THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

2011 ANNUAL REPORT

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 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.

Cover photo: Donnelly Marks

The Commonwealth Fund 2011 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 2011 Annual Report offers highlights of the Fund's activities in the past year.

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A Private Foundation Working Toward a High Performance Health System

2011 Annual Report President's Message

HEALTH REFORM'S FIRST YEAR: SUPPORTING THE ROLLOUT

Karen Davis, President
The Commonwealth Fund

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Page 6 photo: Roger Carr.

HEALTH REFORM'S FIRST YEAR: SUPPORTING THE ROLLOUT

Karen Davis
President

When the first provisions of the Affordable Care Act took effect over a year ago, they heralded the promise of better access to health insurance coverage, financial relief, and health security for millions of Americans. Already health care spending is growing slower than experts originally anticipated. Further significant savings should materialize for government, employers, and families as provisions aimed at transforming health care financing and delivery lead to lower insurance administrative costs, fewer avoidable hospitalizations and hospital-acquired infections, and better management of chronic conditions.

The need for health reform in the United States is irrefutable. The ranks of the uninsured and underinsured continue to swell, even as health care spending consumes almost a fifth of the nation's economic resources—yet without producing health outcomes as good as those in countries that spend half as much per person as we do. The health reform law has the potential to reverse these trends and put the nation on a path to a high performance health system that provides affordable access to high-quality, efficient care. Over the last year, The Commonwealth Fund's work has centered on three major goals:

- Helping health care leaders and the American people understand the Affordable Care Act and what it means for them;
- Supporting implementation of the new law and assessing its potential to move the U.S. along the path to high performance; and
- Laying the groundwork for future health care delivery system change and policy action.

The Fund has strived to clarify the implications of the Affordable Care Act, bring expertise to bear on its implementation, and help health care organizations respond to the opportunities embodied in the legislation.

EXPLAINING HEALTH REFORM AND ITS IMPACT

In the past year, the federal government made considerable progress in rolling out the first provisions of the health reform legislation:

- According to data released by the Centers for Disease Control and Prevention, the Affordable Care Act is already benefiting this group: since September 2010, when a policy allowing children to remain on their parents' insurance plans through age 26 took effect, approximately 2.5 million more young adults ages 19 to 25 have coverage, compared with the number who would have been insured without this policy.
- Seniors and disabled individuals no longer face a "doughnut hole" in their prescription drug coverage. The Centers for Medicare and Medicaid Services estimates that more than 2.2 million people have saved in excess of $1.2 billion on their prescriptions this year, for an average of $550 per person.
- Financial barriers to preventive care services have been removed.
- Tax credits are now available to help small businesses offer affordable coverage to their workers.

Still, many members of the public—and even a number of policymakers—do not understand what is in the Affordable Care Act or how the law will improve health care in the U.S. That's why The Commonwealth Fund launched its online Health Reform Resource Center last spring. Here, visitors can find reader-friendly summaries of all the law's provisions, a tool for sorting through the provisions, an implementation timeline, and links to federal regulations and related Commonwealth Fund research, analysis, and commentary. Every month since its launch, the Health Reform Resource Center has been one of the most-viewed pages on our Web site.

To explain the impact that reform will have on our health system, we introduced a new series of issue briefs, *Realizing Health Reform's Potential,* to explore how the Affordable Care Act benefits different populations and groups, such as women, young adults, and small businesses, as well as how it will improve insurance coverage and help transform the delivery of care. For example, once the law is fully implemented in 2014, nearly all the 27 million working-age women who went without health coverage in 2010 will gain affordable, comprehensive insurance benefits. Health reform will accomplish this by expanding Medicaid to those with the lowest incomes, providing premium tax credits to middle-income individuals, requiring health plans to offer comprehensive benefits like free coverage of preventive care services, issuing tax credits to small businesses, offering new affordable coverage options, and instituting insurance market reforms—for example, by banning gender rating, which contributes to higher premiums for women in the individual insurance market.

Many members of the public—and even a number of policymakers—do not understand what is in the Affordable Care Act or how the law will improve health care in the U.S.

Along with greatly expanding access to affordable, comprehensive health coverage, the reform

law also aims to improve the efficiency and effectiveness of health care delivery. By making major investments in primary care, including preventive services and chronic disease care, the law will shore up an undervalued part of our health system. The Commonwealth Fund's *Realizing Health Reform's Potential* series explores how provisions in the law will help to expand and train the primary care workforce, improve reimbursement for primary care services, and support innovative approaches to delivering care, including the patient-centered medical home model of accessible, coordinated care.

A new series of Commonwealth Fund webinars is also enabling communication among researchers, policymakers, and other health system stakeholders. Featuring expert panelists including senior officials from the U.S. Department of Health and Human Services, the webinars are a rich source of information and analysis about state insurance exchange implementation, the Pre-Existing Condition Insurance Program, and the impact of health reform on boomers. Likewise, a series of briefings conducted with the Alliance for Health Reform in Washington, D.C., has offered additional opportunities to educate policymakers and their staff about the law.

As federal regulations are released to implement provisions of the Affordable Care Act, we have also kept stakeholders informed through timely posts to The Commonwealth Fund Blog. For example, we posted an analysis of a proposed regulation to establish a process for the annual review of "unreasonable" increases in premium rates by insurance carriers across the country. According to the new rule, increases above a 10 percent threshold will be publicly disclosed, along with the insurer's justification. Insurance companies charging unreasonable premium increases may lose the opportunity to participate in the new health insurance exchanges. A recent Commonwealth Fund report had underscored the need for such transparency, finding that employer premiums had increased an average of 50 percent across the states between 2003 and 2010.

INFORMING AND SUPPORTING REFORM'S IMPLEMENTATION

Over the past year, several important pieces of the health reform law have been rolled out, including allowing children under age 26 to stay on or join their parents' health insurance plan, the establishment of state-based insurance plans for people with preexisting health conditions, and the availability of tax credits for small businesses that provide coverage to their employees. The Commonwealth Fund has offered guidance for implementing the coverage expansion provisions, and we have attempted to assist federal and state officials tasked with creating health insurance exchanges—the new marketplaces where small businesses and individuals without employer health benefits will be able to gain access to expanded coverage options. Grantee Timothy Jost, J.D., a professor at the Washington and Lee University School of

The Commonwealth Fund's *Realizing Health Reform's Potential* series explores how provisions in the law will help to expand and train the primary care workforce, improve reimbursement for primary care services, and support innovative approaches to delivering care.

Law, provided timely recommendations for resolving such thorny issues as exchange governance and preventing adverse selection.

The federal government also launched a number of the Affordable Care Act's health care delivery reforms, notably the new Center for Medicare and Medicaid Innovation. Among the new approaches to care delivery that the Center will be testing on a rapid basis are: Pioneer Accountable Care Organizations, which will assume responsibility for coordinating patient care and improving treatment of complex conditions; bundled-payment models to incentivize health care providers to improve transitional care for patients discharged from hospitals and to reduce the likelihood of rehospitalization; and an initiative that will support primary care practices in coordinating care for patients with chronic conditions, other serious illnesses, or disabilities.

The Commonwealth Fund aims to assist leaders in health care delivery that are seeking to join the vanguard of early innovators.

As part of our effort to assist reform implementation, The Commonwealth Fund has considered how the Innovation Center can optimize its efforts to test and disseminate innovative payment and delivery methods. Soon after the Center was formed, we published recommendations to enable it to do its job quickly and effectively. These include: granting the Center more flexibility to develop initiatives with a minimum of administrative delay; trying out a variety of payment reform initiatives, such as global and bundled payment; and encouraging innovative models developed by states and private-sector entities.

Global payment methods, in particular, would encourage hospitals, physician practices, nursing homes, and other providers to work together and would reward those that offer appropriate, high-quality, and efficient care. The question of who receives the global payment, however, remains. The Affordable Care Act helps address this by establishing a new form of health care provider within the Medicare program—the accountable care organization, or ACO. The ACO organizes physicians, hospitals, and other health care providers into a group that becomes accountable for each patient's entire continuum of care and, in return, shares in any cost savings it generates for Medicare.

While the managed care experience of the 1990s illustrates the risks associated with creating large provider groups, there are a number of successful contemporary models, such as the Medicare Physician Group Practice demonstration and organizations like Community Care of North Carolina, to look to for guidance. The Commonwealth Fund's Commission on a High Performance Health System identified 10 essential principles, among them a strong primary care foundation, well-informed patients, and quality reporting, to help ensure the spread of ACOs.

The Commonwealth Fund also aims to assist leaders in health care delivery that are seeking to join the vanguard of early innovators. One of our many case study series focusing on those at the forefront of care innovation, for example, highlighted some of the early leaders in patient safety and their approaches to training, coaching, and motivating staff to engage in safety improvement and their tools and systems for minimizing errors and maximizing learning. Likewise, our quality improvement Web site for health care professionals, WhyNotTheBest.org, has expanded its tracking of an important patient safety measure, central line–associated bloodstream infections data, at the hospital level. Such detailed data can help hospitals pinpoint where performance can be improved.

LAYING THE GROUNDWORK FOR CHANGE

As The Commonwealth Fund's 2010 Biennial Health Insurance Survey demonstrated, the recent recession and continued poor economic climate have had a profound impact on Americans' ability to retain their employer-sponsored coverage. The survey found that in the last two years, a majority (57%) of men and women who lost a job that came with health benefits became uninsured. Combined with the focus on deficit reduction, current economic conditions underscore the importance of slowing health spending growth, clearly one of our most pressing issues over the next decade.

Many leading budget deficit proposals, however, focus on reining in federal spending rather than combating the underlying growth in overall health care costs. By ignoring the latter, such proposals would cap federal budget outlays while putting beneficiaries and other payers at full financial risk for rising costs. Medicare beneficiaries with limited incomes already bear significant costs in the form of medical expenses and premiums. And given the dire fiscal situation in which most states find themselves, federal policymakers must avoid shifting Medicaid costs to them in responding to the continuing budget crisis. In light of the important roles states play in health reform and in efforts to control health care costs, The Commonwealth Fund, through its Federal and State Health Policy Program (formerly

the Federal Health Policy Program), has expanded its investment in state–federal dialogue.

To address the especially acute risks faced by some Americans in times of economic hardship, the Fund has created two new programs: the Vulnerable Populations program and the Dual Eligibles initiative. Ensuring that low-income families and economically disadvantaged minorities have access to quality care, and that people dually eligible for Medicare and Medicaid enjoy well-coordinated care, would not only improve health outcomes but achieve important savings as well.

As the U.S. attempts to reform its health system and control spending, it would do well to look to other industrialized countries, which spend far less of their gross domestic product on health care, for learning opportunities. The Commonwealth Fund's International Symposium on Health Care Policy, "Achieving a High Performing Health Care System: Realizing the Promise of Health Reform," brought together health ministers and leading policy thinkers from Australia, Canada, France, Germany, New Zealand, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom, and the U.S. to examine approaches for addressing shared problems. Participants also discussed findings from the Fund's latest International Health Policy Survey, which found that adults in the U.S. are the most likely to forgo care because of costs and to have trouble paying medical bills.

While the challenges are great, there is no reason why the U.S. cannot achieve far better results that it does. The nation already commits substantial

As the U.S. attempts to reform its health system and control spending, it would do well to look to other industrialized countries, which spend far less of their gross domestic product on health care, for learning opportunities.

resources to health care, and there are much better data available today about areas of care that are amenable to improvement, as well as data on provider performance (including information captured by the Fund's WhyNotTheBest.org Web site). Moreover, many health care leaders, if not responding specifically to opportunities in the Affordable Care Act, are following the spirit of that law, as evidenced by their pursuit of the three-part aim of better care, better patient outcomes, and lower costs.

We at The Commonwealth Fund are committed to tracking progress in health reform, informing the policies required to align incentives with performance, and helping spread successful innovations and best practices. We fully anticipate arriving at a turning point within the not-too-distant future when a half-century of rising uninsured is reversed, and when life expectancy in the U.S.—a nation that devotes so many resources to health care—no longer lags that of most other industrialized nations.

In the year ahead, we look forward to serving as a key resource for federal and state policymakers, as well as private-sector health care leaders, as the process of health reform continues to unfold.

THE COMMONWEALTH FUND

2011 Annual Report
Executive Vice President–COO's Report

Bringing the International Experience to Bear on the U.S. Health Reform Debate: The Commonwealth Fund's Harkness Fellowships Program

Robin Osborn, Vice President and Director
International Program in Health Policy and Innovation

John E. Craig, Jr.
Executive Vice President–COO
The Commonwealth Fund

Cover photos

Upper: 2011–12 Harkness Fellows in Health Care Policy and Practice—(center of photo, left to right) Matthew Inada-Kim (U.K.), Tom Frusher (U.K.), Rachael Addicott (U.K.), and Sarah Derrett (New Zealand)—met with U.K. Secretary of State for Health Andrew Lansley (far right) and health ministers of other countries at the Fund's annual International Health Policy Symposium in Washington, D.C. The Nuffield Trust in the United Kingdom, of which Dr. Jennifer Dixon (far left) is director, is an important partner with the Fund in the international program, including the Harkness Fellowships in Health Care Policy and Practice.
Lower: Commonwealth Fund Vice President and Director Robin Osborn has led the Fund's International Program in Health Policy and Innovation, including the Harkness Fellowships in Health Care Policy and Practice, since its launch in 1998.
(Both photos by John Troha.)

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Bringing the International Experience to Bear on the U.S. Health Reform Debate: The Commonwealth Fund's Harkness Fellowships Program

Private foundations that seek to promote transformative change in the way key systems and institutions work typically pursue a number of complementary strategies. These include:

1. researching the causes of social problems and potential solutions;
2. investing in tests of promising innovations and promoting the spread of successful ones;
3. tracking progress against improvement benchmarks; and
4. communicating results to advance changes in public and private policy that will support innovations and system transformation.

All of these strategies boil down to investments in talented and creative people. Most of the time, foundations invest in experienced professionals through individual projects that advance particular strategies. But foundations also have a long history of investing in people more overtly, through programs that seek to help launch or transform the careers of especially promising individuals. The payoff of such investments is generally expected to be long-term and not necessarily directly tied to a foundation's immediate program thrusts.

In the United States, well-known fellowship and scholars programs in the health care field include the Robert Wood Johnson Foundation's Clinical Scholars program, Health Policy Fellowships, and Executive Nurse Fellows program. Most recently, the Josiah Macy Jr. Foundation in 2010 established the Macy Faculty Scholars program to identify and nurture the careers of educational innovators in medicine and nursing. In addition to such "foundation-owned" programs, a number of foundations choose to invest in people through organizations with ongoing programs such as the National Medical Fellowships, which since 1948 has supported the training of minority physicians.

The Commonwealth Fund has a long history of investing in people through fellowship programs, beginning in 1925 with the Harkness Fellowships. In addition to this international program, the Fund has supported such individual career development activities as Commonwealth Fund Advanced Medical Fellowships (1937–70, precursor to the Robert Wood Johnson Clinical Scholars program); the Fellowship Program in Academic Medicine for Minority Students (1985–93); the Executive Nurse Fellowships program (1988–97); the Mongan Commonwealth Fund Fellowship Program (1996–present, formerly Commonwealth Fund/Harvard University Fellowship in Minority Health Policy); the Association of Health Care Journalists Media Fellowships on Health Performance (2010–present); and the Margaret E. Mahoney Fellowship, for health professional students (launched in 2012).[1]

This essay reports on a review of the Fund's international Harkness Fellowships in Health Care Policy and Practice program, which was undertaken in 2011 at the request of the foundation's board of directors. The findings, which draw on the foundation's long experience in conducting fellowship programs, are likely to be of interest to other organizations that support, or are considering supporting, such programs, as well as to stakeholders in fellowship programs.

