Long-term care providers that fulfill the needs and preferences of the elderly and disabled should be one of the targets for the U.S. health care system. Efforts to transform the institutional culture of nursing homes into one focused on providing "resident-centered care" have attracted wide attention. At the Kansas-based Meadowlark Hills long-term care facility, CEO Steve Shields, a leading proponent of resident-centered care, is working with the Fund to develop a set of tools for other nursing home operators that will enable them to embark on the transformative journey.

Photographer: Eli Reichman/Redux Plus

THE COMMONWEALTH FUND

2005 Annual Report

Working toward the goal of a high performance health care system for all Americans, the Fund builds on its long tradition of scientific inquiry, a commitment to social progress, partnership with others who share common concerns, and the innovative use of communications to disseminate its work. The 2005 Annual Report offers highlights of the Fund's activities in the past year

- **Aiming High: Targets for the U.S. Health System.** Commonwealth Fund president Karen Davis discusses the 10 priorities of the Fund's recently launched Commission on a High Performance Health System.

- **The Fund’s Mission, Goals, and Strategy**
- **Commission on a High Performance Health System**
- **Program Highlights, 2005**
  - The Future of Health Insurance
  - State Innovations
  - Medicare’s Future
  - Health Care Quality Improvement and Efficiency
  - Patient-Centered Primary Care Initiative
  - Special Populations
  - International Program in Health Policy and Practice
- **The Commonwealth Fund’s Approach to Performance Measurement.** Fund executive vice president and chief operating officer John E. Craig, Jr., outlines the foundation’s performance assessment system and a compendium of lessons about how it carries out its work.
- **Treasurer’s Report** and **Financial Statements**
- **The Fund's Founders and Benefactors**
- **Directors and Staff**
- **Grants Approved, 2004–2005**

Karen Davis
President

President's Message
2005 Annual Report

Aiming High: Targets for the U.S. Health System

Ensuring properly coordinated care for patients treated by multiple health care providers in various settings is one of the priority areas identified by The Commonwealth Fund's Commission on a High Performance Health System. Under a grant from the Fund, researchers at the University of Colorado Health Sciences Center are testing the Care Transitions Measure, a new patient survey designed to pinpoint care coordination problems that occur when elderly patients are transferred from one health care setting to another. In the photo, a patient at St. Joseph's Hospital in Bellingham, Wash., receives guidance in filling out the questionnaire.

Photographer: Peter Yates/Redux Plus

Foundations, historically, have responded to voids in public policy by supporting commissions to investigate the state of affairs and chart a course for change. The Flexner Commission, sponsored by the Carnegie Foundation for the Advancement of Teaching, transformed the quality of medical education with its 1910 report. The Committee on the Cost of Medical Care, sponsored by the Milbank Memorial Fund, the Rockefeller Foundation, and the Carnegie Corporation, issued a report in 1932 that was instrumental in the formation of Blue Cross and the financing of health services through prepayment. The Commission on Hospital Care, funded by The Commonwealth Fund, the W. K. Kellogg Foundation, and the National Foundation on Infantile Paralysis in 1942, was pivotal to the enactment of the 1946 Hill-Burton Act, which helped build and modernize the nation's system of hospitals.[1]

Feeling that the time is again ripe for foundation leadership, The Commonwealth Fund has established the Commission on a High Performance Health System. The Commission's goal is to move the nation toward a health care system that provides better access, higher quality, and greater efficiency, with particular focus on the most vulnerable members of our society. The specific objectives of the Commission are to define the characteristics of a high performance health system; identify and analyze promising approaches being used across the country and around the world; set realistic benchmarks and targets for tracking change over time; and recommend immediate and long-term practical steps and policy measures. The coming year will be devoted to a fact-finding process and the release of a national scorecard on the performance of the U.S. health system.

TEN PRIORITY AREAS

The Commission has just begun its work, yet it has already identified ten priorities for its own deliberations—and, ultimately, for a health system aligned to achieve the goal of high performance. Survey results, policy research, and the promising approaches of innovators show that these are areas of great concern, where positive change could make a real difference to patients, payers, and the future of the system itself.

In short, a high performance health system would be organized around ten core values:

1. Long, healthy, and productive lives.
2. The right care.
3. Coordinated care over time.
4. Safe care.
5. Patient-centered care.
6. Efficient, high-value care.
7. Universal participation.
8. Affordable care.
9. Equitable care.
10. Knowledge and capacity to improve performance.

The following sections explain why each area is important and action is urgently needed.

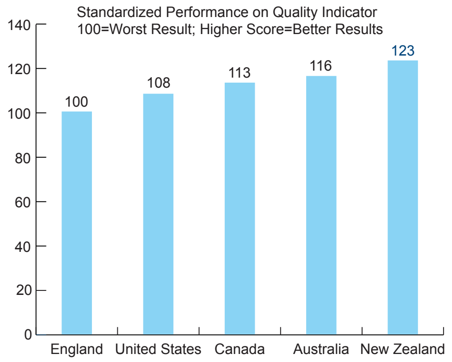
1. Long, Healthy, and Productive Lives

At the most basic level, what Americans want from their health care system is "life, liberty, and the pursuit of happiness." They want to benefit from the best of modern medicine, free from worry about medical bills and assured that they and their loved ones will have the opportunity to be healthy and productive.

The reality is starkly different. In the United States, life expectancy at birth for men is 74.5 years, a year less than the average across all industrialized nations and four years less than the average in the best-performing country.[2] Women in the United States, with a life expectancy of 79.9 years at birth, live longer than men yet similarly fall one year behind the average for women in industrialized nations and five years behind the best-performing country. These differences cannot be attributed solely to variations outside the health system, such as our relatively high poverty rate. A Commonwealth Fund international working group on quality indicators finds that the United States falls behind other countries on the quality of health care delivered in a number of areas.[3] New Zealand has much better five-year survival rates for colorectal cancer, for example, and Canada has better five-year survival rates after kidney transplantation.

In certain important, measurable areas—such as the five-year survival rate of colorectal cancer patients—the U.S. ranks below some other industrialized countries.

Colorectal cancer five-year relative survival rate



Source: P. S. Hussey, G. F. Anderson, R. Osborn et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs,* May/June 2004 23(3):89–99.

High performance health care is essential not only to the health of Americans but also to their economic productivity. A report by the National Committee for Quality Assurance found that improving the performance of all health plans to the level of the best-performing plans would reduce the number of deaths by between 39,280 and 83,600 each year, save between $2.8 billion and $4.2 billion in medical care costs, avoid 83 million sick days, and increase productivity by $13.5 billion.[4]

2. The Right Care

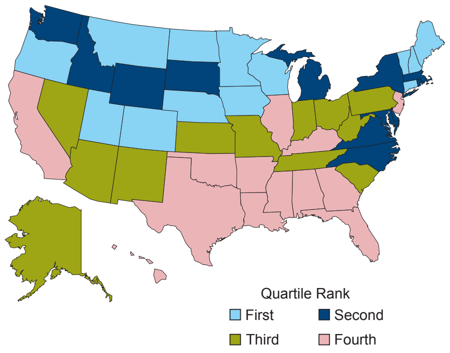
Poorer health outcomes can be attributed in part to the failure of our health care system to ensure that Americans receive the right care. A RAND Corporation study documented that recommended care is delivered only 55 percent of the time.[5] The rate varies across health conditions, ranging from 76 percent for treatment of breast cancer to 23 percent for hip fractures. But even the best rate is not good enough: it is not acceptable that one-fourth of women with breast cancer fail to get a chance at a healthy outcome because the care rendered does not meet professional standards. A study cofunded by The Commonwealth Fund at Mount Sinai Medical School found that, among the 14 percent of women diagnosed with breast cancer who received less-than-optimal treatment for their cancer at four northern Manhattan hospitals, nearly one-third of the failures could be traced to the lack of an effective mechanism for following up with the women and ensuring they receive needed care.

This uneven application of the best that modern medicine has to offer is troubling, but it is particularly troubling that those without health insurance are much less likely to receive high-quality care. The Institute of Medicine estimates that 18,000 uninsured Americans between the ages of 25 and 64 die each year simply because they are uninsured and therefore get lower-quality care or fail to receive preventive care that might have detected conditions at an earlier stage.[6]

Even for people with insurance coverage, quality of care is uneven. One analysis of Medicare medical records found wide variations across states on 22 quality indicators.[7] More must be done to understand why states like Maine and Minnesota consistently rank in the top tier while states like California, Florida, and Texas are at the bottom. Differences exist even in the best states. A study by the Maine Quality

All Medicare beneficiaries have health coverage, yet the quality of care they receive differs significantly from state to state.

Performance on Medicare quality indicators, 2000–2001



Source: S. F. Jencks, E. D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association,* Jan. 15, 2003 289(3):305–12.

Note: State ranking based on 22 Medicare performance measures.

Forum found that the percentage of hospitalizations that could have been prevented with better primary care varies twofold, from 15 percent of all hospital patients in some regions of the state to more than 30 percent in others.[8]

3. Coordinated Care over Time

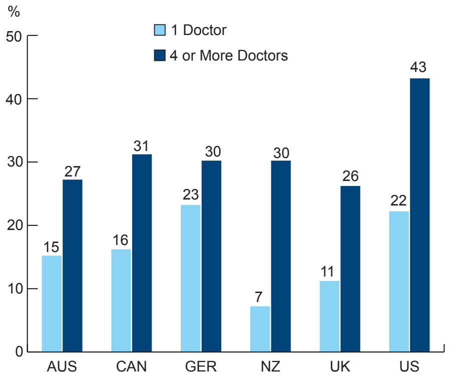
Very few things are more debilitating or discouraging to seriously ill patients and their families than navigating the complex U.S. health care system. Going from doctor to doctor, seeking out specialized services from surgery to rehabilitative care, patients often feel alone, confused, and frustrated. Commonwealth Fund surveys have found that Americans are more likely than their counterparts in other countries to report problems with poor coordination of care, including medical records that are not available when a patient shows up for an appointment, doctors who order duplicate tests, and a host of other shortcomings.[9] About one-fourth of Americans report such problems—the percentage rises precipitously with the number of doctors involved in a patient's care.

A systematic approach to coordinating care can make a difference. The Commonwealth Fund is supporting an evaluation of a project that uses advanced practice nurses to follow elderly congestive heart failure patients after hospital discharge. This simple intervention reduces the percentage of patients who are rehospitalized and cuts the total cost of care by over 35 percent.[10] The Medicare program has selected this promising model as one of eight to be included in a pilot project on improving chronic care.

There are also considerable opportunities to improve the coordination of acute and long-term care. A Fund-supported study is developing new ways to pay nursing homes to reward those that prevent hospitalization through measures such as influenza vaccinations or prompt medical attention to certain common conditions. Today, hospitalization rates among New

Problems with coordination of care mean poorer quality—not to mention frustration and lost time for patients and doctors. Patients who need to see four or more doctors are especially likely to experience coordination problems.

Coordination problems* by number of doctors



Source: C. Schoen et al., "Taking the Pulse: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005). Based on the 2005 Commonwealth Fund International Health Policy Survey.

*Either records/results did not reach doctor's office in time for appointment or doctors ordered a duplicate medical test

York nursing homes vary by a factor of four, perhaps in part because homes receive higher compensation when a resident is hospitalized.[11] Coordinating payments under Medicaid, which covers nursing home care, and Medicare, which covers hospital care, could help bring financial rewards into alignment with desired performance.

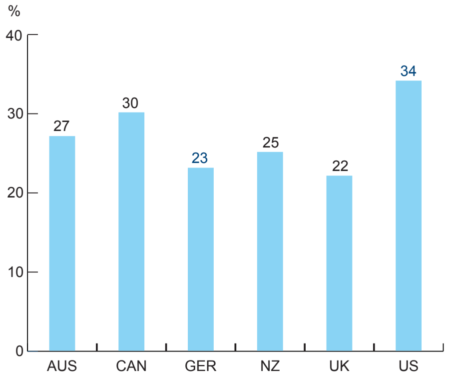
4. Safe Care

Five years after the publication of the landmark Institute of Medicine report *To Err Is Human*, funded in part by The Commonwealth Fund, the U.S. health system still gets a C+ on patient safety, according to patient safety expert Robert Wachter, M.D.[12] Some strides have been made, but many possible and desirable changes remain unimplemented. For example, one-third of Americans report they have directly experienced a medical error in the last two years—a rate in excess of those reported in industrialized nations such as Germany and the United Kingdom.[13]

However, some promising actions are being taken. The 100,000 Lives Campaign, spearheaded by the Institute for Healthcare Improvement, has engaged more than 2,900 hospitals in reducing preventable adverse events—such as acquiring ventilator-associated pneumonia—that can cost hospital patients their lives.[14] The Joint Commission on Accreditation of Healthcare Organizations requires that hospitals have a policy of notifying patients of preventable adverse events, and some state health agencies require reporting medical errors. Insurers could reinforce these efforts by declining to pay for hospitalizations in which patients experience one of 27 well-defined "never events"—serious, largely preventable adverse events that should never happen in American hospitals, according to the National Quality Forum.[15] In January 2005, HealthPartners of Minnesota began a policy of withholding payments to hospitals for such medical errors.

Errors by physicians or hospitals, getting the wrong medication or dose, or failing to be notified about lab results (or receiving the wrong results) are disturbingly common problems, especially in the United States.

Any medical mistake, medication error, or lab error* in the past two years



Source: C. Schoen et al., "Taking the Pulse: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005). Based on the 2005 Commonwealth Fund International Health Policy Survey.

*Among those with blood test, x-rays, or other medical tests in the past two years

The state of Minnesota, meanwhile, has enacted a law requiring hospitals to disclose when a “never event” occurs.

5. Patient-Centered Care

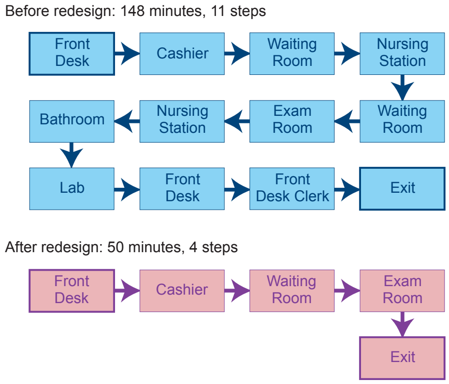
The health system too often reflects the preferences of physicians and other health care personnel rather than ensuring that patients have good experiences with care. Some leading organizations have vastly improved the services they provide to patients by mapping out the patient’s journey through the health system and figuring out ways to make that journey quicker and more satisfying. With Fund support, for example, the Primary Care Development Corporation has worked with clinics in low-income communities to redesign office visits. One result has been a reduction in the average time a patient spends during a visit—from 148 minutes and 11 steps to 50 minutes and four steps.[16]

Patient-centered care—an approach that encourages providers to view all aspects of care from the patient’s perspective—fosters better quality as well as simple efficiency. The two are often related. For example, about half of patients report shortcomings in communicating with their physicians: they leave the doctor’s office with unanswered questions, do not perceive that the physician always listens carefully, or do not understand the explanations the doctor offers.[17] In many cases, the result is failure to adhere to recommended treatments and an increased risk of emergency care.

Increasingly, patients want to be active, engaged partners in their care. Such partnerships are essential if patients are to manage chronic conditions effectively and adopt healthier lifestyles. Patients want information about their health conditions and access to their medical records. Giving patients with chronic health conditions self-care plans that work for them and supporting them in changing unhealthy behaviors are highly effective in controlling

Working with clinics that serve low-income patients, the Primary Care Development Corporation mapped a typical patient visit and simplified the process.

Before redesign: 148 minutes, 11 steps



Source: P. Gordon and M. Chin, *Achieving a New Standard in Primary Care for Low-Income Populations: Case Study 1: Redesigning the Patient Visit* (New York: The Commonwealth Fund, Aug. 2004).

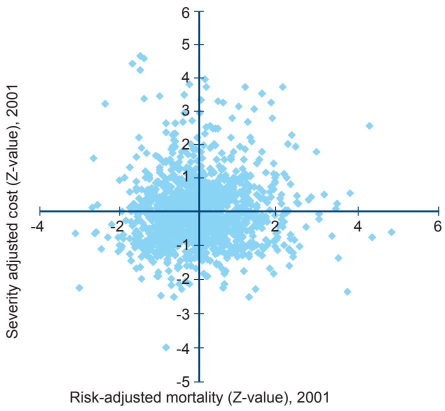
conditions from diabetes to congestive heart failure.[18] Periodically reviewing patients' medication lists and improving communication between patients and physicians can reduce medication errors, improve outcomes, and lower costs.

6. Efficient, High-Value Care

The United States spends far more of its economic resources on health care than other countries do. Yet, higher spending doesn't mean that we receive more or better care. On a per capita basis, fewer Americans are hospitalized than their counterparts in other countries, with about the same number of physicians. The real difference is that we pay more for health care. For example, other major industrialized countries pay less than half what we pay for prescription drugs.[19] They also invest more in primary care and less in specialist care, perhaps gaining more value-per-dollar spent than the United States.

Hospital costs and patient outcomes vary widely, and there is little relationship between the two factors.

Variation in hospital mortality and cost per patient



Source: H. J. Jiang, Center for Delivery, Organization and Markets, Agency for Healthcare Research and Quality.

Note: Data from 10 Healthcare Cost and Utilization Project states. Mortality is a weighted composite of 10 risk-adjusted inpatient mortality rates. Cost has been adjusted for wage index, case mix, and severity of illness.

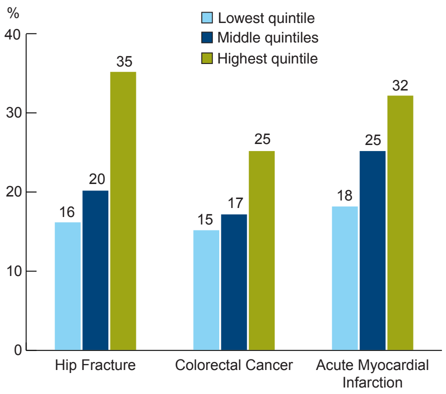
Particularly troubling are new studies finding wide variations in the cost and quality of U.S. health care. A Commonwealth Fund-supported study found, for example, that the quality of hospital care varies widely from hospital to hospital and from city to city.[20] Others studies are documenting that there is no clear relationship between health outcomes and costs, for example between hospital mortality rates and the cost of hospital care.

Much of the variation seems to be a consequence of care that is not standardized. Some of the nation's finest hospitals deploy twice as many physicians as other hospitals, with no clear differences in patient outcomes.[21] How much care costs depends very much on where a patient goes for care—or, in some cases, where an ambulance takes a patient in a serious emergency.

In many ways, we get what we pay for. Our fee-for-service payment system rewards the provision of more specialized services, not good outcomes. It pays for defective services—willingly paying twice when a foreign object is left in a patient after surgery or a misplaced imaging test has to be repeated. It gives hospitals no financial incentive to reduce complications or prevent rehospitalizations by making sure patients understand how to take their medications and manage their conditions at home. It does not reward nursing homes that prevent pneumonia or flu by making sure all residents are immunized. It fails to encourage investment in primary care that avoids preventable hospitalizations. It does not pay for devices that help asthmatic children monitor their peak flow rate and report early symptoms of trouble to their pediatricians, and it does not reward screening young children for developmental delays or guiding parents in helping their children grow up healthy and ready to learn in school. If we want different results, we must reward the results we want to achieve.

In some hospitals, it is very common for hip fracture patients to see more than 10 different doctors; in others, the likelihood is much less. The lesson here is that our system lacks sensible, common standards.

Average percentage of patients seeing 10+ different physicians in first year of care within academic medical center hospitals



Source: E. S. Fisher et al., "Variations in the Longitudinal Efficiency of Academic Medical Centers," *Health Affairs* Web Exclusive, October 7, 2004.

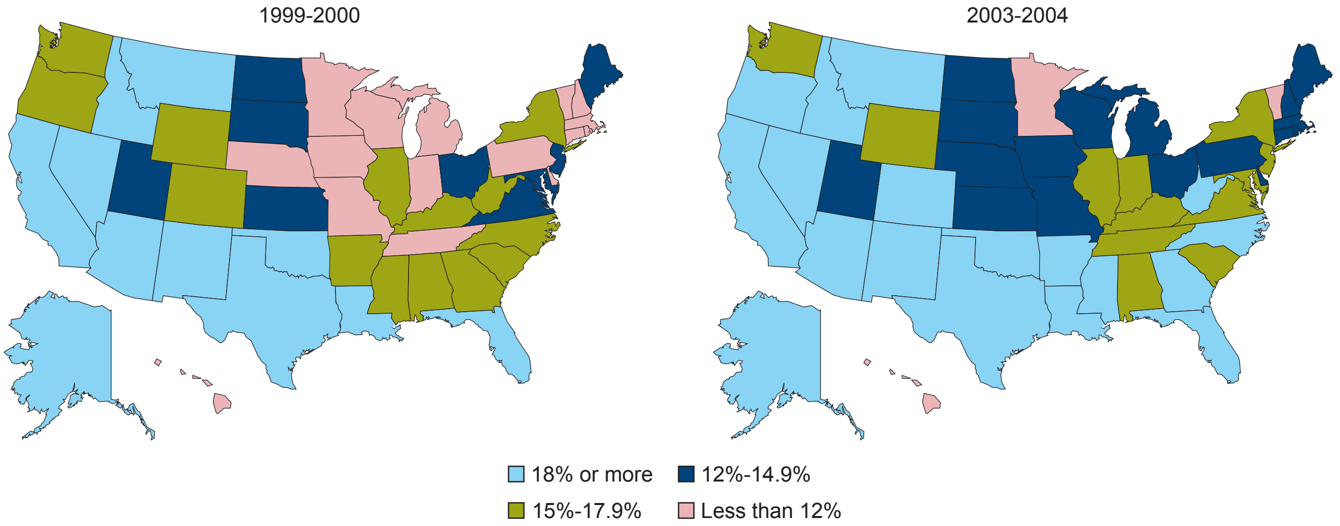
Note: Quintiles of practice intensity ("treatment groups") corresponded closely to regional differences in price and to illness-adjusted Medicare spending.

7. Universal Participation

Despite spending more on health care than any other nation, the United States is the only industrialized nation without universal health insurance coverage. The number of uninsured Americans has increased steadily over the last five years, from 40 million in 2000 to 46 million in 2004. [22] In the absence of federal leadership, some states have responded by adopting programs to expand health insurance coverage. The state of Maine, for example, recently enacted Dirigo Health Care, which enables small businesses to purchase coverage, with workers paying their share of premiums on a sliding-scale basis.[23] The Commonwealth Fund provided funding for technical assistance to design and launch the program, which bears careful monitoring as a possible model for other states and the nation.

With the number of uninsured Americans continuing to grow, some states have taken action to expand health insurance coverage.

Percent of non-elderly population uninsured by state



Two-year averages 1999–2000 and 2003–2004 from the Census Bureau's March 2000, 2001 and 2004, 2005 Current Population Surveys. Estimates provided by the Employee Benefits Research Institute.

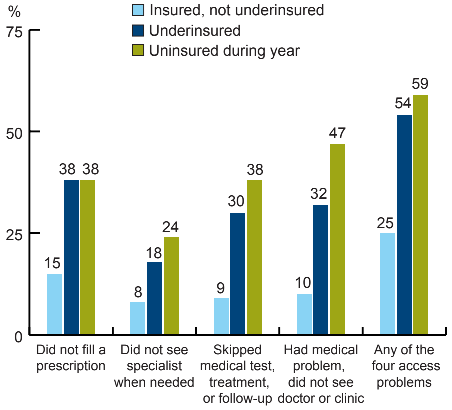
Data from 2003 show that, in addition to the 46 million uninsured adults, another 16 million U.S. adults were *under*insured—meaning their insurance did not protect them adequately against catastrophic health care expenses.[24] An estimated 35 percent of people ages 19 to 64 had either no insurance, sporadic coverage, or insurance coverage that exposed them to high health care costs and increased the chances they would go without needed medical care.

Recent increases in deductibles—the amount insured individuals must pay before their health benefits begin—will likely place growing numbers of insured patients and their families at risk.[25] Employers are beginning to offer "high-deductible health plans" with minimum deductibles of $1,000 for individuals or $2,000 for families, which qualify for tax-sheltered health savings accounts. These plans are relatively new, but research over the last three decades suggests that high out-of-pocket costs lead to underuse of essential care, failure to fill prescriptions necessary to control chronic conditions, and increased emergency room use and hospitalization.[26]

Instability of health insurance also contributes to another important difference between the United States and other industrialized nations: we are less likely to have lasting relationships with our doctors. Only 37 percent of American adults report that they have been with the same physician for five years or more, compared with more than half of adults in other countries.[27] This lack of continuity has implications for communication, adherence to recommended care, and access to preventive, primary, and specialized care.

Underinsured adults are almost as likely as adults without health insurance to report problems with access to care.

Adults ages 19-64 reporting access problems due to cost, by insurance status



Source: C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005.

8. Affordable Care

The high costs of health care and inadequate health insurance coverage are undermining the financial security of millions of Americans. Two of five adults—an estimated 77 million people age 19 or older—struggle with medical bills, have recent or accrued medical debt, or both.[28] Medical bills or accrued medical debt are problems for more than half of adults with incomes below $35,000 per year and for 62 percent of low-income adults who lack health insurance.

Even those who have health insurance are not immune to financial troubles: three-fifths of working-age people who reported problems were insured at the time their medical bill or debt problem occurred. The trend toward higher deductibles in employer plans may be undercutting one of the major purposes of health insurance coverage—protecting against financial catastrophe. High out-of-pocket costs are a particularly difficult problem for lower-income families. Twenty-nine percent of adults with incomes below $20,000 spend over 5 percent of their incomes on out-of-pocket health care costs, not including premiums, compared with 2 percent of those with incomes above $60,000.[29]

Affordability is an issue for many employers as well. The average family premium for health insurance coverage was $11,000 in 2005—more than the earnings of a minimum-wage worker.[30] The proportion of firms offering health benefits has declined from 69 percent in 2000 to 60 percent in 2005.[31] If health care costs continue on their current course, a greater and greater share of the federal budget will need to be devoted to Medicare and Medicaid, which provide insurance coverage to our nation's oldest, sickest, and poorest individuals.

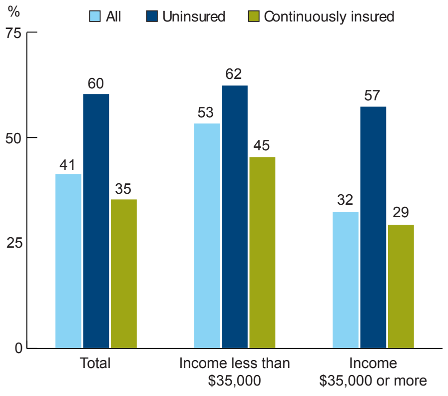
9. Equitable Care

For too long, we have tolerated wide disparities in the opportunity to live a healthy life. The disparities exist along many dimensions, but perhaps most striking are differences associated with insurance coverage, income, race or ethnicity, health status, and age. Many of these risk factors go together: for example, compared with white Americans, minority Americans are more likely to have low incomes. But even holding constant for income, minority Americans have markedly poorer health outcomes and receive lower-quality care.[32]

In a country that prides itself on equal justice for all, it is difficult to find any dimension of the U.S. health care system that performs equally for all Americans. The uninsured are less likely to get needed care.[33] Low-income workers are less likely to have sick leave and paid time off to see a physician.[34] Minority patients are more likely to have chronic conditions such as diabetes or hypertension, and less likely to have those conditions well-controlled.[35] Disabled and sicker adults are more likely to report medical errors and problems with uncoordinated care.[36] Patients that do not speak English are less likely to be able to understand their physicians and

Two of every five adults have medical bill problems or struggle with accrued medical debt. The problem is most acute among low-income and uninsured people.

Adults ages 19–64 with medical bill problems or outstanding debt*



Source: The Commonwealth Fund Biennial Health Insurance Survey, 2003.

Note: Income groups based on 2002 household income.

*Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

recommended medical treatment.[37] Immigrants work hard to succeed in this country, but all too often fail to be taken care of when their health fails.

10. Knowledge and Capacity to Improve Performance

We can do better. We have the wealth, the health care institutions, the dedicated professionals, the technological progress, the medical research, and the ingenuity required to make the U.S. health care system truly the best in the world.

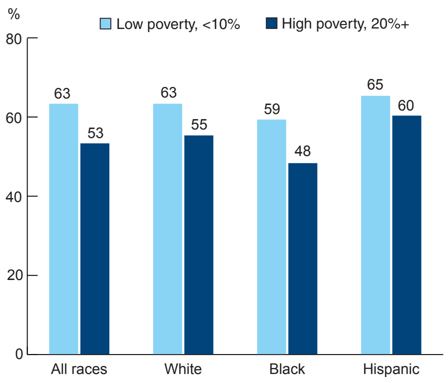
To mobilize those resources more effectively, we need much better information on health system performance—nationally, regionally, and at the level of the individual health system, hospital, or medical group. We need data on how we are doing and what the best practices or most promising innovations are in care delivery. We need a transparent health care system, with information accessible to everyone—patients, their families, health care professionals, and those who pay for care, including insurers, employers, and government agencies. We need a modern health information system that makes it easy for physicians, nurses, and other health professionals to give the right care in the right way every time.

POLICY OPTIONS FOR IMPROVING HEALTH SYSTEM PERFORMANCE

These changes will require a lot of work, but transformation is indeed possible. A recent Commonwealth Fund survey of health care leaders found a notable convergence of opinion among the nation's foremost experts, even on as difficult a challenge as reducing the percentage of Americans without health insurance. These experts agreed it is possible to cut the uninsured rate in half over the next ten years and to hold health care spending to a modest increase, from 15 percent to 16 percent of gross domestic product.[38]

The chances of surviving cancer are very different for American women of different racial or ethnic backgrounds, and for women living in high-poverty areas compared with low-poverty areas.

Five-year survival rate for women diagnosed with cancer, 1988–1994



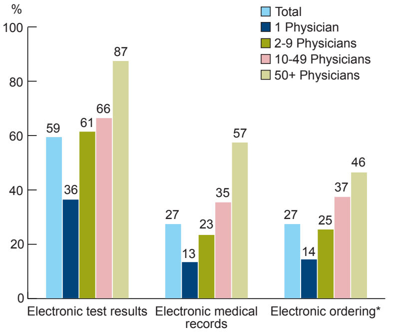
Source: G. Singh et al., *Area Socioeconomic Variations in U.S. Cancer Incidence, Mortality, Stage, Treatment and Survival, 1975–1999*, National Cancer Institute, 2003.

Note: Low poverty denotes Census tracts where less than 10 percent of households have incomes below the federal poverty level; high poverty denotes Census tracts where more than 20 percent of households have incomes below the federal poverty level.

Use of information technology is increasingly common in large physician practices, but smaller practices continue to lag behind.

Physician use of information technology, by practice size

Percent who "routinely/occasionally" use

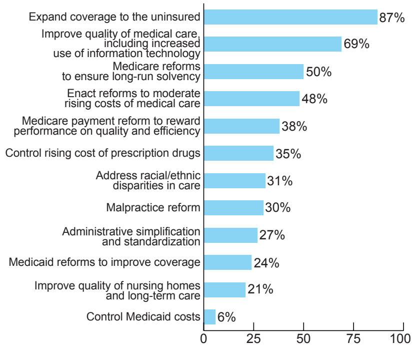


Source: A. Audet, M. Doty, J. Peugh et al., "Information Technologies: When Will They Make It Into Physicians' Black Bags?" *Medscape General Medicine,* December 7, 2004.

*Electronic ordering of tests, procedures, or drugs.

A Commonwealth Fund survey of health care opinion leaders revealed 10 priorities for Congressional action.

