



Karen Davis

President's Message

# From Place to Place: Learning from Innovations in Health Policy

KAREN DAVIS

States often serve as laboratories for innovation in the health care system. A successful experiment in one place can stimulate others to take action. When national health policy seems paralyzed by division, resourceful states can take the lead in developing new solutions, using a pragmatic mix of strategies to expand health insurance coverage and improve care. Further, states are well-positioned to encourage innovation by localities or within regions.

One way to encourage thoughtful change is to create opportunities for learning. New perspectives open up when state and local leaders study firsthand the policies of other states and regions, or when national leaders examine the workings of health care systems in other countries. The Commonwealth Fund has increasingly tried to mine the rich lode of health care experiences, across the United States and internationally, for strategies to enhance health care access and quality. Through surveys, case studies, analyses of best practices, and projects to test and evaluate

promising approaches, the Fund seeks a better understanding of widespread problems, geographic variations, and what can be done to close the gaps.

States generate innovation in part because of their proximity to the front lines of health care delivery: when the media holds a lens to a medical error or poor conditions in a nursing home, the state feels the heat. Plus, states have historically been the guardians of the public health. Since the passage of Title V of the Social Security Act in 1935, states have worked with the federal government to design and implement programs to improve maternal and child health. The creation of the Medicaid program in 1965 made states the major developers of policy for insuring low-income residents, using federal matching funds. That role was enhanced in 1997, when the Children's Health Insurance Program (CHIP) extended states' latitude to cover low-income children.

The state context is not without significant challenges. In boom economic times, some states responded by expanding coverage under Medicaid or CHIP and implementing new programs to cover the uninsured—but others did not, and none had the means, or perhaps the political will, to commit the necessary resources to make high-quality health care accessible to all. Problems may seem more manageable at the state level, yet entrenched opposition can be a formidable obstacle to change here, too. The most ambitious states play a vital role by pioneering new approaches, and states often have innovative ideas waiting in the wings. Yet federal resources are often needed to finance services, and to provide greater support for the most impoverished states or during times of economic downturn. Indeed, turning good ideas into action often requires the stimulus of new resources, such as federal demonstration or matching grants or recent tobacco settlements.

#### **STATES AS POLICY LEADERS: EXPANDING HEALTH INSURANCE**

A few states have achieved “near universal” health insurance coverage for their residents using a handful of common practices. They have tapped federal matching funds through Medicaid, CHIP, and federal waivers. They have proceeded incrementally and developed programs to cover specific population groups. Many states have found a key to successful expansion in tying those programs together under a single administrative umbrella, an approach that facilitates coordination and can make enrollment easier and less confusing for families.

States have tried to maintain a mix of public and private coverage, although regulating the individual insurance market and maintaining employer-sponsored insurance have been uphill battles. Most states have

turned to private managed care plans to provide coverage. Retaining the participation of commercial plans has also been a struggle, yet some states have increased their capacity by cultivating relationships with safety-net health plans committed to serving low-income communities. Successful states have paid careful attention to concerns raised by managed care plans, health care providers, and consumer advocacy groups.

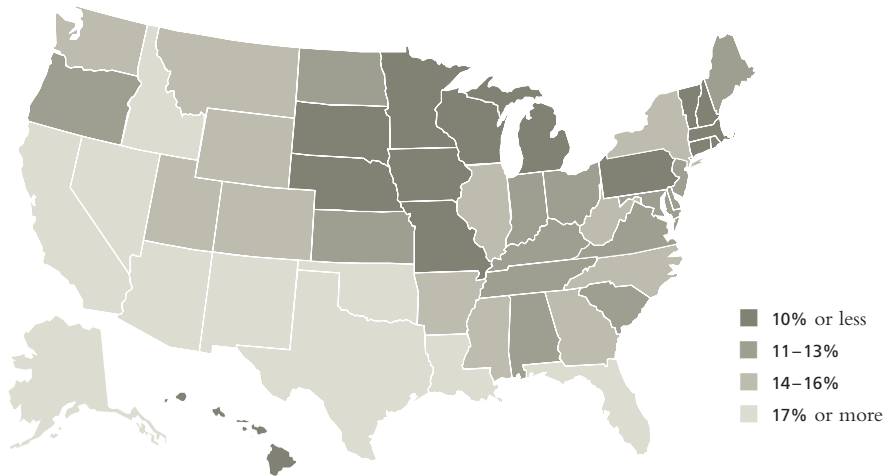
The primary obstacles to achieving universal coverage at the state level have been vulnerability to economic downturns, which reduce tax revenues and increase outlays for unemployment and other programs, and uneven capacity and will. Some states have shown great leadership and innovation in expanding health insurance during good economic times, yet more permanent solutions will demand greater federal financial participation and countercyclical policies to offset the effect of economic recession.