ORIGINS OF THE HARKNESS FELLOWSHIPS[2]

Originally called "Commonwealth Fund Fellowships," Harkness Fellowships were initiated in 1925, just seven years after the founding of the foundation. The program was envisioned as a "reverse Rhodes Scholarship," and its goals were advancing international understanding and encouraging maintenance of the "special relationship" between the U.S. and the United Kingdom. At first the program sponsored U.K. university graduates from any field, but in due course it was expanded to include most of the English-speaking countries and, from 1952 to 1977, a number of Western European countries as well. Its alumni are a distinguished group, including many civil servants and academics with quite distinguished careers, as well as journalists such as Alistair Cooke and business leaders such as Christopher Hogg, former CEO of the textile manufacturer Courtaulds and former chairman of Reuters Group, Sir Peter Parker, former chairman of British Rail and Mitsubishi Electric, U.K., and Hugh Fletcher, former CEO of Fletcher Challenge, once New Zealand's largest company.

The Commonwealth Fund's financial setbacks arising from the stagflation of the 1970s forced a retrenchment in the Harkness Fellowships, limiting them to the United Kingdom, Australia, and New Zealand after 1977. Growing evidence that a general program was no longer needed to encourage promising young foreign professionals to undertake postgraduate study in the U.S., as well as concerns about the Fund's ability to add value to the work of fellows from many fields unrelated to the foundation's health care focus, led the board in 1988 to restructure the program. Harkness Fellowships were to enable early- to midcareer professionals to undertake a yearlong sabbatical conducting research or other work involving social policy issues.

In 1996, continuing concerns about insufficient synergy between the Fund's international fellowship

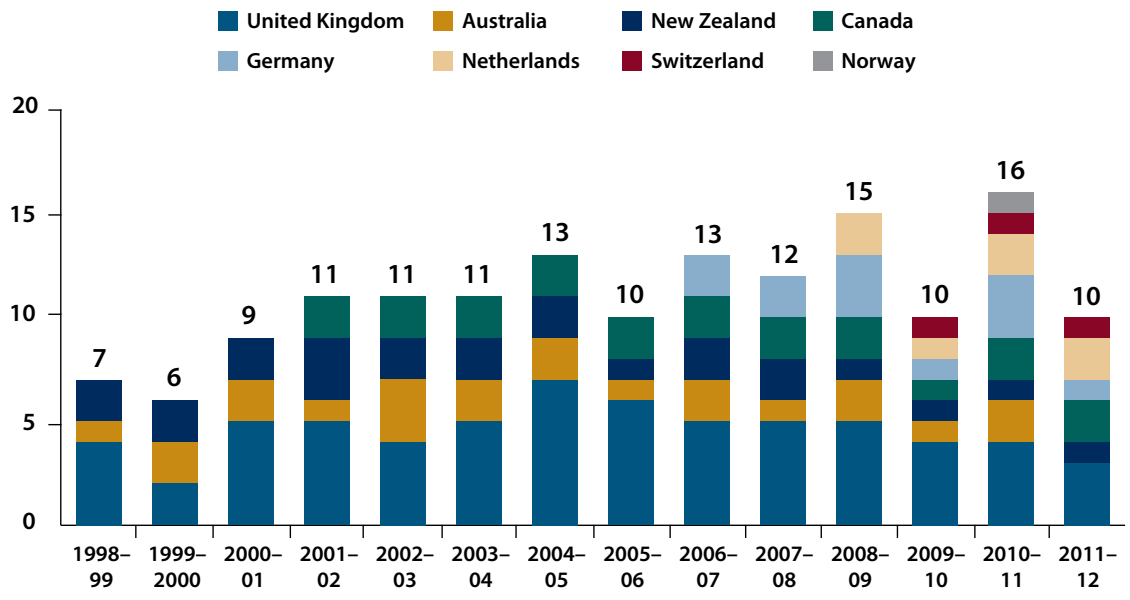
program and its domestic activities, combined with the intensified focus of the latter on health care reform, led to a further review of the program. The decision was made to use the fellowships to build an international network of policy researchers devoted to improving the performance of health systems in industrialized countries. In refocusing Harkness Fellowships, the board simultaneously authorized expansion of the Fund's international work to include an annual ministerial-level international health policy symposium in Washington, annual international surveys enabling comparisons of the performance of health systems, and other international comparative health policy and health services research activities.

GOALS AND STRUCTURE OF THE HARKNESS FELLOWSHIPS IN HEALTH CARE POLICY AND PRACTICE

The Harkness Fellowships in Health Care Policy and Practice began in 1998 as the centerpiece of The Commonwealth Fund's new International Program in Health Policy and Innovation, whose mission is to bring the international experience to bear on the U.S. health care reform debate and drive for delivery system improvement. The Harkness Fellowships program has been directed by Robin Osborn, vice president and director of the Fund's international program, since the program was redesigned. With her innovative leadership, the program has been enriched and continually expanded.

The initial countries participating in Harkness Fellowships in Health Care Policy were the U.K., Australia, and New Zealand. Under Ms. Osborn, the

Exhibit 1. Harkness Fellows in Health Care Policy and Practice, by year and country (total of 154)



program has been broadened to include nine countries, beginning with Canada in 2001 (through the Canadian Associates, who are not tenured in the U.S.) and, with the recruitment of international funding partners, Germany in 2006, the Netherlands in 2008, Switzerland in 2009, Norway in 2010, and Sweden in 2012. As shown in Exhibit 1, 154 fellows have participated in the program through the 2011–12 fellowship year.

Harkness Fellowships in Health Care Policy and Practice provide a unique opportunity for midcareer health services researchers, practitioners, policymakers, and managers from participating countries to spend 12 months in the U.S., conducting original research and working with leading U.S. health policy experts. Specific objectives for fellows include the following:

- publishing in a peer-reviewed journal or producing a significant policy report from the fellowship experience and making continued contributions to the literature post-fellowship;
- becoming recognized leaders in their home country;
- influencing health policy, research, and health care delivery; and
- contributing to a robust network of international health policy experts for exchanging information on innovations and policy changes.

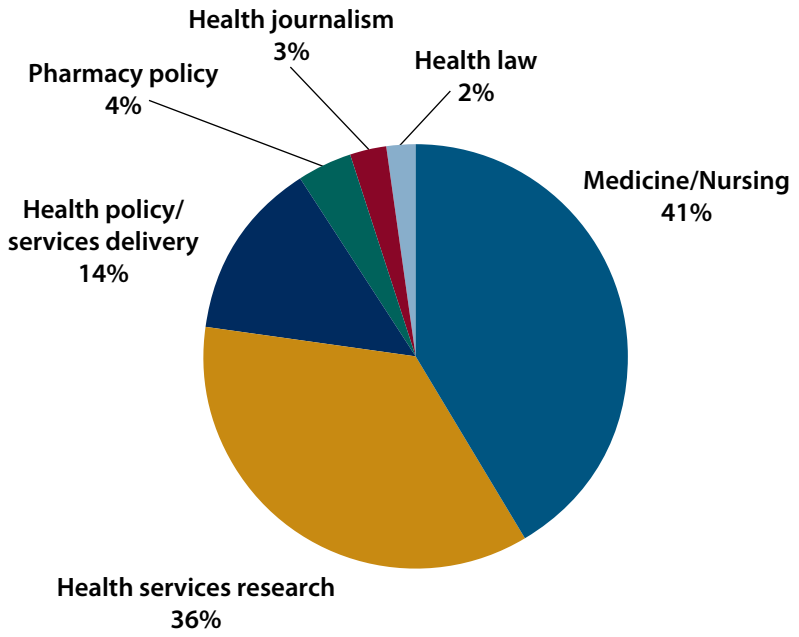
The program director and the fellowships senior advisor work with fellows to develop a substantial research project, with publishable deliverables, and place them with U.S. mentors, who are leading health policy researchers or policymakers.[3] The Commonwealth Fund provides a strong infrastructure for the program: fellows assemble every six to eight weeks for policy briefings, methodological seminars, and international symposiums; they also participate in site visits that expose them to Washington policymakers, innovations in U.S. health care delivery and policy, and the Canadian health system.[4]

Fellows are selected competitively in each country by selection committees comprising leading health policy officials, researchers, and Commonwealth Fund management.[5] The average age of fellows selected through 2011 was 37, with a range of 27 to 53, and 44 percent were women. At the time of selection, 41 percent of fellows were in medicine/nursing, 36 percent in health services research, 14 percent in health policy or management, 4 percent in pharmaceutical policy research, 3 percent in journalism; and 2 percent in law (Exhibit 2).

The Fund's Web site has a dedicated online forum designed to encourage policy exchanges among fellows and to promote continued collaborations upon their return home. With support from the Small Grants Fund, a number of research projects have been undertaken by returned fellows, with results featured at Alliance for Health Reform briefings on Capitol Hill and at the Fund's annual International Symposium on Health Care Policy, among other venues. The Commonwealth Fund also promotes articles published by fellows in peer-reviewed journals through the *In the Literature* publication series, e-alerts, and *Commonwealth Fund Connection* newsletter.

The first Harkness Alumni Washington Policy Forum, which took place in Washington, D.C., in May 2011, brought together 24 leading Harkness

Exhibit 2. Harkness Fellows by discipline/field, 1998–2012 (total of 154)



alumni from the U.K., Canada, Australia, Germany, Netherlands, and New Zealand to meet with U.S. policymakers. Participation was competitive, based on submitted research reports, most of which were prepared by teams of fellows. The aim of the forum was to highlight health care policy and delivery system innovations that are under way in other countries and consider how they can inform U.S. health reform.[6]

Fellows typically bring their families with them to the U.S., and the total fellowship (including stipends, family allowances, travel, and research funds) is valued at about $107,000 for individuals and $144,000 for families. Under Robin Osborn's leadership, funding partners for Harkness Fellowships have been recruited in all countries except Australia and New Zealand, and these partners currently bear 44 percent of the fellows' cost.[7] Since 2008, countries that enter the program must provide full funding for their fellows.

The International Program in Health Policy and Innovation takes up 8 percent of The Commonwealth Fund's total extramural budget, of which 55 percent is for the Harkness Fellowships. The fellowship is directly administered by the Fund's international program staff (five staff members, including Ms. Osborn), with the aid of the fellowships senior advisor. The total annual cost of the Harkness Fellowships to the Fund is approximately $2.1 million: $1.2 million for fellowship awards; $400,000 for conducting the seminars and other activities cited above; $200,000 for fellowship recruitment, promotion, and selection; and $300,000 for program staffing. Country partners provide an additional $1.2 million in direct fellowship costs. All other non-fellowship costs related to program operations are borne by the Fund, although

partnering organizations in the participating countries provide some direct support for fellow recruitment and returned fellows' networking activities.

PREVIOUS EXTERNAL REVIEW OF THE HARKNESS FELLOWSHIPS IN HEALTH POLICY PROGRAM

At the request of The Commonwealth Fund's board and management team, David Blumenthal, M.D., of the Mongan Institute for Health Policy at Massachusetts General Hospital carried out an external review of the Fund's International Program in Health Policy and Innovation in the spring of 2004.[8] Based on a survey of 160 key informants, including 44 Harkness Fellowship alumni and all mentors, and on interviews with senior U.S. and country policymakers, the review produced a highly positive assessment of the program and cited evidence that it was making progress toward achieving all of its stated goals. The review focused particularly on the Harkness Fellowships:

> The Harkness Fellowships received the strongest endorsement of all program activities. During personal interviews with key informants, the Fellowships were described as integral to the international program. Harkness Fellows were themselves extremely supportive of the fellowship. When asked about their experience, Harkness Fellows responded that the program was an excellent investment and that it proved valuable to their professional development and advancement. Moreover, all Harkness Fellows rated the overall quality of the fellowship either moderately or very highly. The vast majority of Harkness mentors also rated the overall quality highly (93%). Finally, 97 percent of Fellows responded that they would recommend the Harkness Fellowship to others considering applying, and 100 percent of Harkness mentors would recommend the Fellowship for someone considering applying. Harkness mentors were also unanimous in their willingness to act as mentors again in the future and to recommend doing so to colleagues.
>
> Personal interviews also reflected the high regard for the Harkness Fellowship. The opinion was that Harkness Fellowships were creating a cohort of young policymakers, and that the program had enormous personal benefits. The cohort of Harkness Fellows was described as "quite impressive."

The 2004 external review generated helpful recommendations for improving the Harkness Fellowships, including upgrading the Canadian Associate Fellowship to make it comparable to the full fellowship (with 12 months tenure in the U.S.), expansion of the program to include Germany, continued efforts to expand the pool of high-quality applicants in each country, and an increase in the fellowship stipend, which was considered inadequate by a substantial number of fellows. The reviewers also recommended development of an activity that would strengthen post-fellowship collaboration among fellows and their continued engagement with the international policy research community and The Commonwealth Fund.

As a result of this review, the Fund began expanding the roster of participating countries (as noted above, beginning with Germany in 2006), strengthened the Canadian Associate Fellowship by augmenting research funds for the fellowship project, increased the stipend, and conducted a policy conference for all alumni in 2005.

2011 REVIEW OF THE HARKNESS FELLOWSHIPS

By 2011, a substantial number of Harkness Fellows had resumed their careers in their home countries for an extended period, and The Commonwealth Fund's board felt that it was time to undertake a more comprehensive assessment of the program's impact. Of particular interest was determining the extent to which the fellowship's apparent success was broad—reaching beyond those fellows who, because of their high-ranking positions in government or academia, are obvious stars. The review was confined to the first 10 classes of Harkness Fellows from the U.K., Australia, and New Zealand, and the first two classes of German fellows; fellows in the 2008–09 and later cohorts were not included, as it was too early to judge their career advancement.[9]

Criteria for judging the performance of the program were based on the extent to which specific program objectives were being met:

1. Harkness Fellows produce a peer-reviewed journal article (the stated deliverable) while

Harkness Fellows in Senior Academic Positions Are Having an Impact Through Research and Publications

Kieran Walshe (U.K.)
Professor and Chair,
University of Manchester

Regulation and quality: Walshe has published 51 peer-reviewed articles in *Health Affairs, BMJ, Milbank Quarterly,* and other journals. He is adviser to the House of Commons Health Select Committee, and his work on regulation and patient safety has influenced the NHS Care Quality Commission and Department of Health. As director of the National Institute for Health Research/SDO Program, he has a strong influence on NHS–funded evaluations.

Russell Gruen (Australia)
Professor of Surgery,
University of Melbourne

Evidence-based policy, disparities, and professionalism: Gruen has published 48 peer-reviewed articles in *New England Journal of Medicine, JAMA, Lancet,* and other journals. As director of the National Trauma Research Institute, he has a key role in integrating research into policy and practice and has further influence on policy and practice as a member of the Victorian Quality Council.