"Which of the following health care issues should be the top priorities for Congress to address in the next five years?"



Source: The Commonwealth Fund Health Care Opinion Leaders Survey, November–December 2004.

Leaders across the health care sector—from academia and research institutions, health care delivery organizations, health insurance companies, pharmaceutical and other health industries, consumer advocacy organizations, labor, and government—showed remarkable consensus on a policy agenda and options for change. Their top five priorities for Congress include expanding coverage to the uninsured; improving the quality of medical care, including increased use of information technology; instituting reforms to ensure the long-run solvency of Medicare; establishing measures to moderate rising health care costs; and adjusting Medicare payment reforms to reward provider performance on quality and efficiency.[39]

The survey respondents were also surprisingly unified in their opinions regarding the most promising policy strategies. To expand health insurance coverage, they recommend letting small businesses and individuals buy coverage through the Federal Employees Health Benefits Program, giving incentives to employers to expand coverage, providing tax credits or other subsidies to low-wage workers, requiring employers to contribute to a fund if they don't provide coverage, and providing federal matching funds for expansion of Medicaid and the Children's Health Insurance Program to everyone below 150 percent of the federal poverty level.[40]

To tackle the issues of quality and health care costs, they recommend rewarding more efficient and high-quality medical care providers, improving disease management and primary care case management, using evidence-based guidelines to determine when a test or procedure should be done, expanding the use of information technology, and having all payers (including private insurers, Medicare, and Medicaid) adopt common payment methods and rates.[41]

These are just a few of the possibilities before us. The Commonwealth Fund Commission on a High Performance

Health System will examine these and other options available to a nation with such exceptional resources and capacity. It is our hope that the Commission's work will be pivotal in moving the nation toward a high performance health system, one that offers better access, improved quality, and greater efficiency to all Americans.

NOTES

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[1] K. Davis, "Toward a High Performance Health System: The Commonwealth Fund's New Commission," *Health Affairs* 24 (Sept./Oct. 2005): 1356–60.

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

2005 Annual Report

The Fund's Mission, Goals, and Strategy

Prior to approving the creation of the Commission on a High Performance Health System, the Fund's Board of Directors heard from a number of national experts in health care policy. At its April 2005 retreat, the Board heard Arnold Milstein, M.D., Worldwide Partner for Mercer Human Resource Consulting, and Gail Wilensky, senior fellow at Project HOPE, discuss possible ways of achieving greater efficiency in health care delivery and financing.

Photo: John Troha/Redux Plus

At its annual retreat in April 2005, the Fund's Board of Directors undertook a thorough examination of the foundation's work over the last five years and sought the strategic advice of leaders in health policy and practice. The Board also agreed upon a revised mission statement that is consistent with the foundation's earlier mission yet recognizes that a high performance health system is needed to meet broad objectives for coverage, quality, and efficiency:

> The Commonwealth Fund was established in 1918 by Anna M. Harkness with the broad charge to enhance the common good.
>
> The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.
>
> The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

The Commonwealth Fund was established in 1918 by

Anna M. Harkness with the broad charge to enhance the common good.

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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

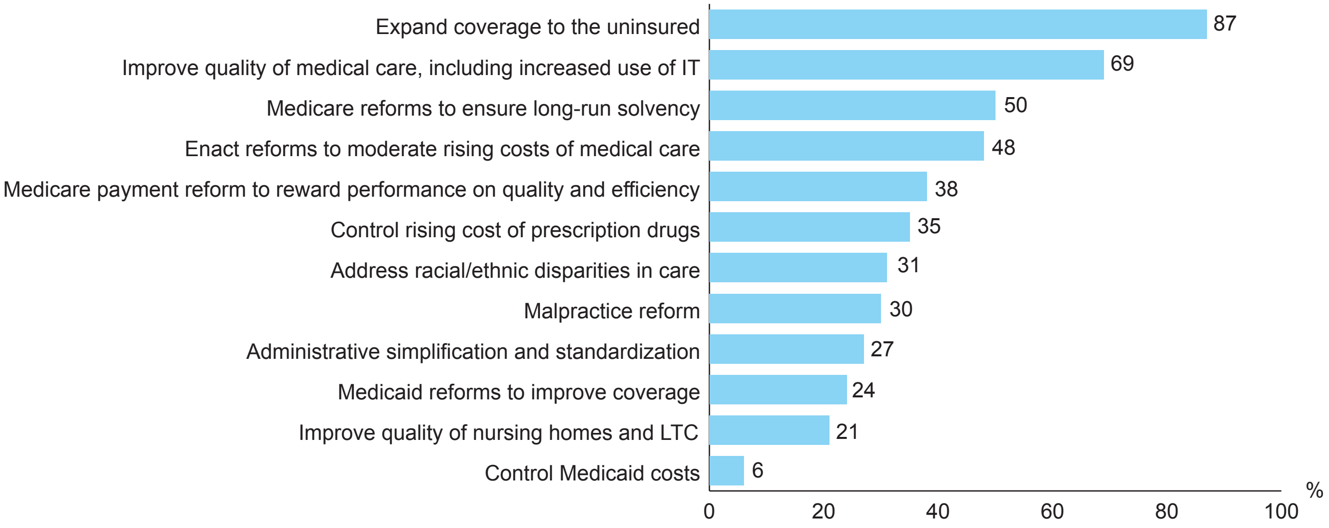
PROGRAMMATIC GOALS DIRECTLY ASSOCIATED WITH THE COMMISSION

- **Improve health insurance coverage and access to care for all Americans** by increasing the knowledge of the public and of policy leaders about the uninsured and underinsured and the consequences of inadequate coverage, and by stimulating new efforts at the federal and state government levels and private sector to expand insurance coverage.
- **Enhance Medicare's capacity to be an innovative leader in coverage, quality improvement, and value** by evaluating policy options and practices for achieving better access, improved quality, and greater efficiency for Medicare beneficiaries—particularly the most vulnerable ones—and for the health care system overall.
- **Improve the quality and promote the efficiency of health care services** by reporting on opportunities to increase the effectiveness, safety, and cost-effectiveness of health care at all levels of delivery; identifying, evaluating, and disseminating promising models of care, as well as the practices of high-performing health care providers and systems; and exploring policy changes or opportunities to achieve higher quality and efficiency.

- **Identify, assess, replicate, and diffuse policies and practices that improve the ability of the health care system, particularly primary care practices, to deliver sensitive and appropriate care to all patients**, and create more opportunities for patients and their families to provide information on their experiences to their providers that can be used as a platform for improvement of care.

Obtaining the views of health care opinion leaders on health policy issues helps inform debates and shape the Fund's strategy.

Recommended top health policy priorities for Congress over the next five years



Source: The Commonwealth Fund Health Care Opinion Leaders Survey, Nov.–Dec. 2004.

Identify and assess working solutions at the state or local level that contribute to high performance by addressing access, quality, and efficiency, and disseminate those experiences to stimulate new efforts to improve state and local health system performance. This goal includes supporting work in the Fund's community, New York City.

GOALS FOR PROGRAMS ADDRESSING SPECIAL POPULATIONS

- **Enhance the possibilities that children will develop normally and be able to reach their full potential** by expanding the availability of excellent child development information and services for families with children from birth to age 3; enhancing the accessibility, quality, and efficiency of health services for young children; adopting new standards of professional well-child care practice; and encouraging states to leverage their funding for child health care to improve child development services and preventive care.

- **Foster the growth of the knowledge, leadership, and capacity needed to address the health care needs of a growing minority population** by training leaders and by identifying policies and practices that will promote equitable health outcomes for minority, low-income, and other underserved populations, eliminate existing disparities in care, and enhance the performance of safety net systems of care.
- **Transform institutional long-term care and the quality of life of elderly Americans in nursing homes and other long-term care facilities** by identifying, evaluating, and promoting the adoption of resident-centered care and enhancing long-term care system performance; equipping the professional leaders of long-term care organizations to lead transformational change; and identifying state and federal policy, payment, and quality initiatives that will support the industry's adoption of resident-centered care.

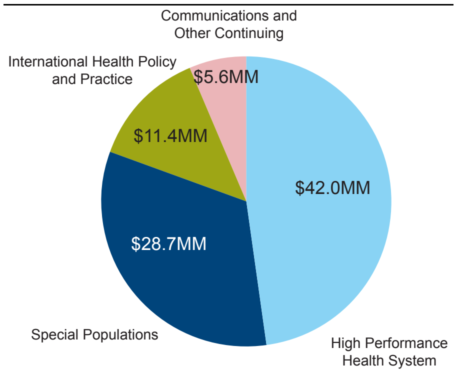
GOALS FOR THE INTERNATIONAL PROGRAM

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

GOALS FOR COMMUNICATIONS/DISSEMINATION

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

Planned extramural grants spending: $87.7 million Fiscal years 2005-06 through 2009-10



The Fund’s total programmatic spending over the five-year period 2005-09 is expected to be $140.6 million. Of that amount, it is anticipated that 62 percent, or $87.7 million, will be spent as grants, allocated across program areas as follows: 48 percent to promoting a high performance health system, 33 percent to addressing the health care needs of special populations, 13 percent to international health policy and practice, and 6 percent to communications and other continuing programs. 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. Reflecting the foundation’s value-added approach to grantmaking, 38 percent of the total budget will be devoted to intramural units engaged in research, program development, and management, collaborations with grantees, and dissemination. This allocation includes $9.4 million to communicate the results of Fund-sponsored work and funds to operate programs directly managed by the foundation.

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.

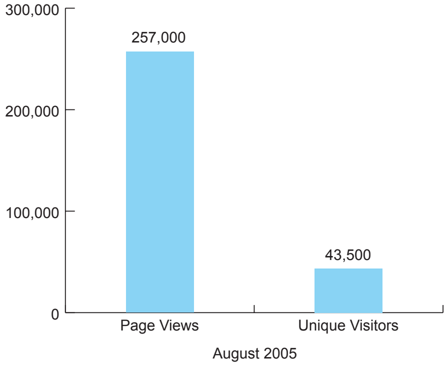
The Fund regularly reviews its major programs and activities to assess their effectiveness and reexamine their strategies. Every five years the Fund's Board of Directors conducts a special retreat to take stock of the foundation's work over an extended period, assess its institutional capacities, and lay out an agenda for the following five years. The April 2005 retreat assessed the Fund's work over the last five years from a variety of perspectives: the progress in each program made toward goals set out in 2000, with concrete examples of the Fund's impact; a report on the extent to which the Fund is realizing the ambitious communications objectives that are so closely linked to its grantmaking strategy; an assessment of the institutional capacities of the Fund that are the sine qua non for all its programmatic and communications activities; and a synthesis of lessons that have been learned from the Fund's grantmaking experience over an extended period of time.

The Board's conclusion was that the nation would be well-served at this juncture by the foundation establishing the Commission on a High Performance Health System, charged with developing recommendations for changes in clinical care, organizational, administrative, information, and payment systems that are essential if this country is to meet fundamental equity and quality issues in health care. The proposed Commission and associated new initiatives are promising mechanisms for bringing the Fund's strengths to bear at a critical juncture in the evolution of American health care.[1]

The Fund's continuing commitment to communicating the results of its work to influential audiences was evidenced in 2004-05 by further enhancements of its Web site, cmwf.org. These included the addition of "Quality Matters" and "States in Action" newsletters; a bimonthly e-newsletter "The Commonwealth Fund Digest" of Fund-sponsored research on health policy and practice; and improvements in the site search engine. With approximately 43,000 unique visitors and one-quarter million Web page views each month, the site is proving to be a highly efficient and productive vehicle for distributing and publicizing the more than 300 Fund reports, newsletters, media releases, peer-reviewed journal articles, and data releases produced by the foundation's grantees and staff each year.

To help inform health policy making and its own program strategies, the Fund launched during the year, with Harris Interactive, an online bimonthly survey of health care opinion leaders. The survey is designed to provide an ongoing measure of expert views of health policy priorities and options for addressing key issues, and strengthens the Fund's capacities for helping inform policy debates with new, timely information.

The Fund's Web site has more than 43,000 monthly visitors, accessing a wide range of new information on health policy and practice



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2005 Annual Report

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

The Commonwealth Fund's Commission on a High Performance Health System is identifying policies and practices in health care delivery and financing that would lead to improved system performance. Pictured here are Commission member Glenn Hackbarth; Senior Policy Director Anne Gauthier; Chairman James J. Mongan, M.D.; and Executive Director Stephen Schoenbaum, M.D.

Photo: John Troha/Redux Plus

Officially launched by The Commonwealth Fund on June 1, 2005, the Commission on a High Performance Health System was formed in response to mounting evidence that the fragmented U.S. health care system, fraught with waste and inefficiency, is in need of fundamental transformation.

While U.S. health spending is well over twice the per capita average among industrialized nations, these expenditures have not translated into better health for Americans overall. More than a third of the population reports problems accessing health care services, many related to cost. Medical errors account for tens of thousands of deaths annually, while only half of adults received recommended medical care. Disparities in health and health care based on insurance status, income, race, and ethnicity are pervasive. High administrative overhead and inefficiencies in the delivery of services inflate costs and compromise the quality of care.

Led by distinguished experts representing a broad range of backgrounds and perspectives, the new Commission is working on solutions to these and other problems. The Commission hopes to achieve expanded access, higher quality, and greater efficiency, while paying particular attention to those Americans who are most vulnerable because of income, insurance status, race/ethnicity, health, or age.

The group's first tasks are to 1) define the dimensions of performance in which the U.S. health system should excel, and

James J. Mongan, M.D.
Commission Chairman

Stephen C. Schoenbaum, M.D.
Commission Executive Director

2) develop a clear framework of attributes that would lead to high performance. Completion of the first task will lay the groundwork for an annual "scorecard" that measures health system performance in each dimension and will help in setting short-, medium-, and long-term goals for improvement. The second step will enable the Commission to consider the policies and practices that are most critical to achieving its goals, as well as to determine how best to move these onto public and private agendas.

The Commission will also yield important benefits to The Commonwealth Fund as an institution, informing the future direction and emphasis of the foundation's grantmaking programs. In turn, the Commission will derive benefits from new projects developed by those programs. Particularly germane to the Commission's work will be the activities and research undertaken by the programs on Quality Improvement and Efficiency, Medicare's Future, and Future of Health Insurance, as well as the recently launched State Innovations Program and Patient-Centered Primary Care Initiative. In addition, the Commission will provide valuable input in choosing the topics covered at the Fund's annual Bipartisan Congressional Retreat.

The Commission meets three times each year. At its first meeting in New York in July 2005, members began considering activities to pursue, including development of a framework for high performance and a health system scorecard. At the November meeting, held in Washington, D.C., the commissioners continued this work and began discussions on key policy issues to consider as well as possible performance measures for the annual scorecard. Future meetings are likely to include visits to institutions or organizations aimed at improving insurance coverage, access to care, quality of care, and cost performance.

Anne Gauthier
Commission Senior Policy Director

Cathy Schoen
Commission Research Director

The Commission's chairman is James J. Mongan, M.D., president and CEO of Partners HealthCare System, Inc. Support is provided by executive director Steve Schoenbaum, M.D., who is also the Fund's Executive Vice President for Programs; senior policy director Anne Gauthier, who is based at AcademyHealth in Washington, D.C.; and research director Cathy Schoen, the Fund's Senior Vice President for Research and Evaluation. The Commission Management Team also includes the Fund's president, Karen Davis, and its executive vice president and chief operating officer, John E. Craig, Jr. The Washington-based Alliance for Health Reform, an organization co-chaired by Senators Jay Rockefeller and Bill Frist, has received grants from the Fund to manage the logistics of the Commission meetings and to cosponsor policy briefings, roundtables, and the Bipartisan Congressional Retreat.

Members of the Commission on a High Performance Health System

James J. Mongan, M.D. (Chair)
President and Chief Executive Officer
Partners HealthCare System, Inc.

Maureen Bisognano
Executive Vice President and Chief Operating Officer
Institute for Healthcare Improvement

Christine K. Cassel, M.D.
President and Chief Executive Officer
American Board of Internal Medicine and ABIM Foundation

Michael Chernew, Ph.D.
Professor
Departments of Health Management and Policy,
Economics, and Internal Medicine
University of Michigan

Patricia Gabow, M.D.
Chief Executive Officer and Medical Director
Denver Health

Fernando A. Guerra, M.D., M.P.H.
Director of Health
San Antonio Metropolitan Health District

Glenn M. Hackbarth, J.D.
Consultant

George C. Halvorson
Chairman and Chief Executive Officer
Kaiser Foundation Health Plan, Inc.

Robert M. Hayes, J.D.
President
Medicare Rights Center

Cleve L. Killingsworth
President and Chief Executive Officer
Blue Cross Blue Shield of Massachusetts

Sheila T. Leatherman
Research Professor
School of Public Health
University of North Carolina

Gregory P. Poulsen, M.B.A.
Senior Vice President
Intermountain Health Care

Dallas L. Salisbury
President and Chief Executive Officer
Employee Benefit Research Institute

Sandra Shewry
Director
State of California Department of Health Services

Glenn D. Steele, Jr., M.D., Ph.D.
President and Chief Executive Officer
Geisinger Health System

Mary K. Wakefield, Ph.D., R.N.
Associate Dean for Rural Health and Director
Center for Rural Health
University of North Dakota

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Steve Wetzell
Vice President
HR Policy Association

Sara R. Collins, Ph.D.
Senior Program Officer

2005 Annual Report

The Future of Health Insurance

The Commonwealth Fund's Task Force on the Future of Health Insurance formally ended work at its spring 2005 meeting. Launched in 1999, the Task Force was an independent, nonpartisan forum that explored strategies to expand and improve health insurance coverage for the under-65 population. Its members, drawn from the health care, business, labor, government, and policy research communities, collaborated 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.

The mission and work of the Task Force continues under the Program on the Future of Health Insurance and is a core focus of the Fund's Commission on a High Performance Health System. James J. Mongan, M.D., the president and CEO of Partners HealthCare System, Inc., who chaired the Task Force, is now heading the Commission. Former Task Force members Fernando Guerra, M.D., George Halvorson, and Sandra Shewry are members of the Commission as well.

Among its efforts to improve health insurance coverage, access, and efficiency, the Fund's Program on the Future of Health Insurance tracks trends in employer-sponsored insurance—for the last half-century the backbone of health coverage in the U.S. A recent Fund study found that 22 million workers—many of them in restaurant, retail, and other service industries—lack coverage because their employers do not offer it to them.

Photo: Martin Dixon

The Program on the Future of Health Insurance envisions an efficiently run health insurance system that provides the nation's workforce with access to comprehensive, affordable health coverage. While helping to sustain a national policy focus on the growing numbers of uninsured and "underinsured" Americans, the program also identifies strategies to expand and improve coverage. Its grantees and staff accomplish these goals by: 1) tracking changes in employer-based coverage and insurance markets; 2) analyzing the effects of change on the extent and quality of coverage; 3) documenting the consequences of being uninsured and underinsured with respect to access to care, health status, productivity, and financial security; and 4) developing and analyzing strategies to expand, improve the affordability of, and increase the administrative efficiency of health insurance.

Due to rising health care costs, a weak labor market, and a growing number of uninsured Americans, health care reform became a major issue in the 2004 presidential campaign. Fund staff released a series of reports and issue briefs that informed policymakers, the media, and the public on the dimensions of the problem and strategies that could expand coverage and make it more affordable. In October 2004, Fund senior program officer Sara Collins, Ph.D., president Karen Davis, Ph.D., and colleagues published an issue brief based on the Commonwealth Fund Biennial Health Insurance Survey documenting the lack of health benefits and sick leave among low-wage earners and the implications in terms of access to care and medical bill problems.[1] Also in that month, Collins, Davis, and grantee Jeanne Lambrew, Ph.D., published the final version of *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals,*[2] which compared the various cost estimates of President Bush's and Senator Kerry's health plans. Both studies were frequently cited in the press leading up to the election, as were data from the original survey report, *The Affordability Crisis in U.S. Health Care*.[3]

After the election, the program continued to inform and advance the debate over health insurance reform. Timely analyses of initiatives implemented or championed by the Administration and Congress provided crucial information about the ability of these new policies to reduce the uninsured rate, enhance access to affordable care, or lower insurance costs to workers and businesses.

One such initiative is the Health Coverage Tax Credit Program, enacted as part of the 2002 Trade Act. Designed to help make insurance coverage more affordable to workers displaced by globalization, the program has been closely studied by Fund grantee Stan Dorn, J.D., of the Economic and Social Research Institute. In two papers published by the Fund in April and October 2005, Dorn and colleagues reported that despite a promising start, the program has been unable to enroll eligible individuals at the rate expected, primarily because the premiums charged by health plans are too costly for many unemployed workers.[4] Dorn suggests a number of ways that future expansion policies based on tax credits might be designed to realize higher enrollment, including subsidizing premium payments so that enrollees can afford them, providing access to health plans that cover preexisting conditions, and simplifying what can be a burdensome application process.[5] Both the Administration and Congress have drawn from this research in their efforts to improve the program.


Stan Dorn, J.D.
Economic and Social Research Institute

Fund work also has evaluated the potential of health savings accounts (HSAs), which were created as part of the Medicare Modernization Act of 2003. Used in combination with high-deductible health plans, HSAs allow people to save pretax dollars for deductibles and other out-of-pocket costs. The accounts are part of an overarching philosophy that maintains greater personal responsibility for health care costs will lead to more prudent use of health care services.

Policymakers favoring HSAs also hope that they will attract uninsured individuals and families into the individual insurance market with the promise of lower premiums and tax-preferred savings. Yet, an April 2005 Fund issue brief by grantees Sherry Glied, Ph.D., of Columbia University and Dahlia Remler, Ph.D., of Baruch College estimated that this new tax incentive would cover fewer than 1 million previously uninsured people.[6] The authors found that more than half of the uninsured have incomes so low that they do not owe income taxes and thus would not realize tax benefits from HSAs. In addition, to the extent that HSAs encourage well-compensated healthy workers in small firms to abandon job-based coverage, they threaten to destabilize the small group insurance market.


Sherry Glied, Ph.D.
Columbia School of Public Health

Glied and Douglas Gould examined how insurance expansion policies initiated at the federal level would affect coverage in each of the 50 states, finding wide-ranging variability in the number of newly insured. In a June 2005 article in *Health Affairs*, the authors showed that the uninsured rate in some states could be reduced by as much as 20 percent under various policies, including refundable tax credits for the non-group market, tax credits for small-firm workers, and expanding eligibility for Medicaid or the State Children's Health Insurance Program.

The Future of Health Insurance program also tracks changes in employer-sponsored health coverage—the backbone of the U.S. system of health insurance—and considers the implications of these changes for the extent and quality of coverage. Since 2000, the number of uninsured climbed by 6 million to nearly 46 million Americans, with nearly all of the increase attributable to a decline in employer-sponsored coverage.[7] In an article published in *Inquiry*, Fund staff documented the cost burden to businesses, workers, and the health system when employers fail to offer coverage to their employees.[8] The authors found that 22 million workers do not have coverage through their jobs because their employers do not offer it to them. Employers that offer health coverage to their employees' dependents spend an estimated $31 billion a year insuring workers who are employed elsewhere.

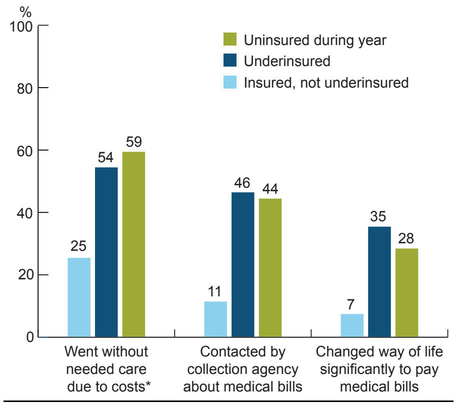
Health expenditures and job-based insurance premiums are outpacing economic growth and wages by substantial margins.[9, 10] Many employers are coping with rising premiums by offering new insurance products that shift more financial risk to employees. Rising responsibility for costs among working families raises concerns that: 1) patients with moderate and low incomes and/or chronic illness will forgo needed care; 2) family budgets and retirement savings will be placed under stress from climbing out-of-pocket medical costs; and 3) families will find it increasingly difficult to pay medical bills and thus incur mounting medical debt. Using the Commonwealth Fund's 2003 Biennial Health Insurance Survey, Karen Davis and colleagues found in an April 2005 Fund report that adults with deductibles of $1,000 or more have significantly greater difficulty accessing care due to cost compared with those with lower or no deductibles.[11]

In an article in the June 2005 *Health Affairs*, Cathy Schoen and colleagues developed a measure of "underinsurance" based on people's out-of-pocket costs and deductibles relative to their incomes. [12] Applying this measure to data from the Commonwealth Fund Biennial Health Insurance Survey, the authors found that at least 16 million adults were underinsured in 2003, in addition to the 46 million uninsured. The underinsured reported problems accessing needed care and problems with medical bills at rates similar to the uninsured.

The new Biennial Health Insurance Survey, to be published in 2006, will assess the stability and adequacy of insurance coverage, focusing on the effects of high deductibles

Medical bill problems cause high numbers of underinsured and uninsured adults to go without needed care and to experience financial stress.

Percent of adults ages 19–64



* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor because of costs.

Source: The Commonwealth Fund 2003 Biennial Health Insurance Survey.

and out-of-pocket spending on the health care of people with chronic illnesses and/or low incomes. In addition, with support from the Fund, the Employee Benefit Research Institute is fielding an online survey to examine adults' experiences with high-deductible plans, HSAs, and other medical savings accounts.

With Fund support, John Hsu, M.D., of Kaiser Permanente is evaluating the effects of high-deductible plans and HSAs, which Kaiser has offered since 2004. Hsu and colleagues are assessing the impact of these new products on health care use, costs, and health outcomes through analysis of plan data and interviews with enrollees. Findings will inform national policy as well as benefit design in the private sector.

Rising premiums are making coverage in the individual insurance market increasingly expensive—leaving few affordable options for older adults, those with low incomes or preexisting medical conditions, or others without access to job-based coverage. Priced out of the individual market and left out of the employer-based market, some people are turning to discount medical cards. Not true coverage, these cards instead provide discounts to purchasers for certain medical services. As reported by Georgetown University's Mila Kofman, J.D., in a March 2005 Fund issue brief, some of these cards provide a measure of value to purchasers. But others have serious drawbacks, including exaggerated claims of savings, difficulty finding participating doctors, and providers who fail to give cardholders promised discounts. Fund grantees are now examining the proliferation of these cards among temporary and contract workers, who traditionally have had little access to employer-based coverage.

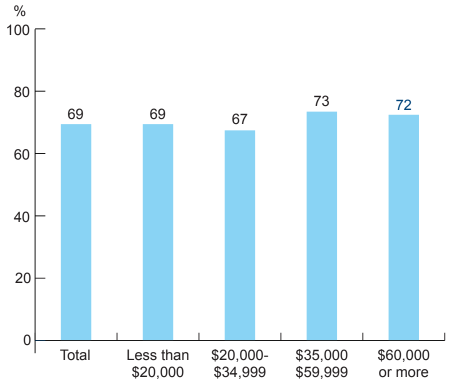
Consumers' medical bill problems and medical debt are other symptoms of the affordability crisis in health insurance coverage. In a Fund publication that received wide attention in the press, Fund senior analyst Michelle Doty, Ph.D., and her colleagues reported that while it is the uninsured who most often experience problems paying medical bills and incur medical debt, even many working-age adults who are continually insured are affected. The study, ***Seeing Red: Americans Driven into Debt by Medical Bills,*** also found that working-age adults incur significantly higher rates of medical bills and debt than adults 65 and older. The *Washington Post, Chicago Tribune,* and Bloomberg.com were among the media outlets that ran stories.

The Future of Health Insurance program also monitors the changing dynamics of insurance coverage in the United States. Fund-supported research has found that, while many people remain uninsured for long periods, others cycle on and off coverage. People with gaps in coverage are as likely to experience difficulty accessing care and paying medical bills as those who are continually uninsured. Fund-supported projects are examining the characteristics of people who “churn” in and out of different sources of insurance coverage, the effect of such churning on their access to health care, and the costs to public insurance programs.

Adults nearing retirement but still too young for Medicare are at risk of losing their insurance coverage, according to the recent Commonwealth Fund Survey of Older Adults.[13, 14, 15] Nearly a quarter of older adults were uninsured just before entering Medicare. Older adults are particularly vulnerable to high medical costs, since 70 percent have at least one chronic health condition. Majorities of older adults who were surveyed expressed interest in new policy options to protect them from the high costs of medical care, both before and after retirement. An option developed by Fund staff would let older adults set aside a percentage of their paychecks in an account within Medicare to use when they became eligible for the program and enabling them to buy into Medicare before age 65.

Interest in Medicare Health Accounts is strong across income groups.*

Percent of adults ages 50–70 in working families interested in a Medicare Health Account, by income



* Respondents were asked: "Thinking about paying for your health care in the future, would you be interested in having 1% of your (and/or your spouses') earnings deducted from your paycheck(s), tax-free, and placed in your own Medicare account(s) to use for long-term care or other expenses not covered by Medicare?"

Source: S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. How, and A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund, June 2005).

Young adults, too, often find themselves in an insurance coverage limbo. An earlier Fund issue brief by Sara Collins and colleagues found that substantial churning in young adults' insurance coverage is a result of changes in their eligibility for public or private insurance as well as graduation from high school or college.[16, 17] In a May 2005 update of their analysis, the authors showed that coverage in this population continues to deteriorate: the number of uninsured young adults climbed by more than 2 million from 2000 to 2003.

Policy options presented in the brief formed the basis of a bill introduced by Representative Vic Snyder (D-Ark.) to give states the option to increase the age limit for Medicaid and State Children's Health Insurance Program from age 18 to 23.[18] Another option in the brief—that insurance companies be prohibited from writing policies that exclude dependents under age 26—was enacted by the California legislature but not signed into law.[19]

The program is also supporting research on the administrative cost burden stemming from the nation's fragmented system of health insurance coverage. Because providers care for patients insured by various private and public plans, they must contend with multiple payment schedules, claims forms, credentialing requirements, and other regulations. Such complexity creates excess transaction costs as well as barriers to improving quality of care. The Fund and the Robert Wood Johnson Foundation are funding research to measure the scope of the problem, identify sources of the highest costs, and propose public and private remedies to reduce administrative burdens. In related work, grantee AcademyHealth is conducting case studies of health care organizations' efforts to reduce administrative complexity.

NOTES

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[18] H.R. 3192, Medicaid/SCHIP Optional Coverage for Young Adults Act of 2003.

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2005 Annual Report

State Innovations

States are exploring health care reform from a number of angles, ranging from universal coverage efforts to incentive programs that foster improvements in health care quality and efficiency. In the past year, Fund-supported work has highlighted Maine's ambitious Dirigo health reform initiative, signed into law by Governor John Baldacci (pictured) in 2003.

Photo: Andy Molloy/*Kennebec Journal,* Augusta, Me.

Building on its long history of supporting state efforts to improve health care, The Commonwealth Fund established the State Innovations program in April 2005. The new program encourages states to develop and implement major improvements in health system performance, including efforts to expand insurance coverage, promote high-quality care, enhance value and efficiency, and meet the health needs of vulnerable populations. The hope is that successful models will spur other states—perhaps even the federal government—to undertake similar reforms.

While no state could currently be described as a model of high performance, there has been movement in the right direction. States are exploring opportunities to achieve universal coverage, offer accessible performance information, and align public and private purchasing strategies and incentives for quality, efficiency, and simplification. An ideal system—whether on the state or national level—would feature "zero tolerance" of health disparities, affordable personal health care costs, and public coverage that is simple and seamless to access.