A measure of the challenge for future progress in covering the uninsured can be seen in disparities in rates of health insurance coverage across the United States. In Rhode Island, for example, only 7 percent of people are uninsured, compared with 23 percent in New Mexico, a threefold difference. On average, 9 percent of residents of the ten best states are uninsured, compared with 19 percent in the ten worst. The variations reflect differences in rates of poverty, job characteristics, rates of employer-sponsored insurance, and immigration, but most states that do well also have systematic public policies to expand health insurance coverage.

Fund-supported case studies of Rhode Island, Oregon, New Jersey, and Georgia by Sharon Silow-Carroll and colleagues of the Economic and Social Research Institute and the Center for State Health Policy at Rutgers University have highlighted the value of integrating multiple strategies to reach diverse

Innovative policies and federal incentives enabled some states to take advantage of the recent boom economy to improve health insurance coverage for their residents, with a few states even achieving "near universal" coverage.

#### Population without health insurance



R. Mills, U.S. Census Bureau, Current Population Reports, P60-220, *Health Insurance Coverage: 2001, 2002*. Uninsured rates are three-year averages, 1999-2001.

populations. Rhode Island expanded coverage to low-income children and their parents through its RIte Care program, a Medicaid/CHIP managed care program created in 1994 and enlarged incrementally to reach an enrollment exceeding 115,000. A unique feature is its commitment to quality improvement through performance standards, data collection, and a holistic approach to health care, with a strong emphasis on prevention. Rhode Island has also been creative about solving administrative challenges and forging beneficial partnerships. When faced with withdrawal of participating health plans, the state created "stop loss" provisions for some high-cost services, thus reducing costs and risk to plans, and developed a working relationship with the safety-net Neighborhood Health Plan. Rhode Island's experiences underscore the need for flexibility, constant monitoring, and judicious adjustment in light of changing circumstances.

The case studies found noteworthy innovations in the other states, as well. Oregon supplemented its Oregon Health Plan with a public-private partnership that allows low-wage workers to use state subsidies to purchase coverage through their employers, the individual market, or the state's high-risk pool. New Jersey instituted regulatory reform to make private insurance more affordable and accessible and, after a brief experiment with subsidized private coverage, built up its Medicaid/CHIP program to achieve lower costs and greater administrative efficiencies. Georgia also built on its Medicaid/CHIP program, in addition to using its purchasing leverage to open its state employee benefits program to staff in rural critical access hospitals and making Medicaid and CHIP uniform in the provider panel.

New York has been a leader in expanding health insurance by tapping federal matching funds for

programs to cover low-income children, parents, and childless adults. At the Greater New York Hospital Association, the Fund supported an analysis by Rima Cohen and Taida Wolfe, who gleaned operational lessons from 13 states to guide the implementation of the new Family Health Plus program. An important court decision specified that New York must extend coverage to approximately 200,000 low-income legal immigrants, a change that will address a major cause of high uninsured rates in New York City and other urban areas. Soon after the September 11, 2001, terrorist attack on the World Trade Center, New York implemented its Disaster Relief Medicaid program, which enrolled 350,000 people in a four-month period, many of them newly eligible through Family Health Plus or as a result of the judicial ruling.

New York has built broad-based support for its public program expansions, in part by packaging them with initiatives that benefit the private sector. The Healthy New York program, for example, provides “stop loss” protection for small business and individual insurance coverage in the private market. A Fund-supported analysis by Katherine Swartz of the Harvard School of Public Health found that Healthy New York has reduced individual insurance premiums by about 30–50 percent and HMO premiums for small businesses by 15–30 percent, although enrollment to date has been modest.

Minnesota, with one of the lowest uninsured rates in the nation, has also integrated multiple strategies. Five state-sponsored programs cover more than a half-million Minnesotans, or four in five state residents who are not covered under private insurance or Medicare. Like Rhode Island and New York, Minnesota has tapped federal matching funds to cover low-income adults and children and used state-only funds to cover

others in need. MinnesotaCare, which covers low-income families and individuals without access to employer-subsidized group coverage, is financed in part by a 1.5 percent tax on health care providers’ gross revenues. Analyses of Minnesota programs and 29 state high-risk programs by Deborah Chollet and Lori Achman at Mathematica Policy Research note that Minnesota’s high-risk pool is the largest and most successful in the country, serving over 25,000 people, or 6 percent of those covered in Minnesota through the individual health insurance market.

The current impasse in national health policy makes the notion of using federal funds to stimulate demonstration projects especially appealing. For example, it might make sense to test a tax credit program—one of the most prominent policy proposals at the federal level—within a state, using the state’s income tax system to administer the credits and financial transfers from the federal government to cover the cost. Similarly, states could experiment with an electronic insurance clearinghouse to simplify enrollment and maximize the inclusion of eligible beneficiaries, or pilot mechanisms that use state purchasing leverage to assure the participation of private plans, or open up public insurance programs to give families with low and modest incomes more seamless, stable coverage as they move in and out of employment.