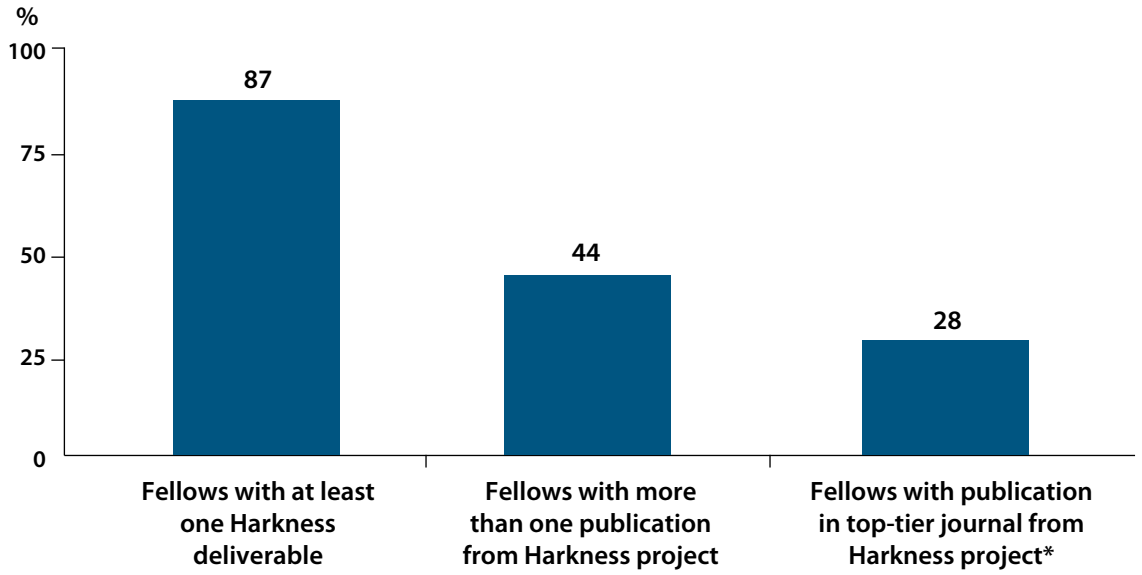
Peter Crampton (New Zealand)
Dean of the Faculty of Medicine,
University of Otago

Primary care: Crampton has published 45 peer-reviewed articles on primary care funding, use of teams, governance, and ownership of community-based clinics. His research contributed to the major health resource allocation formulas in New Zealand. In addition to his academic influence as dean of the Otago Medical School, he has served on ministry advisory commissions on physician workforce, resource allocation, and primary health care.

Jane Pirkis (Australia)
Professor and Director,
Centre for Health Policy and Economics, University of Melbourne

Mental health: Pirkis has published more than 85 peer-reviewed journal articles. Her work on improving mental health access and outcomes has influenced national and World Health Organization guidelines, and her evaluations of several large-scale programs have had an impact on their future direction, as evidenced by the introduction of caps on copayments for patients.

Exhibit 3. The great majority of Harkness Fellows meet the deliverables requirement of a peer-reviewed publication or report to their health minister



* Top-tier journals: *Health Affairs, Milbank Quarterly, New England Journal of Medicine, Journal of the American Medical Association, Annals of Internal Medicine, Archives of Internal Medicine, BMJ,* and *Lancet.*

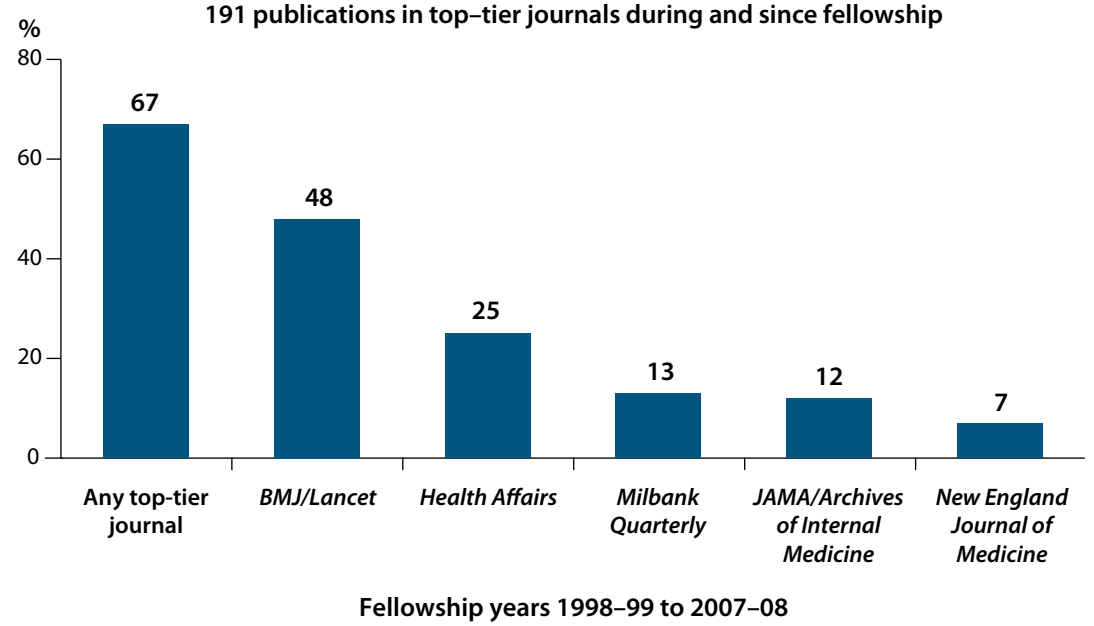
Source: 2011 Impact Survey of Fellows and internal program files.

on tenure, and they publish in top-tier journals—at least post-fellowship.

2. Returned fellows become nationally recognized leaders in their home countries and move into senior positions of influence in academia, policy, and health care delivery.
3. Returned fellows make a significant impact on policy, health services research and the knowledge base for health care reform, or on health care delivery system transformation.
4. The program develops a robust international network of health policy experts who are engaged in ongoing cross-national comparative research and collaborations.
5. Alumni rate the Harkness Fellowship as being very important to their careers.

The 2011 review, carried out by Fund management and program staff with substantial input from country experts, used the following methods. First, the 89 fellows in the 1998–99 through 2007–08 cohorts were surveyed about their careers post-fellowship, including the extent to which they hold senior policy roles and are influencing policy debates in their home country or in the U.S., and whether their work is receiving media attention and their research and leadership is influencing practice. For the 1998–2008 alumni, the review team developed complete profiles and compiled a database containing survey responses with specific examples of fellows' impact, updated CVs, and comprehensive lists of publications produced before, during, and following the fellowship. Second, using these dossiers, two members of the selection committee in each country, together with a Fund staff team including the president, executive vice president–chief operating officer, executive vice president for programs, senior vice president for research and evaluation, and

Exhibit 4. Much of Harkness Fellows' work is being published in top–tier journals



Note: JAMA = *Journal of the American Medical Association.*
Source: 2011 Impact Survey of Fellows and internal program files.

international program director, were asked to rate the success of each fellow on five domains:

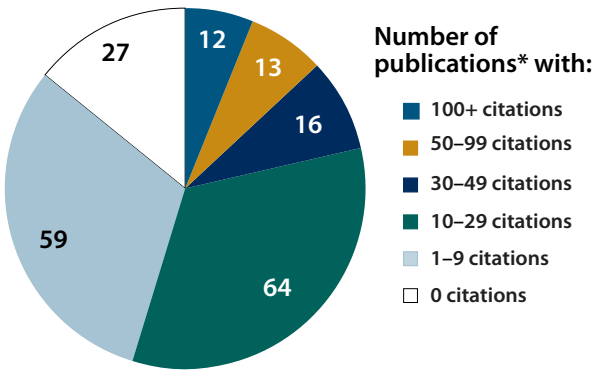
1. overall fellowship and career achievement;
2. contribution to the health services research and health policy literature;
3. impact on policy;
4. impact on delivery system improvement; and
5. overall leadership.

A Likert scale of 1 (disappointing performance) to 5 (very high performance) was used for this purpose, with country experts rating only fellows from their respective countries.[10]

Assessing Harkness Fellows' Productivity and Achievements: The Data

Looking first at the data on outcomes, the review found that the great majority (87%) of Harkness Fellows meet the deliverables requirement of a peer-reviewed publication or report to their health minister: indeed, 44 percent produce more than one publication from their fellowship project, and 28

Exhibit 5. Harkness Fellows' publications in top-tier journals are also being cited by other researchers



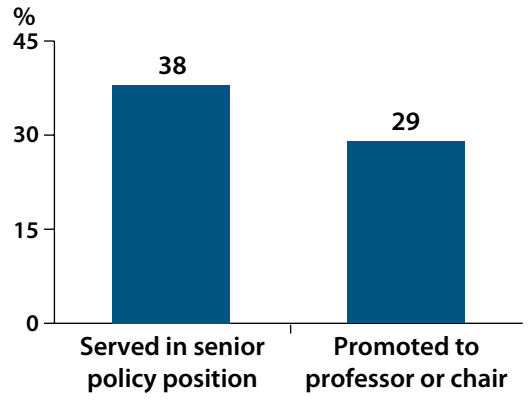
* 191 publications in top-tier journals (includes articles during and post-fellowship)
Source: ISI Web of Knowledge (Thompson Reuters).

percent publish their results in top-tier health policy journals (Exhibit 3).[11]

Fellows' publications span the fields of health services and health policy research, with the most significant publications in the following areas: financing of health care, insurance coverage issues, health care regulation, quality improvement, child and adolescent health, and pharmaceuticals policy. Since many fellows at the time of selection do not have significant records of publishing in the fields of health policy and health services research, their marked success in producing published papers while on fellowship, or shortly afterward, is noteworthy—and a sure indicator of the program's success in developing a new cadre of international health care researchers.

Looking at fellows' publications both during and after the fellowship year, the review found that two-thirds of fellows have published in a top-tier health policy journal—for example, almost half have published in *BMJ* or *Lancet,* and one-quarter have published in *Health Affairs (*Exhibit 4). Fellows' publications are also being cited by other researchers: 12 of the 191 publications in top-tier journals, for example, have been cited 100 times or more, and another 13 have been cited from 50 to 99 times (Exhibit 5). Harkness Fellows, through their Commonwealth Fund publications, have also helped inform the U.S. health care reform debate.

Exhibit 6. Nearly two of five Harkness Fellows have served in senior policy positions post-fellowship, and almost one-third have advanced to professor or department chair



Source: 2011 Impact Survey of Fellows.

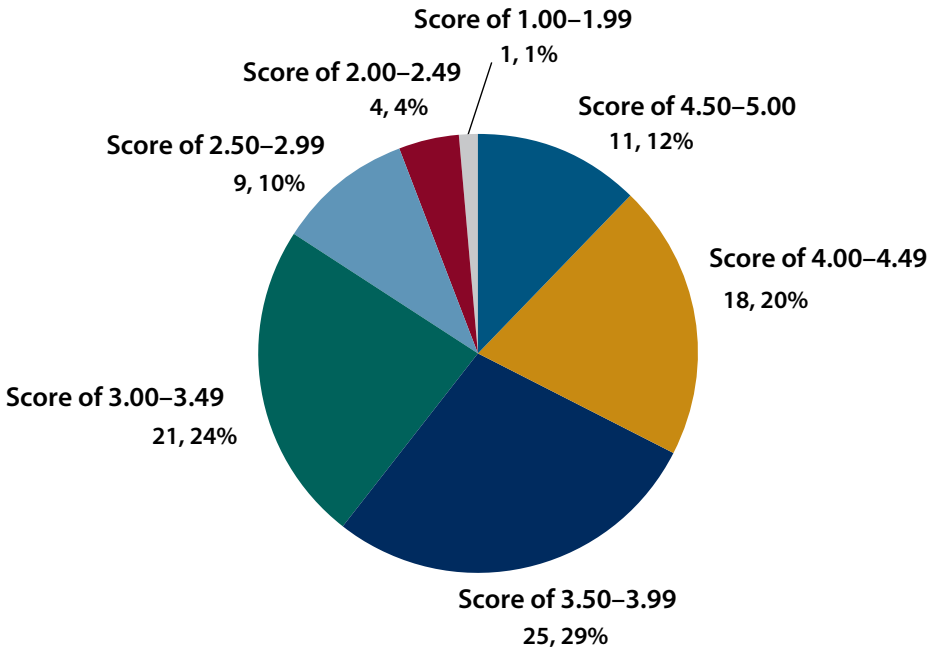
Most returned fellows reported continuing engagement in cross-national health policy (83%), a finding confirmed by the 71 percent who reported being invited abroad to speak at a major conference or serve as a policy consultant or country expert. More than two-thirds of Harkness Fellows alumni also report post-fellowship collaborations with other fellows (71%), and their U.S. mentors or other U.S. experts (67%).

In terms of career advancement, more than one-third of Harkness Fellows have now served in senior policy positions post-fellowship, with nearly the same proportion advancing to professor or department chair (Exhibit 6). Others are leading health care delivery improvements or have leading roles in research organizations. While it is not possible to tie such rapid career advancement directly to the fellowship, an overwhelming majority of Harkness alumni themselves (91%) say that the fellowship was extremely or very valuable to their career achievements.

Expert Panels' Assessment

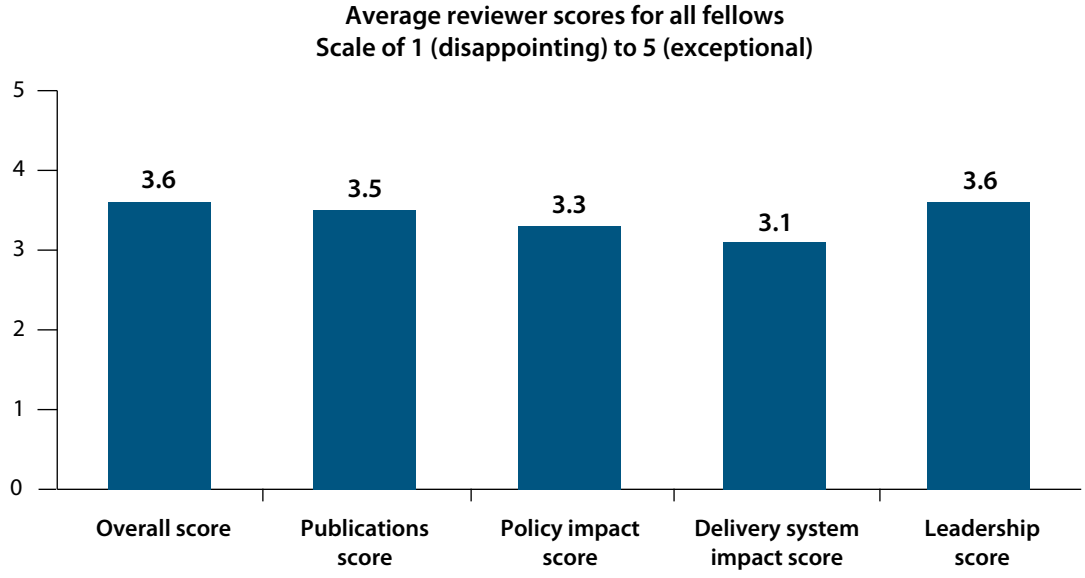
Turning to the assessments of fellows by the expert panels, the 89 alumni received an overall performance score averaging 3.6 on the 1-to-5 scale, with a score of 3 itself signifying solid performance. Fellows' performance was heavily tilted toward the upper

Exhibit 7. Reviewers' ratings of Harkness Fellows on overall performance indicate that the great majority have met or exceeded expectations



Source: 2011 Review Panel Ratings.

Exhibit 8. Harkness Fellows have performed beyond expectations on multiple dimensions



Source: 2011 Review Panel Ratings.

end: 85 percent of fellows measured up to expectations or did substantially better than expected, with a score of 3 or higher (Exhibit 7). One of three fellows was rated between 4 and 5, the top ratings, and seen as a nationally recognized leader back home.