To support states in these efforts, the Fund is targeting four types of activities. The first one will be to generate new data about health system performance at the state level. This information will allow states to measure and compare progress to develop specific goals for achieving best-practice outcomes.

Work already in progress includes an initiative of the National Academy for State Health Policy to identify policies and practices in all 50 states that are likely to support high performance. In a parallel effort, the Rutgers Center for State Health Policy has begun identifying quantitative indicators of high performance for states. Both projects, with reports slated for release in 2006, will be closely aligned with the performance measures used by the Fund's Commission on a High Performance Health System.

Second, the State Innovations program is supporting case studies of innovative efforts for achieving high performance. The Economic and Social Research Institute is currently investigating public and public–private efforts targeting insurance coverage expansion and efficiency in state health care spending, and the Fund will continue seeking to identify innovations that merit further exploration.

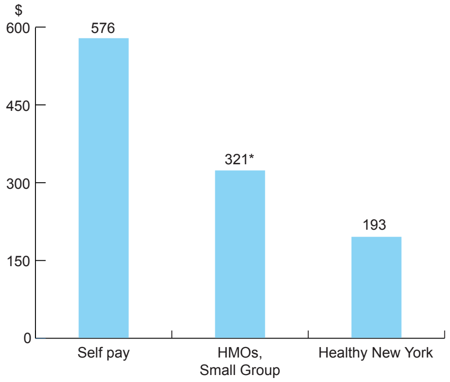
Third, the Fund is seeking to support evaluations of promising practices so that states may better understand what works, what does not work, and where future opportunities lie. Finally, the Fund is disseminating its work directly to state policy leaders through the newsletter *States in Action* (launched in May 2005) and through partnerships with organizations that convene state leaders.

Katherine Swartz, Ph.D.
Harvard School of Public Health

In the past year, the Fund's work has highlighted programs in Maine and New York that aim to expand coverage to small businesses and individuals who are unable to afford the high price of insurance. Katherine Swartz, Ph.D., of the Harvard School of Public Health revisited the Healthy New York program to see how well it was reaching its target population—small businesses and workers who are not offered health insurance—after three years of existence.[1] The program, operating under budget projections and maintaining more than 90,000 enrollees, illustrates that reinsurance can be an effective model in reducing the high cost of coverage, especially

Reinsurance can help make insurance more affordable to workers eligible for programs like Healthy New York.

Average monthly individual insurance premium in New York City



* New York State average.
Sources: Self-pay average premiums from United Hospital Fund (UHF) analysis of New York State Department of Insurance (NYSDI) direct-pay premium data, Feb. 2005. Small group premium data from *Employer Sponsored Health Insurance in New York: Findings from the 2003 Commonwealth Fund/HRET Survey* (New York: The Commonwealth Fund, May 2004). Healthy New York average premiums from UHF analysis of 2004 NYSDI data.

when paired with a somewhat limited benefit package. Another reinsurance model in Arizona has also been successful, Swartz found, in dramatically lowering overall program costs.

In Maine, the passing of the ambitious Dirigo Health Reform Act has brought the state national attention. In three reports released this year, researchers from the National Academy for State Health Policy described the overall framework of the Dirigo reforms—intended to achieve universal coverage, cost controls, and quality improvement—analyzed benefit and cost-sharing structures, and discussed the public's perception of the program.[2, 3, 4] Dirigo is notable for its innovative approach, particularly the way in which premiums, deductibles, and copayments are scaled to enrollee income in order to keep total out-of-pocket spending to an affordable level.

With support from competitive grants made by the federal Health Resources and Services Administration, many other states have been collecting data and developing strategies to extend coverage to the uninsured. As reported by Sharon Silow-Carroll and Tanya Alteras, since 2000, 46 states, four U.S. territories, and the District of Columbia have received grants of about $1 million each to develop customized state plans, and eight states and one territory have received grants to design and plan the pilot projects.[5] In a second report, analysts from the Economic and Social Research Institute reported on the major strategies states are considering. To avoid creating a financial burden for any one sector, many of these approaches seek ways to share costs among employers, consumers, Medicare and Medicaid, and state governments.

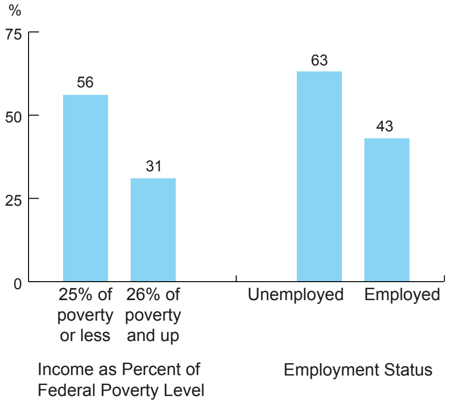
Most states have recovered, or are recovering from, the economic difficulties they experienced earlier in the decade, but some coverage programs have been severely cut. Even in states where reductions have been modest, there is a heightened awareness that health care cost inflation exceeds state revenue growth, and that strategies to stretch limited state dollars are essential to preserving benefits. In a series of four reports, Silow-Carroll and Alteras teamed up to identify innovative ways of financing health care with limited means.[6] The strategies they describe include building on employer-based coverage through programs that offer premium assistance; targeted care management; pooled and evidence-based pharmaceutical purchasing; and strategic uses of uncompensated care funds. The reports encourage policymakers to learn more about these innovations and how they might be replicated or adapted in their own state.

In addition to promoting successful models and potential new opportunities, the State Innovations program seeks to draw insights from recent history. In a study on the effects of Medicaid cuts, a team of researchers led by sociologist Bill Wright, Ph.D., examined the impact that Oregon's Medicaid benefit cuts have had on low-income enrollees.[7] Not surprisingly, many individuals lost coverage due to the higher costs, and many experienced a decline in health status. However, the analysis suggests that these negative impacts may be reduced considerably if coverage is restored within six months—a finding other states may want to consider as budgets rebound.

With an increasing number of individuals excluded from employer-based health insurance, many Americans are turning to the individual insurance market. A study by Nancy Kane and Nancy Turnbull from the Harvard School of Public Health examined the impact of state regulation in making the individual market more accessible and affordable.[8] After studying regulations in seven states, Kane and Turnbull found that stricter regulation can help people secure coverage. The researchers recommend reforms that require broadened access, short waiting periods, standardized benefits, and

Medicaid benefit cuts fall disproportionately on the unemployed and people with very low incomes.

Percent of standard Oregon health plan members citing increased premiums and cost-sharing as reason for leaving plan



Source: B. Wright, M. Carlson, J. Smith, et al., I*mpact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan*, The Commonwealth Fund, July 2005.

limited rate variation. Still, affordability remains a serious problem. The group market, they say, functions more effectively, with the individual market remaining a last-resort option for consumers.

In an article published in *Health Affairs*, a research team led by Joel Cantor, Sc.D., of the Center for State Health Policy at Rutgers University evaluated the individual insurance market in New Jersey.[9] The authors noted that improvements in access to employer-sponsored insurance had caused healthier enrollees to pull out of the individual insurance market, leaving sicker individuals with rapidly rising costs. In the coming year, Cantor will model alternative regulatory strategies for supporting the market to make it available for those who need it.

In addition to projects aimed at covering the uninsured, the Fund has supported work to help understand the consequences of insurance "churning," which occurs when people cycle on and off health insurance. Fund support has enabled researchers Laura Summer, Gerry Fairbrother, Ph.D., and Sherry Glied, Ph.D., to explore the issue, focusing on populations that experience the most churning, the impact on access to coverage and care, and the amount of health care dollars that are wasted. Early findings reported at an AcademyHealth meeting in June 2005 indicate that state policies can make a difference in insurance stability. One panelist—Vicki C. Grant, Ph.D., from the Southern Institute on Children and Families—illustrated how streamlining the Oregon Health Plan resulted in shorter enrollment times and fewer unintended disenrollments.

Finally, as part of efforts to address problems in the local community, the Fund supported the collection and analysis of new data about health in New York City. In partnership with the city's Department of Health and Mental Hygiene, the Fund helped to produce reports on health disparities in New York and on issues surrounding women's health.[10] This work vividly illustrates a wide gap in the overall health status between rich and poor New Yorkers, as well as failures to achieve recommended levels of cancer screening and heart disease prevention, especially among women.

NOTES

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Stuart Guterman
Senior Program Director

2005 Annual Report

Medicare's Future

Nearly 6 million Americans qualify for Medicare because of severe and permanent disabilities. But there's a catch: these individuals must undergo a two-year waiting period prior to enrollment. Fund-sponsored research has found that the waiting period decreases access to medical care and other services, which in turn can lead to physical and mental deterioration.

Photo: Eli Reichman/Redux Plus

Since 1995, the Program on Medicare's Future has worked to enhance Medicare's ability to meet the health care needs of the nation's elderly and disabled and to protect the most vulnerable among them from financial hardship. Over the past several years, the program has been monitoring the impact of the Medicare Modernization Act of 2003 as it is implemented, focusing on the Medicare prescription drug benefit and its effects on low-income, chronically ill, and frail beneficiaries. The program also has examined the role of Medicare private plans and supported efforts to improve the quality, effectiveness, and coordination of care provided to beneficiaries.

Medicare is now offering a voluntary prescription drug benefit. Beneficiaries began enrolling in mid-November 2005 and have until May 15, 2006, to choose a drug plan without incurring a penalty. Beneficiaries are being confronted with a wide and potentially confusing array of health plan options, with varying benefit designs and features. The Fund is supporting research to identify areas in which the drug benefit may present problems to certain groups of beneficiaries, particularly those with low incomes or poor health status, and to suggest strategies to ensure that beneficiaries receive the coverage they need.

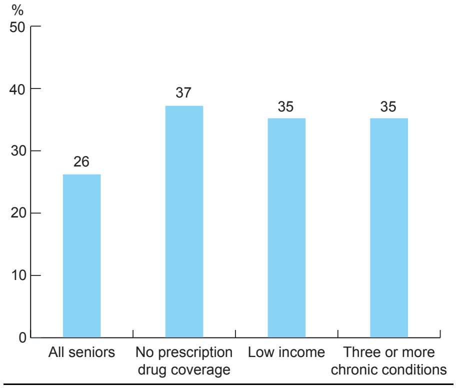
Recent research demonstrates the challenges that beneficiaries will face. Led by Dana Safran, Ph.D., researchers at Tufts–New England Medical Center, the Henry J. Kaiser Family Foundation, and the Fund conducted a survey of more than 17,000 Medicare beneficiaries. The responses indicate that many older adults have complex drug regimens and multiple prescribing physicians and pharmacies, with some obtaining drugs from Canada and Mexico. Among those with three or more chronic conditions, 73 percent reported taking five or more medications and 42 percent spent $100 or more per month on medications. According to the survey, four of 10 seniors do not take all of the drugs prescribed to them, citing cost, side effects, perceived lack of effectiveness, or the belief that the medication was unnecessary.[1]

Many Medicare beneficiaries face financial difficulties associated with high out-of-pocket costs. About 20 percent of potential enrollees will be eligible for subsidies under the new prescription drug plan because of their low incomes. However, a Fund-supported study led by Bruce Stuart, Ph.D., estimated that 38 percent of enrollees would have high spending that falls in the so-called "doughnut hole"—a gap in coverage in which beneficiaries are responsible for 100 percent of drug costs—and another 14 percent will exceed the threshold for catastrophic coverage. The authors of the study project drug bills of nearly $11,000 from 2006 to 2008 for the average high spender and bills of $12,300 over that same period for the average catastrophic spender.[2] Although plans providing coverage that fills the doughnut hole will be available, they will be more expensive or will provide more limited coverage—generic drugs only, for example—for this range of expenses.

In a Fund-supported study, Gerard Anderson, Ph.D., of Johns Hopkins University and colleagues explored

Lack of coverage, low income, and chronic illness make it harder for seniors to adhere to their prescribed drug regimens.

Percent of seniors not adhering to prescribed drug regimens due to cost



Source: D. G. Safran et al., "Prescription Drug Coverage and Seniors: Findings from a 2003 National Survey," *Health Affairs* Web Exclusive, Apr. 19, 2005.

mechanisms for eliminating the coverage gap in the Medicare drug bill. The authors concluded that Congress could eliminate the doughnut hole if Medicare were to pay no more than the benchmark drug prices of Canada, the United Kingdom, and France, although there could be a trade-off in terms of decreased spending by pharmaceutical companies on research and development.[3]

The new Medicare Part E benefit outlined by Karen Davis and colleagues would also eliminate the doughnut hole. In an October *Health Affairs* Web Exclusive, the authors presented a new comprehensive benefit option for the traditional fee-for-service Medicare program.[4] Beneficiaries who choose to enroll in the option, dubbed “Medicare Extra,” would no longer need to purchase a private drug plan as well as Medigap supplemental coverage to meet their coverage needs. The new option, which provides benefits similar to the main plan covering federal employees, would eliminate the gap in prescription drug benefits and protect beneficiaries from catastrophic out-of-pocket costs—not only for drugs, but for hospital and physician services as well.

Research indicates that premiums and out-of-pocket medical expenses now constitute 22 percent of Medicare beneficiaries’ incomes and will reach 30 percent by 2025.[5] To improve the financial security of older adults, the Fund’s program is exploring new strategies to encourage individuals to save more for their retirement. The Commonwealth Fund Survey of Older Adults found that nearly seven of 10 respondents were interested in a “Medicare Health Account,” which would allow them to save for health costs not currently covered by Medicare.[6]

In addition to cost concerns, the program is monitoring the quality of drug prescribing. According to a Fund-supported study, prescription rates for antipsychotic medications are increasing, with more than one of four Medicare beneficiaries in nursing homes receiving antipsychotics between 2000 and 2001.[7] This study, led by Becky Briesacher, Ph.D., raised questions regarding the appropriateness of prescribing. With Medicare preparing to assume Medicaid's role in covering prescriptions for the nursing home population, the time is ripe to evaluate prescribing guidelines and current use of antipsychotic drugs.

The Fund will continue to monitor the implementation of the new prescription drug benefit and its effect on the accessibility, quality, and cost of the medicines beneficiaries need. To this end, program work will explore the drug utilization patterns of Medicare beneficiaries with 10 conditions that have been singled out by federal officials as requiring special attention. As the Medicare prescription drug benefit changes the landscape of retiree health benefits, the Fund will collect information on employer behavior regarding retirees in response to these changes.

The MMA greatly expands the role of private health plans in Medicare: the prescription drug benefit is available solely through private plans, and the legislation substantially increases payments to private plans for care provided in the Medicare Advantage (MA) program. As reported in a December 2004 issue brief, Brian Biles, M.D., and colleagues estimated that extra payments to MA plans total $2.72 billion, or an average of $546 more than fee-for-service costs for each of the 5 million enrollees.[8] A Fund grant enabled Robert Berenson, M.D., to examine the structure of payments to private insurers. In a *Health Affairs* Web Exclusive article, he said that Congress must consider whether extra payments to private plans might be better used to benefit all Medicare beneficiaries.[9] The Fund will continue to explore the implications of Medicare Advantage for the Medicare program and its beneficiaries.

In the past year, the Fund has remained dedicated to protecting the most vulnerable of beneficiaries, including "dual eligibles," or elderly and disabled Americans enrolled in both Medicare and Medicaid. With Medicaid prescription drug coverage expiring on December 31, 2005, it will be crucial to ensure the continued protection of Medicaid enrollees as they move into Medicare drug plans.

Findings from a Fund-supported study of more than 3,000 of Maryland's dual eligibles indicated that the transition to the new prescription benefit could put these beneficiaries at risk. Charles J. Milligan, Jr., J.D., who conducted the study, recommended a number of federal policy changes, including allowing for 90-day prescriptions, expanding the enrollment period, and using open or shared formularies.[10]

Nearly 6 million Americans qualify for Medicare because of severe and permanent disabilities. These beneficiaries must undergo a two-year waiting period prior to enrolling in Medicare. In a study cosponsored by the Fund and the Christopher Reeve Paralysis Foundation, Bob Williams and others conducted focus groups and in-depth interviews with individuals in the Medicare two-year waiting period.[11] They found that the waiting period decreases access to medical care and other services, which in turn can lead to physical and mental deterioration and the inability to lead productive and full lives. For example, many respondents felt they needed better access to health services in order to begin working again, and only two of 21 reported working at all. The Alliance for Health Reform, the Fund, and the Christopher Reeve Paralysis Foundation held a briefing to highlight the challenges that disabled Americans face during the waiting period.

To further inform debates on this topic, the Fund is supporting the Medicare Rights Center in the development of narrative case histories describing the experiences of individuals in the waiting period, as well as retrospective case

Robert M. Hayes, J.D.
Medicare Rights Center

histories of those who have completed the waiting period and currently have Medicare coverage. The collection of narratives will be disseminated to policymakers and the media.

More than 80 percent of Medicare beneficiaries have at least one chronic condition, and the 23 percent of beneficiaries with five or more conditions account for 68 percent of all Medicare spending.[12] In addition to efforts to ensure access to needed care, Fund work seeks to promote quality and efficiency within the Medicare program. Under a Fund grant, Robert Berenson, M.D., has been working to identify ways of integrating pay-for-performance efforts in the private and public sectors and bringing stakeholder groups—providers, consumers, and purchasers—together to address key issues. Marilyn Moon, Ph.D., is receiving Fund support to investigate mechanisms to improve Medicare's cost-effectiveness, including enhanced use of primary care management.

The Fund will continue to conduct analyses and develop policy recommendations to ensure that Medicare meets the health care needs of the elderly and disabled. With rising health costs, concerns about the quality and appropriateness of care, and a population increasingly dealing with chronic conditions, Medicare faces considerable challenges. In coming years, the Program on Medicare's Future will focus on strengthening Medicare's ability to perform its traditional roles and identifying ways in which Medicare can ensure that beneficiaries receive appropriate, effective, and efficient health services and better outcomes.

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[9] R. Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'" *Health Affairs* Web Exclusive, Dec. 15, 2004.

[10] C. Milligan, *Impact of the Medicare Prescription Drug Benefit on Home- and Community-Based Services Waiver Programs* (New York: The Commonwealth Fund, Apr. 2005).

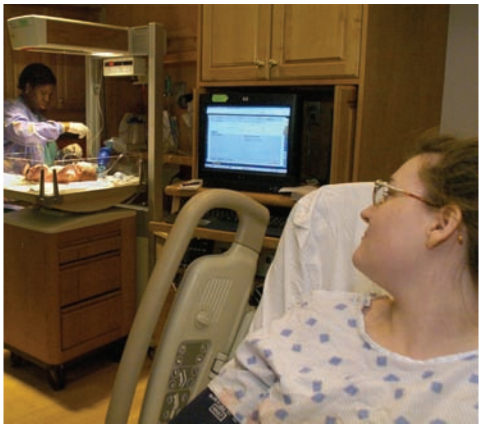
[11] B. Williams, A. Dulio, H. Claypool et al., *Waiting for Medicare: Experiences of Uninsured People with Disabilities* (New York: The Commonwealth Fund and Christopher Reeve Foundation, Oct. 2004).

[12] G. Anderson, "Medicare and Chronic Conditions," *New England Journal of Medicine,* July 21, 2005 353(3):305–9.

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

2005 Annual Report

Health Care Quality Improvement and Efficiency



With Commonwealth Fund support, researchers are assessing the value of “intelligent” patient records and interactive decision-support systems at four MedStar Health hospitals in Washington, D.C. Obstetrics specialists are recording every procedure in an effort to reduce mistakes and adhere to best practices.

Photo: Nanine Hartzenbusch/*Baltimore Sun*

The philosophy behind the Fund’s Program on Health Care Quality Improvement and Efficiency 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 the 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 an influential article in *Health Affairs* demonstrating that quality improvement principles and tools have not permeated the medical profession.[1] Drawing on results of the Commonwealth Fund 2003 National Survey of Physicians and Quality of Care, Fund staff Anne-Marie Audet, M.D., Michelle Doty, Ph.D., Jamil Shamasdin, and Stephen Schoenbaum, M.D., reported that a majority of physicians are not engaged in quality improvement practices, are not routinely using data to assess their performance, and are reluctant to share quality-of-care measures with the public. According to the authors, the science of quality improvement has been, for the most part, “institutionalized” but not yet “professionalized.” Accelerating physician participation in quality improvement efforts, they say, will require building the infrastructure to support quality and enhancing physicians’ knowledge and skills.

To engage physicians in quality improvement, the program is cofunding a project with the American Board of Internal Medicine Foundation to identify physician practices that are successfully using performance data to improve quality. The initiative, “Putting Quality into Practice,” will produce a compendium of best practices, to be accompanied by filmed interviews with a selected group of physicians. These resources will help explain physicians’ actions and motivations, describe barriers they encounter and the solutions they have devised, and illustrate the value of their quality improvement activities.

Several Fund-sponsored efforts in the past year have sought to gather and disseminate information on quality. A chartbook focusing on the quality of health care services delivered to Medicare beneficiaries—part of a series of Fund chartbooks on quality—presents information distilled from 400 studies on preventive care, treatment of chronic conditions, mental health, and other topics.[2] Authors Sheila Leatherman and Douglas McCarthy report on Medicare’s successes in ensuring access to needed care and improving the provision of certain preventive services; they also pinpoint areas where the program can improve quality and eliminate health disparities. For example, while the rate of mammograms for women over age 65 has tripled over the past decade, influenza vaccination rates still vary widely by state. In 2003, 80 percent of Medicare enrollees in Minnesota received

Physicians' willingness to share quality-of-care data is limited

Willingness to share data with:*	Yes, Definitely/ Probably	No, Definitely/ Probably Not
Medical leadership	71%	27%
Physicians' own patients	55%	44%
General public	29%	69%
Other physicians	72%	26%

* Answers to survey question: "To improve high quality of care in the U.S., which of the following do you think should have access to 'Quality of Care' data about individual physicans?"

Source: A.-M. J. Audet, M. M. Doty, J. Shamasdin, and S. C. Schoenbaum, *Physicians' Views on Quality of Care: Findings from the Commonwealth Fund National Survey of Physicians and Quality of Care* (New York: The Commonwealth Fund, May 2005).

flu shots, compared with only 60 percent in Nevada.

The Medicare quality chartbook was released at an Alliance for Health Reform briefing in Washington, D.C., that brought together a large group of policy leaders and experts. Leatherman and McCarthy are now working on a series of "quality snapshots," which will be published twice a year, beginning in 2006, to provide up-to-date information on important quality indicators, as well as new data on emerging issues.

While data on the quality of care in health plans have been available for more than a decade, until recently there has not been similar information on the care delivered by hospitals. The Hospital Quality Alliance Program—the first national initiative to report information on hospital performance on a routine basis—was launched in 2003. By the first quarter of 2004, well over 3,168 hospitals had reported on at least one measure of quality. Fund-supported researcher Ashish K. Jha, M.D., and his colleagues were the first to examine these hospital data. Their findings, published in the *New England Journal of Medicine,*[3] reveal that quality of hospital care varies widely by geographic region, type of hospital, and clinical condition. In the next phase of this project, Jha will examine the relationship between hospital quality and cost.

This year, the Fund-sponsored Colloquia on Quality Improvement, chaired by David Blumenthal, M.D., marked the fifth anniversary of the publication of *To Err Is Human,* the Institute of Medicine's landmark report.[4] At an expert forum, members of the original IOM committee as well as leaders from the Joint Commission on Accreditation of Healthcare Organizations, National Patient Safety Foundation, and other key organizations reviewed evidence of progress in the past five years and made recommendations for next steps. Writing in the online edition of *Health Affairs,* Robert M.

Robert M. Wachter, M.D.
University of California,
San Francisco

Wachter, M.D., one of the speakers, argued that despite some improvements in patient safety, considerable deficiencies still exist. In his patient safety "report card," he awarded the government's regulatory response the highest grade; the lowest scores went to the malpractice system and other vehicles for accountability.[5]

In an article published in the *Journal of the American Medical Association*, medical safety experts Lucian Leape, M.D., and Donald Berwick, M.D., made the case that *To Err Is Human* has made a profound impact on public attitudes as well as the actions of organizations—even though it has not yet resulted in comprehensive, nationwide improvements in safety.[6] The authors say that the single most important strategy to achieve safety is to set "strict, ambitious, quantitative, and well-tracked national patient safety goals."

Medical and surgical procedures, once performed only in hospitals, now routinely take place in ambulatory care settings. Yet little is known about the quality and safety of care provided in doctors' offices and outpatient clinics. In the coming year, the Fund is supporting the Health Research and Educational Trust to conduct a survey of ambulatory care safety practices in collaboration with the Medical Group Management Association. This project will provide new data on the current state of safety in ambulatory care and identify areas in need of improvement.

In December 2004, the Institute for Safe Medication Practices awarded the Fund a "Cheers Award" in recognition of its efforts to improve patient safety.

This year has witnessed important progress toward a national health information network, which has the potential to improve the safety, efficiency, and effectiveness of care. In a Fund-supported study appearing in the *Annals of Internal Medicine*,[7] Rainu Kaushal, M.D., estimated that achieving an ideal national health information network—including electronic health record systems, electronic claims submissions, computerized physician order entry, and electronic prescribing, among other features—will cost $156 billion over five years in capital investment and $48 billion in annual operating costs.

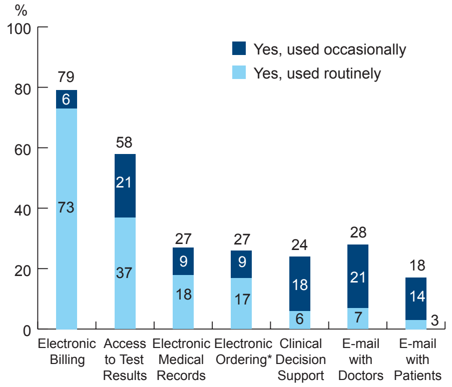
Hospitals would be most affected financially by the investments required to acquire hardware, while the cost of interoperability would be borne mostly by physicians, Kaushal says. Her analysis should be a useful guide for the newly established Office of the National Coordinator for Health Information Technology as well as for lawmakers debating the merits of pending health information legislation.

Another article, prepared by Fund staff and published in *Medscape General Medicine,* demonstrates that physicians face specific challenges in adopting information technology.[8] Based on Fund survey data, the analysis revealed that only a quarter of doctors' practices routinely use technology to improve operational efficiency and clinical care. Diffusion of technologies such as electronic health records, computerized prescribing and order entry, clinical decision support, and physician–patient e-mail correspondence has been slow. Physicians in solo and small group practices were most likely to cite barriers to adoption of health IT—a finding that the authors say will require special attention, since three-quarters of U.S. physicians provide care in such practices.

Fund support to Robert Miller, Ph.D., has enabled a study of the costs and benefits of implementing electronic health records in solo or small group physician practices. His survey, published in *Health Affairs,*[9] found that practices that had adopted the technology reaped financial benefits from improved billing and reduced personnel costs. While the practices had improved access to data, few used the electronic health records to systematically improve chronic and preventive care. Initial costs averaged $42,000 per provider

Use of information technology to improve quality and efficiency is still limited

Percent indicating "routine" or "occasional" use



* Electronic ordering of tests, procedures or drugs.

Source: A.-M. J. Audet, M. M. Doty, J. Shamasdin, and S. C. Schoenbaum, *Physicians' Views on Quality of Care: Findings from the Commonwealth Fund National Survey of Physicians and Quality of Care* (New York: The Commonwealth Fund, May 2005).

and ongoing costs averaged $8,100. The average practice paid for its system in less than three years.


Robert Miller, Ph.D.
University of California,
San Francisco

In the coming year, a grant to the Johns Hopkins School of Medicine will support a survey of physicians in 156 Texas hospitals to assess the structural and functional capabilities of their IT systems and determine whether these capabilities translate into improved quality and lower costs.

Programs that align payments to health care providers with the quality of care they deliver have been blossoming. More than 100 insurers nationwide have implemented so-called pay-for-performance initiatives, and Medicare is considering adopting such policies as well.


Meredith B. Rosenthal, Ph.D.
Harvard School of Public Health

Despite this activity, evidence about the impact of performance incentives is still scarce. With Fund support, Meredith Rosenthal, Ph.D., at the Harvard School of Public Health conducted one of the first formal evaluations of a large pay-for-performance program, implemented by the PacifiCare health plan in 2003, among more than 200 California group practices. In May 2005, Rosenthal presented preliminary findings to members of the House Subcommittee on Employer–Employee Relations, as well as to the IOM Committee on Redesigning Health Insurance Benefits, Payment and Performance Improvement Programs. Her study, published in the *Journal of the American Medical Association,*[10] shows that, compared with PacifiCare's physician groups in Oregon and Washington that did not participate in the incentive program, PacifiCare's California network demonstrated greater quality improvement on one of three clinical measures. Although practices that were historically high performers earned the most rewards, lower-performing practices improved significantly.

Rosenthal suggests that policies that pay explicitly for quality improvement, rather than strictly rewarding high achievement levels, could alter the incentives for high-performing and low-performing groups and increase the overall impact of incentives. Rosenthal is currently examining how financial incentives targeting both physicians and patients affect cost and quality in a large health and welfare trust for culinary workers in Nevada.

In order to build the capacity for change in the health care system, the Program on Health Care Quality Improvement and Efficiency has promoted the “learning collaborative” model, in which experts help to facilitate improvements by offering clinical or technical support and organizing staff into quality improvement teams. With Fund support, the nonprofit Primary Care Development Corporation led learning collaboratives in four community health centers in New York City. According to the case study reports published by the Fund in August 2004, the clinics were able to make significant improvements in key operations: reducing waiting times; offering on-demand appointments with patients’ primary care providers; enhancing revenue collections; and attracting and retaining patients. Another Fund grant to the Primary Care Development Corporation will enable the evaluation of 25 learning collaborative teams to determine what organizational characteristics contribute to the achievement, maintenance, and spread of improvements.

NOTES

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[1] A. M. Audet, M. M. Doty, J. Shamasdin, and S. C. Schoenbaum, “Measure, Learn, and Improve: Physicians’ Involvement in Quality Improvement,” *Health Affairs,* May/June 2005 24(3):843–53.

[2] S. Leatherman and D. McCarthy, *Quality of Health Care for Medicare Beneficiaries: A Chartbook* (New York: The Commonwealth Fund, May 2005).

[3] A. K. Jha, Z. Li, E. J. Orav et al., “Care in U.S. Hospitals—The Hospital Quality Alliance Program,” *New England Journal of Medicine,* July 21, 2005 353(3):265–274.

[4] Committee on Quality of Health Care in America, Institute of Medicine, *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 1999).

[5] R. M. Wachter, "The End of the Beginning: Patient Safety Five Years After *To Err Is Human*," *Health Affairs* Web Exclusive, Nov. 30, 2004.

6 L. L. Leape and D. M. Berwick, "Five Years After To Err Is Human: What Have We Learned?" Journal of the American Medical Association, May 18, 2005 293(19):2384–90.

[7] R. Kaushal, D. Blumenthal, E.G. Poon et al., “The Costs of a National Health Information Network,” *Annals of Internal Medicine,* Aug. 2005 143(3):165–73.

[8] A. M. Audet, M. M. Doty, J. Peugh et al., “Information Technologies: When Will They Make It Into Physicians’ Black Bags?” *Medscape General Medicine,* Dec. 7, 2004.

[9] R. Miller, C. West, T. M. Brown, “The Value of Electronic Health Records in Solo or Small Group Practices,” *Health Affairs,* Sept./Oct. 2005 24(5):1127–37.

[10] M. B. Rosenthal, R. G., Frank, Z. Li et al., “Early Experience with Pay-for-Performance: From Concept to Practice,” *Journal of the American Medical Association,* Oct. 12, 2005 294(14):1788–93.

