tel: (212) 371-1000
communications@archny.org

National Medical Fellowships
$6,000
2003 Annual Awards Gala
Vivian Manning Fox
President and CEO
5 Hanover Square, 15th Floor
New York, NY 10004
Tel: (212) 483-8880
natmed@worldnet.ett.net

New York Academy of Medicine
$6,000
2004 Tenth Annual Gala
Jeremiah A. Barondess, M.D.
President
1216 5th Avenue Room 602
New York, NY 10029-5293
Tel: (212) 822-7201
jbarondess@nyam.org

United Hospital Fund of New York
$8,500
2003 United Hospital Fund Gala, September 29, 2003
James R. Tallon, Jr.
President
350 Fifth Avenue, 23rd Floor
New York, NY 10118
Tel: (212) 494-0777
jtallon@uhfnyc.org

2004 Annual Report

SUMMATION OF PROGRAM AUTHORIZATIONS

Year Ended June 30, 2004	Major Program Grants	Picker Program Grants	Small Grants Fund Grants	Total
Program Grants Approved				
Improving Insurance Coverage and Access to Care	$ 3,475,765	—	$ 363,183	$ 3,838,948
Task Force on the Future of Health Insurance	1,560,198	—	163,256	1,723,454
Program on Medicare's Future	1,296,437	—	140,977	1,437,414
Health Care in New York City Program	619,130	—	58,950	678,080
Improving the Quality of Health Care Services	6,431,348	1,350,256	763,063	8,544,667
Health Care Quality Improvement	2,513,276	—	303,367	2,816,643
Quality of Care for Underserved Populations	1,234,628	—	104,442	1,339,070
Commonwealth Fund/Harvard University Fellowships in Minority Health Policy	800,000	—	—	800,000
Child Development and Preventive Care	1,883,444	—	191,958	2,075,402
Picker/Commonwealth Program on Frail Elders	—	1,350,256	163,296	1,513,552
International Health Care Policy and Practice	2,025,199	—	123,542	2,148,741
Communications	859,352	—	93,500	952,852
Health Policy, Research & Evaluation	—	—	40,000	40,000
Other Continuing Programs	193,500	—	70,269	263,769
Total Program Grants Approved	**$12,985,164**	**$1,350,256**	**$1,453,557**	**$15,788,977**
Grants Matching Gifts by Directors and Staff				$441,311
Program Authorizations Cancelled or Refunded and Royalties Received				($1,088,959)
Total Program Authorizations				**$15,141,329**

2003 Annual Report

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.

The Commonwealth Fund
One East 75th Street
New York, NY 10021-2692

Telephone (212) 606-3800
Facsimile (212) 606-3500
cmwf@cmwf.org
www.cmwf.org