Interestingly, the U.S. raters generally gave fellows higher scores than did the home-country experts—a disparity possibly reflecting the latter's more in-depth knowledge of fellows' performance since their return. Country reviewers also appear to have been tougher in their scoring, while U.S. reviewers took greater account of fellows' contributions to the U.S. health reform debate. In concert, the two sets of reviewers probably provide a balanced assessment.

As noted above, in addition to providing overall ratings of each fellow, reviewers were asked to rate fellows on their performance in four domains: publications both during and after the fellowship; impact on policy (home country and U.S.); ability to advance delivery system improvements; and leadership and career advancement. As a group, the 89 fellows were regarded as successful in all four areas (Exhibit 8). They scored highest on leadership and career advancement (3.6) and publications (3.5), and also performed somewhat better than expected in influencing policy (3.3). Predictably, they have

Harkness Fellows in Senior Policy Positions Have an Impact

Ron Paterson (New Zealand)

New Zealand Health and Disability Commissioner (former): Paterson was charged with protecting patients' rights in the New Zealand health system and had authority to recommend physician and hospital corrective action, a ministry investigation, or legal or disciplinary action. He established the patients' complaints system and a policy on open disclosure and public reporting of adverse events, and put patient safety and quality firmly on the health policy agenda.

Martin Marshall (U.K.)

NHS Deputy Chief Medical Officer (former): Marshall oversaw quality and standards for the NHS, the National Patient Safety Agency, and the NHS quality regulator. He has written 69 peer-reviewed articles (including one in *JAMA* cited over 300 times). His work on public disclosure of provider performance data has influenced policy in the U.K., France, Germany, and the Netherlands. In May 2011, Martin was invited to 10 Downing Street to advise Prime Minister David Cameron on health reform.

Andreas Gerber (Germany)

Director of Economics, German Institute for Quality and Efficiency in Healthcare (IQWiG): Gerber is a senior decision-maker in the German agency charged with comparative and cost-effectiveness review. He has a strong influence on how health economic evaluations are performed on new drugs and technologies in Germany and on the requirements of the Federal Joint Committee, which assesses benefit in making coverage decisions.

Kalipso Chalkidou (U.K.)

Founding Director, International Program, National Institute for Health and Clinical Excellence (NICE): Chalkidou has been a leading voice on the use of evidence in improving health system performance, publishing frequently in the *Milbank Quarterly, Health Affairs,* and *JAMA*. In 2009, she founded NICE's International Program, where she works with developing nations to establish institutions for comparative effectiveness research modeled after NICE.

had less influence in improving delivery systems at this point in their careers (score of 3.1). Within three of the four domains, scores were again heavily weighted toward the upper end.

While several fellows who were older than average at the time of selection were regarded by the scorers as having been particularly strong performers, in general, age at selection has not greatly influenced fellows' performance. The selection process has paid particular attention to the often higher risks arising with both younger and older candidates—and, when necessary, particular attention has been given to the structure of these fellows' placement and projects.[12]

According to the reviewers' assessments, strong performance post-fellowship is not confined to the earliest classes of fellows who have had an extended period to capitalize on their fellowships experience: more recent cohorts of fellows are judged to be performing about as well as earlier alumni.

Ability to Attract Partners

In addition to the records of returned fellows, a further measure of the success of Harkness Fellowships in Health Care Policy and Practice is its history of attracting partners who see it as worthy of a substantial investment. As noted earlier, countries beyond the original group of the U.K., Australia, and New Zealand have sought participation in the program, and public and private funders in the U.K, Germany, Netherlands, Norway, and Sweden have committed substantial financial support.

Another set of key partners are fellows' mentors in the U.S., who make a major time investment in advising fellows while on tenure. The roster of mentors who have worked with multiple fellows over the last 14 years is quite distinguished, and includes the following: Donald Berwick, M.D., (Institute for Healthcare Improvement); Andrew Bindman, M.D. (University of California, San Francisco/San Francisco General Hospital); David Blumenthal, M.D. (Massachusetts General Hospital); Benjamin Chu, M.D., Murray Ross, Ph.D., and Robert Crane (Kaiser Permanente); Carolyn Clancy, M.D. (Agency for Healthcare Research and Quality); Thomas Lee, M.D. (Partners Community Healthcare); Sherry Glied, Ph.D. (Mailman School of Public Health, Columbia University); Mary Naylor, Ph.D. (University of Pennsylvania); and Edward Wagner, M.D. (Group Health Cooperative of Puget Sound).

Ensuring Continued Success

The 2011 review identified four issues that require attention to ensure the continued success of the Harkness Fellowships:

1. Building strong applicant pools in each country.
2. Addressing the question of expansion to additional countries and choice of potential new country participants.
3. Integrating the fellowships more closely with the Fund's U.S. programs.
4. Strengthening the Harkness Fellows alumni network to ensure continued, career-long engagement in international health policy and systems improvement exchanges.

In all countries, applicant pools for Harkness Fellowships are limited. The challenges to attracting candidates include the stipend amounts (which

were increased in 2008 and will be again in 2012); political and health system changes in countries that increase the risk of a year-long leave of absence; current professional and project commitments; the complexity of moving families (typically working spouses and children) for a single year abroad in the U.S.; and the short supply of health policy and services researchers in most countries, at least compared with the U.S. Recruitment strategies to date include extensive rosters of country nominators; seminars for potential candidates, featuring reports by returned fellows; a Harkness Fellows Web site spotlighting returned fellows' work and illustrating the value of the fellowship; advertising in print and online; and in-country marketing by foundation and government partners. Also helping to strengthen applicant pools are webinars that further market the program and assist candidates in completing applications, as well as new online features providing fellows with practical tips and guidance on family relocation.

The success of Harkness Fellows in Health Care Policy and Practice makes the question of further expanding the program to additional countries a continuing one. Commonwealth Fund budget and staffing constraints, the labor-intensive nature of the program, and quality-of-experience goals of the fellowship have led to management's conclusion that total annual program capacity must be limited to 16 to 17 fellows. When deciding whether to bring an additional country into the fold, three criteria dominate: 1) the relevance of the proposed country's health system innovations to U.S. health care reform; 2) the availability of fellows who are fluent in English; and 3) the commitment of local sponsors to underwrite the new country's fellows. Given the overall capacity constraint, adding countries now requires reduction in the slots available for some existing countries—a further tradeoff that must be weighed.

The Fund's board has wrestled with the issue of incorporating fellows from Asia, Latin America, and other emerging markets but has determined that capacity constraints dictate keeping the focus on English-speaking and Western European industrialized countries.[13] Fortunately, the Fund's annual International Symposium on Health Care Policy provides an opportunity for other countries to participate in the exchange of information on health system innovations.

The Commonwealth Fund recognizes that greater integration of the Harkness Fellowships with the Fund's U.S. programs would be mutually beneficial. To this end, consideration will be given to linking Harkness Fellows' projects to the activities of Fund grantees, and pairing Harkness Fellows with members of the Fund's program staff to develop closer relationships and engage fellows in the Fund's programs and events.

From its inception, the Harkness Fellowship in Health Care Policy and Practice was envisioned as a career-long commitment to international exchange on health policy and delivery system innovations. The 2011 review underscored the need to develop multiple strategies for ensuring that returned fellows do not fall by the wayside because of a lack of opportunity for continued exchange. The foundation already uses its Small Grants Fund to support occasional research projects proposed by returned fellows, and many of these involve interaction with U.S. experts, including their fellowship mentors. Alumni fellows are also invited to participate in the

Fund's annual International Symposium, Alliance for Health Reform briefings on Capitol Hill, and other Fund-sponsored events when they have unique expertise and experience to offer.

As a result of the 2011 program review, the foundation's board has approved repeating the highly successful May 2011 Harkness Alumni Policy Forum. As described above, this forum will bring together, on a competitive basis, 20 to 25 former fellows with senior U.S. policymakers and will generate publishable papers on health care reform developments internationally. Additionally, alumni will be encouraged to participate in Harkness Alumni Network online forums and to submit blog posts on reform developments and innovation case studies. All country funding partners are also being asked to organize, on a regular basis, alumni events designed to promote continuing exchange among fellows and their U.S. colleagues.

LESSONS FROM THE HARKNESS FELLOWSHIPS IN HEALTH CARE POLICY AND PRACTICE

In undertaking program reviews like this year's examination of the Harkness Fellowships, The Commonwealth Fund seeks to draw lessons not only applicable to improvement of its own operations but also of use to other organizations that are involved in or contemplating similar activities. Seven principal insights emerge from the foundation's experience with the Harkness Fellowships in Health Care Policy and Practice.

1. Fellowship programs can be a highly effective way for foundations to build cadres of researchers and practitioners capable of advancing social improvements. Foundations are especially suited for making such long-term investments, owing to these institutions' typically long-range perspective and freedom to experiment with and back promising, but as yet unproven, talent and ideas.

2. In a global economy, U.S. foundations have much to gain by looking beyond our shores for ways to address their missions. The Commonwealth Fund's 1996 decision to develop an international program, including the Harkness Fellowships, had far-reaching effects not only on the foundation's strategy, but ultimately on the U.S. health care reform debate of 2009–10. An external review of the Fund's Commission on a High Performance Health System in 2010, for example, concluded that:

   > Overall, respondents most commonly mentioned the international comparative surveys and related reports from the Fund as the most visible and helpful single contribution [to the health reform debate]. . . . The majority of respondents regarded the Fund as having substantial impact on the health care reform debate, in many cases behind the scenes, mainly as a supplier of data and analyses on coverage, cost, and quality of care. One respondent noted specifically the importance of the Fund's work examining and comparing the U.S. to other nations.[14]

3. While foundations often treat the fellowships they sponsor as a separate program activity only indirectly connected to their major programs, the Harkness Fellowships experience demonstrates the utility of such programs in directly advancing specific

program strategies—in this case, bringing the international experience to bear on the U.S. health care reform debate.

4. The more closely a fellowship program is tied to a foundation's principal program strategies, and the greater the expectations for the fellowships in the short- to intermediate-term, the stronger the case is for the foundation to administer the program directly, rather than delegating the responsibility to an external organization. Through its direct conduct of the Harkness Fellowships, the Fund ensures a strong voice in fellows' selection and placement with mentors and in the design of their research projects. Direct administration has also facilitated regular interactions with fellows that enrich staff's thinking on health reform issues and the Fund's domestic program strategy and lead to lasting professional relationships.
5. Programs like the Harkness Fellowships require substantial financial commitment and investment, which needs to grow over time to ensure that support is adequate to attract top candidates. As the Fund's experience indicates, with well-designed and -operated fellowship programs, foundations can leverage their infrastructure investments and expand the program's reach by seeking funding partners. In addition to the resources that partners provide, they add significant prestige, help promote the fellows and disseminate their work, and provide long-term career support.
6. Fellowship programs, as much as other foundation programs, benefit from periodic reviews.[15] Foundation-backed fellowship programs are particularly at risk of not-so-benign neglect by their sponsor: their goals are long-term and not always clearly stated; success in achieving objectives is difficult to measure; and their conduct is usually delegated to external organizations, which can encourage foundation managers to place them low on their worry lists. Moreover, because fellowship programs (unlike most other foundation-sponsored enterprises) have no natural endpoint, there is a heightened possibility they will continue past a useful life. And in contrast with most other foundation-sponsored programs, fellowships develop constituencies that can be resistant to change when it is needed. On the other side of the coin, in the absence of periodic reassessments, still-effective fellowship programs may be dropped—their current relevance underappreciated and their achievements unsung. Regular external program reviews can help guard against these risks, while generating insights for strengthening fellowship programs.

Throughout their histories, external reviews of fellowship programs sponsored by The Commonwealth Fund, the Robert Wood Johnson Foundation, and other philanthropies have contributed greatly to the programs' continued vitality—or in some cases, the decision to bring them to an end. As an example:

> In 2002, as the Robert Wood Johnson Foundation considered the future of the [Clinical Scholars] program, the record of its graduates, and the changing environment in medicine and health care, a number of options emerged. One option was to "declare victory" and

devote resources to other programs and challenges. Another option was to take an "if it isn't broken, don't fix it" position and continue the program with minor changes. What the Foundation ultimately decided, however, was to revamp the Clinical Scholars Program in a way that would continue its aims, while structuring it for the 21st century environment in academic medicine and society.[16]

7. Fellowship programs need leadership, innovation, and hands-on nurturing to achieve excellence and maintain their value. Value-adding foundations like The Commonwealth Fund—which maintain strong professional staffs to develop programs, work closely with grantees in designing and communicating the results of projects, and conduct research internally that enriches and capitalizes on grant-supported work—are sometimes charged with "spending money on themselves." Fellowship programs like the Harkness Fellowships are a good example of why investment in inspired and experienced professional staff to carry out pathbreaking activities directly can be a very wise investment by the foundation.

   The importance of strong leadership and vision are clearly evident in the growth and improvement of the Harkness Fellowships over the 15-year tenure of program director and Fund vice president Robin Osborn: The number of countries participating in the program over that time has tripled. Relationships with ministries and foundation partners have been established to enable returning fellows to productively leverage their U.S. experience. A rich program of briefings and site visits now brings fellows together throughout the year with a who's who of U.S. policy. Influential U.S. policy thinkers regularly serve as mentors for the fellows, guiding their research to ensure maximum relevance and policy influence. And, through high-profile events like the Harkness Alumni Policy Forum, Harkness Fellows are showcased and collaborations extending well beyond the fellowship year are promoted. Perhaps most telling, nine of 10 fellows now rate the Harkness Fellowships as critically important to their careers.

The 2011 review of The Commonwealth Fund's Harkness Fellowships in Health Care Policy and Practice provided substantial reassurance to the Fund's board and management that the program is making a unique contribution to international exchange on policies and innovations for improving the performance of health systems. Both during and after their fellowships, participants are making important contributions to the drive for improved system performance not only in their home countries, but also in the U.S. This cadre of leaders is likely to make a substantial mark over the long term.

Notes

[1] Under the leadership of Margaret E. Mahoney (then a program officer at the Carnegie Corporation and later, from 1980 to 1995, president of The Commonwealth Fund), the Clinical Scholars Program was initially jointly sponsored by the Fund and the Carnegie Corporation in 1969. The Robert Wood Johnson Foundation assumed full responsibility for it in 1972, and it is still regarded as a flagship activity for that foundation. See Jonathan Showstack et al., "The Robert Wood Johnson Foundation Clinical Scholars Program," in *To Improve Health and Health Care*, vol. VII (Robert Wood Johnson Foundation, 2004).

The Commonwealth Fund Fellowship Program in Academic Medicine for Minority Students was conducted by National Medical Fellowships. Bristol-Myers Squibb began cosponsoring the program in 1990 and was the sole sponsor from 1993 to 2003. The Fund's Executive Nurse Fellowships program was conducted by a team at the University of Rochester School of Nursing.

In honor of the Fund's late director James J. Mongan, M.D., the Minority Health Policy Fellowships program was renamed by the Fund's board this year as the Mongan Commonwealth Fund Fellowship program and expanded to provide fellows with a competitive opportunity for a second year, during which they can obtain a practicum experience in health policy or delivery system improvement.

[2] John E. Craig, Jr., "History of the Harkness Fellowships Program of The Commonwealth Fund," background paper for the Fund board's July 1996 review of the Harkness Fellowships.

[3] Senior fellowship advisors have included Gerard Anderson (1998–2002, professor at Johns Hopkins Bloomberg School of Hygiene and Public Health); Nicole Lurie (2002–06, senior scientist with Rand Corporation at time of fellowship service and currently Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services); and Bradford Gray (2007–present, senior fellow at Urban Institute and editor of *Milbank Quarterly*).