#### **STATES AS LABORATORIES: EXTENDING DRUG COVERAGE TO SENIORS**

Twenty-eight states have mounted programs to help low-income seniors purchase medications. Although most programs are quite small and do not eliminate the need for a Medicare prescription drug benefit, they do offer insight into how seniors across the country are affected by patterns of retiree health coverage, managed care penetration, and the generosity of state Medicaid and pharmaceutical assistance programs.

Seniors who worked in the industrial sector of the North Central region of the country are more likely to have retiree health benefits, while seniors living in the West are more likely to be enrolled in managed care plans with prescription drug benefits. These cross-state experiences have important implications for the design of a national Medicare prescription drug benefit.

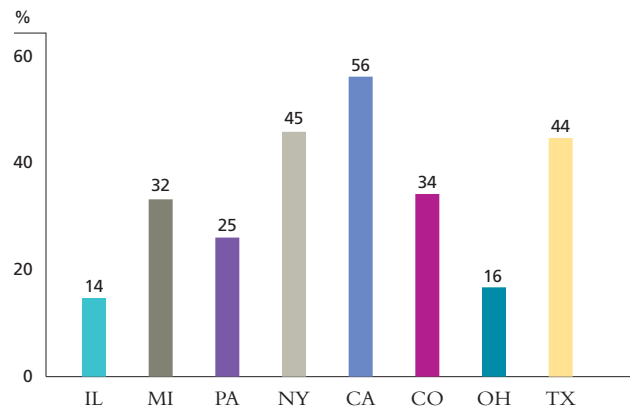
A Fund report by Kimberly Fox, Thomas Trail, and Stephen Crystal of Rutgers University Center for State Health Policy explains that New Jersey, New York, and Pennsylvania account for three-quarters of state appropriations for pharmaceutical assistance and half of all enrollment. Illinois and Vermont have received waivers to obtain federal Medicaid matching funds for a drug-only benefit for low-income seniors who are not otherwise eligible for Medicaid.

A 2001 survey of seniors in eight states, cosponsored by the Kaiser Family Foundation, The Commonwealth Fund, and the New England Medical Center, reveals that state programs, including Medicaid, still leave many seniors at risk. Among seniors with incomes below the federal poverty level (about \$8,590 for a single elderly person in 2001), fewer than half were covered by Medicaid in seven of the eight states.

Medicare is a national program, but the patchwork system of supplemental prescription drug coverage—through Medicaid, state pharmaceutical assistance programs, employer retiree health benefits, managed care plans, and individually purchased Medigap policies—means that the adequacy of protection depends largely on where seniors live. The Kaiser/Commonwealth/Tufts-New England Medical Center survey found that the share of low-income seniors lacking drug coverage ranges from 20 percent in New York and California to 38 percent in Michigan and Texas. Employer-sponsored retiree plans provide drug

**A recent survey of elderly Americans living below the poverty line found that less than half in most states receive drug coverage through the Medicaid program.**

**Percent of poor seniors with Medicaid drug benefits**



Kaiser/Commonwealth/Tufts-New England Medical Center, 2001 Survey of Seniors in Eight States.

coverage to approximately half of seniors in Michigan and Ohio, but to less than a third in California, Colorado, and Texas. Medicare managed care plans cover a large number of seniors in California (30 percent) and Colorado (24 percent) but fewer than 15 percent in the other six states in the survey. Most at risk of not having coverage are seniors in states like Texas, which have low rates of employer retiree coverage, few Medicare managed care plans, limited Medicaid coverage, and no state pharmaceutical assistance program.

As important as state efforts have been, even the best states are not filling the gap for low-income seniors. Twenty-two percent of seniors in the survey reported that they did not fill a prescription because it was too expensive or that they skipped doses of their medications to make them last longer. Among those without drug coverage, 35 percent of seniors and 42 percent of low-income seniors skipped doses or did not have prescriptions filled. Nearly one-third of seniors with diabetes who lack drug coverage skipped

doses or did not fill a prescription. Coverage is also important for preserving limited retirement savings: 42 percent of low-income seniors without drug coverage reported spending \$100 or more per month on medications, compared with 17 percent of seniors with drug coverage. Almost half of low-income seniors without drug coverage in Illinois, Ohio, and Texas reported paying high monthly out-of-pocket costs for prescription drugs, compared with one-third in California, Colorado, New York, and Pennsylvania.

Inadequate as it is, the protection available under current sources of drug coverage seems to be eroding. A Fund report by Marsha Gold and Lori Achman at Mathematica Policy Research presents evidence that managed care plans are raising patient cost-sharing for prescription drugs and setting more restrictive limits on benefits. In-depth case studies in seven cities by Geraldine Dallek, Brian Biles, and colleagues at George Washington University document the instability in Medicare managed care plan participation, withdrawal of physicians and other providers from participating plans, and the growing challenge of choosing among plans with very different restrictions on benefits.