Melinda K. Abrams
Senior Program Officer

2005 Annual Report

Patient-Centered Primary Care Initiative

One of the defining features of a high performance health system is its responsiveness to patients' preferences and needs. Increasingly, patients expect physicians to provide them with access to their medical information, to treat them as partners in care decisions, and to address their concerns.

Despite being named one of the key components of quality health care by the Institute of Medicine (IOM), "patient-centeredness" has yet to become the norm in primary care. One of five American adults has trouble communicating with doctors, and one of 10 feels they were treated disrespectfully during a health care visit.[1] Moreover, The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care shows that only one-third of physicians receive feedback from patient surveys and just 16 percent communicate with patients via e-mail.[2]

A high level of responsiveness to patients' needs and preferences is one of the defining features of a high performance health care system. For one of the first projects of the Fund's new Patient-Centered Primary Care Initiative, experts will develop and test measures that enable accrediting agencies and others to determine the extent to which physicians provide patient-centered care—a necessary first step toward establishing a reward or incentive program.

Photo: Michael Maloney/Black Star

To help address these deficiencies, the Fund in 2005 launched the Patient-Centered Primary Care Initiative, seeking to promote the redesign of primary care physician practices and health care systems. Through a combination of research, outreach, and intervention, the initiative aims to make the IOM recommendation to design care around patients' needs a reality.

The essay, "A 2020 Vision of Patient-Centered Primary Care," published in the *Journal of General Internal Medicine* in October 2005, outlines what it will take to make physician practices more centered around patients.[3] In the article, the Fund's Karen Davis, Stephen Schoenbaum, M.D., and Anne-Marie Audet, M.D., proposed that the following seven attributes should define a patient-centered primary care practice:

1) superb access to care
2) patient engagement in care
3) clinical information systems that support high-quality care, practice-based learning, and quality improvement
4) care coordination
5) integrated and comprehensive team care
6) routine patient feedback to doctors
7) publicly available information.

Ensuring that all Americans have a medical home is a first step toward creating a patient-centered health system, say Davis and colleagues. A package of patient-centered services—such as e-mail visits, automated patient reminders, access to electronic medical records, same-day appointments or walk-in hours—could be supported, they argue, through a fixed monthly fee. In addition pay-for-performance contracts similar to those employed in the United Kingdom could encourage primary care practices to measure and improve the quality of care delivered. Demonstration projects could test the viability of such models and develop a "business case" for patient-centered care.

Two Fund-supported projects are beginning to respond to the challenge put forth in the "2020 Vision" paper. Under one grant, the National Committee for Quality Assurance is developing and testing a comprehensive set of measures to assess a patient-centered practice. These measures will enable accrediting agencies and other organizations to determine the extent to which physicians provide such care—a necessary first step toward establishing a reward or incentive program. A second project led by Dana Safran, Sc.D., of Tufts–New England Medical Center is examining the strength of the relationship between patient experience and clinical performance at the individual physician and practice levels. The results from this work will provide much-needed information to help motivate a greater investment in and commitment to patient-centered care.

In the upcoming year, the Patient-Centered Primary Care Initiative will be seeking a better understanding of which features of a patient-centered practice are meaningful to patients and associated with high-quality care. Policy analysis and demonstration projects sponsored by the program will also ensure that patients' experiences are featured in efforts to improve quality and efficiency.

NOTES

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[1] 2001 Commonwealth Fund Survey of Health Care Quality. http://www.cmwf.org/surveys/surveys_show.htm?doc_id=228171

[2] 2003 Commonwealth Fund Survey of Physicians and Quality of Care. http://www.cmwf.org/surveys/surveys_show.htm?doc_id=278869

[3] K. Davis, S. C. Schoenbaum, A.-M. J. Audet, "A 2020 Vision of Patient-Centered Primary Care," *Journal of General Internal Medicine,* Oct. 2005 20(10):953–57. http://www.cmwf.org/publications/publications_show.htm?doc_id=307907

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

2005 Annual Report

Quality of Care for Underserved Populations

Many projects supported by the Quality of Care for Underserved Populations program evaluate health care delivery innovations that address the needs of minority and low-income patients. At La Causa Resource Center in Milwaukee, Wisc., parents are mentoring other parents to help them better manage their children's asthma—part of a trial under way at the Medical College of Wisconsin.

Photo: University of Wisconsin–Milwaukee Media Production

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

- supporting models of high-performance health care for underserved populations;
- promoting patient-centered care for these populations; and
- highlighting policies that lead to improved care.

Racial and ethnic disparities in health care quality are well documented in the Institute of Medicine's report, *Unequal Treatment,* as well as in the Agency for Healthcare Research and Quality's annual National Healthcare Disparities Report.[1,2] While recent findings suggest that some progress has been made in closing the gaps,[3] significant efforts are still needed to ensure high-quality care for all minority and low-income patients.

One of the strategies of the Underserved Program is to identify and disseminate best practices in safety net hospitals and community health centers, which serve large numbers of racial and ethnic minorities and low-income patients. Although these health systems face challenges due to lack of resources, they have demonstrated the ability to provide high-quality care.

In a Fund-supported study, Marsha Regenstein, Ph.D., and colleagues at the National Public Health and Hospital Institute found that clinical outcomes for public hospital patients with diabetes—many of whom are particularly vulnerable due to low income and lack of health insurance—were comparable to or, in some cases, even better than national averages for all hospitals.[4] Still, neither public hospitals nor managed care plans performed as well as the Veterans Administration (VA), a public health system that has rigorous protocols for quality improvement. The authors suggest that the VA's success in managing patients with diabetes can serve as a model for delivering high-quality care to underserved patients.

In 1998, the Bureau of Primary Health Care initiated health disparities collaboratives, which enable community health centers (CHCs) and other safety net providers to work together to improve the quality of patient care. The Fund and the Agency for Healthcare Research and Quality are cosponsoring an evaluation of these collaboratives for patients with hypertension, diabetes, and asthma to determine whether they have been effective in reducing disparities. Preliminary findings show that CHCs deliver care of comparable quality to that delivered in other sectors of the health care system, despite the challenges presented by disadvantaged populations.[5] There is room for improvement, however:

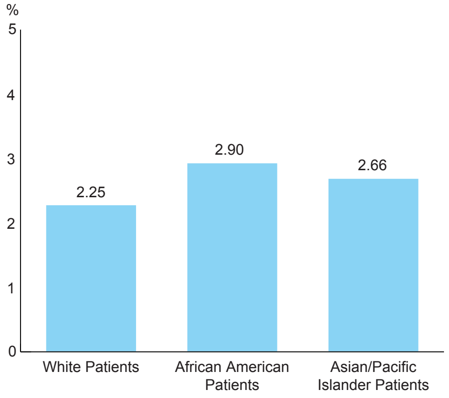
quality of care was found to vary by patient as well as health center characteristics, such as use of electronic health records.

To catalyze improvements in the health care received by minority patients in Medicaid managed care plans, the Fund is supporting the Center for Health Care Strategies (CHCS) in the development of the Best Clinical and Administrative Practices (BCAP) initiative. BCAP leaders are identifying highly effective practices used by state Medicaid agencies to improve quality and evaluating federal and state regulations that address racial and ethnic health disparities. They are also working with 12 Medicaid managed care plans in a demonstration project to improve care for minority patients. Best practices and lessons will be posted on the CHCS and Fund Web sites and disseminated to Medicaid agencies and managed care plans through the BCAP Quality Summit.

Much of the literature on health disparities finds that minority patients presenting with the same symptoms and background as white patients are less likely to receive appropriate care for their conditions.[6] Minority patients are also less likely than white patients to get their care from high-performing health systems, according to a Fund-supported study. Dana Mukamel, Ph.D., from the University of California, Irvine, found that when African Americans saw cardiothoracic surgeons for diagnostic or therapeutic procedures, they were less likely than white patients to go to high-quality hospitals or see high-quality surgeons.[7] Mukamel also found that after the release of surgeon "report cards" in New York State, black patients' access to the best hospitals and the best providers improved.[8] Before the reports were available, patients chose surgeons based primarily on observable characteristics, such as years of experience or price; patients' behavior changed, however, with the availability of explicit quality information, such as surgeons' mortality rates for specific procedures.

African Americans and Asian/Pacific Islanders are more likely to be treated by physicians with higher average risk-adjusted mortality rates.

Average risk-adjusted mortality rate of physicians treating...



Note: The mortality rate statewide for all patients was 2.44% in 1996 and 2.22% in 1997.
Source: B.M. Rothenberg et al. "Explaining Disparities in Access to High Quality Cardiac Surgeons," *Annals of Thoracic Surgery* 78 (July 2004): 18-24.

The Fund is also supporting work to identify high-performing health systems for racial and ethnic minorities by using the 10 hospital quality measures adopted by the National Voluntary Hospital Reporting Initiative. Researchers at the Health Research and Educational Trust are working with the private University HealthSystem Consortium to collect and analyze the quality data, which are stratified by race, ethnicity, and primary language to measure disparities in inpatient care. The research team is also conducting case studies to assess how individual hospitals respond to reporting quality data by race/ethnicity. Another research team, based at George Washington University, is developing protocols for using the reporting framework at six major public hospitals that treat large minority populations.

Patients who have limited proficiency in English or difficulty comprehending physician instructions and health information often experience problems accessing care. Many also receive lower-quality care or underutilize appropriate health services. With support from the Fund, Glenn Flores, M.D., from the Medical College of Wisconsin, found that parents with limited English proficiency (LEP) are three times more likely than English-proficient parents to have a child in fair or poor health, and twice as likely to have had a child spend one or more days in bed with an illness in the past year.[9]

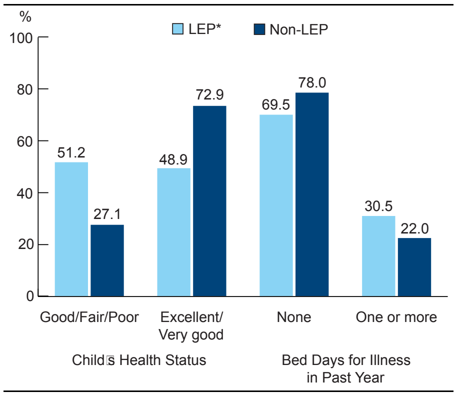
Glenn Flores, M.D.
Medical College of Wisconsin

Flores concluded that parental LEP is a more precise measure of language barriers in health care than the primary language spoken at home—and recommends that health plans routinely collect information on their patients' English proficiency to measure demand for interpreter services.

Although the importance of having well-trained medical interpreters is widely recognized, there are few national standards of practice. With support from the Fund and the California Endowment, the National Council on Interpreting in Health Care has laid the groundwork for creation of such

Limited English proficiency of parents can negatively affect children's health status.

Percent



Source: G. Flores, M. Abreu, and S.C. Tomany-Korman, "Limited English Proficiency, Primary Language at Home, and Disparities in Children's Health Care: How Language Barriers Are Measured Matters," *Public Health Reports* 120 (July/August 2005): 418-30.
Note: P-values (from chi-square test): child health status, <0.001; bed days for illness in past year, 0.004.
* LEP=Limited English Proficiency

standards.[10] In a Council report reviewing interpreting standards in the United States and around the world, Marjory Bancroft, founder and director of CrossCultural Communications, found that conference, legal, and sign-language interpreting are far more developed than community or health care interpreting.

Health care providers who would like to offer translation services to their LEP patients must find qualified interpreters and secure resources to pay for their services. This can be particularly challenging in solo or small group practices, in which nearly 60 percent of physicians practice. The Fund provided support to the National Health Law Program to identify promising models for providing language services in small group settings.[11] The innovative practices identified include designating a staff member to direct language access planning; determining language needs at first point of contact with patients; and hiring bilingual mid-level practitioners or dedicated staff interpreters.

The Underserved Populations program is also supporting the dissemination of the National Quality Forum’s safe practice regarding informed consent, whereby patients are asked to “teach back” their comprehension of a surgical procedure and its risks.[12] So far, a number of hospitals have implemented this practice among patients with limited English proficiency or low health literacy.

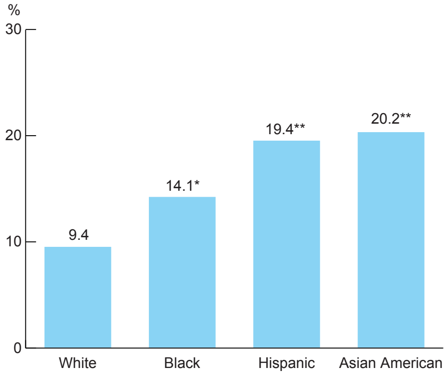
Good patient–provider communication is an important component of health care providers’ “cultural competency,” but there is more to it than that. Cultural competency involves responsiveness to all aspects of a patient’s culture, enabling providers to promote greater engagement of patients in managing their medical conditions.

Fund-supported research has found that perceptions of disrespect affect whether patients heed doctors’ advice or return for treatment. In an analysis of the 2001 Health Care

Quality Survey, George Washington University's Janice Blanchard, M.D., and RAND's Nicole Lurie, M.D., found that minorities are significantly more likely than whites to report being treated with disrespect by their providers.[13] Respondents who reported disrespectful treatment were more likely to report not following their doctors' advice and putting off needed medical care.

Percentage of patients who felt they were looked down upon/treated with disrespect by their doctors.

Percent



Source: J. Blanchard and N. Lurie, "R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care," *Journal of Family Practice* 53 (Sept. 2004): 721.
* $p \leq 0.10$
** $p \leq 0.001$

As a first step toward developing standards for cultural competency training, implementation, and assessment, the Fund has commissioned a series of papers exploring aspects of cultural competency and patient-centered care for minorities. Using the papers as a basis for discussion, the Fund will host a roundtable meeting of experts to determine next steps in this effort.

The Fund also seeks to promote awareness of health care disparities, and of federal and state policies that can help reduce them. Support for press conferences and a congressional briefing, for example, enabled the Summit Health Institute for Research and Education, Inc., to inform key policymakers about findings from the Institute of Medicine's *Unequal Treatment* report and the Agency for Healthcare Research and Quality's National Healthcare Disparities Reports. Summit also provided information and technical assistance to national advocacy organizations that promote policies addressing health disparities.

In June 2005, the Fund and the Alliance for Health Reform sponsored a roundtable discussion, "Leveraging Quality Data to Eliminate Disparities," that explored ways of using quality data to identify disparities and applying these methods to publicly funded health programs. One of the panelists, Bruce Siegel, M.D., a professor at the George Washington University School of Public Health and Health Services, presented Fund-supported work showing that public hospitals are able to report quality indicators stratified by race and ethnicity. Siegel showed that this can help hospitals identify areas where quality improvement efforts can not only improve care but also reduce inequities in the care delivered.

In response to studies documenting widespread failings in access to care and quality of care for millions of minority children, Senior Program Officer Anne C. Beal, M.D., published a *Health Affairs* article outlining federal interventions that may reduce racial disparities in pediatric care.[14] These policies include broadening health care coverage, adopting common quality improvement efforts, improving the training of health care providers, and boosting the ranks of minority clinicians. The recommendations from this paper have been reported to the Department of Health and Human Services Office of Minority Health and the Congressional Black Caucus Health Braintrust.

In addition, John McDonough, Ph.D., of the consumer health advocacy organization Health Care For All prepared a Fund report[15] that provided state policymakers with a menu of disparity-reduction policy interventions implemented at the state or local level. He identified a number of key strategies that should be considered, from establishment of minimum standards for culturally competent health services to greater minority representation within the health care workforce. The New England Coalition for Health Equity sponsored a symposium focused on implementation of McDonough's recommendations.

Fellowship in Minority Health Policy

Improving the health care system's capacity to address the needs of minority and disadvantaged populations is the goal of the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy. Directed by Harvard Medical School's Joan Reede, M.D., the program offers an intensive, one-year, full-time program of study to future physician-leaders who intend to pursue careers in minority health care or health policy. Approximately five fellows each year complete academic work for a master's degree in public health or public administration.

Dora L. Hughes, M.D., a 1999–2000 Minority Health Policy Fellow, is currently a legislative assistant to U.S. Senator Barack Obama.

Most of the 46 alumni physician fellows hold appointments at schools of public health or medicine, and several have assumed leadership roles in public health departments or community health centers. Past fellows also serve on numerous local and national advisory committees related to minority health.

Over the past year, several alumni of the fellowship have seen their research published in peer-reviewed journals. For an issue of *Health Affairs* devoted to health care disparities, Amal Trivedi, M.D., described a disparities report card he developed for states, which he based on Fund-sponsored work by John McDonough, Ph.D. In the same issue, Joseph Betancourt, M.D., reported that fostering "cultural competence" has been gaining attention, not only as a strategy to reduce racial and ethnic disparities but more broadly as a means of improving the quality of health care. In addition, Yvette Roubideaux, M.D., authored a Fund report documenting health care disparities among American Indians and Alaska Natives (AIANs) and progress made in the last five years to reduce gaps in care. She concluded her paper with 10 recommendations for future action.

Under Dr. Reede's leadership, the fellowship program in the past year has established connections with state and local health departments and sought post-fellowship support from several organizations. It has also created a national advisory committee, which mentors fellows and identifies possible employment opportunities.

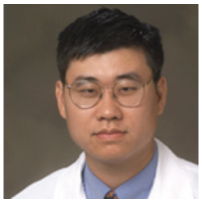
2005–06 Fellows in Minority Health Policy

- **Kansky Delisma, M.D.**, emergency room attending physician at the Veterans Administration Medical Center in Connecticut. Dr. Delisma is particularly interested in migrant health issues, especially those relevant to the rapidly growing Haitian American community.

- **Jean LeClerc Raphael, M.D.**, chief resident of pediatrics at Boston Medical Center. Dr. Raphael has a keen interest in poverty and chronic disease, as well as health care in the juvenile justice system. He aims to combine a career of clinical medicine with active engagement in the policy and legislative arenas.

- **Sarah Perez McAdoo, M.D.**, chief resident in obstetrics and gynecology at Baystate Medical Center, Massachusetts. Her interest focuses on adolescent reproductive health and teenage pregnancy prevention. She is particularly interested in becoming an advocate for the health of Latinas.

- **Anthony L-T Chen, M.D.**, lead family physician at the International Community Health Services, Holly Park Medical & Dental Clinic; and clinical assistant professor at University of Washington Department of Family Services. Dr. Chen has a strong interest in cross-cultural medicine and cultural competency in health care, community-oriented primary care, and Asian health issues.



- **Don Suk Lee, M.D.**, internal medicine resident at Aurora Sinai Medical. Dr. Lee will focus his research on developing an efficient health care delivery system in an urban, underserved area, with particular emphasis on serving minority and disadvantaged populations.

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[7] B. M. Rothenberg, T. Pearson, J. Zwanziger et al., "Explaining Disparities in Access to High-Quality Cardiac Surgeons," *Annals of Thoracic Surgery,* July 2004 78(1):18–24.

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[9] G. Flores, M. Abreu, and S. C. Tomany-Korman, "Limited English Proficiency, Primary Language Spoken at Home, and Disparities in Children's Health and Healthcare: How Language Barriers Are Measured," *Public Health Reports,* July/Aug. 2005 120(4):418–30.

[10] M. Bancroft, *The Interpreter's World Tour: An Environmental Scan of Standards of Practice for Interpreters* (The California Endowment, Mar. 2005).

[11] M. Youdelman and J. Perkins, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field* (New York: The Commonwealth Fund, May 2002).

[12] National Quality Forum, *Learning from Early Adopters: Improving Patient Safety Through Informed Consent in Limited English Proficiency/Low-Literacy Populations,* NQF Policy Brief (Dec. 2003).

[13] J. Blanchard and N. Lurie, "R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care," *Journal of Family Practice,* Sept. 2004 53(9):721.

[14] A. C. Beal, "Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care," *Health Affairs*, Sept./Oct. 2004 23(5):171–79.

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

Edward L. Schor, M.D.
Vice President

Melinda K. Abrams
Senior Program Officer

2005 Annual Report

Child Development and Preventive Care

With Commonwealth Fund support, pediatric practices affiliated with Kaiser Permanente Northwest, including this one in East Portland, Ore., are testing a special version of the Promoting Healthy Development Survey, which will help pediatricians provide the services that professional guidelines recommend and parents say they want.

Photo: Jeff Lee/Redux Plus

The Fund's Child Development and Preventive Care Program is helping to create the professional and policy infrastructure necessary for reforming pediatric preventive care, especially services dealing with young children's 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.

Creative reform of health care policy and systems is likely to occur first among states. Partnerships within state governments and between public and private entities are critical in formulating policies to encourage and sustain improvements in care. In an effort to engage states in quality improvement, the Fund recently supported Vernon Smith, Ph.D., of Health Management Associates, to convene a cross-section of state government leaders from public health, Medicaid, the State Children's Health Insurance Program, mental health, and education. Despite the fiscal and administrative challenges facing state governments, officials are optimistic that improvement in quality of care for young children is possible, Smith found. These leaders' recommendations include developing specific child health quality measures, monitoring performance on an ongoing basis, making information about the quality of care easily available, rewarding superior performance, and using performance measures in purchasing and program decisions.

State Medicaid programs are the most important part of the public safety net of health services available to low-income children: each year, more than 50 percent of low-income American children receive care covered by Medicaid. Since these children are at great risk for poor developmental outcomes, the program has focused on improving the quality of developmental services and preventive care within Medicaid. The Fund's support of eight state Medicaid programs has led to innovations in the provision of well-child care, as well as changes in state policy to support these improvements.

For example, North Carolina Medicaid, with support from the state pediatric society, has begun mandating the use of standardized developmental screening instruments during selected well-child visits. So far, more than 12 North Carolina counties and 75 pediatric practices have adopted the developmental screening model developed by Marian Earls, M.D., in Greensboro, N.C. Developmental screening rates in model practice sites increased from less than 16 percent in 1999 to 85 percent in 2005. Meanwhile, Anne Marie Murphy, Ph.D., director of Illinois's Medicaid agency, recently announced that the state is now reimbursing health care providers for maternal depression screening during well-child visits, even if the mother is not a Medicaid beneficiary—a policy change resulting from Illinois Medicaid's Assuring Better Child Health and Development (ABCD) project, supported by the Fund.

Anne Marie Murphy, Ph.D.
Illinois Medicaid and SCHIP Programs

The Fund's long partnership with the National Academy for State Health Policy has stimulated interest in improving the quality of preventive and developmental services and has supported the exchange of information and models of care among states. For example, after witnessing the success of a local improvement partnership in Vermont among pediatric practices, Medicaid, and other state agencies, Utah and Illinois are establishing similar practice networks, with Medicaid as a lead partner.

The Center for Health Care Strategies (CHCS) has also worked with Medicaid to improve children's health care. Drawing from the experience of 11 Medicaid plans that participated in a learning collaborative to improve developmental services, CHCS prepared a practical guide for health plans that will help them work with primary care practitioners to introduce standardized developmental screening, develop educational materials for parents, and streamline systems for identifying children with developmental problems and referring them to specialists. For example, CommunityCARE of Louisiana developed a standardized tracking referral form that allows plans to monitor families who were referred for additional services.

Although the Child Development and Preventive Care Program does not support clinical research, it is very involved in evaluating various systems and models of care. The Fund's work clearly demonstrates that the quality and use of screening and other developmental services in pediatric practices can in fact be improved.[1,2] One of the lessons from the state-level quality improvement initiatives the foundation supports is that success requires ongoing partnerships between state health agencies and health care providers, insurers, and educators. To facilitate the forming of such alliances, the Fund has supported the development of Improvement Partnerships in Arizona, New York, Rhode Island, Washington, and the District of Columbia.

The Fund also seeks to strengthen connections between physician practices and the other developmental services their patients and families need. A good example is the support provided for an evaluation of the Connecticut-based *Help Me Grow* program, a training and referral system that assists child health practices in securing services for at-risk children.[3] *Help Me Grow*'s toll-free telephone hotline contributed to a doubling of the rate of identification of developmental concerns in participating practices, from 9 percent to 18 percent. Because of the promise shown, Orange County, Calif., and the state of Hawaii are interested in replicating the model.

Following the tenet that holds "what gets measured is what gets done," health systems, state Medicaid programs, and physician practices continue to use the Promoting Healthy Development Survey (PHDS) to measure the quality of preventive child health care.[4] Developed in part with Fund support by Christina Bethell, Ph.D., at the Oregon Health and Science University, PHDS, along with its variants, is the leading global measure of well-child care.

A recent Fund report by Henry Ireys, Ph.D., at Mathematica Policy Research, Inc., examined how Medicaid programs are using external quality review organizations to champion quality measurement, especially for child developmental services. A related toolkit provides practical advice to states on how to make the best use of their external quality reviews. To better measure progress toward high-quality developmental services, the Fund benchmarked the current provision of developmental services through the National Survey of Early Childhood Health and described the current status of children's development and its determinants through a partnership with Child Trends.[5]

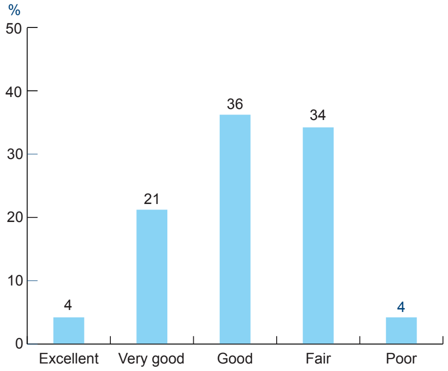
Another key program strategy is to promote the review and revision of clinical standards of developmental care. The schedule for well-child care has not been substantially revised since it was first published by the American Academy of Pediatrics nearly 40 years ago. Under a project led by J. Lane Tanner, M.D., of the University of California, San Diego, experts will recommend a new schedule for well-child care that responds to the needs of today's families. Michael Weitzman, M.D., and colleagues at the University of Rochester, meanwhile, are developing the first authoritative and comprehensive guide to preventive pediatric care. The guide will likely be an important reference for teaching, practice, and evaluation.

Michael Weitzman, M.D.
University of Rochester

Other projects will help to establish standards for organizing and managing efficient pediatric practices. Stanford University's David Bergman, M.D., is producing guidelines that will help practices provide effective and efficient care based on the latest innovations and research.

Pediatric faculty see the need for improved residency training in developmental and behavioral pediatrics.

Percent of respondents



Note: 1 percent of survey respondents answered "don't know."

Source: E.L. Schor and C. Elfenbein, *A Need for Faculty Development in Developmental and Behavioral Pediatrics* (New York: The Commonwealth Fund, Nov. 2004).

To ensure that effective approaches to care are disseminated and adopted, the Fund is supporting a number of learning collaboratives, including one with the American Academy of Pediatrics. Preliminary results from participating practices in 10 states indicate a significant increase in rates of assessing parents' strengths (from 3% to 29%), using flow sheets to ensure complete care (from 21% to 77%), and using structured developmental screening instruments during well-child visits (from 29% to 75%).

In a recent Fund survey, pediatric faculty members reported that better resident and faculty training is needed in developmental and behavioral pediatrics. Pediatric nurse practitioner programs, too, have recognized the need to strengthen their training in this area. The Fund is supporting a major effort by the Association of Faculty of Pediatric Nurse Practitioner Programs to pilot-test a new curriculum for practitioners in 20 training programs around the country. The new curriculum will be informed by a series of training modules developed with Fund support by Steve Parker, M.D., at Boston University.

In an effort to improve the skills of practicing physicians, the Fund supported *Medscape* to host an hour-long webcast on developmental screening in primary child care settings. The session has been accessed by more than 20,000 people, and more than 2,500 clinicians have received continuing education credit. A follow-up survey of participants showed a 29 percent increase in developmental screening in their practices.

The Child Development and Preventive Care Program will continue to seek ways to address the persistent challenges of financing preventive care. Due in part to the fragmented system of health care for children in the United States, as well as the budget constraints faced by states' Medicaid programs, equitable reimbursement for pediatric preventive care remains a continuing dilemma.

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Mary Jane Koren, M.D.
Senior Program Officer

2005 Annual Report

Picker/Commonwealth Program on Quality of Care for Frail Elders

A resident enjoys a moment at the Meadowlark Hills long-term care facility in Manhattan, Kan. At Meadowlark Hills, nursing home “culture change” is on full display. Its CEO, Stephen Shields, is currently working with the Fund to develop a set of tools for other nursing home operators that will enable them to provide resident-centered care.

Photo: Eli Reichman/Redux Plus

The concept of patient-centered care—care delivered in accordance with the needs and desires of patients—is starting to gain traction in health care, including the field of long-term care. When Congress passed the Omnibus Budget and Reconciliation Act of 1987, new standards for nursing home quality were put in place, giving resident-centered care a statutory basis and stimulating a handful of providers and long-term care professionals to think creatively about how nursing homes could be transformed.

From these beginnings, efforts to move the culture of nursing homes from an institutional model to one centered on residents have attracted the attention of providers, consumer advocacy groups, and government agencies. The Picker/Commonwealth Program on Quality of Care for Frail Elders is deeply involved in these efforts. The projects it supports seek improvement in nursing home quality by testing and evaluating emergent models of resident-centered care and promoting nursing home “culture change” among stakeholder groups.

One of the most revolutionary ideas for what nursing homes should be comes from William Thomas, M.D. He argues that if nursing homes function as residents' homes, they should be built on a residential scale. Thomas has developed a model for small group homes, which he calls Green Houses, and a system for providing care that borrows from home care rather than the acute care practices that have shaped the industry.

With Fund support, the University of Minnesota's Rosalie Kane, M.D., has evaluated the first four Green Houses, which were built in Tupelo, Miss. Kane has found that, compared with their counterparts at older facilities, Green House residents, staff, and families are more satisfied and residents function at higher levels. Kane is now analyzing the business case for the Green House model, and the Robert Wood Johnson Foundation is supporting its replication.

The Fund also has supported the development of the Wellspring model, in which nursing homes join together in ongoing quality improvement collaboratives. This past year, two new Wellspring alliances have been created, one in Maryland and one straddling North and South Carolina. In addition, Wellspring Innovative Solutions, the entity formed to disseminate the model, has developed a package of training materials that can be used by quality improvement organizations (QIOs).

Some nursing home facilities require practical guidance to put the tenets of culture change into practice. With Fund support, Stephen Shields, a leading proponent of resident-centered care and the CEO of Meadowlark Hills, a long-term care facility in Kansas, is producing a comprehensive "toolkit" for nursing homes operators, including a leadership guidebook, policy and procedure manuals, human resource management systems, and a quality improvement process that reinforces the philosophy of resident-centered care. Shields and his mission were the focus of a CBS News segment in October 2005.


Rosemary Fagan
Pioneer Network

As part of its new Nursing Home Quality Initiative, the Centers for Medicare and Medicaid Services (CMS) is making QIOs responsible for improving nursing home quality and requiring them to promote resident-centered care. To take advantage of this opportunity, the Fund is supporting the Pioneer Network, a diverse group of providers, researchers, and practitioners with long experience in nursing home culture change, to share its expertise and resources with QIOs and others interested in nursing home quality. The Pioneer Network's "Summit 2020" provided an opportunity for newcomers to the culture change movement to meet the leaders, develop a shared understanding of resident-centered care, and map out strategies for change.

CMS's "Eighth Scope of Work" for QIOs is to bring culture change to at least 10 percent of nursing homes in each state. To accomplish this, QIOs are expected to build coalitions of key stakeholders within their states. A Fund-supported meeting led by the Rhode Island QIO—the leading Nursing Home Quality Initiative—brought together interested parties to form such coalitions and begin work on state-specific action plans. Known as the St. Louis Accord, the gathering was attended by 377 people from all 50 states, including ombudsmen, surveyors, QIO staff, and members of nursing home trade associations.