[4] Program activities throughout the year include: 1) five-day orientation at the Fund's headquarters in New York (Sept.); 2) International Health Policy Symposium in Washington, D.C., including a meeting of each country's fellows with the visiting health minister (Nov.); 3) Institute for Healthcare Improvement (IHI) seminar in Boston (Feb.); 4) Policy Week in Washington, D.C. (March); 5) Canada Policy Site Visit, Montreal and Toronto (May); 6) leadership seminars throughout the year; 7) qualitative methods training seminar; and 8) final reporting seminar (June).

[5] The current selection committee chairs are: in the U.K., Julian Le Grand, former adviser to Prime Minister Tony Blair; in Australia, Philip Davies, professor of health systems and policy, University of Queensland; in Canada, Pierre-Gerlier Forest, president of the Pierre Trudeau Foundation; in Germany, Christof Veit, CEO, BQS German National Institute for Quality Measurement in Health Care; in New Zealand, Karen Poutasi, chief executive, New Zealand Qualifications Authority; in the Netherlands, Ab Klink, former Dutch Minister of Health, Welfare and Sport; in Norway, Magne Nylenna, M.D., chief executive, Norwegian Knowledge Centre for the Health Services, University of Oslo; and in Switzerland, Stefan Spycher, vice director, Federal Office of Public Health. Els Borst-Eilers, former Dutch Minister of Health, Welfare, and Sport, chaired the Netherlands selection committee through 2011; John-Arne Røttingen, until recently Director General of the Norwegian Knowledge Centre for the Health Services, University of Oslo, chaired the Norwegian selection committee through 2011. The makeup of the country selection committees is approximately two-thirds country experts and one-third Commonwealth Fund management.

[6] Participating U.S policymakers included Donald M. Berwick, M.D., director of the Centers for Medicare and Medicaid Services (CMS); Sherry Glied, Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services; Elizabeth Fowler, Special Assistant to the President for Healthcare and Economic Policy, National Economic Council; Jeanne Lambrew, Deputy Assistant to the President for Health Policy (White House); David Blumenthal, M.D., former director of the Office of the National Coordinator for Health Information Technology (ONCHIT); Hoangmai Pham, M.D., director of Accountable Care Organization Programs, CMS; Carolyn Clancy, M.D., director of the Agency for Healthcare Research and Quality (AHRQ); and Melinda Buntin, senior adviser to ONCHIT.

[7] Current and former funding partners include: in Canada, the Canadian Health Services Research Foundation (2001–present); in the U.K., The Health Foundation (2003–08), The Nuffield Trust (2009–present), and the National Institute for Health Research Service Delivery and Organization Programme (2010–present); in Germany, the Robert Bosch Foundation (2007–present) and B. Braun Foundation (2008–present); in the Netherlands, the

Ministry of Health, Welfare, and Sport (2008–present); in Switzerland, the Careum Foundation (2009–present); in Norway, the Research Council of Norway (2010–present); and in Sweden, the Ministry of Health and Social Affairs (2012).

[8] David Blumenthal et al., *Evaluation of The Commonwealth Fund International Program in Health Policy and Practice*, Report to the Board of The Commonwealth Fund, March 26, 2004.

[9] Canadian Associate Fellows were also excluded, because of the limited nature of their fellowship.

[10] The country reviewers were: in the U.K., Julian Le Grande (professor of social policy, London School of Economics) and Chris Ham (CEO, the King's Fund); in Australia, Jane Hall (director, Centre for Health Economics Research and Evaluation, University of Technology, Sydney) and Christopher Baggoley (CEO, Australian Commission on Safety and Quality in Healthcare); in New Zealand, Karen Poutasi (chief executive, New Zealand Qualifications Authority) and Toni Ashton (head, Health Systems Section, School of Population Health, University of Auckland); and in Germany, Christof Veit (CEO, German National Institute for Quality Measurement in Health Care) and Reinhard Busse (chair, Health Care Management Dept., Berlin Technical University).

[11] The top-tier health policy journals were identified as: *Health Affairs, Milbank Quarterly, New England Journal of Medicine, Journal of the American Medical Association, Annals of Internal Medicine, Archives of Internal Medicine, BMJ,* and *Lancet*.

[12] The absence of a long track record and limited health policy/services research experience makes younger fellows higher risk; among the challenges that older fellows can face is breaking out of their established comfort zone of research.

[13] As a result of the 2011 review of the fellowships program, the Fund's board approved converting the limited Canadian Associates fellowships (two slots) to a single, fully tenured fellowship identical to those from the other participating countries.

[14] Donald Berwick, Sheila Burke, and T.R. Reid, *2010 External Review of The Commonwealth Fund's Commission on a High Performance Health System*, report to The Commonwealth Fund Board of Directors.

[15] Gregg Meyer, Jennifer Edwards, and David Blumenthal, "Experience of The Robert Wood Johnson Foundation Health Policy Fellowship," *Health Affairs*, Spring (II), 1994:264–70.

[16] Showstack et al., "The Robert Wood Johnson Foundation Clinical Scholars Program." and A. McGehee Harvey, M.D., *For the Welfare of Mankind: The Commonwealth Fund and American Medicine* (Baltimore, Md.: Johns Hopkins University Press, 1986), 282–86.

THE COMMONWEALTH FUND

2011 Annual Report

THE FUND'S MISSION, GOALS, AND STRATEGY

In addition to its fiduciary responsibilities, The Commonwealth Fund's 12-member Board of Directors has responsibility for the Fund's mission and goals, and works closely with management in setting the foundation's program strategy. The Board pays a great deal of attention to assessing the performance of programs and the foundation overall. Board Chairman James R. Tallon, Jr., meets with staff groups each year to discuss program strategies, results, and issues.

Photo by Donnelly Marks

MISSION

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 and practice is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

GOALS

The Commonwealth Fund's Board of Directors believes that the foundation will have been successful in achieving its mission if it is able to move the U.S. health care system measurably toward one that:

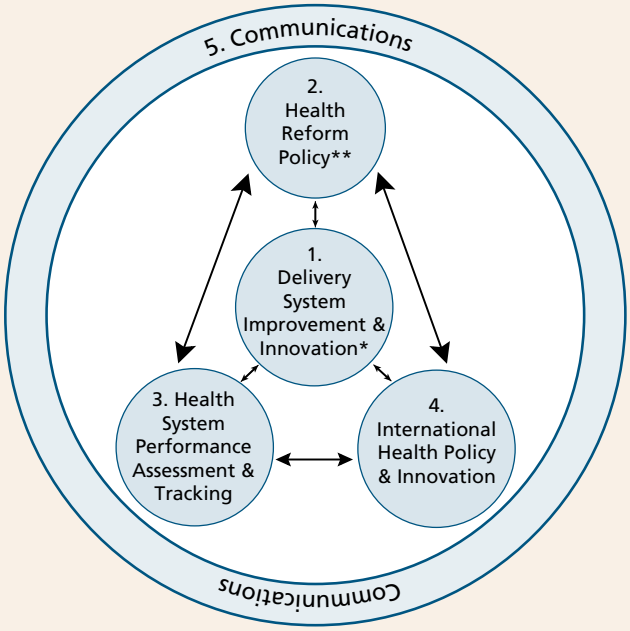
- provides access and equity for all
- delivers high-quality, patient-centered care
- is affordable and efficient
- promotes the health of the entire population, and
- continuously innovates and improves.

STRATEGIES

To achieve these goals, The Commonwealth Fund pursues five integrated program strategies:

1. Identify, describe, assess, and help spread promising models of health care delivery system change that provide population-based, patient-centered, high-quality, integrated care. This strategy cuts across the continuum of care, including primary care medical homes linked to other community providers; acute, postacute, and long-term care; care systems for vulnerable and special-needs populations; and integrated health systems and accountable, coordinated care organizations.
2. Identify, develop, evaluate, and spread policy solutions that will expand access to affordable, high-quality, and high-value care for all—with special attention placed on vulnerable populations—and foster solutions for bending the cost curve.
3. Assess and track progress toward a high performance health system in order to identify top performance benchmarks, high-performing organizations, and best practices and tools, and to stimulate action to improve performance.
4. Translate and disseminate lessons from the international experience, with the aim of facilitating the spread of health system innovations.
5. Maintain and enhance the Fund's role in serving as a key resource to health system leaders and policy officials on reform implementation issues, and effectively communicate and disseminate the results produced by the Fund's grants and its research programs.

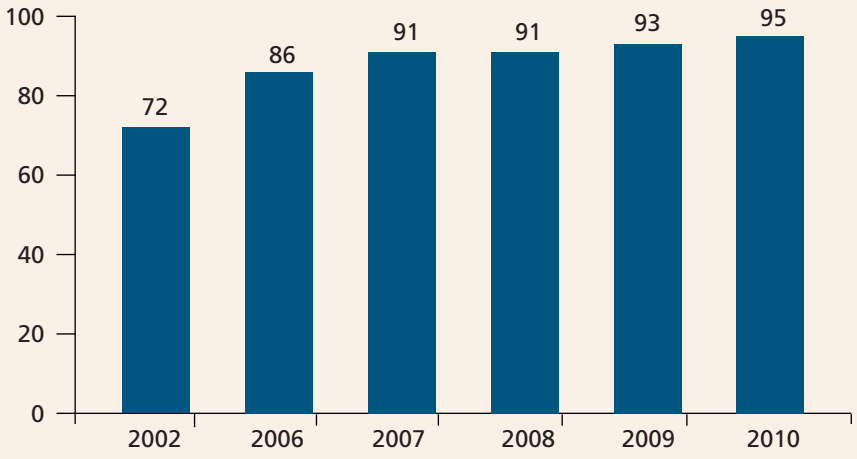
Exhibit 1. The Commonwealth Fund's Integrated Programs



* Patient-Centered Coordinated Care; Health System Quality and Efficiency; Long-Term Care Quality Improvement; Vulnerable Populations.
** Affordable Health Insurance; Payment and System Reform; Commission on a High Performance Health System; Federal and State Health Policy.

Exhibit 2. The Commonwealth Fund's Performance Scorecard: Adding Value to the Work of Grantees

Percent of grantees saying staff contributions were "useful" to "extremely useful."



Source: 2002 Harris Interactive Survey of Fund Grantees and 2006–2010 Mathew Greenwald Audience and Grantee Surveys.

The Fund's value-adding staff is central to executing these strategies successfully. The foundation combines the features of grantmaking and operating foundations, partnering closely with grantees to sponsor research and system innovations but also conducting independent survey and health policy research and investing heavily in communicating results.

PROGRAMS

Each of The Commonwealth Fund's major programs contributes to the execution of the five strategies and involves collaboration across programs.

The programs focused on *Delivery System Improvement and Innovation* include:

- The **Patient-Centered Coordinated Care** program, which promotes the collection and dissemination of information on patient-centered primary care, including patients' health care experiences and physician office systems and practices associated with superior care experience, to advance quality improvement and strengthen primary care; facilitates the adoption of practices, models, and tools that can help primary care practices become more patient-centered and coordinate more closely with hospitals, specialists, and other public and private health care providers in their communities; and informs the development of policies to encourage patient- and family-centered care in medical homes.
- The **Health System Quality and Efficiency** program, which assesses the capacity of organizations to provide coordinated and efficient population-based care and helps expand that capacity; fosters the development and widespread adoption of standard measures for benchmarking the performance of health care organizations over time; and promotes the use of incentives for improving quality and efficiency in health care.
- The **Long-Term Care Quality Improvement** program, which identifies, tests, and spreads measures, practices, models, and tools that will lead to person-centered, high-performing long-term care services; builds strong networks among stakeholders to create a sense of common purpose and shared interest in improving performance and coordinating care; assesses, tracks, and compares the performance of long-term services and supports at the state and national levels; and ensures that long-term services are part of an integrated system of patient care and are a component of provider payment, health information, and care delivery reforms. A focus of this program is developing coordinated care systems for the very vulnerable population that is eligible for both Medicare and Medicaid.
- The **Vulnerable Populations** program, which identifies policy levers for improving equity in health care access and quality across the continuum of care; identifies promising care delivery practices and models, and develops and disseminates policy recommendations to support such innovations and improvements; encourages planning for state and local systems of care able to meet the specific needs of vulnerable populations; and documents and tracks health care utilization and quality for vulnerable populations at the state level. The **Mongan Commonwealth Fund Fellowship** program

at Harvard University aims to develop health care policy and delivery system leaders committed to and capable of transforming health care for vulnerable populations.

The programs focused on *Health Reform Policy* include:

- The **Commonwealth Fund Commission on a High Performance Health System,** which played a significant role in informing the health care reform debate that led up to the enactment of the Patient Protection and Affordable Care Act of 2010. The Commission's current goals are to help inform implementation of the Affordable Care Act and assess its potential to move the U.S. on a path to a high performance health system; help health care leaders and the American public understand the new legislation and what it means for them; and lay the groundwork for future delivery system change and health policy action. The Commission, which has been active since 2005, continues to assess national and state health system performance and inform health policy at all levels.
- The **Affordable Health Insurance** program, which provides timely analysis of changes in employer-based health insurance, health plans offered in the individual market, and public health coverage for people under age 65, and estimates the impact those changes will have on the numbers covered and the quality of coverage; documents how being uninsured, or underinsured, affects personal health, finances, and job productivity; informs federal and state policymakers and the media about the provisions of the Affordable Care Act and related federal regulations, along with their implications for people and employers; informs implementation of the law through analysis of its key provisions for achieving affordable, comprehensive, and near-universal insurance coverage; and analyzes and develops new policy options for expanding and stabilizing health insurance coverage, making coverage more affordable, and optimizing administrative efficiency.
- The **Payment and System Reform** program, which examines reforms that would align incentives and provide a base for more comprehensive payment reform; models the potential impact of alternative payment reform options within the Medicare program and throughout the health care system; studies how payment reform could stimulate new models of health care delivery that yield better, more coordinated care; and evaluates the potential for broader application of successful payment and delivery models.
- The **Federal and State Health Policy** program, which convenes federal and state policymakers, in both the executive and legislative branches of government, to discuss key health policy issues and to help identify policy solutions; produces written materials on timely issues relevant to federal and state policymakers and their staff, with particular emphasis on implementation of the Affordable Care Act; facilitates a bidirectional flow of information both to inform federal policymakers on state innovations with national health reform implementation implications and to inform state policymakers on federal health policies affecting the development of state reform strategies; and fosters dialogue among policymakers, national stakeholders, and the research community on key health policy issues.

- The **Health System Performance Assessment and Tracking** program, which tracks and compares health system performance by identifying benchmarks for patient care experiences, health outcomes, and cost that states, health care providers, and others can use to set improvement targets; assesses trends in health insurance coverage, access to care, and patient-reported quality of care; and monitors public and private actions to transform health care delivery, including payment innovations, health information technology adoption, and the organization of care.
- The **International Health Policy and Innovation** program, which convenes policy officials and experts to learn from international innovations in the field. The program's activities include: an annual international symposium, attended by health ministers and top policy officials from the industrialized world; annual multinational health care surveys; and the **Harkness Fellowships in Health Care Policy and Practice** program, in which Australia, Canada, Germany, the Netherlands, New Zealand, Norway, Switzerland, Sweden, and the United Kingdom participate. In addition, program staff and grantees produce a variety of publications, including issue briefs and case studies focused on innovative policies and practices identified through cross-national learning.
- The Fund's **Communications** program uses print, broadcast, online, and social media to bring information on health reform and health system transformation to the attention of critical stakeholder groups, especially policy officials and leaders in health care delivery. The foundation's *Realizing Health Reform's Potential* issue brief series enriches public understanding of how the Affordable Health Care Act will affect specific groups, including women, disabled persons, small businesses, persons with preexisting conditions, older adults, and workers undergoing a change in employment status. A media fellowship program conducted by the Association of Health Care Journalists, meanwhile, encourages in-depth reporting on issues related to health system performance and change. *The Commonwealth Fund Blog* features topical analyses by staff, grantee, and external policy experts and is a major source for analysis of state health insurance exchange regulations and the status of states' progress on exchange implementation. The online Health Reform Resource Center provides a timeline of the Affordable Care Act's major provisions and an interactive tool for searching specific provisions by year of implementation, category, and stakeholder group.