Retiree coverage is also eroding. According to the 2001 Retiree Health and Prescription Drug Coverage Survey, jointly commissioned by the Kaiser Family Foundation, The Commonwealth Fund, and the Health Research and Educational Trust, the percentage of firms with 200 or more workers offering retiree health benefits fell from 41 percent to 34 percent between 1999 and 2001. Over half of firms reported that they are very or somewhat likely to increase retiree cost-sharing for prescription drugs through higher copayments or coinsurance.

State-level experiences underscore the urgency of federal action to incorporate a prescription drug

benefit in Medicare. Without coverage for medications, Medicare cannot assure access to modern medical care for its beneficiaries, and states cannot fill the gap. One important lesson is that coverage should occur automatically through Medicare: state programs that depend on seniors to learn about their eligibility or enroll separately will probably attract low participation and put many seniors who remain uncovered at risk.

#### **STATES AS GUARDIANS OF THE PUBLIC HEALTH: IMPROVING THE QUALITY OF CARE**

States have traditionally held responsibility for ensuring the public's health. States license physicians, hospitals, nursing homes, and other health care professionals and organizations. Increasingly, they require hospitals and other providers to report medical errors, and some are taking the lead in making information about quality of care publicly available. Yet quality of care varies considerably by location even within states, and information on quality at the level of the individual provider is at a very early stage. Understanding the reasons for area variations and identifying practices and policies that lead to improved quality are important objectives for future research.

Quality improvement organizations (QIOs) monitor the care provided to Medicare beneficiaries and are beginning to play an important role in quality improvement. Although QIOs are not formally linked to state government or mandated to examine health care quality overall, the information they generate about the Medicare program should focus greater attention on quality problems affecting all patients. The Fund is helping to convene experts from the federal Agency for Healthcare Research and Quality and the nonprofit National Committee for Quality Assurance to develop

reliable measures of physician quality. That work should raise awareness of variations in quality and spur improvement efforts.

Medicare quality scores on clinical performance also vary substantially by state. The top five states—New Hampshire, Vermont, Maine, Minnesota, and Massachusetts—earned an average score of 87 out of 100, compared with an average score of 60 for Arkansas, Georgia, Louisiana, Mississippi, and New Jersey, the bottom five states. Perhaps significantly, the New England states that dominate the list of top performers have a history of working together to compare care, feed back results to physicians and hospitals, and encourage adoption of best practices. Other possible explanations for state-level differences include training, staffing patterns, and the presence of information systems and processes to enhance communication and coordination.

The Fund helped call attention to trends and variations in quality of care with the publication in May 2002 of *Quality of Health Care in the United States: A Chartbook*, by Sheila Leatherman and Douglas McCarthy. Drawing on results from more than 150 published studies, the chartbook provides measures of the quality of health care with respect to effectiveness, patient safety, access and timeliness, patient-centeredness, and disparities. Most measures demonstrate modest improvement over time but still fall far short of optimal levels of quality.

The regional variations highlighted in the chartbook show that higher levels of performance are both necessary and feasible. In Iowa and North Carolina, for example, 83 percent of children ages 19–35 months have received all recommended doses of five key vaccines, whereas only 64 percent of Texas children are similarly immunized. Immunization levels have risen

over the past decade as a result of expanded public and private financing and special initiatives, but further improvement will probably require education and better monitoring and reminder systems.

Similar variations occur in the appropriate treatment of acute illnesses. The percentage of Medicare patients prescribed a beta-blocker when discharged from a hospital after a heart attack ranged from a low of 47 percent in Mississippi to a high of 93 percent in the District of Columbia and Massachusetts. Leatherman and McCarthy note that up to 18,000 deaths from heart attacks could be prevented each year if all eligible patients received beta-blockers.

One area that has been singled out for special attention is the management of diabetes, a disease that affects 16 million Americans. Leatherman and McCarthy found very significant variations in quality measures such as receipt of a glycosylated hemoglobin test in the last year, which ranged from 42 percent in Maine to 17 percent in Alabama. They further note the success of organized state and local efforts to improve the quality of diabetes care. In Arizona, for example, six managed care plans collaborated with the state's Medicare QIO to raise the share of patients with blood sugar under control from 40 percent to 62 percent in a single year.