When Hurricane Katrina hit the Gulf Coast states in August, frail elderly adults, especially those living in long-term care facilities, suffered disproportionately. Mississippi Methodist Senior Services, which owns and operates the Green Houses in Tupelo, Miss., promptly acted on warnings of the impending storm and evacuated over 400 residents from their campuses in Biloxi, Hattiesburg, and Meridian to their more northern facilities. Because of the Fund's involvement with the

Green Houses, a grant was made to assist Mississippi Methodist in caring for relocated residents in the storm's aftermath.

A number of other activities over the past year have cultivated a network of policymakers, health care providers, and researchers interested in nursing home quality improvement. At the "Pragmatic Innovations" meeting, jointly sponsored by the Fund and the National Institute on Aging, Philip Sloane, M.D., of the University of North Carolina disseminated an annotated bibliography on resident-centered care, including research on living space, regulations, organizational structures, and the business case for culture change. Meeting participants then drafted a report, to be submitted for publication, identifying gaps in the knowledge base and proposing a further research agenda.

This year also marked the second in a series of Fund-sponsored long-term care colloquia, "Building Bridges: Making a Difference in Long Term Care," held in conjunction with AcademyHealth's Annual Research Meeting. These colloquia provide unique opportunities for a diverse group of researchers, policy leaders, providers, consumer representatives, and funders to debate the issues, examine proposed solutions, review evidence, and identify additional research needs. This year's sessions covered affordable housing and long-term care services[1] and consumer-directed care and its implications for state and federal policy,[2] among other topics. To follow up on the interest expressed by policymakers attending the colloquium, a day-long session on consumer-directed long-term care will be held in conjunction with AcademyHealth's February 2006 Policy Meeting in Washington, D.C. Several researchers who attended the colloquium are preparing to study still unexplored areas relating to the Green House nursing home model, which was discussed by the housing-with-services panel.

Through this and other efforts, the Program on Quality of Care for Frail Elders is acting to help transform the nation's long-term care facilities into good places to live and work—high-performance organizations delivering resident-centered services.

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[1] S. M. Golant, "Affordable Clustered Housing Care for Older Americans: A Promising but Still Immature Long-Term Care Strategy," 2005 (working paper).

[2] R. Brown, "Consumer-Directed Care and its Implications for State and Federal Long-Term Care Policy," 2005 (working paper).

Robin Osborn
Vice President

2005 Annual Report

International Program in Health Policy and Practice

The mission of the Fund's International Program in Health Policy and Practice is three-fold: building an international network of health care researchers devoted to policy, sparking creative thinking about health policy through international exchanges, and encouraging comparative research and collaboration among industrialized nations. As part of that work, the program conducts high-level international policy forums to promote the exchange of innovations targeting common problems.

At the Commonwealth Fund's 2005 International Symposium in Health Care Policy, leading government officials and experts from several industrialized nations, including Peter Sawicki (speaking), director of Germany's Institute for Quality and Efficiency in Health Care, described his nation's efforts to benchmark the quality of hospital care. Seated next to him is Sir Liam Donaldson, the United Kingdom's Chief Medical Officer.

Photo: John Troha/Redux Plus

2005 International Symposium

For the past eight years, the Fund has hosted an annual international symposium focusing on a health policy topic of mutual concern to the United States and other industrialized nations. This year's symposium, held November 2–4 in Washington, D.C., brought together policy experts to discuss issues surrounding patient choice, health system responsiveness, and ways that health care systems can implement patient-centered care concepts. Participants included health ministers or their designates from Australia, Canada, New Zealand, the United Kingdom, and the United States, as well as senior government officials and leading researchers from each country. In addition, experts from Germany and the Netherlands were invited to share innovations under way in their country.

In the opening keynote address, U.S. Secretary of Health and Human Services Michael O. Leavitt spoke about his recent trip to Asia and concerns about the potentially devastating effects of an avian flu pandemic on world health and economic well-being—and the need for pandemic readiness, both in the U.S. and abroad. Secretary Leavitt stressed the importance of health information technology (IT), not just during times of natural disasters but in efforts to improve the overall quality of health care.

A further highlight of the meeting was the fourth John M. Eisenberg, M.D., International Lecture, delivered by Donald M. Berwick, M.D., president and CEO of the Institute for Healthcare Improvement. Berwick issued a challenge to policy leaders to control and rationalize health care financing, pursue integrated and population-based care, and improve the reliability and safety of care.

At the symposium, Fund senior vice president Cathy Schoen and vice president and International Program director Robin Osborn presented findings from the 2005 International Health Policy Survey. An article based on the findings was published as a *Health Affairs* Web Exclusive, which received extensive media coverage, including an article in the *Washington Post* and an op-ed in the *New York Times*. The six-nation survey focused on the experiences of adults with health problems, and for the first time included Germany, in addition to Australia, Canada, New Zealand, the U.K., and the U.S. The U.K.-based Health Foundation and Germany's Institute for Quality and Efficiency in Health Care provided cofunding for the survey.

The survey results reveal significant differences as well as strikingly similarities among the countries. Medical errors and failure to coordinate care, especially during transitions from one site of care to another, are problems shared by all six countries, as are missed opportunities to engage patients as partners in their care. Between one-fifth and one-third of adults across the six countries reported that a medical mistake, medication error, or lab test error had been made in their care in the past two years. Errors were reported most frequently in the U.S. and Canada, with the U.S. standing apart from the other nations for safety risks, inadequate coordination, inefficient care, financial burdens, and health care access or cost concerns.

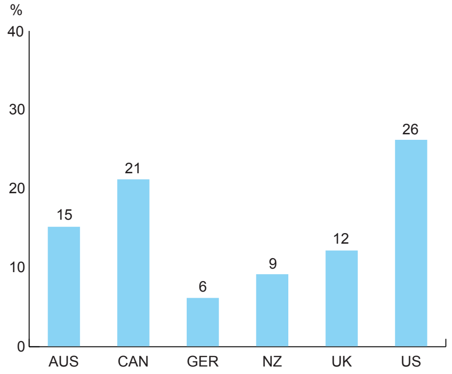
Germany's comparatively strong showing in the survey suggests it is possible to provide universal health insurance coverage while simultaneously ensuring affordability of care and timely access to services.

At the symposium, a policy roundtable discussion among senior officials provided the opportunity for a candid exchange of views on pressing issues, including health care quality, health system sustainability, patient choice, and manpower priorities. Participating were Carolyn Clancy, M.D., director of the U.S. Agency for Healthcare Research and Quality; Pete Hodgson, New Zealand's minister of health; Sir Liam Donaldson, U.K. chief medical officer; Canada's Ian Shugart, senior assistant deputy minister; Philip Davies, deputy secretary of the Australian Department of Health and Ageing; and Peter T. Sawicki, M.D., director of Germany's Institute for Quality and Efficiency in Health Care.

On the last day of the symposium, participants discussed how the U.S. might learn from the policy and health care delivery innovations tried in other countries. Held on Capitol Hill in cooperation with the Alliance for Health Reform, the session highlighted national hospital quality benchmarking in

People in the U.S. rely on emergency rooms for non-emergency care at a rate higher than in other industrialized countries.

Percent of adults who went to the ER for a condition that could have been treated by a regular doctor, if available



Source: C. Schoen, R. Osborn, P. T. Huynh et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive, Nov. 3, 2005.

Germany, patient safety initiatives, and pay-for-performance strategies in the U.K.

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

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

In July 2005, the Fund and the London-based Nuffield Trust cosponsored the seventh in a series of meetings for senior U.S. and U.K. policymakers and quality experts. Entitled "Improving Quality of Health Care in the United States and United Kingdom: Strategies for Change and Action, 2005," the gathering was further enriched by representatives from Australia and New Zealand. Held at Pennyhill Park in Bagshot, England, the meeting addressed four topics: how to get recommended care into practice all the time; how to use information technology to maximize clinical and patient engagement; how to foster professionalism and quality improvement; and what the media's role is in health care quality.

A starting point for the dynamic exchange that followed was the presentation of Australian, U.K., and U.S. case studies of innovative approaches to improve care for chronically ill children. During the conference, participants received an update on the progress of the 2001 bilateral agreement between the U.K. and U.S. for collaboration on quality improvement, and an agenda for future collaboration was discussed.

International Working Group on Quality Indicators

Since 1999, Gerard Anderson, Ph.D., of Johns Hopkins University and Robin Osborn have co-directed the International Working Group on Quality Indicators, a unique collaboration that includes government officials from Australia, Canada, New Zealand, the U.K., and the U.S.; 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 produced in 2004 the first-ever set of quality indicators—30 in all—for benchmarking and comparing health care system performance across countries.

In collaboration with the Fund, the OECD is building on this work through its International Healthcare Quality Indicators Project, also chaired by Dr. Epstein. The OECD has expanded the project to include 23 countries and is further developing the scope and depth of the indicator set. The project, which was endorsed by health ministers at the OECD May 2004 Ministerial meeting, will by early 2006 produce data on participating countries from an initial set of 17 indicators. The objective is to expand the indicator set to include 50 internationally comparable quality measures.

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 for individuals to spend up to 12 months in the U.S. conducting a policy-oriented research study, gaining firsthand exposure to managed care and other models of health care delivery, enhancing methodological skills, and working with leading health policy experts. Two Canadian Harkness Associates, selected in collaboration with the Canadian Health Services Research Foundation, participate in the fellowship seminars, adding a valuable perspective to the program. Beginning with the 2006–07 class, the Fund will expand the Harkness Fellowships to include a fellow from Germany. Nicole Lurie, M.D., senior natural scientist and professor of health policy at the RAND Corporation, serves as the Fund's senior fellowships advisor.

The seventh class of fellows (2004–05) completed a productive year, ending with a final reporting seminar in Boston, Massachusetts, in June 2005. In October, fellows attended the Fund's International Symposium on Health Care Policy and participated in a visit to the Agency for Healthcare Research and Quality. 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. In May, the fellows traveled to Calgary and Vancouver for briefings with senior government officials and health care leaders and a closer look at the Canadian health care system.

In July, The Commonwealth Fund co-sponsored, with the Nuffield Trust and Health Foundation, the first Harkness Fellowships in Health Care Policy Alumni Health Policy Conference. The event, held in England, brought together the first seven classes of Harkness Fellows to exchange views on policy developments in their home countries and to stimulate cross-national research collaborations. The retreat reinforced the Harkness Fellowship network while strengthening the Fund's international network of health policy experts.

The 2005–06 Harkness Fellows in Health Care Policy arrived in the U.S. beginning in August, including two U.K. Harkness/Health Foundation Fellows. Under the guidance of distinguished U.S. and home country mentors, the fellows will conduct research projects, with a final paper or report for senior policymakers the expected end-product. Many of these projects will include cross-national comparisons.

The 2005–06 Harkness Fellows include:

- **Julia Abelson, Ph.D., M.Sc.** (Canadian Associate)
  Associate Professor, McMaster University
  Project Title: Informed and Becoming Informed: The Public and Canadian/U.S. Health Policy

- **Stirling Bryan, Ph.D., M.Sc.** (United Kingdom)
  Professor of Health Economics, University of Birmingham
  Project Title: The Use of Cost-Effectiveness Information in Coverage Policy Decisions in the US and the UK
  Placement: Center for Primary Care and Outcomes Research, Stanford University
  Mentor: Alan Garber, M.D., Ph.D.

- **Anna Dixon, M.Sc. (Econ)** (United Kingdom)
  Lecturer in European Health Policy, London School of Economics and Political Science
  Project Title: Informed Choices: What Use Do Patients Make of Quality Information When Deciding Who To Consult and Where to Get Treated?
  Placement: Department of Planning, Public Policy, and Management, University of Oregon
  Mentor: Judith Hibbard, Dr.P.H.

- **Nisha Dogra, Ph.D., B.M., MRCPsych, M.D.** (United Kingdom)
  Senior Lecturer, University of Leicester, and Honorary Consultant in Child and Adolescent Psychiatry, Greenwood Institute of Child Health
  Project Title: Case Studies to Compare Cultural Competency Training in Managed Care Organizations with Public Hospitals and Non-Health Businesses
  Placement: Institute for Health Policy, Harvard Medical School
  Mentor: Joseph Betancourt, M.D., M.P.H.

- **Derek Feeley** (Harkness/Health Foundation Fellow; United Kingdom)
  Head of National Planning, Scottish Executive Health Department
  Project Title: Developing Health Services fit for 2020 – Strategic Planning to Deliver Health Care for Older People with Long Term Conditions
  Placement: Kaiser Permanente
  Mentors: Robert Crane and Paul Wallace, M.D., and The Honorable Jonathan B. Perlin, M.D.,

Ph.D., Under Secretary for Health,
Department ofVeterans Affairs

- **Sonj Elizabeth Hall, Ph.D., R.N., M.P.H.** (Australia)
  Lecturer in Health Systems and Economics, School of Population Health, The University of Western Australia
  Project Title: The Impact of Policies in the U.S. and Australia on Improving Access and Quality of Care for People Diagnosed with Cancer in Disadvantaged Communities
  Placement: Agency for Healthcare Research and Quality (AHRQ)
  Mentors: Ernest Moy, M.D. and Carolyn Clancy, M.D.

- **Rhys Jones, M.B.Ch.B., M.P.H.** (New Zealand)
  Senior Lecturer, University of Auckland
  Project Title: Effectiveness of Interventions to Reduce Ethnic Disparities in Health Care: A Case Study Review
  Placement: Department of Health Care Policy, Harvard Medical School
  Mentor: John Ayanian, M.D.

- **James Mountford, B.M., B.Ch., M.A.**
  (Harkness/Health Foundation Fellow; United Kingdom)
  Engagement Manager, McKinsey and Company
  Project Title: The Impact of Incentives for Hospital Doctors on Organizational Performance, Quality, and Disparities Across Patient Groups
  Placement: Harvard School of Public Health and Institute for Healthcare Improvement
  Mentors: David Blumenthal, M.D., and Donald Berwick, M.D.

- **Adam Oliver, Ph.D., M.Sc.** (United Kingdom)
  Deputy Director of LSE Health and Social Care and Lecturer in Health Economics and Policy, London School of Economics
  Project Title: Policies and Institutions: A Comparative Analysis of the Goals and Policies of the UK National Health Service and the VA on Performance
  Placement: Columbia University, School of Public Health
  Mentors: Sherry Glied, Ph.D., and Lawrence Brown, Ph.D.

- **Denis A. Roy, M.D., M.P.H., M.Sc., FRCPC**
  (Canadian Associate)
  Director of Information and Knowledge Management, Monteregie Local Health and Social Services Network Development Agency
  Project Title: Development of a New Governance Structure Focused on Continuing Improvement of Performance in the Regional Healthcare System

Packer Policy Fellowships

The Packer Policy Fellowships, a "reverse Harkness Fellowship" program established in 2002, are designed to enable two mid-career U.S. policy researchers or practitioners to spend up to 10 months in Australia conducting research and gaining an understanding of Australian health policy issues relevant to the U.S. Chaired by Andrew Bindman, M.D., the selection committee met in November 2005 and selected the third round of fellows.

- Thomas C. Buchmueller, professor of economics and public policy at the Paul Merage School of Business, University of California, Irvine

- Valerie A. Hepburn, associate director and assistant professor at the Institute of Public Health, Georgia State University.

Ian Axford Fellows, 2006

The Fund administers the Ian Axford (New Zealand) 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, criminal justice, race relations, the environment, and tax policy—to take six-month policy sabbaticals in New Zealand. The Ian Axford Fellowships selection committee, chaired by Robert D. Reischauer, president of the Urban Institute, met in May and selected three 2006 fellows, who will begin their tenure in New Zealand in January 2006. They include:

- Linda Blumberg, senior research associate at The Urban Institute

- Susan Coopedge, assistant U.S. attorney in the Northern District of Georgia

- Saskia Kim, principal consultant in the Senate Office of Research, California State Legislature.

Partnerships with International Foundations

The Commonwealth Fund continues to seek and nurture partnerships with international foundations in order to expand and enrich its current programs. In addition to expanding the Harkness Fellowships in Health Care Policy program to include two U.K. Harkness/Health Foundation Fellows, The Commonwealth Fund's partnership with the Health Foundation features other areas of collaboration. Beginning with the 2004 International Health Policy Survey, The Health Foundation has supported an expanded U.K. sample, making possible statistically significant comparisons among England, Scotland, Wales, and Northern Ireland.

Beginning with the 2005 International Health Policy Survey of Sicker Adults, Germany's Institute for Quality and Efficiency in Health Care provided support for the survey in Germany, expanding the survey to six countries.

Each year since 2001, two Canadian Harkness Associates have participated in the fellowships program as part of an ongoing collaboration between the Fund and the Canadian Health Services Research Foundation. The Fund continues to build on its longest-standing international partnership—that with the Nuffield Trust, with which the Fund has cosponsored an annual International Meeting on Health Care Quality since 1999.

In the fall of 2002, the Fund joined the Bertelsmann International Network for Health Policy and Reform in a 15-nation collaboration for sharing information on policy reforms, innovations, and best practices. The network—which includes independent experts from foundations and research institutions in Australia, Austria, Canada, Denmark, Finland, France, Germany, Japan, Netherlands, New Zealand, Singapore, Spain, Switzerland, the U.K. and the U.S.—provides "real-time" reports twice each year on health sector reforms and trends in industrialized nations.

Research Projects and Other Activities

Through its Small Grants Program, the Fund supports efforts to learn from other countries' experiences. Projects in 2004–05 included sponsorship of international sessions at the 2005 AcademyHealth Annual Research Meeting, which showcased innovative approaches to pharmaceutical coverage and costs, models for disease management and coordination of care for chronically ill patients, and broad-scale implementation of electronic health records. A grant to Karen Scott Collins, M.D., at the New York City Health and Hospitals Corporation, will support a cross-national exchange on quality improvement collaboratives for diabetes and depression in New York City's public safety net hospitals and London-based National Health Service hospitals.

Fund support will also enable examination of the changing public/private mix of financing and health care delivery in seven countries. The project, which will be directed by Dov Chernichovsky of Israel's Ben Gurion University, should offer lessons to the United States regarding access, cost containment, and efficiency.

Finally, the Fund sponsored its first international policy briefing in April on Capitol Hill. Held in cooperation with the Alliance for Health Reform, the event—entitled "Weighing the Evidence: Conducting Reviews of Pharmaceuticals in Four Countries"—was attended by more than 200 congressional staff, Washington policymakers, and journalists. Participants learned about innovative policy approaches in the U.K., Canada, and Germany regarding pharmaceutical costs and coverage, as well as a parallel U.S. demonstration project to encourage evidence-based Medicaid drug policy.

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

Executive Vice President — COO's Report
2005 Annual Report

Foundation Performance Measurement: A Tool for Institutional Learning and Improvement

The Commonwealth Fund's Board of Directors holds an annual retreat to consider external reviews of major programs, hear from expert panels on major health care issues, and discuss long-term program strategy. Directors, including Walter E. Massey, president of Morehouse College, and Samuel C. Fleming, chairman emeritus of Decision Resources, Inc., carefully examine the Fund's grantmaking experience and operating practices for lessons useful in shaping the foundation's work going forward.

Photographer: Martin Dixon

American foundations and nonprofit organizations are responsible to the public for the quality and efficiency of their work. This year, the Independent Sector's Panel on the Nonprofit Sector clarified the terms of that responsibility in its June 2005 report to Congress and the nonprofit sector, Strengthening Transparency, Governance, and Accountability of Charitable Organizations. Representing more than a year's painstaking work by dozens of nonprofit leaders, the report recommends more than 120 actions to be taken by charitable organizations, Congress, and the Internal Revenue Service to strengthen the nonprofit sector.[1] This agenda calls for significant improvement in self-regulation along with a modest increase in governmental oversight—a delicate balance needed to prevent abuses in the sector while preserving the independence that is the heart of its strength.

In its deliberations, the Panel paid particular attention to problems enumerated in the June 2004 Senate Finance Committee Discussion Draft on nonprofit issues and in subsequent hearings and roundtable meetings. Among those problems was the sense that the annual tax returns filed by nonprofits do not provide sufficient information about the effectiveness of organizations' programs, and that there are no commonly accepted procedures for ensuring that nonprofits are evaluating the effectiveness of their programs and services. The 2004 Discussion Draft specifically proposed that tax returns for nonprofits be revised to include "a detailed description of the organization's annual performance goals and measurements for meeting those goals."

The report by the Panel recommends against requiring nonprofits to provide more detailed statements on goals and performance measures in their annual tax returns. Instead, it urges that every charitable organization provide detailed information about its programs—including the methods it uses to evaluate outcomes—through annual reports, Web sites, and other means. In making this recommendation, the Panel points to the already abundant information organizations supply on the IRS tax return and argues that "because of the diversity of the sector and the subjective nature of performance measures, requiring more detailed statements of the performance measures would not provide meaningful information for the public or for regulators." The report notes, as well, that annual performance indicators are inappropriate for many institutions and their programs, given the long-term nature of the investments they make in human resources, medical research, and social interventions.

The Commonwealth Fund agrees with the Panel's assessments. We believe that accountability and transparency are crucial. However, the Fund's own experience confirms that standardized metrics and reporting systems are unlikely to align well with the work of most foundations or be sensitive enough to provide useful lessons. Instead, foundations should assemble an array of methods that allow them to examine their own performance and that of their grantees, make improvements based on lessons learned, and report findings to their various audiences. This holds true especially for the Fund and similar "value-added" foundations, which work directly with grantees to develop projects, carry them to fruition, and disseminate results.

Foundations can learn much from their counterparts throughout the nonprofit sector, just as the Fund has learned over the years from the practices of its peers. In that spirit, we offer an outline of the Fund's own performance assessment system and a compendium of the lessons it has generated about the most effective use of organizational resources.

THE FUND'S APPROACH TO PERFORMANCE ASSESSMENT

The Fund's emphasis on performance assessment derives from its belief that value-added foundations must necessarily be learning organizations. In other words, to add value to the work the foundation supports, the Fund's directors and staff must constantly examine the effectiveness of their strategies, systems, and processes and pay close attention to the environment in which the foundation and its programs and grantees operate. While the Fund is committed to the public disclosure of its activities, products, and accomplishments, its performance assessments are designed principally to assist the foundation's own managers, directors, and advisers.

The Fund employs six performance assessment mechanisms:

1. an annual operational review of programs and Fund activities, focused on work culminating during the year and its impact with respect to improving health care policy and practice;
2. case studies of selected completed grants;

3. annual numeric and qualitative assessments of all recently completed grants;
4. review annually of at least one major program, conducted by an external reviewer and including confidential surveys of key informants;
5. periodic confidential grantee and audience surveys, now augmented with periodic on-line audience feedback surveys; and
6. an overall review of the foundation's general strategy at five-year intervals.

Currently under development is a seventh method—a performance "scorecard" that encompasses measures of the foundation's financial performance, the value of its work to audiences, internal processes, and human resource capacity.

Each technique produces useful information, but the more compelling lessons are drawn from the general trends and patterns that the various approaches reveal. We have therefore distilled the findings from our different assessments into a set of principles that guide the Fund's grantmaking.

PRINCIPLES FOR VALUE-ADDED GRANTMAKING

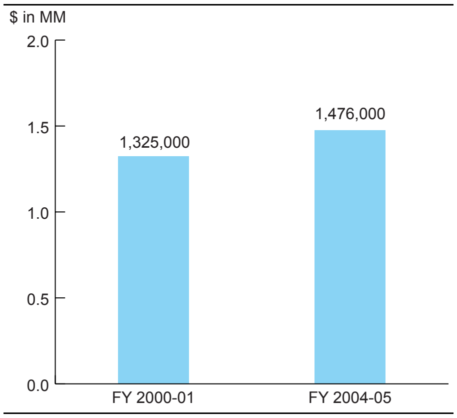
1. Developing Sound Strategies

A foundation's program strategy should be mission-driven, based on sound analysis of the issues it is addressing, attuned to the broader context in which the programs are operating, and geared to the organization's experience and strengths.

- **Focus efforts to achieve effect**. At the July 1995 retreat of the Fund's Board of Directors, former Rockefeller Foundation chairman John Evans, M.D., offered "focus, focus, focus" as the three rules for strategic success in the foundation field. Even very large foundations need to concentrate their efforts, Dr. Evans said, if they hope to make an impact on complex social problems. Taking that advice to heart, the Fund has concentrated on improving health care coverage, access, and quality over the last 10 years; within that framework, it has concentrated further on a limited set of programs designed according to a few basic principles.

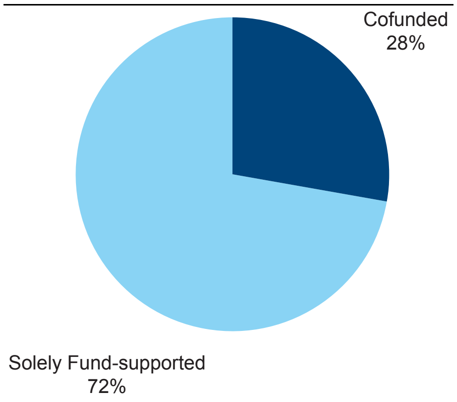
- **Pay attention to timing**. The second triplet of rules for strategic success is arguably "timing, timing, timing." Programs are likely to have greater effect when they are running with the tide of political, economic, social, management, and technological trends. Fund-supported projects that provided unique information at crucial moments, for example, have had major effects on fundamental policy assumptions or best practices in health care.
- **Organize programs around overarching, unified themes**. An annually updated plan for each major program is a highly effective strategic and management tool. Preparing and reviewing the plan provides opportunities to assess work in progress, make strategic course corrections, and gather early feedback from the Fund's executive team on projects being considered for development and funding in the coming year. Defining the dimensions of the problem, assessing the work of other funders in the proposed program area, and carefully thinking through strategic options are essential first steps in developing new programs.
- **Build a staff with the skills needed to add value to the work of grantees, carry out research, and communicate results**. The Fund's investment in professional staff has enabled it to maintain the grantmaking responsibilities for individual senior program officers at the optimal

The average grant dollars for which each Fund program officer is responsible has been maintained at approximately the optimal level recommended by experts on value-added foundations.



Cofunding and other partnerships strengthen projects and leverage the Fund's capacities.

Percent of project dollars, 1995–2005



level of approximately $1.5 million annually, as recommended by experts on value-added foundations. The strength of the Fund's staff allows it to prospect in emerging policy areas (such as health care quality improvement), open up new fields, and attract other funders.

- **Emphasize communications to achieve results**. The Fund's grantmaking and research are designed to create a pipeline of products to be communicated to influential audiences. This perspective ensures a focus on deliverables from the very beginning.
- **Convene meetings of influential policymakers**. By developing signature meetings such as the Bipartisan Congressional Health Policy Conference, the International Symposium on Health Care Policy, and Alliance for Health Reform briefings, the Fund has cultivated important outlets for its work and set a high standard of quality for products created by Fund staff and grantees.
- **Use commissions and task forces strategically**. The Fund has used these bodies to organize its own work on an issue, ensure input and feedback from influential leaders and policymakers, and enhance communication of findings.
- **Actively seek influential partners**. Strong relationships with grantees and partners (who may be cofunders or collaborators) can be mutually productive and can help build a network of influential contacts for expanding a foundation's capacities.

2. Capitalizing on the Fund's Comparative Advantages

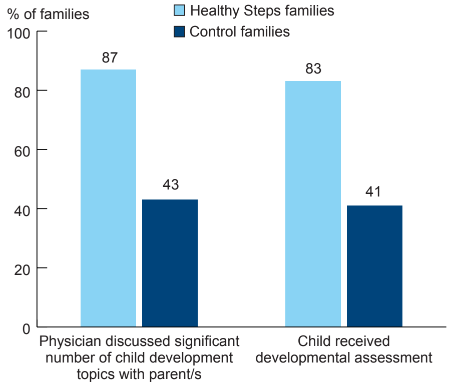
The Fund has honed its niche and assembled a set of resources and capacities that give it an advantage in certain types of work.

- **Sponsor work that will inform key health care policy discussions and spark debates on existing or emerging issues**. Producing information on important policy issues can be a strong suit for a mid-sized foundation like the Fund. The Fund has built a strong staff and cultivated relationships with key grantees, who together bring the requisite expertise, experience, and intellectual creativity to the challenge. Work by the Fund and its grantees contributed to the debate leading up to the 2003 enactment of the Medicare prescription drug benefit; discussion of health plans during the 2004 presidential campaign; and deliberations on high-deductible health plans. Fund-sponsored work also played a role in making Medicare's two-year waiting period for the disabled a front-burner issue.
- **Analyze and report on policy options**. The Fund's Task Force on the Future of Health Insurance was particularly effective in analyzing states' options for improving health insurance coverage and assessing national options for expansion.
- **Assess the impact of public program changes or assist their implementation**. The Fund played a substantial role in tracking the implementation of Medicaid managed care in the late 1990s, and subsequently in assessing the progress and impact of Medicare+Choice/Medicare Advantage. The foundation is now sponsoring work to assess the implementation of the new Medicare

drug benefit, with particular attention to the needs of low-income beneficiaries.

- **Use surveys to develop timely information and build a reputation as an information resource**. Surveys have been very useful to the Fund in identifying emerging issues (such as the growth of consumer debt associated with inadequate health insurance, or patients' problems communicating with their doctors), producing comparative performance data on the health care systems of the U.S. and other industrialized countries, and shaping the foundations' own work. Focus groups have been useful as well for defining problems, developing survey instruments, and giving a human face to survey findings.
- **Invest strategically in secondary data analysis**. The Fund has made selective, modest investments in the analysis of large data sets by experts in the field. That work has produced influential reports on, for example, the growing share of uninsured workers employed by large firms, uninsured Americans' lack of access to new medical technologies, and instability in Medicare supplemental drug coverage (recognition of which helped make the case for Medicare's new drug benefit).
- **Produce case and field studies**. Funding case and field studies of innovative practices has proved particularly useful during a period of rapid change in the health care system and in health care policy, when timely, accurate information is scarce. Based on the Fund's careful review of its experiences, purely descriptive field work is not as valuable as analysis.

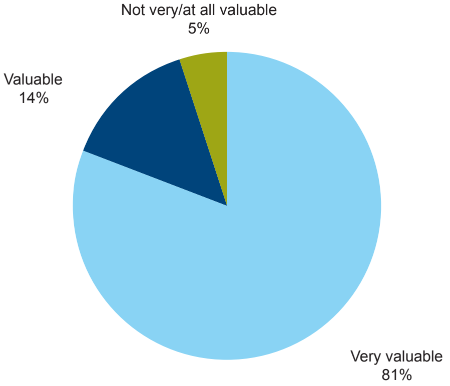
Evaluation of the Fund-supported Healthy Steps pediatrics care demonstration revealed success in promoting attention to child development issues.



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: The Healthy Steps for Young Children Program," *Journal of the American Medical Association*, Dec. 17, 2003, 290(23):3081–91.

- **Select "action projects" judiciously**. The Fund's most successful action projects have tended to be the first to apply an innovative idea to an important but little-recognized problem. A common pitfall of such projects is the "one-shot" interesting innovation. A comparative advantage of value-added foundations like the Fund is their ability to evaluate action projects, stick with a promising approach, and follow up with investments to produce widespread change.
- **Exercise caution respecting commitments to large-scale demonstrations and evaluations**. Large, very expensive undertakings are generally not practical for a foundation of the Fund's size and run counter to its strength of generating needed information quickly and delivering it effectively to influential audiences.
- **Support institutional learning collaboratives and evaluations**. This affordable strategy has helped the Fund catalyze changes in organizational practice that would otherwise require resources beyond the Fund's means.
- **Work with states, either individually or through multistate initiatives**. States have made advances on many fronts, even in an era when federal progress is frequently stymied. The Fund has worked with states to expand health insurance coverage incrementally, track the effectiveness of high-risk insurance pools, address child development issues through Medicaid, and improve hospital safety.
- **Help build quantitative tools to move an issue or field forward**. The Fund has supported the creation of surveys, performance measures, and other tools that help hospitals and other health care

Harkness Fellows in Health Care Policy (1998–2003) report that the fellowship is valuable to their professional development and career advancement.