MEASURING PROGRESS TOWARD A HIGH PERFORMANCE HEALTH SYSTEM

With the encouragement of its Board of Directors, The Commonwealth Fund has identified measures that already exist or can be developed to track progress in achieving the objective of a high performance health system. These include evidence of the following:

- universal access to affordable, comprehensive insurance coverage;
- greater adoption of primary care medical homes as the standard of patient care;
- more patients receiving primary, acute, postacute, and long-term care at benchmark-quality levels, and better coordination of these services across care settings;

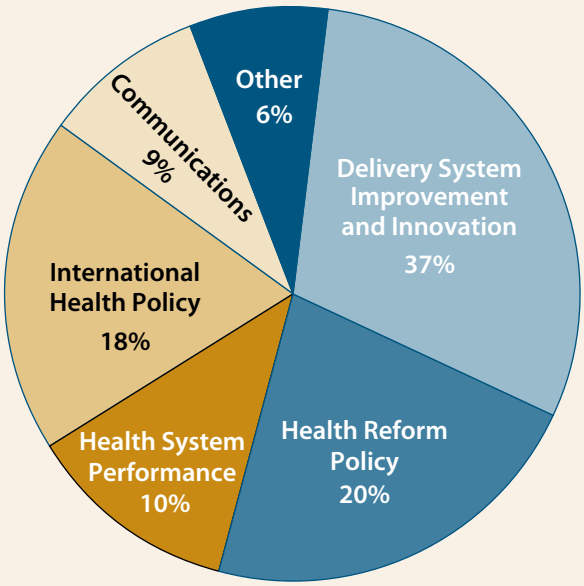
- a greater proportion of physicians providing care in high-performing health systems, and a greater proportion of patients served by high-performing health systems;
- payment incentives that are aligned across payers and providers to enable and reward high-quality, coordinated care, and greater alignment of payment across public and private providers;
- health care spending growing at a rate equal to or below that of the gross domestic product (GDP) plus one percentage point;
- greater equity in access to high-quality care among population groups, and a narrowing of disparities in health and health care outcomes;
- a substantial and growing body of evidence for what constitutes and yields high performance, both within and across care settings; and
- effective leadership at the state and national levels, as well as collaboration among health system stakeholders, to achieve high performance health care.

RESOURCES AND THEIR MANAGEMENT

Over the five-year period 2011–16, The Commonwealth Fund expects to spend $160.7 million, strategically allocated across programs, toward implementing strategies and achieving goals—subject to the availability of funds from the foundation's endowment. The Fund's human resources are as important as its financial ones. They include highly productive professional staff based in the Fund's New York City headquarters and in its Washington, D.C., and Boston offices—as well as an outstanding constellation of advisers, including

Exhibit 3. In the 2011–16 Five-Year Extramural Program Budget, Funds Are Allocated Across Programs Strategically, and All Programs Will Contribute to the Pursuit of the Fund's Five Strategies

Commonwealth Fund Total Five-Year Spending: $161 Million



members of the Commission on a High Performance Health System, principal investigators on Fund grants, and members of the Fund's own Board of Directors.

Reflecting the foundation's value-added approach to grantmaking, approximately 39 percent of the total budget is devoted to intramural units engaged in research and program development, collaborations with grantees, and dissemination of program results to policymakers, health care leaders, researchers, and other influential audiences. The portion of the foundation's total budget devoted to administration is 6 percent.

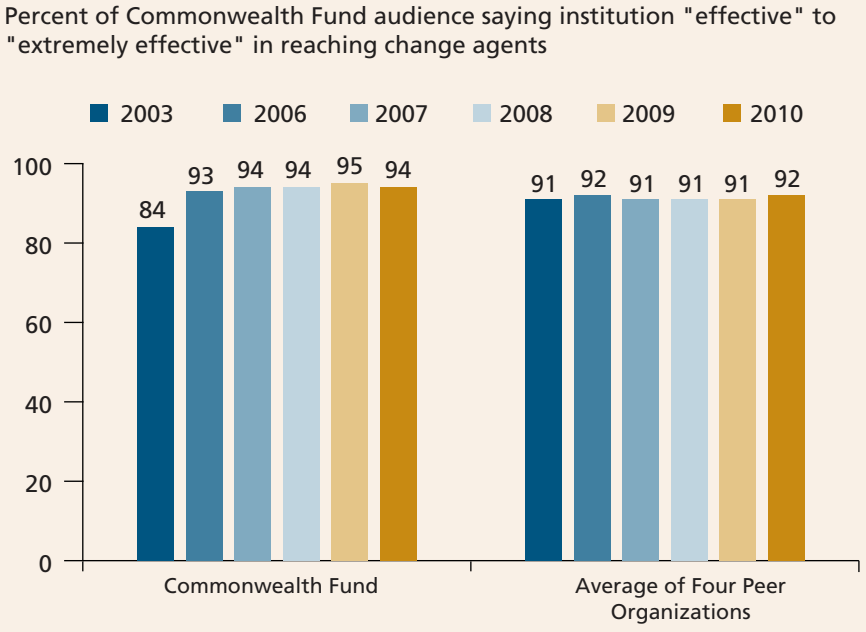
THE FOUNDATION'S PERFORMANCE

The Commonwealth Fund is one of only a handful of foundations that use a performance scorecard to provide their boards with a comprehensive annual assessment of institutional performance and a means to spot weaknesses needing attention. The Fund's scorecard has 23 metrics, covering four dimensions: financial performance, audience impact, effectiveness of internal processes, and organizational capacities for learning and growth.

To help ensure a continued record of success and institutional vitality, the scorecard includes the objective of launching each year at least four new strategic initiatives that spur the foundation to take on new goals and strategies. The "stretch initiatives" for 2010–11 were as follows:

- Develop a program promoting high performance state and local health systems for vulnerable populations.
- Expand the scope of the Long-Term Care Quality Improvement program to include attention to issues around care for beneficiaries eligible for both Medicare and Medicaid.

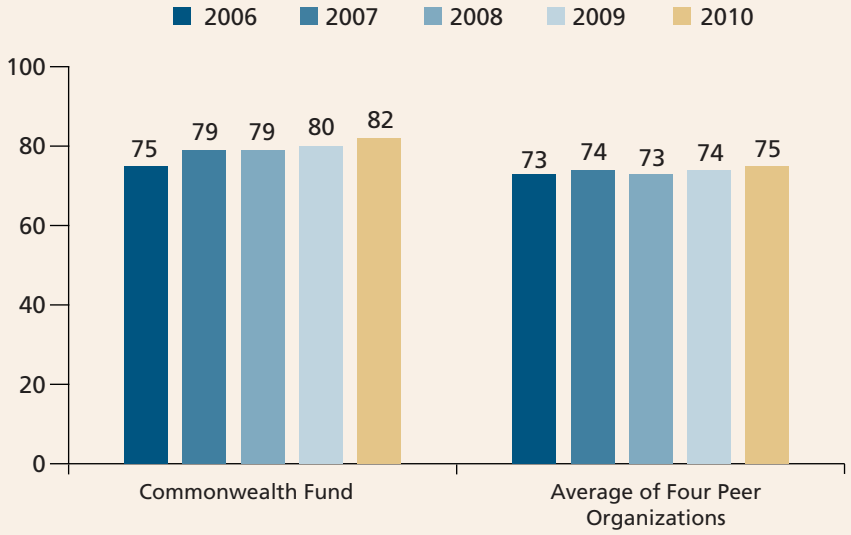
Exhibit 4. The Commonwealth Fund's Performance Scorecard: Reaching Change Agents Effectively



Source: 2003 Harris Interactive and 2006–2010 Mathew Greenwald Commonwealth Fund Audience Surveys.

Exhibit 5. The Commonwealth Fund's Performance Scorecard: Improving Health Care Access, Quality and Efficiency, and the Payment System

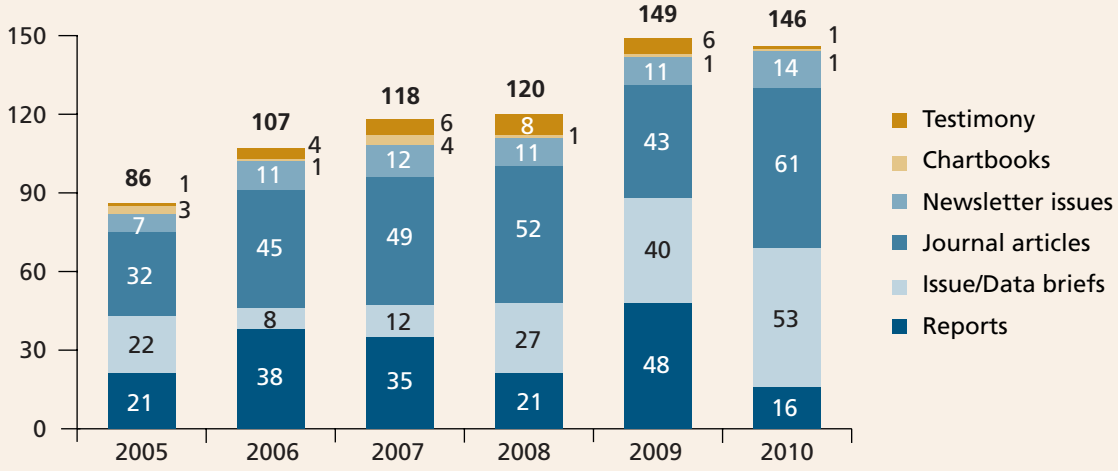
Percent of Fund audience saying institution "effective"to"extremely effective" in improving health care access, quality and efficiency, and the payment system*



*"Payment system" added to questions in 2010 survey.
Source: 2006–2010 Mathew Greenwald Commonwealth Fund Audience Surveys.

Exhibit 6. In Its Grantmaking, The Commonwealth Fund Focuses from the Beginning on Producing Publishable Products and Ensuring Their Dissemination to a Wide Audience

Number of Fund publications



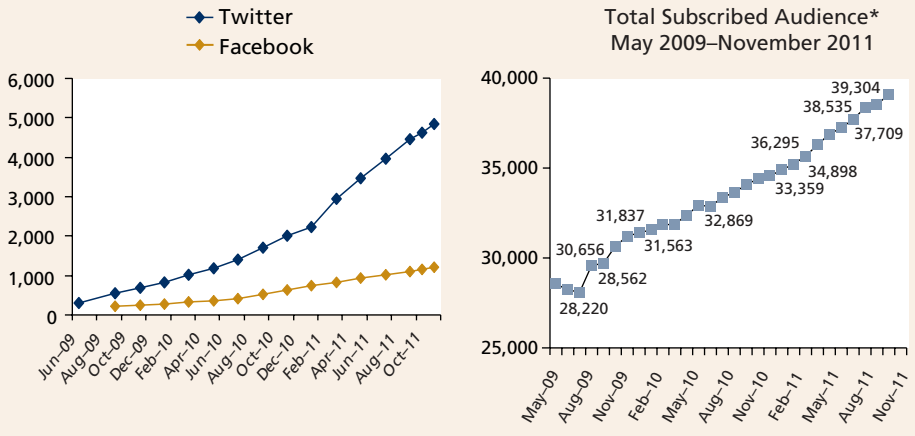
- Develop further options for bending the health care cost curve.
- Strengthen the dialogue between federal and state officials on health care reform implementation.
- Develop the capacity for monitoring the functioning of health care markets.
- Expand the focus of the International Program in Health Policy and Innovation to include additional European countries.

The foundation has made significant progress on all of these initiatives.

The Fund aims to be a learning organization, and consequently places a high value on assessing its own performance. Each year, the Board of Directors commissions a thorough review of a major Fund program, seeking to gauge performance to date and draw lessons to inform the program's future direction. In 2010–11, management undertook an extensive review of the first 10 classes (1998–2008) of the Harkness Fellowships in Health Care Policy and Practice, through which the foundation is making a substantial long-term investment in promoting international exchange to stimulate improved performance of health systems in industrialized countries—particularly the United States. Aided by experts and Harkness Fellowship alumni in the participating countries, the review committee found that most fellows are more than living up to expectations, both during their fellowship and afterward. The assessment also spurred steps intended to enhance the program's success. The review is discussed in the "Executive Vice President and COO's Report" in this *Annual Report.*

The Commonwealth Fund's annual external program reviews, annual reports to the Board on the performance of all grants completed during the year, semiannual audience and grantee surveys, annual confidential surveys of Fund Board members, and periodic surveys of Fund staff—all of which contribute to the Fund's own annual performance scorecard—help to ensure a high level of accountability and institutional learning.

Exhibit 7. The Commonwealth Fund's Electronic Audience Continues to Grow



* Figures represent the combined total of all e-mail registrants, RSS subscribers, Twitter followers, and Facebook fans.

HEALTH SYSTEM QUALITY AND EFFICIENCY

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

HEALTH SYSTEM QUALITY AND EFFICIENCY

Program Goals

The Program on Health System Quality and Efficiency is a major part of The Commonwealth Fund's focus on health care delivery system improvement and innovation. The program's mission is to improve the quality and efficiency of health care in the United States, with special emphasis on fostering greater coordination and accountability among all those involved in the delivery of health care.

The program's work is rooted in the recognition that improvements are most likely to occur when the need for change is understood, measured, and publicly recognized; when providers have the capacity to initiate and sustain change; and when the appropriate incentives are in place. To that end, the program supports projects that:

- assess the capacity of organizations to provide coordinated and efficient population-based care, and help expand that capacity where necessary;
- foster the development and widespread adoption of standard measures for benchmarking the performance of health care organizations over time; and
- promote the use of incentives to improve quality and efficiency in health care.

The program is led by Vice President
Anne-Marie J. Audet, M.D.

Cover: With the ability to identify quickly which patients are at high risk for returning to the hospital once discharged, hospitals should be able to tailor interventions that help prevent rapid readmission—a major source of health care spending in the U.S. With Commonwealth Fund support, Ruben Amarasingham, M.D., shown here with a patient at the Parkland Health and Hospital System in Dallas, has developed an electronic clinical decision support tool that uses data in the patient's electronic medical record to help hospitals predict who is at heightened risk of readmission.

Photo: Steve McAllister

The Issues

The quality and efficiency of American health care is not what it should be. While the basic skill and dedication of the nation's health care providers is not in question, there are nonetheless ample opportunities for improvement in quality, safety, coordination, and patient-centeredness throughout the health care system.

According to The Commonwealth Fund's 2011 National Scorecard on U.S. Health System Performance, as many as 91,000 fewer premature deaths would occur if the United States were to reach the benchmark level of "mortality amenable to health care" achieved by the top-performing country. The relatively poor performance of the U.S. health system, coupled with the nation's standing as the biggest spender on health care in the world, also suggests it is a highly inefficient one. Supporting efforts to increase the value obtained from our health care dollars is one of the Fund's chief goals.