Learning collaboratives are being used increasingly to improve the quality of care, whether by community health centers serving low-income populations, managed care plans, or other health care settings. To succeed, participating teams need access to tools and training in quality improvement techniques, technical



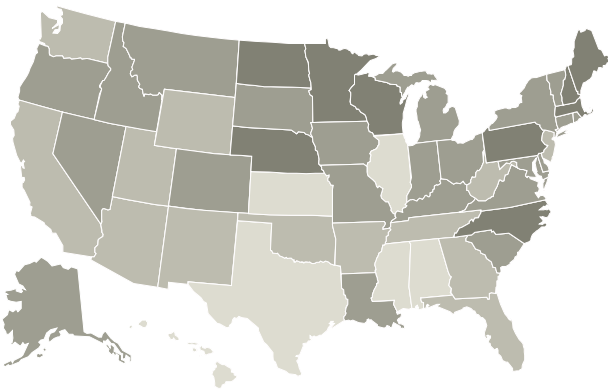
Sheila Leatherman

A new chartbook, coauthored by Leatherman, examines regional patterns in health care quality.

States' performance in managing acute or chronic conditions, such as heart attack or diabetes, can vary significantly. A new Fund chartbook details disparities in the quality of care patients receive by state and region.

Medicare heart attack patients prescribed a beta-blocker at hospital discharge when indicated\*

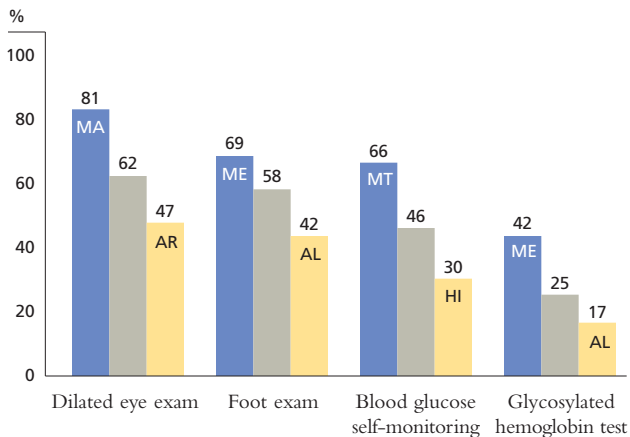
- 80% and over
- 70–79%
- 60–69%
- Under 60%



\*Ideal candidates are those without contraindications, for whom treatment would almost always be indicated based on clinical guidelines.

#### Diabetic adults who had procedure in the past year

- State with the highest rate
- U.S. median
- State with the lowest rate



Sheila Leatherman and Douglas McCarthy, *Quality of Health Care in the United States: A Chartbook*, The Commonwealth Fund, 2002. Data on beta-blocker use from S. F. Jencks et al., "Quality of Medical Care Delivered to Medicare Beneficiaries," *JAMA* 284:1670; and on diabetes management from CDC, "Levels of Diabetes-Related Preventive Care Practices-US 1997-99," 2000.

assistance in implementing those techniques, and feedback on their performance. North Carolina's Medicaid program also provides a financial incentive to participating hospitals and to physicians who agree to improve performance on indicators such as emergency room visits by pediatric asthma patients.

Regular reporting of data can spur improvement efforts. The National Committee for Quality Assurance (NCQA), aided by a loan from the Fund, began collecting and reporting on quality indicators for managed care plans in 1996. According to NCQA's annual *The State of Health Care Quality 2002* report, quality rankings among the eight U.S. Census regions exhibit the same general pattern found in the analysis of Medicare fee-for-service care. In 2002, the New England region (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) ranked first on clinical quality measures such as childhood immunizations, comprehensive diabetes care, controlling high blood pressure, and timeliness of prenatal care. By contrast, the South Central region (Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas) ranked lowest on clinical measures.

Such variations should raise questions about why they are occurring, why the patterns are consistent regardless of measure or data source, and what can be done to share best practices more broadly. NCQA stresses the importance of managed care plan accreditation, noting that 76 percent of plans are accredited in the New England region compared with 39 percent in the South Central region.

States have begun to take a more proactive role with regard to medical errors. In an eight-state survey supported by the Fund in collaboration with the Robert Wood Johnson Foundation and the Agency



for Healthcare Research and Quality, the National Academy of State Health Policy (NASHP) found that mandatory hospital reporting programs vary markedly by state in how they operate, how they define adverse medical events, and what information hospitals disclose. To help states become familiar with the practices and pitfalls of other states, NASHP has prepared a comprehensive workbook on mandatory adverse event reporting systems. It has also convened a workgroup of states to advance the use of such systems: to date, 20 states require error reporting, up from 15 at the beginning of the effort.

#### **STATES AS INNOVATORS: TRANSLATING FOR PATIENTS WITH LIMITED ENGLISH SKILLS**

States are often forerunners of trends that eventually affect the nation as a whole. In the 1990s, a rapid increase in immigration was experienced initially in “gateway” cities such as Los Angeles, Miami, and New York before reaching other parts of the country as immigrants dispersed in search of jobs and economic opportunity. Today, the United States has 28 million foreign-born residents, and more than 44 million Americans speak a language other than English at home. In all, over 300 different languages are spoken in the United States.