Institute for Health Policy, Massachusetts General Hospital, 2003 Survey of Harkness Fellows in Health Care Policy, post-tenure.

providers improve the quality of their care. It has also devoted resources to assembling chartbooks, case studies, and other publications that map the state of existing knowledge and help define an issue.

- **Support the development of talented young individuals**. Fellowship programs for promising young professionals have paid off again and again. The Minority Health Policy Fellows and Harkness Fellows in Health Care Policy perform well individually while on their fellowships, then leverage their abilities in later years.
- **Bring experts and leaders together to sort out issues and build consensus**. Fund-sponsored colloquia and working groups have helped shape national and international agendas and given direction to the Fund's own work.
- **Draw attention to the international experience**. The Fund is unique in attempting to bring the experiences of other industrialized countries to bear in U.S. health care policymaking. That expertise has enriched the Fund's domestic activities and helped build strong ties with governmental leaders in the U.S. and other industrialized countries.
- **Exercise caution when outside familiar areas**. Projects that entail software development, for example, or large, cofunded projects involving abstraction of clinical data, have proven to be disproportionately costly and do not take advantage of the expertise of Fund staff.

3. Executing Strategy

Former Robert Wood Johnson Foundation president Stephen Schroeder, M.D., argues cogently that, in the end, “execution trumps strategy” in the foundation business.[2] Wise use of intramural resources lies at the heart of effective execution and enables value-added foundations to prove their mettle.

- **Start with planning grants**. A planning grant can be a prudent safeguard against blindly leaping into new programs and projects. The Fund uses planning support to test the feasibility of potentially valuable, but risky, projects and to develop business plans for large undertakings.
- **Vigorously vet grant proposals**. The Fund uses a collegial but rigorous process for vetting grant proposals brought forward by program officers. Its features include: 1) joint review by the foundation’s executive management team; 2) independent rating by that team and by program officers of projects’ risk/reward potential; 3) review by external consultants when necessary; and 4) critiquing by Board members.[3] The process keeps the Fund’s executive management and Board in touch with all aspects of the foundation’s work and builds the analytic skills of program staff. The emergence of widespread uncertainties about a proposal during the vetting process is a clear signal to probe further before proceeding.
- **Support only projects that make clear contributions to the program plan**. Projects that have little synergy with other projects, are focused on second-order issues, or are of questionable timing should be set aside.

- **Carefully define the scope of a project**. Fund staff and outside experts help sharpen project design and improve methodology. Research hypotheses need to be clearly stated, and the research design must be sufficiently robust to test the hypotheses objectively.
- **Assess the grantee's institutional capacity**. Good intentions sometimes outpace an institution's ability to change or implement new programs, especially when bureaucratic and financial constraints are also at play. A management consultant may be able to help an organization set priorities and mobilize internal support.
- **Be skeptical about projections that innovations will spread easily**. Clinical innovations do not typically sell themselves to the institutions that can benefit from them. In order to recognize the value of new methods, administrators and professionals often need strong support. Adapting a proven innovative model to local conditions is unavoidable, and is perhaps even essential to successful adoption by institutions. A charismatic founder may not be best suited for managing a successful replication effort.
- **Reach practitioners through their organizations**. The Fund has magnified the practical impact of projects by working with professional, organizational, and trade associations to engage members who might not otherwise be interested in a particular issue.
- **Collaborate with organizations that are powerful agents of change**. The Fund has had success in forging partnerships with organizations that are well-positioned to diffuse innovation.

Examples include the National Academy for State Health Policy, the National Committee for Quality Assurance, the Health Research and Educational Trust, the Institute for Safe Medication Practices, the Organization for Economic Cooperation and Development, the American Board of Internal Medicine, and medical professional societies.

- **Commit to the long-term work of building a movement**. Through the sponsorship of the Picker Institute, the Fund was instrumental in the emergence of the patient-centered care movement in the 1980s and early 1990s. Opportunistic support of selected projects in recent years has helped position the Fund to make another contribution through its new Patient-Centered Primary Care Initiative, focused on developing and using physician performance measures to encourage providers to be more responsive to patients' needs and preferences. The Fund has also contributed to the nursing home culture change movement and to a systemic shift in well-child care toward greater emphasis of developmental issues.
- **Increase funding flexibility through the use of small grants**. The foundation's Small Grants Fund provides a flexible mechanism for undertaking exploratory work, evaluations, or project planning. It thereby helps to improve the risk/return profile of the Fund's major grants portfolio, assists grantees in obtaining funding from other sources, and provides supplemental support for unforeseen follow-up work. Small grants have been particularly useful for commissioning expert analyses of Fund surveys, underwriting small research projects, and supporting meetings and conferences.

- **Exercise caution in joining a large undertaking as a small contributor**. For a foundation to have an impact under such circumstances, it must be perceived as adding significant value through the expertise, time, and energy of its staff.
- **Be alert to the risks of projects whose success and conduct are contingent on government action**. Turnover in government agency staffs and shifting policy priorities can delay or imperil partnerships with agencies. At the same time, the availability of foundation funds can help officials hold to a planned course.
- **Enhance large undertakings with well-chosen add-on projects**. The real payoff of a long-term investment is sometimes realized only with a final, relatively small and unplanned commitment. Communications activities and supplemental data analyses have been particularly useful in this regard.

4. Selecting and Positioning Grantees for Success

The success of any grant is ultimately contingent on the abilities, experience, and commitment of the principal investigators and the strength of the partnership established between them and the Fund.

- **Look to researchers with practical experience in large public programs**. In the Fund's areas of interest, researchers with backgrounds in the Medicaid or Medicare programs often prove to be unusually productive because of their policy instincts and understanding of administrative practicalities. These individuals tend to be based in premier research consulting firms, and therefore expensive, but they usually demonstrate their worth.

- **Work with project directors who have performed well in the past**. The Fund benefits greatly from capitalizing on past investments and relationships. Yet our experience also indicates the need to be on the lookout for diminishing returns with higher-profile researchers whose professional responsibilities and external commitments are continually expanding. In such cases, it is probably not wise to press grantees who are reluctant to take on additional assignments.
- **Be cautious about putting research responsibilities into the hands of non-researcher practitioners**. Investigators whose strengths are largely operational or activist are unlikely to carry out data-specific analysis successfully. In some instances, the pairing of an implementer/activist with a researcher yields a productive partnership.
- **Recognize that technically oriented investigators may need help with communications**. Grantees with strong technical skills and reputations ensure that the work produced is well received in their fields. Products from such grantees sometimes benefit from the efforts of Fund staff to sharpen their policy relevance.
- **Pay particular attention to the leadership of multidisciplinary, synthesizing projects**. The success of chartbooks and commissioned sets of papers depends on a very energetic and capable coordinator, one expert in his or her own right and skilled at leading multidisciplinary teams and drawing out the major lessons from a large body of material.

The success of the Fund's chartbook series on health care quality in the U.S. is due in large part to the skill, experience, and energy of Sheila Leatherman, a professor at the University of North Carolina at Chapel Hill and a leading expert in the quality field. The latest chartbook, on care provided to Medicare beneficiaries, was released in May 2005 at the National Press Club.

5. Contributing to and Monitoring Work in Progress

Value-added foundations have "general contractor" responsibilities that make programs greater than the sum of their individual grants—and the job is far from done with the signing of a grant award letter.

The Fund regularly convenes meetings of program grantees to facilitate the exchange of new research and new approaches to improving health care. In April 2004, grantees of the Quality of Care for Underserved Populations program held a poster session on research projects currently under way. Here, Mara Youdelman of the National Health Law Program shares her thoughts with Laurie Nsiah-Jefferson of Brandeis University.

- **Build synergies among projects by bringing grantees together**. Annual meetings of all program grantees, often including selected experts, are directly beneficial to the conduct of the projects. In addition, they can lead to mutually beneficial collaborations among grantees and help in refining and maintaining vigorous program strategies.
- **Develop realistic timelines, in collaboration with grantees**. Institutional review board processes can delay the start of research projects involving human subjects, and realism regarding them is essential in developing timetables. While it is not always possible to keep projects on schedule, the Fund increases its success rate by having skilled, proactive professional staff. An effective grants management unit issues alerts when projects appear to be delayed or faltering and provides expertise in developing corrective action.
- **Look closely into changes in project leadership**. Experience cautions against assuming that a substitute principal investigator will carry out a project with the same vigor as the original proposer.
- **Recognize that changes at the foundation may weaken oversight of grants**. Foundation staff should be given incentives to devote the necessary attention to older projects, even those no longer in the programmatic spotlight.

- **Cut losses when a project is not working and the situation is irremediable**. This can be particularly hard to achieve when a foundation has a capable, confident, and committed program staff. A strong grants management staff is an effective safeguard in this respect.
- **Be disciplined about closing grants and learning from experience**. By systematically scoring each completed grant on performance and requiring a staff memorandum on lessons learned, the Fund ensures that grants are closed in a timely way, gains early feedback on results, and maintains an important archival record.

6. Communicating Results to Influential Audiences

Foundations operating in the policy arena and seeking to help bring about major system improvements, such as those needed in health care, must take the same hands-on approach to communicating the results of their work as they do in developing and monitoring projects.

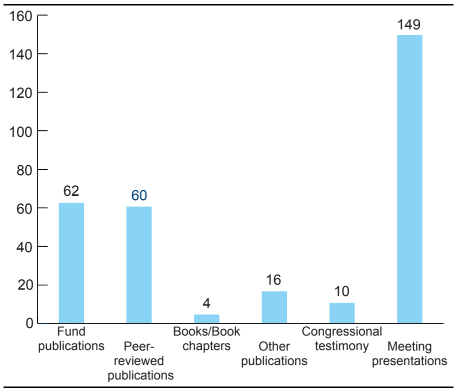
- **Build strong connections between program and communications staff**. A communications unit that is intimately familiar with programmatic work and actively looking for opportunities to package it effectively is central to each program's success. The unit should be led by an experienced and creative leader, who serves on the foundation's executive management team.
- **Develop publishing and distribution strategies geared to the needs of influential audiences for timely, easy-to-use information**. The Fund has emphasized publishing new information to policy audiences in easily

accessible formats. The Fund's commitment to self-publishing most of its survey and sponsored research has paid off in timeliness and media attention.

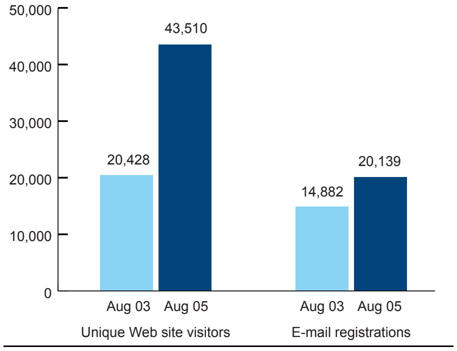
- **Package information to attract targeted audiences**. Program and communications staff should be prepared to provide substantial writing and communications support in the publication of sponsored research. With commissioned sets of reports, sequential releases of the individual papers can build momentum on an issue.
- **Exploit the power of the Internet**. A state-of-the art Web site enables dissemination of research papers, newsletters (including The Commonwealth Fund Digest, Quality Matters, and States in Action), testimony prepared for congressional hearings, grantee profiles, and other research that might not otherwise be widely disseminated. An enhanced e-mail alert system has enabled the Fund to promote sponsored research published in peer-reviewed journals. Additional Web-based communications vehicles such as Washington Health Policy Week in Review and the bimonthly Health Care Opinion Leaders Survey are proving useful to the Fund's audiences and are helping build its reputation as an information resource.
- **Sponsor conferences to disseminate important work**. The Fund often uses small grants to support conferences. The Fund's own staff are intimately involved in developing agendas and selecting presenters in order to achieve the full communications potential of these events.
- **Monitor quality carefully**. Quality control has become a particular challenge in recent years, as the Fund has increased its capacity to publish and

The Fund's publications program and work with grantees helps assure effective dissemination of the results of sponsored projects to influential audiences.

Communications output of 101 grant projects completed July 2003–June 2004



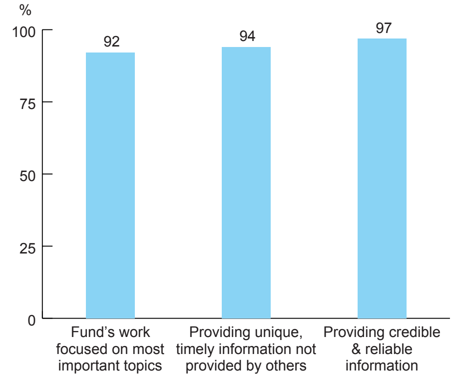
Investing heavily in electronic communications has greatly expanded the Fund's capacity to disseminate the results of its work to influential audiences seeking timely information useful to their work.



disseminate large numbers of documents on its Web site. An internal Web content review committee meets regularly to review materials before they are posted.

- **Survey key audiences to assess effectiveness and obtain feedback**. An audience survey in 2000 provided helpful feedback on Fund publications and encouraged investment in a Fund Web site. A 2003 audience survey instigated a shift to electronic dissemination of publications and upgrades to the site. The Fund is now exploring the use of more frequent online audience surveys and taking advantage of improved methodologies for tracking Web traffic.

The 2003 Survey of Fund Audiences indicates that the Fund is helping meet the information needs of its influential customers.



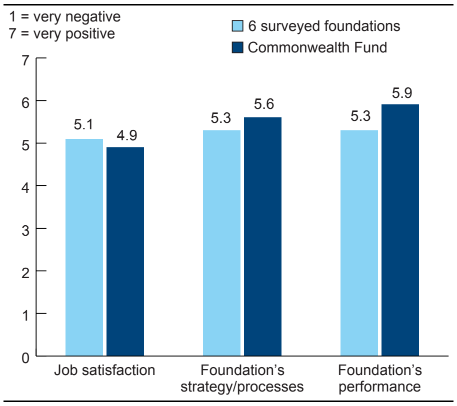
7. Staffing to Accomplish Value-Added Goals

Management consultant Jim Collins argues that great nonprofits, like great companies, concentrate on "getting the right people and hanging on to them" and sees "developing a sustainable resource engine to deliver superior performance" as being as important as strategic focus and pursuit of comparative advantage in distinguishing "great" from simply "good" nonprofits.[4] His principles apply with particular force to value-added foundations.

- **Hire expert, professional staff**. Recruiting and enabling a professional staff is the sine qua non for a mid-sized foundation like the Fund to achieve its mission. The Fund has sought and succeeded in hiring staff who are highly qualified in the various disciplines associated with health policy, as well as research, survey techniques and analysis, and communications.

- **Strive to retain staff and promote stability**. Staff turnover is inevitable in a field of high professional mobility like health care, but the Fund explicitly attempts to retain key staff and take steps to minimize the effects of turnover when it occurs. New staff members receive an orientation on ongoing work and are encouraged to assume accountability for that work.
- **Take steps to identify job satisfaction issues**. The 2005 Center for Effective Philanthropy Survey of Foundation Staff (encompassing six peer foundations) revealed that Fund staff give their organization comparatively high ratings on the effectiveness of its programs and processes. The results also pointed to areas where the Fund could improve job satisfaction.
- **Lead major programs from inside the foundation**. Over the past five years, the Fund has relied increasingly on its own staff to lead selected major programs—a shift from its earlier tendency to use external program directors who had responsibilities to their own organizations and other funders.

Staffs of the Fund and peer foundations rate their organizations positively on job satisfaction, but rate their foundation's processes and performance even more highly.



Center for Effective Philanthropy, 2005 Survey of Foundation Staff (composite scores on multiple dimensions of job satisfaction, foundation processes, and foundation performance).

LEARNING FROM EXPERIENCE

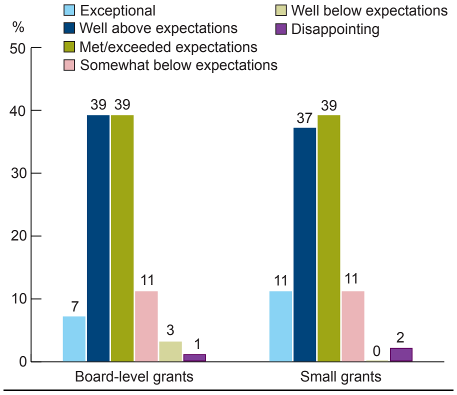
The great majority of Fund projects completed over the last 12 years have met or exceeded expectations—a record that reflects attention to the principles outlined here and a commitment to drawing lessons from experience.[5]

As recently summarized by health policy and management professor Stephen Shortell, a substantial body of management research demonstrates that organizational learning "is often critical for achieving high performance in other domains. It involves the organization's collective ability to incorporate new knowledge and practices."[6] A learning organization, explains Harvard Business School professor D. A. Garvin, is "skilled at creating, acquiring, and transferring knowledge and at modifying its behavior to reflect new knowledge and insights."[7]

A major strength of the foundation sector is the independence and heterogeneity of the institutions that populate it. But regardless of size, mission, donor intent, history, program focus, leadership background and vision, and staff and board capacities, every foundation stands to gain from periodic assessments of its grantmaking experience and the lessons such reviews yield. Especially when operating in fields where evaluating impact is difficult and when funding work that does not easily lend itself to outcomes measurement, foundations can help ensure strong performance and accountability by installing systems and processes for drawing lessons. In the foundation sector, evidence of the presence of robust processes for institutional learning may be among the best available measures of an organization's commitment to high performance.

The great majority of both Board-level and Small Grants Fund projects have met Fund performance expectations.

Performance of 432 Board-level and 484 Small Grants Fund projects, 1992–2004



NOTES

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[1] The report can be downloaded from Independent Sector's Web site, or that of the Panel on the Nonprofit Sector.

[2] Robert Wood Johnson Foundation Annual Report 2001.

[3] Risk ratings are based on established multiple criteria, weighted according to their experience-based level of importance.

[4] J. Collins, "Great to Good and the Social Sectors: Why Business Thinking Is Not the Answer," Nov. 2005.

[5] As noted above, Fund staff prepares an annual report to its Board on all recently completed Board-level grants (greater than $50,000) and Small Grants Fund projects ($50,000 or less), including scoring of individual projects on project performance, grantee performance, risk level, and staff level of effort. Completed projects are scored on a 1 (low) to 5 (high) scale independently by the Fund's president, executive vice president for programs, senior vice president for research and evaluation, director of grants management, and the relevant program officer.

[6] S. M. Shortell et al., "An Empirical Assessment of High-Performing Medical Groups: Results from a National Study," *Medical Care Research and Review,* Aug. 2005 62(4):407–34.

[7] D. A. Garvin, "Building a Learning Organization," *Harvard Business Review,* July 1, 1993 71:(4):78–91.

THE
COMMONWEALTH
FUND

2005 Annual Report

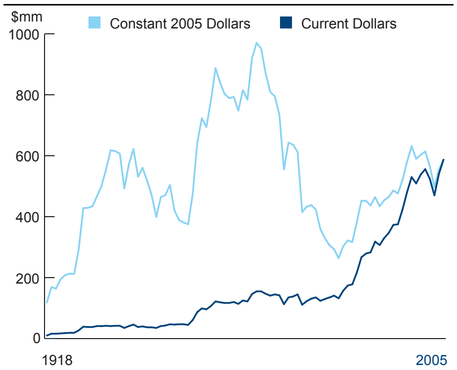
Treasurer's Report

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 ensuring a stable source of funds for programs and the foundation’s perpetuity. The committee determines the allocation of the endowment among asset classes and hires external managers, who do the actual investing. Day-to-day responsibility for the management of the endowment rests with the Fund’s executive vice president and COO/treasurer who, with the assistance of Cambridge Associates consultants, is also responsible for researching policy questions to be addressed by the committee.

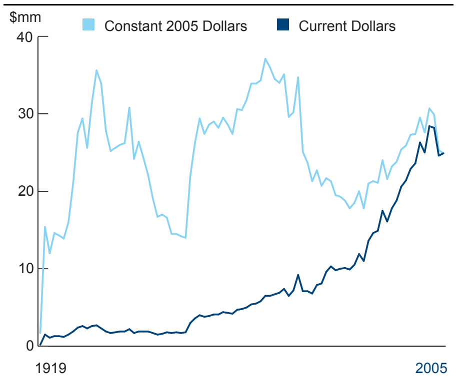
The committee meets at least twice a year to: 1) review the performance of the endowment and individual managers; 2) reassess the allocation of the endowment among asset classes and managers, making changes as appropriate; 3) deliberate investment issues affecting the management of the endowment; and 4) consider new undertakings.

The value of the endowment rose from $571.2 million on June 30, 2004, to $605.5 million on June 30, 2005, reflecting a return of 11.2 percent on the investment portfolio during the year combined with total spending (including programs, administration, investment management fees, and taxes) of $27.8 million. In that 12-month period, the return of the Wilshire 5000 index of U.S. stocks was 8.4 percent; the return of the Lehman Aggregate Bond index was 6.8 percent; and the

The Commonwealth Fund’s endowment, in millions, 1918-2005



The Commonwealth Fund's annual spending, in millions, 1919-2005: Total spending of $674 million over 86 years, or $2.2 billion in constant 2005 dollars



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 8.2 percent. The Fund's overall investment performance exceeded not only that of the weighted market benchmarks, but also the 9.2 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 12.1 percent, well above the Wilshire 5000's 8.4 percent and the median U.S. equity manager's 8.8 percent. The foundation's international, emerging markets, hedge fund, energy, commodities, and venture capital/private equity managers produced very strong returns compared with their market benchmarks, and accounted for the overall superior equity team performance. The Fund's new bond manager team (now including a global fixed-income manager) outperformed the Lehman Aggregate bond index (8.0% vs. 6.8%) in 2004–05.

The Fund's investment returns in 2004–05 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 target allocation from 30 percent to 25 percent, and increasing the energy and commodities allocations of the endowment to 6.5 percent and just over 4 percent, respectively.

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 25 percent commitment to publicly traded U.S. equities, paired with a 20 percent commitment to international equities, including a 5 percent allocation to emerging markets; allocation of approximately 7 percent of the endowment to a passive S&P 500 index fund, to help control investment costs and ensure 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 devoted particular attention during the year to building up the foundation's non-marketable alternative equities—venture capital and private equities—and non-marketable oil and gas and natural resources portfolios. New commitments to eight partnerships totaling $38 million put the foundation well on the road to meeting the target allocations for these types of investments. The committee periodically reviews asset class allocation targets and the permissible ranges of variation around them; except in very unusual circumstances, the portfolio is rebalanced when market forces or manager performance cause an allocation to diverge substantially from its target.

As shown in the figure, the Fund's investment managers as a group outperformed the overall portfolio market benchmark and the median balanced U.S. manager by wide margins over the three-, five-, and seven-year periods ending June 30, 2005. For the last 10 years and over the nearly 24 years since the foundation adopted a multiple manager system,

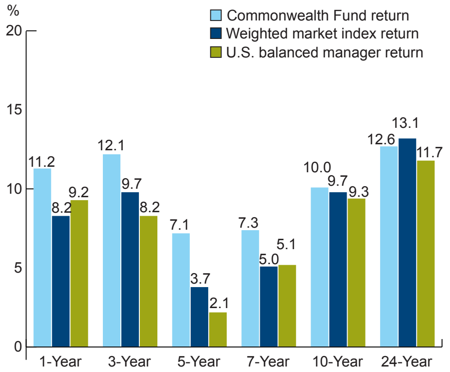
The Commonwealth Fund's endowment management strategy

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

the portfolio's average annual return has exceeded that of the median U.S. balanced manager and equaled or fallen just short of the weighted benchmark index return.

The Commonwealth Fund endowment's average annual investment returns.

Periods ending June 30, 2005

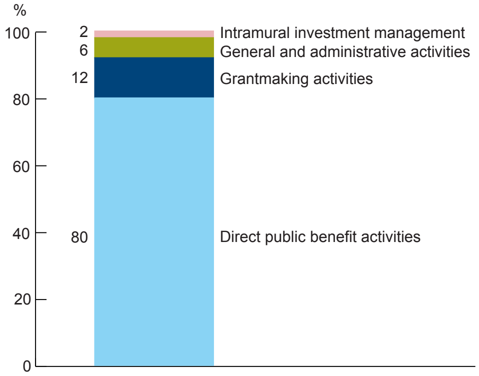


Three considerations determine the Fund's annual spending policy: the aim of providing a reliable flow of funds for programs and planning; the objective of preserving the real (inflation-adjusted) value of the endowment and funds for programs; and the need to meet the Internal Revenue Service requirement of distributing at least 5 percent of the endowment for charitable purposes each year. The Fund's endowment performed comparatively well in the severe equities bear market that began in early 2000, the average annual return on the endowment since the downturn began being 6.5 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 only modest increases in its 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 and—with appropriate strategic adjustments to existing program budgets, the addition of important new initiatives such as the Commission on a High Performance Health System, the State Innovations program, and the Patient-Centered Primary Care Initiative.

As a value-adding foundation, the Fund seeks to achieve an optimal balance between its grantmaking and intramural research and program management activities, while minimizing purely administrative costs. Recognizing that data on expenditures reported in the Internal Revenue Service 990PF annual tax return inadequately reflect the purpose of many expenditures, the analysis in the figure sorts out the foundation's 2004–05 expenditures according to four categories recommended by the Foundation Financial Officers Group: direct public benefit activities (extramural grants and intramurally conducted programs such as research, communications, and fellowships); grantmaking activities, including grants management; general and administrative activities; and intramural investment management. In 2004–05, the Fund's total direct public benefits activities accounted for 80 percent of its annual expenditures. Value-adding oversight of grants took up 12 percent of the Fund's budget, and the intramural costs of managing the endowment, 2 percent. Appropriately defined, the Fund's administrative costs amounted to 6 percent of its budget.

The Fund's total direct public benefit activities—including extramural grants and intramural research, communications, and programs conducted by the foundation—account for 80 percent of its annual expenditures. Value-adding oversight of grants takes up 12 percent of the Fund's budget.



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 earlier shift from mail/paper to electronic distribution of the results of its work and that of grantees, along with a major upgrade of its Web site, accounted for much of the savings achieved on intramural costs. The foundation's ability to take on new initiatives while maintaining all grants programs and the intramural capacities that ensure their effectiveness will enable it to continue to fulfill a unique and highly productive role in American society.

The Commonwealth Fund

INDEPENDENT AUDITORS’ REPORT

Financial Statements
Years Ended June 30, 2005 and 2004

We have audited the accompanying statements of financial position of The Commonwealth Fund (the “Fund”) as of June 30, 2005 and 2004 and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the Fund’s management. Our responsibility is to express an opinion on these financial statements based on our audit.

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

In our opinion, such financial statements present fairly, in all material respects, the financial position of the Fund at June 30, 2005 and 2004 and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Owen J. Flanagan & Co.

September 23, 2005

THE COMMONWEALTH FUND

STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2005 AND 2004

	2005	2004
ASSETS		
CASH	$ 496,911	$ 477,521
INVESTMENTS - At fair value (Notes 1 and 2)	608,341,012	572,128,427
INTEREST AND DIVIDENDS RECEIVABLE	130,281	157,031
PREPAID TAXES - Net (Note 5)	377,905	-
PROCEEDS RECEIVABLE FROM SECURITY SALES - NET	134,397	-
PREPAID INSURANCE AND OTHER ASSETS	31,341	183,687
RECOVERABLE GRANTS	100,526	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 $ 1,562,270 at June 30, 2005 and $1,571,924 at June 30, 2004 (Note 1)	4,516,149	4,471,000
TOTAL ASSETS	$ 614,403,522	$ 578,042,666
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable and accrued expenses	$ 1,169,113	$ 1,027,586
Taxes payable - net	-	875,221
Securities transactions payable - net	-	205,443
Program authorizations payable (Note 3)	17,439,498	17,573,288
Accrued postretirement benefits (Note 4)	2,194,182	1,925,002
Deferred tax liability (Note 5)	2,388,052	1,531,576
Total liabilities	23,190,845	23,138,116
NET ASSETS:		
Unrestricted	591,168,084	554,687,761
Temporarily restricted (Note 7)	44,593	216,789
Total net assets	591,212,677	554,904,550
TOTAL LIABILITIES AND NET ASSETS	$ 614,403,522	$ 578,042,666

See notes to financial statements.

THE COMMONWEALTH FUND

STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2005 AND 2004

	2005	2004
REVENUES AND SUPPORT:		
Interest and dividends	$ 9,054,636	$ 25,501,155
Contribution and other revenue (Note 7)	3,073	4,266
Net assets released from restrictions (Note 7)	172,196	285,211
Total revenues and support	9,229,905	25,790,632
EXPENSES:		
Program authorizations and operating program	21,463,712	21,215,335
General administration	2,516,350	2,578,849
Investment management	3,270,239	3,005,826
Taxes (Note 5)	1,054,799	2,168,405
Unfunded retirement and other postretirement (Note 4)	593,834	367,862
Total expenses	28,898,934	29,336,277
EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS	(19,669,029)	(3,545,645)
NET INVESTMENT GAINS:		
Net realized gains on investments	13,345,794	24,314,863
Change in unrealized appreciation of investments	42,803,558	52,897,785
Total net investment gains	56,149,352	77,212,648
CHANGES IN UNRESTRICTED NET ASSETS	36,480,323	73,667,003
TEMPORARILY RESTRICTED CONTRIBUTION FROM BEQUEST (Note 7)	-	100,000
NET ASSETS RELEASED FROM RESTRICTIONS (Note 7)	(172,196)	(285,211)
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS	(172,196)	(185,211)
CHANGES IN NET ASSETS:	36,308,127	73,481,792
Net assets, beginning of year	554,904,550	481,422,758
Net assets, end of year	$ 591,212,677	$ 554,904,550

See notes to financial statements.

THE COMMONWEALTH FUND

STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2005 AND 2004

	2005	2004
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets:	$ 36,308,127	$ 73,481,792
Net investment gains	(56,149,352)	(77,212,648)
Depreciation expense	268,665	347,871
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Decrease in interest and dividends receivable	26,750	404,392
(Increase) decrease in prepaid taxes - net	(377,905)	131,218
Increase in proceeds receivable from securities sales - net	(134,397)	-
Decrease (increase) in prepaid insurance and other assets	152,346	(29,918)
Decrease in recoverable grants	249,474	-
Increase (decrease) in accounts payable and accrued expenses	104,771	(436,991)
(Decrease) increase in taxes payable - net	(875,221)	875,221
Increase (decrease) increase in program authorizations payable	(133,790)	(1,177,717)
Increase in accrued postretirement benefits	269,180	159,485
Decrease in securities transactions payable - net	(205,443)	(167,065)
Increase in deferred tax liability	856,476	1,056,048
Net cash used in operating activities	(19,640,319)	(2,568,312)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of furniture, equipment, and building improvements - net	(313,815)	(217,057)
Purchase of investments	(391,325,556)	(427,900,969)
Proceeds from the sale of investments	411,299,080	431,134,721
Net cash provided by investing activities	19,659,709	3,016,695
NET INCREASE IN CASH	19,390	448,383
CASH, BEGINNING OF YEAR	477,521	29,138
CASH, END OF YEAR	$ 496,911	$ 477,521
SUPPLEMENTAL INFORMATION -		
Taxes paid: excise and unrelated business income	$ 1,451,449	$ 105,918

See notes to financial statements.