Recent Projects

Redesigning Care for High Performance

Hospitalizations consume nearly one-third of the $2 trillion spent on health care in the United States. Many of these are readmissions for conditions that could have been prevented had proper discharge planning, education, and postdischarge support been provided for patients. In 2009, the Institute for Healthcare Improvement (IHI), with Commonwealth Fund support, initiated the State Action on Avoidable Rehospitalizations (STAAR), a multipronged effort to help hospitals improve their processes for transitioning discharged patients to other care settings and assist state policymakers and other stakeholders with implementing systemic changes that will sustain improvements. According to a report in *Health Affairs* (July 7, 2011) that presented early findings from the initiative, the most important rehospitalization-reduction strategies used so far are improving patient education, ensuring timely follow-up with patients after hospital discharge, and creating universal patient transfer or discharge forms. To date nearly 150 STAAR hospitals in three states have joined more than 500 community-based partners, including nursing homes, home health agencies, and physician practices, in the push to improve care transitions.

STAAR is also informing national efforts to reduce rehospitalizations, highlighting the value of collaboration among hospitals and community-based providers for improving care transitions and keeping discharged patients out of the hospital. The initiative has produced a number of how-to guides and other resources—all available online—to help providers implement best practices for good transitional care.

A concurrent Commonwealth Fund–supported evaluation of STAAR by Pennsylvania State University's Dennis Scanlon, Ph.D., is assessing how well the interventions succeed in reducing hospital readmission rates. The results should hold interest for the Medicare program and other public and provider payers for whom reducing hospitalizations is a priority.

To help hospital leaders get started on a plan for reducing readmissions, a team of experts at the Health Research and Educational Trust (HRET) produced the Health Care Leader Action Guide to Reduce Avoidable Readmissions, with support from both the John A. Hartford Foundation and The Commonwealth Fund. This resource outlines strategies for reducing unplanned readmissions and enables hospitals to estimate the level of effort required for them to implement those strategies.

Accountable Care Systems

As the nation moves toward health care delivery systems that are accountable for the outcomes and health care costs of their patient populations, The Commonwealth Fund is sponsoring efforts intended to ensure the success of this model for achieving coordinated, patient-centered, efficient care. With Fund support, Elliott Fisher, M.D., and colleagues at the Dartmouth Institute for Health Policy and Clinical Practice and the Brookings Institution developed and pilot-tested a "starter set" of health care claims–based measures that could be used both to assess quality of care and to determine payments to accountable care organization (ACO) providers and the shared savings for which they are eligible. In the project's second phase, the team is developing and testing a more advanced set of measures, including clinical outcomes measures and patient-reported measures of care experience and health status. A new case study series produced by the Dartmouth team examines the progress of four diverse health care organizations—from integrated health systems to a community hospital—as they collaborate with their private-payer partners to become accountable care providers. The cases detail how these institutions, which are all taking part in the Brookings–Dartmouth ACO Pilot Program, formed their ACO partnerships, how they are developing the capacity to manage population health, quality, and costs, and how they are dealing with issues of governance, patient attribution, payment, patient and provider engagement, and benefit design.

For ACOs to succeed, new payment models are needed to foster greater accountability for the quality and cost of patient care. One such model is the Alternative Quality Contract, a global payment system for providers developed by Blue Cross Blue Shield of Massachusetts (BCBS) to replace fee-for-service reimbursement and counter rising health care spending. Under the contract, BCBS pays health care providers a comprehensive payment that covers the entire continuum of a patient's care for a specific illness—including inpatient,

outpatient, rehabilitative, and long-term care, as well as prescription drugs. Providers are eligible for a performance bonus if they meet certain quality targets. With Fund support, Harvard University's Michael Chernew, Ph.D., evaluated spending and quality improvement for BCBS patients whose primary care providers participated in the AQC and did the same for a control group of patients whose providers were not in the AQC.

According to a study in the *New England Journal of Medicine* coauthored by Chernew, Harvard colleague Zirui Song, and others, medical spending was modestly lower in the AQC's first year, as patients were referred to providers that charged lower fees. Improvements in the quality of adult chronic care and pediatric care were also evident. In another article, published in *Health Affairs,* Robert E. Mechanic, M.B.A., of Brandeis University, together with Chernew and colleagues, described how physician groups in the AQC have begun to focus on quality improvement, reduce their use of expensive sites of care, and coordinate services for high-risk patients.

Meeting and Raising Benchmarks for Quality

Today, nearly 7,500 hospital executives, quality improvement professionals, medical directors, and others use The Commonwealth Fund's online resource for health care quality benchmarking, WhyNotTheBest.org, to compare their organization's performance against their peers, learn from case studies of top performers, and access innovative improvement tools. With an array of custom benchmarks available, users can compare their organization's performance to the leaders and to national and state averages. Recently, the site added two new benchmarks: health system hospitals and non–health system hospitals.

WhyNotTheBest profiles more than 8,000 hospitals and 400 hospital systems on measures of appropriate care processes and outcomes, patient experiences, readmission rates, mortality rates, patient safety and use of resources. The site also reports on the incidence of central line–associated bloodstream infections for more than 1,300 U.S. hospitals, and it serves as a unique source of all-payer data across 12 states. In the past year, the site added an interactive map that enables users to explore performance at the county, hospital referral region, state, and national levels. The performance map will continue to be developed to track accountable care organizations and other emerging integrated systems and communities of care. Additional efforts this year will focus on outreach to new audiences for WhyNotTheBest, such as business coalitions and employers.

Resources such as WhyNotTheBest are essential for improving performance, but they are only as good as the measures for which they report data. Studies have shown that current measures of hospital readmission rates suffer from a lack of consensus over clinical validity,

among other concerns, and that different rehospitalization measures rank hospitals differently. With Commonwealth Fund support, Gerard Anderson, Ph.D., and Stephen Jencks, M.D., are leading a project to define an easily understood, clinically credible measure that will allow for fairer comparisons among states, regions, and hospitals. This work is especially timely, as the Centers for Medicare and Medicaid Services, in addition to private payers, are instituting incentives and penalties based on readmissions for certain preventable medical conditions.

Assessing Providers' Capacity to Improve Care

Mortality rates for people who have experienced an acute myocardial infarction (AMI)—a heart attack—vary substantially across U.S. hospitals, even when researchers adjust for the severity of the condition or other factors like hospital volume, teaching status, and patients' socioeconomic status. With Commonwealth Fund support, Elizabeth Bradley, Ph.D., and her team at Yale University interviewed more than 150 hospital staff members closely involved in AMI care to identify organizational factors that are common to providers with low AMI mortality rates. In a paper published in *Annals of Internal Medicine* (March 15, 2011), Bradley and her team reported that in the absence of an organizational culture that supports high-quality care, teamwork, and coordination, evidence-based clinical interventions may not be sufficient to improve care and reduce death from AMI. The authors say that hospitals need to set clear goals, secure the engagement of senior management, and establish clear communication and coordination standards.

Access to measures of physician clinical quality remains a challenge. Most commonly used measures—education, board certification, and malpractice history, among others—are mere proxies. With Commonwealth Fund support, researchers from RAND and the University of Pittsburgh, led by Ateev Mehrotra, M.D., used data from a large sample of physicians to examine the relationship between these types of physician characteristics and a range of performance measures. The results of the study, published in the *Archives of Internal Medicine* (Sept. 13, 2010), show that proxy measures are not valid measures of clinical quality, and underscore the need to prioritize expanded public reporting of physician quality data.

Disseminating Best Practices and Innovative Models

Conducting case studies of high-performing provider organizations is an effective way to educate health care stakeholders about best practices for managing chronic diseases, reducing hospitalizations, increasing patient satisfaction, and achieving other important performance goals. A July 2010 Commonwealth Fund case study series profiled three health care organizations participating in the Institute for Healthcare Improvement's Triple Aim initiative. The series, written by Douglas McCarthy and Sarah Klein, sheds light on how each is partnering with providers and organizing care to improve the

health of its patient population and the experience of care, while also controlling the per capita cost of care. The organizations selected—CareOregon, a nonprofit Medicaid managed health care plan, Genesys Health System, a nonprofit integrated delivery system, and QuadMed, a firm that develops and manages worksite health clinics and wellness programs—represent a diversity of approaches.

Another set of Commonwealth Fund case studies documents advancements in patient safety made in the last five years by four health care organizations that were pioneers in the movement. In the series overview, *Keeping the Commitment: A Progress Report on Four Early Leaders in Patient Safety Improvement,* authors McCarthy and Klein describe how these providers were able to reduce serious events of patient harm, improve the organizational safety climate, and reduce malpractice claims as safety interventions spread from individual hospital units to the entire delivery system—even home health care providers. The case studies describe how the four systems—Johns Hopkins Medicine, OSF HealthCare, Sentara Healthcare, and the U.S. Department of Veterans Affairs—have deployed new training, coaching, and motivational methods to engage staff in patient safety work; designed tools and systems for minimizing error and maximizing learning; set ambitious goals; and held individual units accountable for their performance.

The Fund is also sponsoring two evaluations focusing on best practices in health care delivery. The first evaluation, led by Geoffrey Lamb, M.D., is examining the Wisconsin Collaborative for Healthcare Quality, one of the U.S. Department of Health and Human Services' designated Chartered Value Exchange Networks and a leader in public reporting and the sharing of best practices. The other is studying shared decision-making in primary care and specialty clinics that are part of the Group Health Cooperative's network in Washington State. Headed by David Arterburn, M.D., the project is assessing the effectiveness of 12 patient-decision aids on the use of elective surgical procedures, total health care utilization, and total costs.

Future Directions

Although the Affordable Care Act encourages the establishment of accountable care organizations, it is not clear how ready health care providers are to participate in them or if they will be able to develop the capabilities to do so. In the first study of its kind, Commonwealth Fund–supported researchers led by Maulik Joshi, Dr.P.H., of the Health Research and Educational Trust will profile U.S. hospitals and health systems for their readiness to be accountable for the continuum of patient care, including their ability to manage financial risk, receive bundled payment, and calculate and distribute shared savings to providers.

Karen Donelan, Sc.D., of Massachusetts General Hospital and Catherine DesRoches, Ph.D., of Mathematica Policy Research will lead a longitudinal national survey to learn about the organizational settings and local health care markets in which physicians practice, as well as their care coordination processes and relationships with other providers, forms of reimbursement, and use of health information technology. Under a Fund grant to the University of Oregon, Jessica Greene, Ph.D., will evaluate the impact of provider payment reforms instituted by Fairview Health Services, an integrated health system in Minnesota that is discarding fee-for-service and replacing it with payment based on quality of care, productivity, patient experience, and cost.

The 17 U.S. communities chosen to participate in the federally authorized Beacon Community Cooperative Agreement Program are currently engaged in efforts to build and strengthen their health information technology infrastructure to achieve improvements in health care quality, cost-efficiency, and the management of community-level population health. With a combination of Commonwealth Fund and federal support, AcademyHealth has launched the Beacon Evaluation and Innovation Network to assist the Beacon Communities in accelerating the identification, documentation, and dissemination of lessons and results of their individual efforts. The network provides an unprecedented opportunity to expand the effectiveness of the program by helping to coordinate and convene evaluators with external experts to address research challenges and maximize opportunities to disseminate evidence.

LONG-TERM CARE QUALITY IMPROVEMENT

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

LONG-TERM CARE QUALITY IMPROVEMENT

Program Goals

The Picker/Commonwealth Fund Program on Long-Term Care Quality Improvement, part of the foundation's efforts to improve the health care delivery system and spur innovation, aims to 1) raise the quality of postacute and long-term care services and supports, and 2) improve care transitions for patients by integrating these services with the other care that they receive. Specifically, the program seeks to:

- identify, test, and spread measures, practices, models, and tools that will lead to person-centered, high-performing long-term care services;
- build strong networks among stakeholders to create a sense of common purpose and shared interest in improving performance and coordinating care;
- assess, track, and compare the performance of long-term services and supports at the state and national levels; and
- ensure that long-term services are part of an integrated system of patient care and are a component of provider payment, health information, and care delivery reforms.

The program is led by Vice President
Mary Jane Koren, M.D., M.P.H.

Cover: At the Redstone Rehabilitation and Nursing Center in East Longmeadow, Mass., a physician visits with a patient and nurse through PhoneDOCTORx, a promising telemedicine technology that enables nursing home staff to consult with off-site clinicians more easily and potentially avoid the need for hospitalization. The Commonwealth Fund supported a recent evaluation of the intervention.

Photo: Michael Malyszko

A focus of the program is the development of coordinated care systems for the especially vulnerable group of individuals enrolled in both the Medicare and Medicaid programs.

The Issues

As our population ages, an increasing number of people live with multiple chronic conditions, compromised physical function, and sometimes dementia. These problems not only can complicate our ability to manage our health care needs, but they can also jeopardize our ability to remain independent. Access to high-quality postacute care and long-term services and supports is therefore critical for patients trying to get well, stay well, and remain functional—especially older adults living alone.

Patients and their families know this, often from personal experience. Policymakers, on the other hand, generally have been slow to recognize the importance of long-term care to health system redesign, in terms of reducing overall costs and creating a seamless care system for patients.

As implementation of the Affordable Care Act proceeds, The Commonwealth Fund's Program on Long-Term Care Quality Improvement is supporting efforts to help nursing homes and other providers improve their performance and ensure successful transitions for patients as they move from one level of care to the next.

Recent Projects

Advancing Excellence in America's Nursing Homes

Advancing Excellence in America's Nursing Homes is a national, voluntary quality improvement campaign to help nursing homes become good places to live, work, and visit. Launched in 2006 with support from The Commonwealth Fund and the Centers for Medicare and Medicaid Services (CMS), Advancing Excellence was recently incorporated as a not-for-profit educational organization, led by a board representing all those with a major stake in high-quality nursing home care.

The campaign is unique in encouraging the participation of not only nursing home providers but also the individuals who staff facilities and the consumers they serve. To join, nursing homes must agree to work on at least three of eight quality-related issues, such as reducing staff turnover—a problem endemic within the industry—or improving the care planning process to address patients' goals for care. Nursing homes taking part

must also set performance targets and measure change. The campaign works with state stakeholder coalitions called Local Area Networks for Excellence, or LANEs, which help keep nursing homes engaged and moving forward.

Advancing Excellence has achieved great success in attracting nursing homes—now more than 7,400, representing over 47 percent of all U.S. nursing facilities—and in making measurable progress toward quality goals Th rough the campaign's Web site, www.nhqualitycampaign.org, nursing homes can access tools for tracking improvement and comparing facilities' performance, learn about evidence-based practices, and participate in free training webinars. Consumers, meanwhile, can find information that will help them get good care.

Preserving "Critical Access" Nursing Homes

The Commonwealth Fund's abiding interest in reducing disparities in health care for vulnerable populations has led to heightened attention on safety-net health care providers. The recent trend of nursing home closures in inner-city neighborhoods, a phenomenon identified by Brown University's Vincent Mor, Ph.D., and others, points to the importance of nursing homes to the overall health care safety net. Although many of these facilities are of poor quality, they are often the only sources of postacute and long-term care services easily accessible to residents.

With support from the Fund and CMS, a pilot project led by Carol Benner, Sc.M., national director of the Advancing Excellence campaign, is attempting to stabilize "critical access" nursing homes to forestall closure, and then improve them sufficiently to warrant their continued participation in the Medicare and Medicaid programs. The LANE members in Georgia, Illinois, Indiana, and Ohio worked with the management and frontline staff of 18 nursing homes on organizational development aimed at stabilizing staff and improving performance. Over the 10-month pilot, many of the homes reported decreases in staff turnover and improvements in morale.