Some states and localities are responding creatively to the growing need for language translation services in the health care sector. To learn from innovations around the country, the Fund commissioned Mara Youdelman and Jane Perkins of the National Health Law Program to prepare a field report spotlighting 14 projects. The report highlights Washington’s Language Interpreter Services and Translation program, which provides certification testing for interpreters in the state’s seven most prevalent foreign languages and a system for becoming “qualified” in 88 languages plus major dialects. Minnesota has added a billing code for

interpreter services to its Medicaid and CHIP programs. State legislation in Massachusetts requires competent interpreter services in all emergency rooms, and the state department of public health website includes a best practices manual for hospital-based interpreter services, a code of medical interpreter ethics, and other information resources. Youdelman and Perkins also showcase model practices by managed care plans, hospitals, and other organizations, such as a remote simultaneous medical interpreting program, similar to that used by the United Nations, at New York City’s Gouverneur Hospital. With support from the Fund, that program is now being evaluated by the Center for Immigrant Health of New York University School of Medicine.

#### **STATES AS PURCHASERS: LEVERAGING QUALITY FOR LOW-INCOME PATIENTS**

States also function as purchasers of care for low-income populations. Although many states have emphasized insurance expansions over the past few years, some are now learning to use their leverage as purchasers to promote quality improvement.

The Fund is supporting work by the American Public Human Services Association to analyze the quality of Medicaid managed care plans and share clinical performance data on 167 plans with state Medicaid directors. Combined, those plans serve 7 million Medicaid beneficiaries, or 56 percent of all Medicaid managed care enrollees. Measured against commercial plans serving enrollees in employer-based insurance, Medicaid plans offer comparable quality in a few areas, such as well-child physician visits, but fall short in others, such as first-trimester prenatal care, cervical cancer screening, and eye exams for diabetics. Plans whose members receive care in community health centers perform significantly better than Medicaid



Marian Earls, M.D.

Earls's work in North Carolina could influence child development services around the country.

plans as a whole on most benchmarked measures. As an outgrowth of this work, NCQA included Medicaid plan HEDIS data in its recent *The State of Health Care Quality 2002* report.

The quality of care in managed care plans is particularly important for minority patients, who are disproportionately enrolled in such plans. David Nerenz and colleagues at Michigan State University, Lovelace Clinic Foundation in Albuquerque, the University of Texas Health Science Center, and the Henry Ford Health System in Detroit worked with eight health plans to develop a report card on quality of care for minority patients. Their Commonwealth Fund field report demonstrated that it is possible to collect information by race and ethnicity, chart the quality of care delivered to specific groups, and uncover significant disparities. In one health plan, for example, only 20 percent of African American children with asthma received appropriate follow-up care after an acute episode, compared with 40 percent of white children—although both rates are low and indicate need for improvement.

#### **STATES AS INVESTORS: SUPPORTING THE HEALTHY DEVELOPMENT OF CHILDREN**

States have primary responsibility for educating children, and the nation's governors are therefore acutely aware of the cost to society of children with behavioral problems or developmental delays. The Fund has responded through its Assuring Better Child Health and Development (ABCD) program by helping states enhance the capacity of the health care sector to conduct developmental screening of young children, provide anticipatory guidance and counseling to parents, refer children for appropriate intervention,

and structure Medicaid and CHIP programs to assure high-quality services.

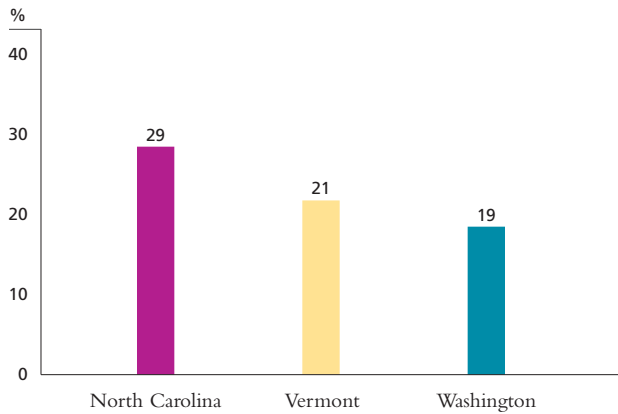
Focus groups and surveys of Medicaid parents in ABCD states have been instructive. A 2001 survey by the Foundation for Accountability of 1,903 parents of children ages 3–48 months enrolled in Medicaid in North Carolina, Vermont, and Washington found that health care providers miss significant opportunities to identify children in need of developmental services and to assist parents in nurturing the healthy growth of their young children. Nearly one young child in five is at significant risk for developmental, behavioral, or social delays, with rates ranging from 19 percent in Washington to 29 percent in North Carolina. Particularly troubling is the fact that, according to parents, less than two-thirds of children at high or moderate risk for delay received follow-up services.