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, 2005 and 2004 comprised the following:

	2005		2004	
	Fair Value	**Cost**	**Fair Value**	**Cost**
U.S. Equities	$ 183,218,869	$ 157,581,858	$ 222,120,398	$ 199,573,796
Non - U.S. Equities	139,418,015	86,726,067	115,787,460	85,420,609
Fixed income	89,458,155	92,583,406	68,882,700	68,427,970
Short-term	16,769,839	16,769,839	24,156,609	24,156,609
Marketable alternative equity	72,222,771	42,111,141	65,567,269	42,140,486
Nonmarketable alternative equity	15,451,026	17,443,048	11,017,563	14,857,943
Inflation hedge	91,802,337	75,723,063	64,596,428	60,972,222
	$ 608,341,012	$ 488,938,422	$ 572,128,427	$ 495,549,635

At June 30, 2005, the Fund had total unexpended commitments of approximately $54.4 million in various nonmarketable alternative equity investments.

The Fund's investment managers may use futures contracts to manage asset allocation and to adjust the duration of the fixed income portfolio. In addition, investment managers may use foreign exchange forward contracts to minimize the exposure of certain Fund investments to adverse fluctuations in the financial and currency markets. At June 30, 2005 and 2004, the Fund had no outstanding derivative positions.

3. PROGRAM AUTHORIZATIONS PAYABLE

At June 30, 2005, program authorizations scheduled for payment at later dates were as follows:

July 1, 2005 through June 30, 2006	$ 13,996,966
July 1, 2006 through June 30, 2007	3,341,690
Thereafter	204,532
Gross program authorizations scheduled for payment at a later date	17,543,188
Less adjustment to present value	103,690
Program authorizations payable	$ 17,439,498

A discount rate of 2.83% was used to determine the present value of the program authorizations payable at June 30, 2005.

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% of the participants' compensation for the years ended June 30, 2005 and 2004, respectively. Pension expense under this plan was approximately $925,000 and $878,000 for the years ended June 30, 2005 and 2004, respectively. In addition, the plan allows employees to make voluntary tax-deferred purchases of these same annuities and/or mutual funds within the legal limits provided for under Federal law.

The Fund also has a group of former employees who retired prior to the inauguration of the above plan and certain other former employees to whom pension benefits have been approved, on an individual case basis, by the Board of Directors. Benefits under this program are paid directly by the Fund to these retirees. These pension payments approximated $62,000 and $60,000 for the years ended June 30, 2005 and 2004, 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. Deferred compensation contributions were $ 22,175 for the year ended June 30, 2005; there were no 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 postretirement medical plan, which is measured as of the end of each fiscal year, is an unfunded plan, with 100% of the benefits paid by the Fund on a pay-as-you-go basis. Such payments approximated $110,000 and $103,000 for the years ended June 30, 2005 and 2004, respectively.

Expected contributions under the postretirement medical plan for the fiscal year ended June 30, 2006 are expected to be approximately $125,000. Additional required disclosure on the Fund's postretirement medical plan for the years ended June 30, 2005 and 2004 is as follows:

	2005	2004
Benefit obligation at June 30	$ 2,133,837	$ 1,754,507
Fair value of plan assets at June 30	-	-
Status - unfunded	2,133,837	1,754,507
Actuarial loss	60,345	170,495
Accrued benefit cost recognized	$ 2,194,182	$ 1,925,002
Net periodic expense	379,331	262,097
Employer contribution	110,151	102,612

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

	2005	2004
Discount rate	4.28%	5.33%
Health care cost trend rates—Initial	7.30	7.10
Health care cost trend rates—Ultimate	7.10	7.20

At June 30, 2005, benefits expected to be paid in future years are approximately as follows:

Year ended June 30, 2006	$ 125,000
Year ended June 30, 2007	$ 135,000
Year ended June 30, 2008	$ 149,000
Year ended June 30, 2009	$ 162,000
Year ended June 30, 2010	$ 194,000
Five years ended June 30, 2015	$ 871,000

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, 2005 and 2004, that excise tax rate was 2%. 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, 2005, distributions approximating $4.7 million are required to be made by June 30, 2006 to satisfy the minimum requirements of approximately $29.2 million for the year ended June 30, 2005.

In the Statements of Financial Position, the deferred tax liability of $2,338,052 and $1,531,576 at June 30, 2005 and 2004, respectively, resulted from expected Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2005 and 2004, the tax provision was as follows:

	2005	**2004**
Excise taxes - current	$ 124,812	$ 1,023,977
Excise taxes - deferred	856,476	1,056,048
Unrelated business income taxes - current	73,511	88,380
	$ 1,054,799	$ 2,168,405

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, 2005 and 2004, net assets released from donor restrictions were $172,196 and $285,211, respectively.

DIRECTORS AND STAFF

The Fund's Board of Directors undertook a thorough review of the foundation's governance documents and practices during the year, resulting in revised By-Laws and new charters for the Executive and Finance, Governance and Nominating, Audit and Compliance, and Investment Committees, as well as a new Code of Ethics and Conflict of Interest policy. The latter includes a "whistleblower" policy and set of procedures designed to strengthen the institution's capacity for self-regulation. The Board also instituted the practice of undertaking a confidential annual Board Development Survey, aimed at helping ensure the Board's fulfillment of its responsibilities and high performance by the foundation.

Recognizing that the performance and job satisfaction of staff are important contributors to institutional performance, the Fund participated, along with five other foundations, in the 2005 Survey of Foundation Staff conducted confidentially by the Center for Effective Philanthropy. The survey provided valuable insights on how the Fund is perceived by its "internal customers," including helpful comparisons with peer foundations.

The survey confirmed that foundations are generally good places to work and uphold high standards of performance. Compared with the staffs of other surveyed foundations, Fund staff rated the foundation more highly on the effectiveness of its program strategies, processes, and operating style—in terms of setting clear objectives, addressing issues in its fields in a timely way, aligning grantee decisions with program objectives, selecting grantees effectively and objectively, collaborating with other organizations, learning from mistakes, understanding its constituencies, being responsive to grantees, and adding value to grantees' work. Fund staff also rated the foundation more highly than did staff of other surveyed foundations on overall performance—making a difference in its fields, disseminating the results of its work, and producing clear outcomes. These staff assessments of the performance of the foundation are themselves a good measure of job satisfaction.

As measured by responses on 44 dimensions of job satisfaction and the work environment, the Fund's performance in this regard was average for the surveyed foundations. Staff rated the Fund comparatively highly on providing the resources to do their jobs well, conveying goals and objectives clearly, recognizing employee potential and contributions, and conducting beneficial annual performance reviews. Most Fund staff said their work gives them a strong sense of personal accomplishment and that they are excited about how their work contributes to the goals of the foundation. To an unusual degree, the Fund provides training and education opportunities to its staff.

Staff turnover at the Fund is approximately the same as turnover at other surveyed foundations.

As at other foundations, Fund staff regards their compensation as somewhat less than what it should be, given their background and experiences. A particular challenge for a foundation like the Fund—employing highly educated and experienced professional staff while pursuing a focused program strategy with strong senior executive oversight—is meeting their needs for autonomy, creativity, and opportunities for growth and advancement. The survey pointed to strategies for promoting job satisfaction at the Fund, and job satisfaction measures will be an important component of the Fund performance scorecard that is under development.

The Center for Effective Philanthropy's annual Survey of Foundation Staff is a significant service to the sector. It is hoped that additional foundations will join the ranks of participants—thereby enhancing the survey's value for benchmarking and tracking performance relative to that of peer institutions.

BOARD OF DIRECTORS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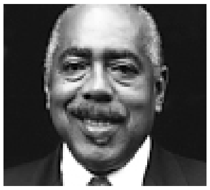
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Anne Mackinnon, *Senior Program Reviewer*

White & Case, *Counsel*

2005 Annual Report

GRANTS APPROVED, 2004 – 2005

TASK FORCE ON THE FUTURE OF HEALTH INSURANCE

AcademyHealth
$290,000.00
Simplification in Health Care Administration
Earlier this year, AcademyHealth and the Fund began a collaboration to identify sources of administrative complexity within health insurance and explore policy options that could lead to greater simplification. With a small grant from the Fund, AcademyHealth held a planning meeting in May 2004 with key thought leaders to assess known areas of administrative complexity, identify research needs for developing a better understanding of the administrative burden, and devise public and private remedies. This project will build on the recommendations of meeting participants by funding new research projects and case studies. The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization Program will provide cofunding.

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Brandeis University
$199,934.00
Medical Debt and the Insured: Investigating Failures of Insurance to Protect Patients from Financial Harm
As many as two-fifths of adults under age 65 have problems paying their medical bills or are paying off accrued medical debt. These individuals sometimes exhaust their savings or borrow against their homes to pay medical bills. Moreover, many patients with debt are either actively discouraged or feel deterred from returning for care to the facility to which they owe money. This project will explore the reasons why health

insurance sometimes fails to protect patients from potentially crippling medical debt. In addition to surveying patient account managers in hospitals and examining the administrative data they will be asked to provide, the investigators will review hospital policies and procedures for collecting the self-pay portion of insured patients' bills. The aim of this work is to determine the relative contributions of insurance and hospital policies to patient debt, identify exemplary hospital practices for handling debt, and develop institutional, state, and federal policy remedies.

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Columbia University
$182,741.00
Examining Insurance Issues and Developing Policy Options to Expand and Establish Coverage, 2004-05
The Fund's Task Force on the Future of Health Insurance explores ways to extend health insurance coverage to uninsured working Americans and their families. In the year ahead, this core grant to Columbia University will support analysis of cutting edge reforms to help keep low-income children continuously insured; examine emergency room use by patients who lack insurance or have unstable coverage; and assess how unstable or otherwise inadequate coverage affects the quality and continuity of patient care. The grant will also support Fund Task Force staff and grantees by providing programming support for the analysis of large federal databases regarding out-of-pocket and catastrophic health costs, the near-poor, and the latest trends in coverage for young adults.

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Economic and Social Research Institute
$99,846.00
Assessing the Effectiveness of Tax Credits as an Aid for the Uninsured: The Trade Act Experience, Phase 2
The Trade Act of 2002 offers an opportunity to examine how effective tax credits can be in helping people obtain health insurance coverage. Under the law, a small subset of uninsured

Americans—early retirees and workers displaced from their jobs due to foreign competition—qualify for fully refundable health coverage tax credits that pay for 65 percent of their health insurance premiums. With Fund support, Stan Dorn of the Economic and Social Research Institute has examined the program's early experiences over the past year and is becoming one of a small number of experts on the new tax credit. Both the administration and Congress have relied on his research findings to explore ways to expand the credit's impact. In Phase 2, Dorn will examine an additional year of experience with the credit, track data on enrollment, accessibility, and affordability, and continue to support evidence-driven policymaking through reports and presentations.

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Kaiser Foundation Research Institute
$227,630.00
Assessing the Impact of High-Deductible Health Plans

High-deductible health plans (HDHPs) are a focal point in discussions about how to contain health care costs. In June 2004, Kaiser Permanente (KP) began offering these plans, and to date it has enrolled approximately 80,000 individuals. For this study, researchers will assess the impact of HDHPs on health care consumption, costs, and health outcomes by examining KP plan data and interviewing approximately 2,500 enrollees. The research team will be comparing the experiences of enrollees before and after they switched to an HDHP, as well as with a comparison group of KP members who did not join an HDHP. Additional analyses will gauge the effects of these plans on low-income enrollees and chronically ill patients. Findings will inform national policy, as well as benefit plan design within the private sector. KP will provide $327,681 in cofunding for the project.

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The President and Directors of Georgetown College
$85,601.00
Federal Grants to State High-Risk Pools: Tracking State Efforts to Strengthen Coverage

To help lower premiums in the individual health insurance market, many states have created high-risk pools that provide coverage to people with high medical expenses. Legislation has recently been introduced to expand a new federal grant program that provides $80 million in matching funds to help finance state high-risk insurance pools. For this project, the investigators will conduct a six-month study of how states use these federal matching grant funds. After first assessing the adequacy, affordability, and accessibility of high-risk pool coverage relative to a benchmark health plan, they will next determine if the matching funds were used to make improvements in these three areas. Through interviews and examination of high-risk pool reports, the project team will also ascertain if funding has been used to offset risk pool losses or reduce insurers' or hospitals' contributions to the pool. This information will assist policymakers as they determine what role, if any, high-risk pools can or should play in health care reform strategies.

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University of Kansas
$202,430.00
Designing a Small Business Subsidy Program for Low-Income Workers in Kansas

The lack of affordable health insurance coverage is a growing crisis for small businesses. In Kansas, where less than half of small firms offer health coverage to their employees, legislation in 2001 enabled creation of a Business Health Partnership to offer the state's small businesses an alternative insurance product that would rely on public subsidies of premiums for low-wage employees. Although the initiative has stalled due to budget constraints, it is anticipated that the Kansas governor will request subsidy funding in 2005 as part of a health reform package. This project will inform state policymakers about the small group insurance marketplace in Kansas, the potential impact of proposals that would use subsidies and tax credits, and the optimum magnitude of these subsidies. If it succeeds, the Kansas approach to covering low-income workers could be a model for other states. Cofunding is being provided by the United Methodist Health Ministry Fund.

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Princeton Survey Research Associates
$260,700.00
The Commonwealth Fund 2005 Biennial Health Insurance Survey
In 1999, 2001, 2002, and 2003, Princeton Survey Research Associates International conducted national surveys for the Fund to assess the stability of adults' health insurance coverage, cost-related difficulties in accessing care, and the extent and impact of medical bill problems. Policymakers learned about the results of these important surveys through widely cited media reports and journal articles, as well as through testimony to Congress. A new survey will update information on coverage and access trends and explore emerging areas of policy concern, including the effect of high-deductible health plans and health savings accounts on lower-wage workers and people with chronic health conditions. This information, which is not available elsewhere, will inform both federal and state debate concerning the future of health insurance coverage.

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Small Grants—Task Force on the Future of Health Insurance

Economic and Social Research Institute
$36,763.00
Analyzing Policy Options for Childrens' Automatic Enrollment in Medicaid and SCHIP

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Economic and Social Research Institute
$49,972.00
Showcasing Innovations in Coverage and Efficiency

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Employee Benefit Research Institute Education and Research Fund
$35,500.00
Sustaining Membership in the Employee Benefit Research Institute Education and Research and Supporting the EBRI Annual Health Confidence Survey
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President and Chief Executive Officer
Employee Benefit Research Institute and
EBRI Education and Research Fund
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Health Research and Educational Trust
$40,040.00
Employer Views of Employee Benefits and Policy Options to Expand Health Insurance Coverage
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National Women's Law Center
$5,000.00
Women's Access to Health Insurance Project: Updating Diagnosing Disparities in Health Insurance for Women
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University of Nebraska
$11,056.00
An Empirical Analysis of Summary Plan Description Language in Employer-Sponsored Health Plans
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University of Washington
$18,324.00
Cost Containment and Expanded Access to Coverage in Washington State

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MEDICARE'S FUTURE

American Institutes for Research
$348,710.00
Critical Issues for Medicare's Future

There is a growing push by policymakers to make Medicare a more efficient, sustainable program. This project will inform the search for new ways to improve Medicare's cost-effectiveness, including enhanced use of primary care case management. Project staff will also assess how beneficiaries are faring under recent changes to Medicare, and how they would fare under proposed changes to benefits. Four separate studies will: 1) analyze patterns of physician services in fee-for-service Medicare to assess the potential of primary care case management to serve beneficiaries better; 2) model the impact of proposals for cutting benefits, including projections of the relative burdens on beneficiaries and taxpayers; 3) assess service use and out-of-pocket spending by beneficiaries with chronic health conditions; and 4) examine the effects of a possible high-deductible coverage option.

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Medicare Rights Center, Inc.
$100,205.00
Waiting for Medicare Coverage: What It Means for the Disabled

After qualifying for Social Security disability support, severely and permanently disabled adults under age 65 must undergo a two-year waiting period before they can enroll in Medicare. Recent Fund-supported studies found that removing this barrier to insurance coverage would allow the disabled to access the critical care they need and gain control over their lives. To draw attention to a policy that sometimes produces devastating consequences, this project will develop a series of narratives describing the real-life experiences of individuals in the waiting period over the course of a year. Project staff also will develop retrospective case histories of those who have completed the waiting period and now have Medicare coverage. The final collection of narratives will be publicized widely to policymakers and the media.

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President and Fellows of Harvard College
$275,100.00
Learning About the Quality and Cost of Care for Hospitalized Medicare Beneficiaries
With support from the major hospital associations, the Centers for Medicare and Medicaid Services are collecting and publicly reporting information provided by nearly all U.S. hospitals on 10 quality-of-care measures for three conditions common among Medicare beneficiaries. Under this grant, Harvard University researchers will link hospital reports with information on hospital characteristics and patient volume data on the three conditions to investigate the following: 1) how hospital performance varies across quality measures; 2) the types of hospitals that report higher-quality care; 3) whether hospitals that score well have lower mortality rates; and 4) the relationship, if any, between hospitals that perform well on quality measures and those that perform well on efficiency measures. These analyses will produce information that could be used to improve the care provided to Medicare beneficiaries as well as other patients.

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The President and Directors of Georgetown College
$126,361.71
Program Direction Grant for The Commonwealth Fund's Program on Medicare's Future
Passage of the Medicare bill entailed some of the most significant changes to the program in its history. Although the new prescription drug benefit will provide substantial assistance to low-income individuals, its true impact remains unclear. Other changes, including incentives intended to

greatly expand the role of private health plans, may in some cases prove detrimental to the frail, sick, and poor. The Fund's Program on Medicare's Future provides independent analysis of changes to Medicare and develops policy options that could improve coverage for beneficiaries. This grant will provide overall strategic direction for the program, 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 Medicare-related reports submitted for Fund publication, prepare issue briefs and summaries of Fund work, and represent the program in public forums.

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The President and Directors of Georgetown College
$182,759.00
Developing Models of Standardized Benefits for Medicare
With passage of the new Medicare law, beneficiaries will increasingly be expected to choose from among a number of private health plan options with varying benefits and features. For many seniors, the options are confusing and, for some, overwhelming. The research team will develop two models of standardized benefits—one for Medicare Advantage plans and one for standalone prescription drug plans—to stimulate debate about the need for standardization in Medicare and the form standardized benefits should take. Project staff will conduct a literature review, interview a range of experts, convene panels to design a set of standard benefits, and hold focus groups with beneficiaries and health insurance counselors to help assess the potential impact of proposed options. This work will improve understanding of what choice in Medicare currently entails for beneficiaries, and how standardized benefit options might simplify their health plan decisions.

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Trustees of the University of Pennsylvania
$193,526.00
Improving Quality and Efficiency: A Coordinated Care Benefit for Medicare Beneficiaries with Heart Failure
Evidence shows that heart disease management programs that include coordinated post-hospital care can improve patients'

outcomes and reduce readmissions. Medicare, however, does not reimburse providers for services targeting the transition between hospital and home. Drawing from their previous research, the project team, in collaboration with the International Heart Failure Consortium, will propose a new, post-discharge coordinated care benefit for Medicare beneficiaries with heart failure. Project staff will: a) highlight which specific interventions produce the greatest gain in health outcomes for different categories of patients; b) estimate the potential costs, benefits, and savings of such a benefit; and c) work with policymakers to develop a benefit prototype. This work could also inform similar efforts targeting other chronic conditions.

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Small Grants—Medicare's Future

Columbia University
$29,879.00
The Potential for Medicare-Led Malpractice Reform
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Metropolitan Jewish Health System Corporation
$40,000.00
Funding Medicare Out-of-Pocket and Long-Term Care Costs: Evaluating the Case for the Integration of Enhanced Private Savings Incentives Integrated with Public Financing
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Project HOPE/The People-to-People Health Foundation
$49,711.00
Developing a Framework for Analyzing Clinical and Cost-Effectiveness of Medicare Expenditures
Gail R. Wilensky, Ph.D.

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University of Maryland
$2,940.00
Implications of Medicare Part D Prescription Drug Coverage on Home and Community-Based Services Waiver Programs
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HEALTH CARE IN NEW YORK CITY

Montefiore Medical Center
$124,244.00
Linking Pediatric Emergency Departments to Primary Care
In 2000, one of six emergency department (ED) visits by children under age 15 was classified as non-urgent. This project will test whether linking pediatric ED patients with primary care sites could decrease non-urgent visits over time. Activities will include: 1) faxing a record of the ED visit to the patient's primary care physician if there is one; 2) calling the family to arrange for a follow-up visit; 3) identifying a primary care site and appropriate health insurance for children lacking either; and 4) counseling patients on the best way to seek health care services. If the intervention is shown to be effective and is broadly disseminated, thousands of unnecessary ED encounters in New York could be avoided, with significant cost savings. Montefiore Medical Center will provide in-kind support.
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New York City Health and Hospitals Corporation
$165,000.00
Using Emergency Department Coordinators to Link Adults to Primary Care Clinics
The Bellevue Primary Care Clinic in New York has instituted

several initiatives to improve access to primary care providers and reduce waiting times in the clinic. Nevertheless, many patients continue to rely on the emergency department (ED) for routine primary care. With the assistance of a patient care coordinator, the project will test whether initiating and guiding patients through a primary care office visit at the time of the ED visit could increase future use of primary care services. Project staff will assess patients' satisfaction with their visits and identify the reasons patients rely on the ED for non-urgent care. Findings will help guide Bellevue and other facilities in their efforts to foster appropriate utilization of health services. Bellevue Hospital Center will provide in-kind support for this project.

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New York City Health and Hospitals Corporation
$125,000.00
Comparing Diabetes Care Management Models to Improve Primary Care Access
Commonwealth/Health Services Improvement Fund Grant
The Queens Health Network (QHN) in New York City has developed disease management programs for its chronically ill patients, reporting measurable success for its diabetic patients. Now QHN is seeking to incorporate care management interventions into its primary care for patients requiring the more intensive one-on-one support of a qualified clinician. This project will evaluate the effectiveness of three care management models for diabetic patients: two models that will employ nurses as care managers and test different levels of engagement by the primary care provider, and one model, staffed by a nurse practitioner, to test the impact of expanding the care manager's role to conduct additional activities. The study will monitor care utilization, medical costs, and clinical measures, as well as self-management behaviors and outcomes. The model that is most successful could be incorporated in QHN's general approach to treating chronic illness.

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United Hospital Fund of New York
$120,000.00
Modeling Options for Improving Health Insurance in New York
Commonwealth/Health Services Improvement Fund Grant
Senior staff at the United Hospital Fund (UHF) and Commonwealth Fund will jointly develop a framework for expanding and improving insurance coverage for New Yorkers. Key elements of the framework will include: 1) achieving major reductions in the numbers of uninsured people; 2) reducing "churning" in coverage and insurance instability; 3) making insurance affordable for lower-income working adults; and 4) leveraging public insurance programs to improve quality and efficiency. The project team will explore possible ways of financing a coverage expansion—from tapping into existing flows of funds to identifying new financing sources—and estimate the impact on coverage and costs. UHF will provide cofunding for the project, in addition to convening state health policy leaders to discuss coverage and financing issues.

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HEALTH CARE QUALITY IMPROVEMENT AND EFFICIENCY

Center for Health Policy Development
$132,196.00
Enhancing the Effectiveness of State Adverse Event Reporting Systems and Feedback to Hospitals
Twenty-two states have mandated reporting of medical errors by hospitals. Experience has shown, however, that chronic underreporting and poor feedback are limiting the potential of state reporting systems to improve the safety of care. The National Academy for State Health Policy will convene a summit of state regulators and hospital administrators to address barriers to complete data reporting and feedback. The project team will prepare a Web-based toolkit to assist state reporting system administrators, hospital officials, and other key stakeholders in ensuring safer hospital care.

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Health Research and Educational Trust
$323,136.00
Assessing and Improving Patient Safety in Ambulatory Care
Frances Cooke Macgregor Grant
Medical and surgical procedures, once performed only in hospitals, now routinely take place in ambulatory care settings. Despite this shift, most information about health care safety applies mainly to hospitals; little is known about how the care provided in ambulatory settings compares. For this project, a national survey of group physician practices conducted in collaboration with the Medical Group Management Association will furnish new data on the current state of ambulatory care safety and identify areas for improvement. Project staff will develop the survey instrument with the input of experts in patient safety. Data from the survey, together with prior and ongoing Fund-supported work assessing medication practices in U.S. hospitals, will form the basis for the design of future interventions to improve the safety of care.
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Massachusetts General Hospital
$472,759.00
The Commonwealth Fund Quality Improvement Colloquia, Series 3
The five Quality Improvement Colloquia held so far have brought together approximately 100 of the nation's foremost leaders in health policy, health care delivery, and health services research to address the most pressing issues in the field of quality improvement. The grant covering the second colloquia series has been supporting meetings on overuse of health care services, clinical performance assessment, and implications of the new Medicare law for quality, as well as a monthly electronic newsletter. This grant will support a third series of colloquia on patient safety, measurement of hospital performance, and a topic to be determined. Fund and project staff also will continue hosting online debates on selected quality improvement topics and begin a new series of case studies of innovative improvement practices, which will be profiled in the monthly newsletter and posted on the Fund's Web site.
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MedStar Research Institute
$224,601.00
Evaluating the Impact of Electronic Medical Records and Interactive Decision-Support Systems on Obstetric Care Quality and Efficiency
Electronic medical records linked to physician order entry and clinical decision support are gaining wider currency in health care. There is only limited evidence, however, regarding the impact of "intelligent" technologies on health care quality and efficiency. Focusing on the obstetric care provided in four hospitals, this project will evaluate the extent to which electronic medical records and interactive decision-support systems, used at the point of care, can improve physicians' adherence to best practices and reduce medical errors. The evaluation will also assess the financial return on investing in such tools, as well as potential changes in malpractice liability.
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National Committee for Quality Assurance
$279,181.00
Developing Standard Measures of Physician Quality and Efficiency
Across the country, coalitions of health plans, employers, and physician organizations are collecting and disseminating information about the quality of care doctors provide. Lack of standardized performance measures, however, can create confusion for providers, consumers, and purchasers. It can also add to administrative complexity and limit opportunities to compare performance data. The National Committee for Quality Assurance will create a set of standardized performance metrics for gauging the quality and costs of primary care, as well as the care provided by specialist physicians and physician groups. These measures, which will be equivalent to Health Plan Employer Data and Information Set (HEDIS) health plan quality indicators, could be applied nationally by the private sector as well as by the Centers for Medicare and Medicaid Services.
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Primary Care Development Corporation
$265,688.00
Sustaining and Spreading Learning Collaboratives: Ingredients for Success
Although learning collaboratives can improve the performance of health care organizations, sustaining these improvements and communicating them to other organizations will require the additional work of establishing processes and creating system changes. Building on previous Fund support for a series of community health center collaboratives led by New York City's Primary Care Development Corporation, this project will study up to three collaborative-sponsoring organizations, as well as approximately 25 participating teams, to determine what organizational characteristics contribute to the successful achievement, maintenance, and spread of improvements. This knowledge will enhance the efforts of other health care organizations to improve quality.

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Regents of the University of Minnesota
$132,960.00
Exploring Performance-Based Payment Strategies for Nursing Home Care in Minnesota
Reimbursement systems powerfully influence the behavior of nursing home operators. Traditional "case-mix" payment systems create major disadvantages for those homes that provide resident-centered care. Seeking to align payment with performance, the Minnesota legislature is considering enacting a new payment system that would reward high-quality, high-efficiency providers. This project will develop models to help nursing homes and legislators estimate the financial benefits and costs of operating under the proposed system. The investigators will also describe the current relationship between quality and cost among different types of Minnesota nursing homes. Together, these analyses will help Minnesota's legislature assess the merits of establishing a pay-for-performance system.

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Trustees of the University of Pennsylvania
$220,366.00
Coordinating Care Between Hospital and Home: Translating Research into Practice, Phase 2
Coordinating the care provided to extremely frail older adults following their discharge from the hospital significantly reduces the need for subsequent readmission. To promote adoption of this model of care coordination, the project team is collaborating with the Aetna Corporation to devise a workable program for patients enrolled in managed care. With support from the Fund and the Jacob and Valeria Langeloth Foundation, the research team laid the groundwork for implementing the advanced practice nurse model in Phase 1. In Phase 2, project staff will test the model's impact on clinical outcomes, costs, and patient satisfaction in a portion of Aetna's mid-Atlantic market. If the intervention proves successful, Aetna will consider offering the service as a defined benefit. Project findings, which will be shared with other insurers, could also inform the development of a transitional care benefit for Medicare or Medicaid.

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University of North Carolina at Chapel Hill
$298,246.00
Quality Snapshots Series
The Fund's series of chartbooks on the quality of U.S. health care has been widely praised and highly valued by thousands of readers, among them health care providers, researchers, policy leaders, and child health advocates. The project team will bolster the successful chartbook series with Web-based, interactive Powerpoint charts—Quality Snapshots—that provide updated data on selected quality indicators included in previous chartbooks as well as new information on additional quality indicators and emerging health care issues. Twice yearly, the Fund will release 25 of these charts through its Web site, with additional dissemination through e-mail alerts and possibly other electronic media. By maintaining a spotlight on key quality-of-care issues, Quality Snapshots will aid the efforts of providers and policymakers to identify problem areas and institute improvements.

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Small Grants—Health Care Quality Improvement and Efficiency

American Board of Internal Medicine Foundation
$28,000.00 and $48,200.00
Stepping Up to the Plate: Organized Physician Leadership and the Quality Agenda, Phases 1 and 2
Daniel B. Wolfson, M.H.S.A.
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Brain Trauma Foundation
$40,000.00
Adoption of Standards of Care for Brain Trauma Patients: A Case Study
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Quality Improvement Program Director
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Health Tech Strategies, LLC
$7,500.00
2005–2006 Capitol Hill "Steering Committee on Telehealth and Healthcare Informatics" Educational Series and Technology Demonstration
Neal Neuberger
President
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McLean, VA 22101
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Harris Interactive, Inc.
$12,500.00
Strategic Health Perspectives
Katherine Binns, M.B.A.
Senior Vice President, Health Care
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New York, NY 10003

Tel: (212) 539-9629
kbinns@harrisinteractive.com

National Business Coalition on Health
$25,000.00
A Call to Action to the Business Coalitions to Foster Patient-Centered Care Using "How's Your Health"
Suzanne Mercure
Project Director
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Fredricksburg, VA 22406
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University of North Carolina at Chapel Hill
$31,695.00
Expansion of the Chartbook on Quality of Care for Elderly Medicare Beneficiaries
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SPECIAL POPULATIONS

QUALITY OF CARE FOR UNDERSERVED POPULATIONS

Center for Health Care Strategies, Inc.
$211,941.00
Addressing Racial and Ethnic Disparities in Health Care: A Medicaid Managed Care Collaborative
The Center for Health Care Strategies (CHCS) has developed the Best Clinical and Administrative Practices (BCAP) initiative to catalyze improvements in the health care received by enrollees in Medicaid managed care plans. For this project, BCAP's leaders will work with Fund grantee David Nerenz to: 1) identify best state practices for linking race/ethnicity data from various sources with quality improvement data; 2) identify federal and state regulations that foster reduction of racial/ethnic health care disparities, as well as the performance incentives states include in their contracts with Medicaid plans; and 3) select, through a competitive process, 12 Medicaid managed care plans to participate in a BCAP demonstration project to improve care for minority patients. Best practices in these areas will be disseminated to Medicaid agencies, managed care plans, and others through a BCAP Quality Summit, national conferences, and the CHCS and

Fund Web sites. The Robert Wood Johnson Foundation will provide cofunding.