The ABCD program has tested ways to improve screening of young children, detect maternal depression or other family risk factors, and guarantee that children and parents receive services that are known to be effective in nurturing healthy growth and development. In North Carolina, for example, the Guilford Child Health Clinic, a large pediatric practice serving low-income children, developed a model for integrating “best practice” developmental services into health care delivery through screening at well-baby visits, referrals and service coordination, and educational materials and resources for parents and clinicians. In one simple but effective innovation, the clinic asks parents to fill out a questionnaire on each child's development during routine well-baby visits, thus helping clinicians focus on parents' specific concerns and recognize developmental issues that warrant referral to the state's early intervention program.

The National Academy of State Health Policy, which manages the ABCD program, has also compiled

States have an incentive to invest in early intervention to promote the healthy growth of young children. Roughly one-fifth of low-income children are at risk for developmental, behavioral, and social delays.

Low-income children ages 3–48 months at high or moderate risk for delays



Foundation for Accountability (FACCT), Promoting Healthy Development-PLUS Study of Medicaid Families in Three States, 2001.

information on promising practices for primary care providers, localities, and states and shared its findings with state and federal policy officials. NASHP notes that states are using multiple strategies to improve accountability, create comprehensive and coordinated systems of care for all children, build strong connections across programs serving low-income families, strengthen professional education and licensure systems, and create public awareness and education campaigns.

#### STATES AS REGULATORS: RAISING NURSING HOME QUALITY

States have historically played an important role in assuring the quality of nursing home care. With the Nursing Home Reform Act of 1987, the federal government moved to establish standards of care, specify patient rights, and set limits on the use of physical restraints and psychotropic drugs. More recently, the federal government has required submission of data

on standard measures of quality of care. States inspect nursing homes annually under federal contract to ensure compliance.

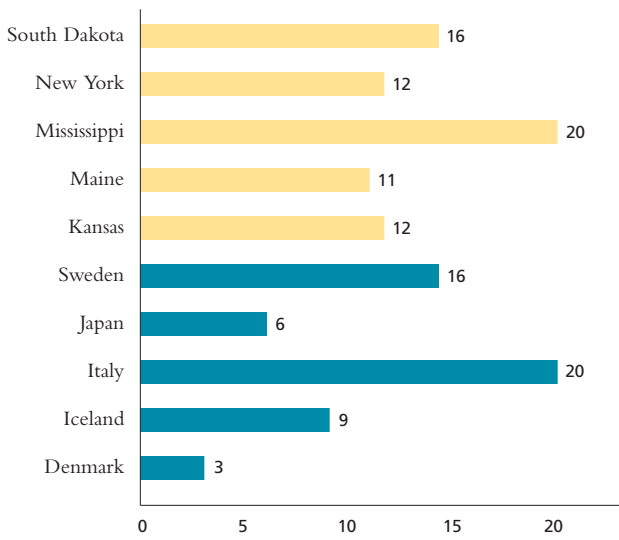
In 1994, spurred by the growth of quality measurement and a desire to stand out in an increasingly competitive market, 11 freestanding, not-for-profit nursing homes in eastern Wisconsin joined together to create an alliance known as Wellspring Innovative Solutions. They sought to make their nursing homes better places to live by improving clinical care and better places to work by giving employees the skills and authority they needed to do their jobs well, improve performance, and work toward common goals.

The Wellspring model includes consultation by a geriatric nurse practitioner, who trains teams of staff members in seven domains of care. The homes also share comparative quality data on resident outcomes—a practice that prompts them to learn from one another and adopt good practices that emanate from the ideas of frontline staff. A Fund-supported evaluation concluded that this collaborative approach has successfully reduced staff turnover and improved performance on state inspections without increasing costs. The model is being tested in other settings in Wisconsin and Illinois, and the evaluation findings are being disseminated to federal and state policy officials. Wellspring's success could eventually help shift the emphasis in quality improvement away from state inspections and sanctions and toward more innovative models.

Cross-state and cross-national learning about nursing home care has also been facilitated by quality indicator data. Comparing the use of physical restraints and psychotropic drugs in five states and in Denmark, Iceland, Italy, Japan, and Sweden, Harkness Fellow Carmel Hughes and colleagues in each country concluded that federal legislation in the United States

Data on the use of physical restraints in nursing homes suggest that federal guidelines are being applied quite differently by states—but also that techniques used in other countries could have additional, positive effects.

Percent of nursing home residents controlled by physical restraints



Carmel M. Hughes et al., "The Impact of Legislation on Psychotropic Drug Use in Nursing Homes: A Cross National Perspective," *Journal of the American Geriatrics Society* 48, 8 (2000): 931–7.

has reduced the use of physical and chemical restraints, but that the changes have not necessarily translated into better outcomes for residents. Physical restraint use was lower in three of the five states than in Italy or Sweden, but Denmark achieved the lowest rate—3 percent—using techniques such as behavior management. Based on another cross-national analysis, Harkness fellow Kieran Walshe has argued for new strategies to improve nursing home quality that are less dependent on government regulation.

#### CROSS-NATIONAL COLLABORATION: AN OPPORTUNITY FOR LEARNING

Learning from cross-national experiences in improving health care is a relatively new development. Despite limitations in data and methods, the World Health Organization has taken the lead in comparing national

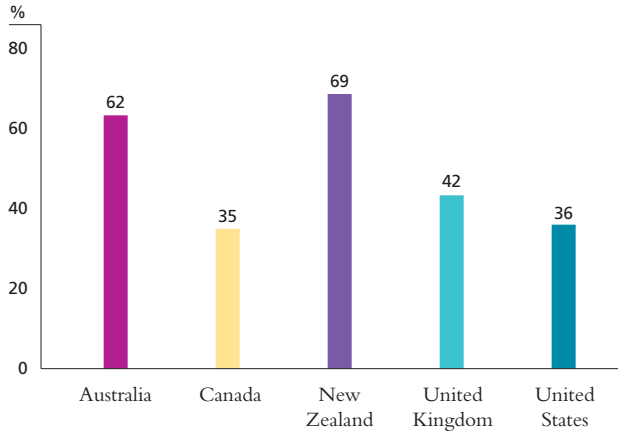
health system performance and raised the right question: How can countries use their health care resources to do a better job of improving the health of all their people? Generating comparative data on health system indicators such as quality, accessibility, responsiveness to patients, health outcomes, equity, and cost can help countries assess their performance and guide reform.

Since 1998, the Fund has supported surveys in Australia, Canada, New Zealand, the United Kingdom, and the United States that gather the views of patients regarding health care access, quality, and cost. The survey data are frequently cited in government reports and research analyses, while also serving as a starting point for what has become a lively annual symposium attended by health ministers from the five countries and other national leaders. Annual conferences on quality improvement in the United States and the United Kingdom have led to a formal collaboration between the two countries to share information and strategies, focusing particularly on medical errors, information systems, and quality reporting.

Public opinion about a health system is often related to personal experiences in obtaining care. The Commonwealth Fund 2001 International Health Policy Survey found that, among the five nations, the United States has the poorest record on cost-related barriers to care. A bright spot for the United States is its short hospital waiting times for elective or non-emergency surgery. The survey uncovered for the first time that patients in the United States and Canada have comparatively more difficulty getting same-day physician appointments. Interestingly, patients in New Zealand, who have the easiest access to same-day care, were far more likely to give their physicians excellent or very good ratings on six measures of responsiveness (72 percent) than were American patients (61 percent).

Patients in New Zealand are almost twice as likely as Canadians or Americans to get same-day appointments when they need them. Not surprisingly, New Zealanders also tend to give their physicians high ratings for responsiveness.

Patients receiving same-day appointments when sick



The Commonwealth Fund 2001 International Health Policy Survey.

Many physicians argue that responsiveness is an impossible standard, given the high demand for their services. The Institute for Healthcare Improvement in Boston has engineered office design, however, to make same-day appointments available to patients, and practices in the United States and other countries have adopted the techniques with remarkable results. In New York City, the Fund helped the Primary Care Development Corporation implement the program successfully in primary care clinics serving low-income communities.

#### THE FUND'S COMMITMENT TO LEARNING

As detailed in this *Annual Report*, The Commonwealth Fund is working on a number of fronts to foster cross-area learning from health care experiences and policies. The Task Force on the Future of Health Insurance is identifying workable solutions states are using to expand and improve health insurance coverage. The Health Care

in New York City Program is showing how innovation at the state level can have a powerful effect on a major city, reducing urban problems and setting an example for national action. The Program on Medicare's Future is analyzing policy options to improve prescription drug coverage for the nation's seniors and disabled. The Health Care Quality Improvement Program is developing better systems for measuring and reporting on quality of care, while also testing incentives to accelerate quality improvement. The Program on Quality of Care for Underserved Populations seeks to make health care for minority and low-income populations safer, more effective, and more responsive to patients' needs. The Child Development and Preventive Care Program is helping to assure that all children get a healthy start in life and the opportunity to develop into productive adults. The Picker/Commonwealth Fund Program on Quality of Care for Frail Elders fosters best practices for improving care and retaining a qualified workforce in nursing homes. The International Program on Health Policy and Practice stimulates international exchange and collaboration.

In all its work, the Fund builds on a long-standing tradition of scientific inquiry, commitment to social progress, partnership with others who share common concerns, effective use of communications, and mobilizing talented people. Increasingly, it strives to forge collaborations among people in a position to improve health care access and quality, whether leaders in the health care sector or policy leaders at the state, national, and international levels. The conviction that all can gain from sharing knowledge guides the Fund's work as it pursues a "2020 vision for American health care."