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George Washington University
$249,562.00
Enhancing the Reporting of Public Hospital Disparities Data
This project will assess the usefulness of the 10 hospital quality measures adopted by the National Voluntary Hospital Reporting Initiative (NVHRI) for measuring disparities in care and for supporting hospital programs designed to reduce racial/ethnic disparities. Focusing on six major public hospitals that treat large minority populations, the investigators will: 1) develop protocols for using the NVHRI framework to collect data on the 10 measures, preferably by uniform classifications of race and ethnicity; 2) collect and analyze the quality data, stratified by race and ethnicity, that have been reported by the six hospitals; and 3) develop recommendations for how other hospitals might use the NVHRI to report hospital quality data by race and ethnicity. Project staff will develop a series of case studies to explore the use of NVHRI for reducing disparities.

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Health Research and Educational Trust
$299,966.00
Linking Race and Ethnicity Data with Inpatient Quality-of-Care Measures in Private Hospitals
In recent years, it has become clearer that reporting quality-of-care data spurs providers to embark on improvement activities, and that such activities can help reduce racial and ethnic disparities. The National Voluntary Hospital Reporting Initiative (NVHRI) aims to foster quality improvement through various measurement and improvement activities. As of May 2004, nearly 2,000 hospitals had submitted data for at least one of the 10 NVHRI hospital quality indicators; all must do so by August 2004 or face financial penalties. The investigators for this project will work with the private University HealthSystem Consortium to: 1) collect and analyze data based on the 10 hospital quality indicators stratified by

race, ethnicity, and primary language to measure disparities in inpatient care; 2) conduct case studies to assess the hospitals' responses to reporting quality data by race/ethnicity; and 3) assess the feasibility of implementing a uniform framework for collecting data on race, ethnicity, and primary language. Massachusetts General Hospital and Henry Ford Health Systems will provide cofunding.

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Medical College of Wisconsin
$247,158.00
Using Parent Mentors to Improve Asthma Care for Urban Minority Children, Phase 2

Asthma, the most prevalent chronic childhood illness, disproportionately affects minority children. The investigators on this project are conducting a community-based trial to test whether minority parents trained as mentors can successfully coach other minority parents to manage their children's asthma. In Phase 1, the investigative team recruited parent mentors and initiated enrollment of participants and their families. In Phase 2, the investigators will continue participant recruitment and begin the randomized trial. Funding for a third and final phase to evaluate outcomes and summarize the experiences of children, parents, mentors, and physicians will be requested if work proceeds satisfactorily. Ultimately, this mentoring model could help to reduce hospitalizations and emergency room visits, lower costs for asthma care, reduce asthma morbidity, empower parents to manage their children's conditions, and, eventually, 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.

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The Regents of the University of California
$272,477.00
Improving Chronic Disease Management for Populations with Limited Health Literacy and English Proficiency, Phase 2

Patients who have limited proficiency in English or difficulty comprehending physicians' instructions and health information also experience difficulties accessing care, receive lower-quality care, or underutilize health services. In the project's first phase, investigators developed and implemented two types of self-management support: automated, telephone-based management, and group medical visits tailored to the needs of diabetes patients with these limitations. Through a randomized, controlled trial, project staff are now comparing the reach and efficacy of these methods of diabetes care. In Phase 2, the investigators will complete the trial and evaluate: 1) the extent of patient engagement with the two interventions; 2) changes in patients' self-care, satisfaction, and glycemic control; and 3) cost-effectiveness.

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Wake Forest University Health Sciences
$213,763.00
Chartbook on Health Status and Health Care Quality for Minorities in the United States
For this project, researchers will create a chartbook on the quality of medical care for America's racial and ethnic minorities. This comprehensive resource, which will draw upon Fund survey data and numerous other sources, will also highlight promising programs and practices for improving minority health care and reducing disparities. The researchers will include data on minority Americans of all ages, as well as information on patients with limited English proficiency. In addition to raising public awareness of minority health issues, the chartbook will be valuable to researchers and policymakers involved in efforts to eliminate disparities in health and health care. Douglas McCarthy of Issues Research, Inc., who has played a major research role in the development of earlier Fund chartbooks, will contribute to this project.

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Small Grants—Quality of Care for Underserved Populations

American Medical Association Foundation
$23,980.00
Ethical Force Program Initiative on Patient-Centered Communication for Vulnerable Populations
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Brigham and Women's Hospital
$47,261.00
Disparities in Medication Errors and Adverse Drug Events in Children
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The Commonwealth Fund
$45,000.00
Cultural Competency Papers for 2005 Expert Roundtable
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International Society for Quality in Health Care
$12,251.00
21st International Conference on Quality in Health Care
Lee Tregloan
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Latino Health Institute, Inc.
$10,000.00
Everybody Counts: State Infrastructure and Capacity to Eliminate Racial and Ethnic Health Disparities in New England

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COMMONWEALTH FUND/HARVARD UNIVERSITY FELLOWSHIP IN MINORITY HEALTH POLICY

President and Fellows of Harvard College
$800,000.00
The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: Support for Program Direction and Fellowships, 2005–06

Addressing pervasive racial and ethnic disparities in health and health care requires trained, dedicated physicians who can lead efforts to improve minority Americans' access to quality medical services. The Fellowship in Minority Health Policy has played an important role in addressing these needs. During the year-long program, young physicians undertake intensive study in health policy, public health, and management, all with an emphasis on minority health issues, at the Harvard School of Public Health or John F. Kennedy School of Government. Fellows also participate in special program activities. Since 1996, 40 fellows have successfully completed the program and received a master's degree in public health or public administration. In the coming year, program staff will select a 10th group of four fellows, provide current fellows with an enriched course of study and career development, and conduct ongoing evaluation activities.

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CHILD DEVELOPMENT AND PREVENTIVE CARE

Arizona State University
$258,907.00
Preparing Pediatric Nurse Practitioners to Assess, Manage, and Prevent Current Morbidities of Childhood
Improving the quality of preventive and developmental services for children requires a team effort within practice settings. Physicians often look to nursing staff, especially pediatric nurse practitioners (PNPs), to provide important aspects of well child care. Medical educators, however, are concerned that graduating PNPs are not up to the task: they see a need to greatly improve the content and quality of PNP training. This project will actively engage leaders in PNP education in the development, implementation, and evaluation of a new prevention curriculum for child development and behavior. In so doing, it will draw on clinical tools and curricular materials developed with support from the Fund.

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Center for Health Policy Development
$313,249.00
Building State Medicaid Capacity to Support Children's Healthy Mental Development, Phase 2
Authorization to Support the ABCD Initiative for Up to Four States
In January 2004, the Fund launched the second phase of the Assuring Better Child Health and Development initiative (ABCD II) to help states promote the healthy mental development of low-income, young children under age 5. Medicaid agencies in California, Illinois, Iowa, Minnesota, and Utah are working to ensure that: young children at risk of developmental or behavioral delay are identified in primary pediatric settings and referred to specialists; parents at risk of depression are referred to mental health professionals; billing and reimbursement policies facilitate use of these services; health care professionals have the training to provide developmental services; and new care models are tested in primary pediatric practice. The National Academy for State Health Policy will continue to manage the state collaborative to foster innovation, coordinate technical expertise, and disseminate results to all 50 states. Illinois's project is being supported by the Michael Reese Health Trust.

Neva Kaye
Program Director

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Children's Hospital and Research Center at Oakland
$332,939.00
Rethinking Well-Child Care
Traditionally, preventive care for children has been driven by concerns about preventing infectious disease and ensuring adequate nutrition. Today, however, concerns about children's development and behavior are foremost in parents' minds. This project will develop a new schedule and content for well-child care that responds to the developmental needs and challenges faced by children and families. The research team will solicit input from a broad group of stakeholders, including the American Academy of Pediatrics, parents, health care providers, public and private health care programs, public agencies, and professional organizations.

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Greenville Hospital System
$114,199.00
Testing a Model for Developmental Assessment of At-Risk Children
Identifying developmental delays in young children early and providing appropriate interventions can lead to better long-term cognitive, social, and emotional outcomes. Currently, children suspected of having problems may wait up to two years before receiving diagnostic evaluations and subsequent treatment. For this project, investigators will test the feasibility and cost of a standardized protocol, administered by a team of nurse practitioners and social workers, to perform developmental assessments more efficiently. In turn, the protocol will expedite children's receipt of needed services. The model should be of great interest to child health care providers, parents, special educators, and public and private health care agencies and organizations as a means to improve access to developmental services while reducing costs. The Greenville Hospital System will provide in-kind support.

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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, 2003-04.

Iowa Department of Human Services
$55,000.00
Iowa's Care for Kids Healthy Mental Development Initiative, Phase 2
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Minnesota Department of Human Services
$55,000.00
Great Start Minnesota, Phase 2
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State of California Department of Health Services
$50,000.00
Best-PCP-Behavioral, Developmental, Emotional Screening and Treatment by Primary Provider in Medi-Cal Managed Care, Phase 2
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Deputy Director, Medical Care Services
Medi-Cal Managed Care Division
MS 4404, PO Box 997413
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Tel: (916) 440-7800
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Utah Department of Health
$52,641.00
Enhancing Utah's Capacity to Support Children's Healthy Mental Development, Phase 2
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The President and Directors of Georgetown College
$129,589.00
Linking Pediatric Developmental Care to Community Resources

Many children with developmental problems and their families are not receiving all the services they need because their primary care providers are not making sufficient use of clinical, educational, and family support resources in the community. Through a review of published and unpublished papers and extensive interviews with key individuals, the investigators will determine how successful links are formed with community-based services. Clinicians and health systems will receive practical guidance on connecting families to such services and case studies describing effective models around the country. Policymakers, meanwhile, will be informed of ways to promote and facilitate adoption of these models. The project's findings will be useful in establishing protocols and standards for systems that link pediatric care to related services for children and families.

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University of Rochester
$320,810.00
Developing a Manual for Pediatric Preventive Services: Bright Futures in Practice

Although clinical performance standards are essential for improving the quality of preventive health care and developmental services for children, few such standards exist. This project will develop the first authoritative, comprehensive guide to preventive pediatric care and developmental services. It is intended to serve as the authoritative reference for teaching, providing, and evaluating preventive care for children and will thus serve a critical role in facilitating the assessment and improvement of clinical developmental services. Companion work on well-child care is being supported by the federal Maternal and Child Health Bureau.

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University of Vermont and State Agricultural College
$287,010.00
Fostering Partnerships Within States to Improve Children's Development and Preventive Services
Over the past several years, Fund-supported initiatives in North Carolina, Utah, and Vermont have successfully brought together child health care providers, professional societies, health departments, Medicaid programs, academic institutions, community organizations, insurers, and others to improve preventive and developmental services for young children. Acknowledging the effectiveness of this approach, the Centers for Medicare and Medicaid Services confirmed that all activities of the Vermont partnership are eligible for federal matching funds. This project will help five other states develop the infrastructure for improvement partnerships and undertake learning collaboratives to improve care for young children.

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Small Grants — Child Development and Preventive Care

American Academy of Pediatrics, Inc.
$13,966.00
Promoting the "Open Forum" Meeting Model Among Child Development Stakeholders

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Association of Maternal and Child Health Programs
$8,985.00
Improving Quality of Preventive Care in States
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Child and Family Policy Center
$45,000.00
Using State-Level Data to Inform State Children's Health Insurance Program (SCHIP) Reauthorization
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Tel:(515) 280-9027
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Children's Hospital Corporation
$25,000.00
Identification of Developmental Concerns in Young Children
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George Washington University
$25,000.00
Educating Health Policymakers about the Importance of Medicaid to Promote Children's Health and Development
Sara Rosenbaum, J.D.
Chair, Department of Health Policy
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Health Systems Research, Inc.
$11,518.00
Mapping Referral Resources to Support Children's Development
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President
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National Initiative for Children's Healthcare Quality
$25,000.00
Fourth Annual Forum for Improving Children's Health Care Quality
Colleen O'Rourke
Director of Public Events and Marketing
730 Airport Road, Bolin Creek, Suite 104
Chapel Hill, NC 27514
Tel: (617) 754-4900
corourke@nichq.org

University of North Carolina at Chapel Hill
$46,538.00
Supplemental Funding to Support the Evaluation of the Breakthrough Series on Child Development in North Carolina and Vermont
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Wayne State University
$9,374.00
The Science of Children's Development: Planning a Curriculum for Pediatric Residency Education
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PICKER/COMMONWEALTH PROGRAM ON QUALITY OF CARE FOR FRAIL ELDERS

AcademyHealth
$120,000.00
The Commonwealth Fund/AcademyHealth Long Term Care Colloquium, Year 2
Although demand for long-term care services continues to grow, this important health care sector has been a relatively low priority for policymakers, as well as health services researchers. Meaningful communication between these groups

and collaboration on work have been limited. The first Fund-supported Long-Term Care Colloquium successfully engaged practitioners, researchers, and policy officials in addressing key issues related to the financing and delivery of long-term care. The second will focus attention on critical long-term care issues and problems; foster discussion and consensus among policymakers, practitioners, and researchers on potential solutions; and identify further research needs.

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American Health Quality Foundation
$152,561.00
What Does Resident-Centered Care Look Like? Creating a Training Video for Staff of Quality Improvement Organizations

There has been much discussion about the need for "culture change" within nursing homes to make these facilities more focused on residents' needs and preferences. Starting next year, Medicare-sponsored Quality Improvement Organizations (QIOs) will be required to promote culture change in each of their state's nursing homes. The challenge is to prepare QIO staff to assist facilities with this transformation. Working with culture change expert LaVrene Norton, the project team will create a training video for QIO staff to help illustrate the changes homes must undergo to become resident-centered. While the QIOs are the primary audience, the video and its accompanying training materials should also be useful to providers, regulators, and consumers.

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Brown University
$121,917.00
Examining Racial Concentration and Disparities in Nursing Home Quality of Care

Research has shown that the quality of care provided in nursing homes with predominantly minority resident populations is poorer than care provided in predominantly white facilities. In some cases, a disproportionate concentration of minority residents can simply be attributed to the demographics of the surrounding communities. However, there appears to be evidence that segregation also influences the racial composition of some facilities. The research team will describe the extent of racial and ethnic segregation in U.S. nursing homes and evaluate its impact on quality of care. Findings from the study will inform the development of recommendations regarding ways to reduce racial segregation and address disparities in care to policymakers and quality improvement organizations.

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Long Term Care Community Coalition
$135,839.00
Using Federal Civil Monetary Penalties and State Fines to Promote Nursing Home Innovation

Civil monetary penalties are one of a number of sanctions states may impose on nursing homes that provide poor care. In addition to their deterrence effect, such penalties offer an opportunity to stimulate quality improvement in nursing homes. Not much is known, however, about whether states are exercising their fining powers or how collected monies are being used. The investigators on this project will seek answers to these questions by surveying and interviewing nursing home regulatory directors, ombudsmen, and consumers in each state. The survey will be supplemented by in-depth case studies of the use of civil monetary penalties in five to seven states. The research findings, together with an action plan developed by the project team, should help states become more proactive in their use of this important tool for quality improvement.

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National Citizens' Coalition for Nursing Home Reform
$209,988.00
Mobilizing Consumer Organizations to Promote Resident-Centered Care in Nursing Homes

The Pioneer Network's movement to promote resident-centered nursing home care is making life better for many frail elders. Still, only a small fraction of nursing homes nationally has embraced this approach, which focuses on the needs and preferences of residents and their families. The project team will help lay the foundation for a consumer-led campaign to raise public expectations for nursing home care. As a first step, project staff will survey all nursing home consumer groups to discover what they know about resident-centered care and their strengths as consumer organizations. Where necessary, project staff will provide education in resident-centered care and training to promote such care. The project team will then produce a toolkit for consumer groups, providers, and others to educate them about resident-centered care and enlist them in an effort to encourage the nursing home industry to adopt this approach as the new standard of care.

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Pioneer Network
$235,486.00
Providing Leadership and Resources Within the Culture Change Movement for Nursing Home Care

The Pioneer Network has provided the primary impetus for the "culture change" movement within the nursing home industry. Acknowledging the importance of this shift, the Centers for Medicare and Medicaid Services will be requiring the Quality Improvement Organizations (QIOs) to promote resident-centered care—a mandate that is expected to stimulate a rapid increase in the number of nursing homes seeking assistance in the transformative process. This grant will enable the Pioneer Network to seize this collaborative opportunity with the QIOs, enabling Pioneer to prepare new programs, enhance its Web site, develop new educational materials, and organize its wide network of contacts into a talent pool accessible to providers making the change to resident-centered care. The Pioneer Network will provide in-kind support for this project.

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Wellspring Innovative Solutions
$250,000.00
Wellspring Innovative Solutions: Replicating the Model
The Wellspring model, an ongoing quality improvement collaborative among alliances of nursing homes, has demonstrated its ability to improve performance without raising costs. A program-related investment will provide a line of credit to stabilize Wellspring Innovative Solution's cash flow until it attains its goal of 20 or more alliances of about 10 homes each. This level of activity will permit Wellspring to function as a financially independent, nonprofit business providing services to nursing homes that are seeking to improve quality.

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Small Grants — Picker/Commonwealth Program on Quality of Care for Frail Elders

American College of Health Care Administrators
$28,650.00
Excellence in Long Term Care: Developing a Self-Assessment Tool for Nursing Home Adminstrators
Mary Tellis-Nayak, M.S.N., M.P.H.
President and CEO
300 N. Lee Street, Suite 301
Alexandria, VA 22314-2807
Tel: (703) 739-7900
mtn@achca.org

IDEAS Institute
$28,178.00
Exploring the Value of Private Bedrooms in Nursing Homes
Margaret Calkins, Ph.D.
Senior Researcher
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Kirtland, OH 44059-9580
Tel: (440) 256-1883
mcalkins@idkeasinstitute.org

National Senior Citizens Law Center
$30,000.00
Improving Nursing Homes Through Advocate Education
Eric Carlson, J.D.
Staff Attorney
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University of North Carolina at Chapel Hill
$29,205.00
Pragmatic Innovations in Long-Term Care That Improve Resident Quality of Life
Philip D. Sloane, M.D., M.P.H.
Elizabeth and Oscar Goodwin Distinguished Professor of Family Medicine
Cecil C. Sheps Center for Health Services Research
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Rhode Island Quality Partners, Inc
$24,500.00
Saint Louis Accord: Setting an Agenda for Action for the Eighth Scope of Work
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PATIENT-CENTERED PRIMARY CARE INITIATIVE

National Committee for Quality Assurance
$300,716.00
Enhancing Patient-Centered Care in Office Practice
While several small-scale studies have shown that patient-centered care interventions can improve clinical outcomes, so far there has been only limited implementation of patient-centered care concepts in physician practices. This project will develop and test measures and tools to define and evaluate the quality of patient-centered care in office practices. These activities will lay the groundwork for integrating these metrics into one or more programs that could identify and reward physicians who provide high-quality, patient-centered care.
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INTERNATIONAL PROGRAM IN HEALTH POLICY AND PRACTICE

Harris Interactive, Inc.
$350,000.00
International Health Policy Survey, 2005
The 2005 International Health Policy Survey, the eighth 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 of how well their health care system is performing on key measures of patient-centeredness: round-the-clock care, emergency care, patient choice, medical errors, doctor-patient communication, patient involvement in decision-making, waiting times, coordination of care, addressing health literacy, and access to prescription drugs. The survey findings will be released at the Fund's 2005 International Symposium to highlight the impact of different health care delivery systems. The results should generate substantial interest among health ministers, policymakers, researchers, and the media. Project staff will submit a paper discussing survey results to Health Affairs for Web publication, and the Fund will publish the findings as part of its series of international issue briefs. Cofunding will be provided by The Health Foundation to expand the size of the U.K. survey sample.

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Johns Hopkins University
$50,000.00
Cross-National Comparisons of Health Systems Quality Data, 2005
Comparisons between the U.S. health care system and the systems of other industrialized countries reveal striking differences in spending, availability and use of services, and health outcomes. This grant will support the eighth report in an annual series of analyses of key health data for the 30 member countries of the Organization for Economic Cooperation and Development (OECD). The report will provide an update of overall trends in health system performance, with an emphasis on health spending, coverage, hospital capacity and utilization, pharmaceutical costs, use of technology, trends in the supply of health professionals, and quality of care. In comparing health system data, the study will illustrate the impact of different national policies on health

system efficiency. Findings will be presented at the Fund's October 2005 International Symposium on Health Care Policy and submitted to Health Affairs for possible Web publication. A chartpack containing core components from the OECD database, available on the Fund"s Web site, will be updated as a resource for journalists, policymakers, and researchers.

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President and Fellows of Harvard College

$92,673.00

Alternative Approaches to Compensating Medical Injury: Lessons From International Models

U.S. physicians and hospitals are experiencing serious difficulties obtaining affordable professional liability insurance. The current system often fails to provide compensation to injured people and does little to promote patient safety. To inform the development of an alternative approach, this project will examine the design and experience of the no-fault administrative systems used to compensate medical injuries in Sweden, New Zealand, Denmark, and Finland. The study will address the criteria used to determine which medical errors are compensable; the process used to develop the criteria; and the performance of these criteria in terms of efficiency, reliability, validity, and fairness to patients and providers. Findings will help stimulate interest in a potentially more promising option for malpractice reform. A paper discussing the study's findings will be submitted for consideration as a Health Affairs Web Exclusive.

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The Commonwealth Fund

$225,000.00

International Symposium on Health Care Policy, Fall 2005

The Fund's eighth annual International Symposium on Health Care Policy will focus on patient choice and health system responsiveness. In bringing together leading policymakers and researchers from Australia, Canada, New Zealand, the United Kingdom, and the United States—as well as Germany and other selected European countries—the symposium will highlight for U.S. policymakers how other health systems are: improving responsiveness and access, 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, ensuring round-the-clock access to health care, promoting health literacy, and using information technology to help empower patients. Presenters will highlight innovative policies, incentive structures, and health care delivery models that support these changes and improve quality. To reach a broader policy audience, the Fund will webcast a health ministers' roundtable discussion; in addition, the second day of the symposium will be held on Capitol Hill. Commissioned papers from the symposium will be submitted to *Health Affairs* for consideration as Web Exclusives.

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The Commonwealth Fund
$1,158,268.00
Harkness Fellowships in Health Care Policy, 2006–07
Support for a ninth class of approximately 12 Harkness Fellows in Health Care Policy will allow the Fund to continue to develop promising junior policy researchers and practitioners from Australia, New Zealand, and the United Kingdom. A two-day policy retreat—the first reunion of Harkness Fellows in Health Care Policy—will be held in July 2005 at Pennyhill Park, co-sponsored by the Nuffield Trust and the Health Foundation.

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The Nuffield Trust
$70,000.00
Commonwealth/Nuffield International Conference on Health Care Quality Improvement, 2005
Since 1999, the Fund and The Nuffield Trust have sponsored annual symposia that have brought together senior government officials, leading health researchers, and practitioners from the United States and United Kingdom for an exchange on quality improvement policies and strategies. These transatlantic meetings have focused on such critical issues as: patient safety, strategies to change provider and

organizational behavior, the use of information technology, disparities in health care, and public reporting on provider performance data. One of the series' products is an agenda for U.S.–U.K. collaboration on quality improvement efforts, formalized in an agreement signed by the two countries in 2001. Participants at the seventh quality improvement conference 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 quality initiatives in different countries to gauge their impact and sustainability.

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Small Grants — International Program in Health Policy and Practice

The Commonwealth Fund
$5,000.00
International Exchange Affiliate Meeting
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The Commonwealth Fund
$16,500.00
International Innovations in the Pharmaceutical Review Process
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Health Services Research Association of Australia & New Zealand
$25,000.00
Fourth Australia–New Zealand Health Services Research and Policy Conference
Paul Dugdale
Health Services Research Association of Australian & New Zealand

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University of Technology, Sydney
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New York City Health and Hospitals Corporation
$25,000.00
North East London Strategic Health Authority Learning Partnership
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The Nuffield Trust
$50,000.00
The Commonwealth Fund Harkness Fellowships in Health Care Policy Alumni Health Policy Conference, July 2005
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The Commonwealth Fund Harkness Fellowships in Health Care Policy Alumni Health Policy Conference, July 2005
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Organisation for Economic Cooperation and Development (OECD)
$22,700.00
OECD Health Care Quality Indicators Project—December 2004 Meeting
Jeremy Hurst
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Trustees of the University of Pennsylvania
$5,000.00
International Nursing Shortages and Nurse Migration Commonwealth Secretariat Policy Initiative

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COMMUNICATIONS

Alliance for Health Reform
$184,750.00
2005 Health Policy Seminars and Congressional Staff Retreat

Alliance for Health Reform briefings are 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 six briefings and host a congressional staff retreat. Possible briefing topics include: quality of care for Medicare beneficiaries; medical debt; implementation issues in the new Medicare drug benefit; international health policy issues; identification of high-performing health care systems; health care issues for adults ages 50 to 70; and increasing program enrollment for individuals dually eligible for Medicare and Medicaid. The Catholic Health Association of the United States will provide cofunding for the congressional staff retreat.

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Harris Interactive, Inc.
$91,000.00
Health Care Opinion Leaders Poll

The Health Care Opinion Leaders Poll, developed in conjunction with Harris Interactive, Inc., will help the Fund advance public debate over crucial health policy issues and, in the process, enhance the foundation's visibility and relationships with experts and key audiences. Project staff will establish a panel of high-level experts across multiple sectors and regularly sample their opinions on major policy issues. This vehicle will be augmented with commissioned commentary from policy experts, with a focus on innovative, solution-oriented thinking. Poll results and commentaries will be posted on the Fund's Web site and disseminated to Fund audiences through e-mail alerts.

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Project HOPE/The People-to-People Health Foundation
$201,060.00
Strategic Web Publishing Partnership with Health Affairs
The Fund has had an online publishing partnership with Health Affairs since 2002 to support the journal's Web Exclusive initiatives and allow it to establish a robust online presence. The partnership has provided opportunities to publish Fund-supported research more often and faster than traditional means allow, while also raising the Fund's professional and public profile. This project will support general Web Exclusive operations as well as articles on international health policy issues.

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Small Grants — Communications

American Medical Association
$5,000.00
Fifth International Congress on Peer Review and Biomedical Publication

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Center for Excellence In Health Care Journalism
$5,000.00
6th Annual Association of Health Care Journalists Conference

Andrew Holtz, M.P.H.
Interim Executive Director

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Columbia Journalism Review
$10,000.00
Journalists' Online Guide to Medicare Part D
Trudy Lieberman
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Kaiser Family Foundation
$8,500.00
40th Anniversary of Medicare and Medicaid
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Kaiser Family Foundation
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Barbara Jordan Conference Center
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WGBH Educational Foundation
$47,500.00
WGBH Health Desk
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Small Grants — Health Policy, Research and Evaluation
Harris Interactive, Inc.
$36,843.00
International Health Policy Survey—Expanded U.S. Sample

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ORGANIZATIONS WORKING WITH FOUNDATIONS

AcademyHealth
$38,000.00
General Support
W. David Helms, Ph.D.
President and Chief Executive Officer
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Grantmakers in Aging, Inc.
$6,000.00
General Support
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Executive Director
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Tel: (937) 435-3156
cfarquhar@giaging.org

Grantmakers In Health
$15,000.00
General Support
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President and Chief Executive Officer
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Health Services Research Association of Australia & New Zealand
$1,000.00
General Support
Jane Hall, Ph.D.
Professor and Director
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New York Regional Association of Grantmakers
$11,500.00
General Support
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Nonprofit Coordinating Committee of New York
$35,000.00
General Support
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Rockefeller University
$90,000.00
Transfer and Maintenance of The Commonwealth Fund's Archives
Darwin H. Stapleton, Ph.D.
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stapled@mail.rockefeller.edu

Small Grants — Special Opportunities

Alfred E. Smith Memorial Foundation, Inc.
$8,000.00
Alfred E. Smith Memorial Foundation Dinner, October 21, 2004
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

Foundation Center
$15,000.00
General Support for 2005
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    President
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    sle@fdncenter.org

Greater New York Hospital Association
$1,000.00
2005 GNYHA-UHF Health Services Research Symposium
    Tim Johnson
    Executive Director
    555 West 57th Street, 15th Floor
    New York, NY 10019
    Tel: (212) 506-5420
    tjohnson@gnyha.org

Independent Sector
$12,500.00
General Support
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National Hispanic Medical Association
$5,000.00
National Hispanic Medical Association Inaugural Gala
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    President
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    Tel: 202-628-5895
    nhma@nhmamd.org

National Medical Fellowships
$6,000.00
2004 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
$6,000.00
New York Academy of Medicine Gala 2005
Jeremiah Barondess, M.D.
President
1216 5th Avenue Room 602
New York, NY 10029

Tel:(212) 822-7201
barondess@nyam.org

Center for Effective Philanthropy
$7,000.00
2005 Foundation Staff Perception Report
Kevin Bolduc
Associate Director
675 Massachusetts Ave., 7th Floor
Cambridge, MA 02139
Tel: 617-492-0800 ext. 202
kevinb@effectivephilanthropy.org

Fund for Public Health in New York, Inc.
$2,000.00
Women at Risk Breakfast
Bonnie Kerker, Ph.D.
Director, Comunity Epidemiology Unit
125 Worth Street
New York, NY 10013
Tel: (212) 442-9994
bkerker@health.nyc.gov

Primary Care Development Corporation
$5,000.00
2005 Spring Gala Dinner
Ronda Kotelchuck
Executive Director
22 Cortlandt Street, 12th Floor
New York, NY 10007
Tel: (212) 437-3917
rkotelchuck@pcdcnyc.org

United Hospital Fund of New York
$8,500.00
United Hospital Fund Gala 2004
James R. Tallon, Jr.
President
350 Fifth Avenue, 23rd Floor
New York, NY 10118
Tel: (212) 494-0700
jtallon@uhf.org

University of Colorado Foundation
$25,000.00
The Quigg and Virginia S. Newton Endowed Chair in Leadership

Carolyn Whitehead
Interim Vice President for Development
Regent Administrative Center
206 SYS 57
Boulder, CO 80309
Tel: (303) 492-5366
carolyn.whitehead@cufund.org

Women's Prison Association and Home, Inc.
$4,000.00
2005 Annual Benefit Dinner

Ann L. Jacobs
Executive Director
110 Second Avenue
New York, NY 10003
Tel: (212) 674-1163
ajacobs@wpaonline.org

2005 Annual Report

SUMMATION OF PROGRAM AUTHORIZATIONS

Year Ended June 30, 2005	**Major Program Grants**	**Picker Program Grants**	**Small Grants Fund Grants**	**Total**
Program Grants Approved				
Improving Insurance Coverage and Access to Care	$3,681,524	—	$319,185	$4,000,709
Task Force on the Future of Health Insurance	$1,641,257		$196,655	$1,837,912
Program on Medicare's Future	$1,506,023	—	$122,530	$1,628,553
Health Care in New York City Program	$534,244	—	$0	$534,244
Improving the Quality of Health Care Services	$7,243,894	$1,225,791	$682,301	$9,151,986
Health Care Quality Improvement	$2,671,608	—	$192,895	$2,864,503
Quality of Care for Underserved Populations	$1,494,867	—	$138,492	$1,633,359
Commonwealth Fund/Harvard University Fellowships in Minority Health Policy	$800,000	—		$800,000
Child Development and Preventive Care	$1,976,703		$210,381	$2,187,084
Picker/Commonwealth Program on Frail Elders		$1,225,791	$140,533	$1,366,324
Program on Patient-Centered Primary Care	$300,716			
International Health Care Policy and Practice	$1,945,941	—	$149,200	$2,095,141
Communications	$292,060	—	$81,000	$373,060
Health Policy, Research & Evaluation			$36,843	$36,843
Other Continuing Programs	$196,500	—	$105,000	$301,500
Total Program Grants Approved	$13,359,919	$1,225,791	$1,373,529	$15,959,239
Grants Matching Gifts by Directors and Staff				$403,243
Program Authorizations Cancelled or Refunded and Royalties Received				($1,339,028)
Total Program Authorizations				**$15,023,454**