The Pioneer Network

Since 1997, the Pioneer Network has worked with a broad coalition of long-term care stakeholders to promote person-centered care in America's nursing homes. Pioneer staff, with Commonwealth Fund support, have provided nursing homes that are pursuing culture change with training, practical tools, and access to a community of peers. In the past year, for example, staff compiled "Just in Time" toolkits to help homes implement person-centered improvements to resident dining, physical environment, and staffing, and comply with federal regulations in those areas.

The Pioneer Network also plays an important policy role, helping federal officials dismantle barriers to culture change and promote improvement. Recently, Pioneer's leadership, working closely with CMS officials, informed the development of revised regulations issued to guide states on the use of civil monetary penalty (CMP) funds collected from nursing homes in violation of quality standards. The final rule, which will take effect in 2012, stipulates that 90 percent of Medicare's portion of penalty funds held in escrow during the appeals process may be used for activities that improve care for nursing home residents; formerly these funds were conveyed to the U.S. Treasury. In addition, Pioneer has begun collaborating with the Office for the Assistant Secretary for Planning and Evaluation on ways to advance culture change as a quality improvement strategy and evaluate its impact on nursing home residents. This work will support CMS in its effort to design the culture change demonstration projects called for in the Affordable Care Act.

Expanding Nursing Homes' Capacity to Improve Care

Surprisingly, researchers in the past have been unable to find a clear association between staffing levels in nursing homes and quality of care. A recent study by the University of Pittsburgh's Nicholas Castle, Ph.D., investigated this issue and identified several staffing characteristics, such as turnover, use of agency staff, and mix of professional staff, that together with staffing levels, do in fact influence quality. To help senior-level managers in nursing homes see how changes to one or more of these characteristics can affect quality, Castle developed a Web-based staffing and quality simulation tool called Staff Assist, which he has introduced to nursing home associations around the country.

A number of studies have shown that a sizable number of hospital admissions of nursing home residents could be avoided if nursing home staff were given the skills and tools necessary to provide safe care to residents. Recent Commonwealth Fund support enabled a team led by Joseph Ouslander, M.D., at Florida Atlantic University to refine and test INTERACT-II, a set of clinical tools he helped develop that assist nursing home staff in the early identification, assessment, communication, and documentation of acute changes in residents' health status. Of the 25 facilities across Florida, Massachusetts, and New York that took part in the six-month trial, there was a 17 percent overall reduction in hospitalizations, as reported in an April 2011 article in the *Journal of the American Geriatrics Society*. And while the average implementation cost per nursing home was $7,700, the savings to Medicare for a typical 100-bed home are estimated at approximately $125,000 per year. (The INTERACT-II tools can be found at http://interact2.net.)

Long-Term Care Scorecard

The Affordable Care Act will greatly expand the availability of Medicaid-funded community-based long-term services and provide states with financial incentives intended to forge a better balance between nursing home care and services delivered in the home or by community-based providers. As states embark on this new era in long-term care, they will need the means to assess progress in expanding access to a range of affordable, high-quality long-term care services.

Following on the success of the Fund's national and state health system scorecards, Susan Reinhard, R.N., Ph.D., and her team from AARP collaborated with The Commonwealth Fund and the SCAN Foundation to develop the first-ever state performance scorecard focused on long-term care. The report, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers,* examines four key dimensions of performance—affordability and access, choice of setting and provider, quality of life and quality of care, and support for family caregivers—and assesses each state's performance overall as well as on 25 individual indicators. It finds that all states need to improve; even the top three states (Minnesota, Washington, and Oregon) have a long way to go to create a high-performing system of long-term services and supports. According to the authors, areas for improvement include home care, assisted living, nursing home care, and supports for family caregivers.

Future Directions

In addition to continuing its support for person-centered care and quality improvement in nursing homes, the Commonwealth Fund's Program on Long-Term Care Quality Improvement is supporting a number of projects aimed at improving care transitions for patients. Barriers separating long-term care from the rest of the health care system fragment what should be a seamless continuum of care for the 10 million Americans

with chronic illnesses or disabilities who rely on these services. This lack of integration harms quality of care and drives up costs. With Fund support, the Long-Term Quality Alliance, a broad-based coalition of leaders in health and long-term care, aging, policy, and consumer advocacy, will identify opportunities in the Affordable Care Act for achieving better care coordination and transitional care, develop options to overcome challenges to incorporating long-term care into state and national reform activities, and harvest examples of innovative person-centered transitional care practices. The Alliance is also developing the Innovative Communities Learning Program to promote community-level coordination across all service providers—health care, social services, transportation, and housing—with the goal of improving transitions between care settings and reducing rehospitalizations.

Under another Commonwealth Fund grant, a team led by Penny Hollander Feldman, Ph.D., of the Visiting Nurse Service of New York will determine whether home health care agencies can effectively use the Care Transitions Measure, a three-item patient questionnaire developed previously by Eric Coleman, M.D., with Fund support, to assess how well patients are prepared to manage their care prior to being sent home from the hospital. The study will test whether home health agencies are able to use the tool to assess how well a hospital prepares patients for home care, predict the level of resources new patients will require, tailor services to patients' individual needs, and provide hospitals with feedback on discharge planning activities.

Additionally, Harvard Medical School researchers, led by David Grabowski, Ph.D., are working closely with a telemedicine vendor and 11 nursing homes in Massachusetts to provide physician consultation and treatment recommendations to on-site staff during evenings and weekends. It is hoped that this intervention will be shown to provide a safe, cost-effective way to reduce hospitalizations, and rehospitalizations, of nursing home residents.

PATIENT-CENTERED COORDINATED CARE

A Private Foundation Working Toward a High Performance Health System

PATIENT-CENTERED COORDINATED CARE

Program Goals

In support of The Commonwealth Fund's efforts to promote delivery system improvement and innovation, the Program on Patient-Centered Coordinated Care sponsors activities aimed at improving the quality of primary health care in the United States, including efforts to make care more centered around the needs and preferences of patients and their families. To achieve this mission, the program makes grants to:

- strengthen primary care by promoting the collection and dissemination of information on patients' health care experiences and on physician office systems and practices that are associated with high-quality, patient-centered care;
- assist primary care practices with the adoption of practices, models, and tools that can help them become more patient-centered and coordinate more closely with hospitals, specialists, and other public and private health care providers in their communities; and
- inform the development of policies to encourage patient- and family-centered care in medical homes.

The program is led by Vice President
Melinda K. Abrams, M.S.

Cover: At the primary care practice of Dr. Michael Richter in Rego Park, Queens, N.Y., patient panel manager Sparkle Jones assists staff in identifying and reaching out to patients with unmet needs. Dr. Richter's practice is participating in a New York City pilot program in which small safety-net physician practices share the services of a patient-panel manager. The Commonwealth Fund, through its, Patient-Centered Coordinated Care program, is supporting an evaluation of the pilot's effectiveness.

Photo: Roger Carr

The Issues

As defined by the Institute of Medicine, patient-centered care is "health care that establishes a partnership among practitioners, patients, and their families . . . to ensure that decisions respect patients' needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care."

There is substantial evidence that health systems that have a strong primary care foundation deliver higher-quality, lower-cost care overall and greater equity in health outcomes. Research also shows that patient-centered primary care is best delivered in a medical home—a primary care practice or health center that partners with its patients in providing enhanced access to clinicians, coordinating health care services, and engaging in continuous quality improvement.

Recent Projects

Promoting and Evaluating the Patient-Centered Medical Home

In April 2008, The Commonwealth Fund launched the five-year Safety Net Medical Home Initiative to support the transformation of primary care clinics serving low-income and uninsured people into patient-centered medical homes. Led by Jonathan Sugarman, M.D., president and CEO of Qualis Health, a nonprofit quality improvement organization based in Seattle, and Ed Wagner, M.D., of the MacColl Institute for Healthcare Innovation, the initiative involves 65 clinics in five states: Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania. The Qualis/MacColl team is providing technical assistance to local quality improvement organizations that, in turn, are helping the clinics achieve benchmark levels of performance in quality and efficiency, patient experience, and clinical staff experience. Eight foundations have joined The Commonwealth Fund in support of the initiative. To extend the reach and impact of the Safety Net Medical Home Initiative, the project team is developing a Web-based national curriculum for quality improvement coaches to support the nation's 1,300 community health centers in becoming effective medical homes.

Under another Fund grant, Marshall Chin, M.D., and a team of researchers at the University of Chicago are evaluating whether clinics participating in the Qualis/MacColl initiative are in fact able to make the changes necessary to function as medical homes. The team is also assessing the extent to which sites receiving technical assistance and enhanced reimbursement for providing medical home services improve their performance on measures of quality, efficiency, patient experience, and clinician or staff satisfaction. While data on patient impact is not yet available, baseline results of physician and clinic staff surveys show that when a safety-net clinic has more core medical home features—

systems for tracking patients with unmet needs, personnel to help patients manage their chronic conditions, resources for quality improvement—the physician and clinic staff report higher morale and greater satisfaction with their jobs.

Given the large number of medical home evaluations the Fund is supporting, The Commonwealth Fund established the Patient-Centered Medical Home Evaluators' Collaborative, cochaired by Meredith Rosenthal, Ph.D., and Melinda Abrams, to align evaluation methods, share best practices, and exchange information on ways to improve evaluation designs. A key objective of the collaborative is to reach consensus on a core set of standardized measures in each of the key areas under investigation, such as care utilization, cost savings, clinical quality, patient experience, and clinic staff experience. In an August 2010 article in *Medical Care Research and Review,* Rosenthal and colleagues provided recommendations for measuring changes in utilization and costs in medical home evaluations. Information about the collaborative and its progress can be found on the Fund's Web site.

Building Capacity for Delivering Patient-Centered Coordinated Care

The Commonwealth Fund also is supporting efforts to improve the measures by which primary care practices achieve accreditation as medical homes, with a particular focus on making the measures more patient- and family-centered. In 2006, the Fund supported the National Committee for Quality Assurance (NCQA) in its work with the nation's leading primary care specialty societies to develop criteria for assessing and recognizing practices as medical homes. As of November 2011, at least 15,000 clinicians at more than 2,900 primary care practices have officially been recognized as patient-centered medical homes. Under a subsequent grant, Sarah Scholle, Dr.P.H., and her colleagues at NCQA developed and tested additional criteria for recognition based on patients' experience, including the quality of patient–clinician communication, patient self-management, and care coordination. The new medical home standards were released in January 2011.

Helping Smaller Physician Practices Share Patient Care Resources

Because of their limited resources and capacity, smaller independent physician practices often struggle to meet all the functional requirements of a medical home, from providing round-the-clock patient access to using a team approach to chronic disease management. Research has shown, however, that when primary care providers in the same community band together to share local resources, such as quality improvement coaches or care coordinators, they can enhance their capacity and improve performance. With Commonwealth Fund support, Ann S. O'Malley, M.D., of the Center for Studying Health System Change (HSC) is identifying primary care sites that jointly provide after-hours coverage, helping patients avoid trips to the emergency department. Her research

team is preparing cases studies of these physician practices to provide guidance for other practices looking to replicate effective models.

Another HSC team, led by Emily Carrier, M.D., is exploring how independent primary care practices develop and implement agreements with specialists, hospitals, and nursing homes to coordinate care for the patients they share. The findings could aid in the development of accountable care organizations and bundled-payment systems that are predicated on well-coordinated care. Also under study is the potential of shared patient panel management, which involves identifying and reaching out to patients with chronic illness who are overdue for office visits as well as patients requiring follow-up treatment with a specialist.

Improving Policy and Financing to Promote Patient-Centered Care

Forty-one states are developing patient-centered medical home programs for their Medicaid and Children's Health Insurance Program enrollees. With Commonwealth Fund support, Neva Kaye and Mary Takach of the National Academy for State Health Policy (NASHP) are working with state Medicaid officials to ensure beneficiaries have access to a medical home. In 2009, NASHP assisted eight states—Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia—with creating incentives and payment models that encourage primary care sites to become medical homes, helping new medical homes obtain official certification, and developing measurement strategies to monitor and evaluate quality and cost outcomes statewide.

In 2011, NASHP launched its third Medicaid medical home consortium to help up to 17 states strengthen, expand, and sustain medical home initiatives that they previously established. Additionally, the NASHP team is developing a new policy curriculum to inform federal officials about the states' experiences. In a July 2011 *Health Affairs* article, NASHP's Mary Takach noted the promising early results of recent state policies centered on medical home qualification and payment, including improved access to care, quality, and cost control. For more information about states' efforts to promote medical homes, view NASHP's interactive medical home map or download the Commonwealth Fund/NASHP report, *Building Medical Homes: Lessons from Eight States with Emerging Programs*.

To identify the most effective way to reimburse primary care providers that attain high performance, the Pennsylvania Chronic Care Initiative—the most extensive multipayer medical home demonstration program in the nation—is testing four different models for financially rewarding primary care sites that function as patient-centered medical homes. A Fund-supported team of RAND and Harvard University researchers headed by Mark W. Friedberg, M.D., is assessing the differential impact of these payment approaches—which range from per-member per-month care management fees to shared savings—on health care utilization, efficiency, cost, and quality of care.

Future Directions

The Affordable Care Act includes a number of provisions intended to strengthen primary care in the United States. To aid successful implementation of these reform efforts, The Commonwealth Fund's Program on Patient-Centered Coordinated Care will support projects in a number of areas.

Making medical homes successful. To help the spread of medical homes, health system leaders, clinicians, and policymakers need information on the factors that lead to improved efficiency and lower costs. Under a Commonwealth Fund grant, a team of researchers at Pennsylvania's Geisinger Health System is studying how its organization's medical home program is achieving reductions in costly hospital admissions and readmissions. Additional Fund-supported analyses will examine effective ways to streamline and standardize implementation of medical homes in primary care sites.

Resource-sharing. Owing to their limited resources, smaller independent physician practices typically are unable to deliver the breadth of services and engage in the range of quality improvement activities that are more common in larger practices. The Fund is supporting research into effective models for sharing clinical support services and health information systems that enable practices to provide coordinated care, after-hours appointments, and other services expected from medical homes. For example, Tara Bishop, M.D., and Lawrence Casalino, M.D., at Weill Cornell Medical College are evaluating a pilot program in New York City in which safety-net practices will share the services of a patient-panel manager, who helps ensure patients receive recommended routine services and chronic disease care.

Policy implementation. As the Affordable Care Act's primary care provisions take effect, a Commonwealth Fund priority will be to share early lessons from the field with local, state, and federal policymakers to help ensure full advantage is being taken of the opportunities provided in the legislation. For example, with Fund support, NASHP staff will work with a select group of states on creating "health homes" (medical homes) for care of patients with chronic illness.

Improving care coordination. Commonwealth Fund support is aiding efforts to identify and assess promising models for improving information-sharing among primary care clinicians and specialists, hospitals, and other providers in both safety-net and commercial settings. One such project, led by Timothy Ferris, M.D., at Massachusetts General Hospital, is comparing successful primary care–based care management programs, which have been shown to improve quality of care and health outcomes for high-risk patients as well as reduce per capita expenditures.

VULNERABLE POPULATIONS

A Private Foundation Working Toward a High Performance Health System

VULNERABLE POPULATIONS

Program Goals

As part of The Commonwealth Fund's efforts to support delivery system improvement and innovation, the Program on Vulnerable Populations is designed to ensure that low-income, uninsured, and otherwise disadvantaged minority populations are able to obtain care from high-performing health systems capable of meeting their special needs. To achieve this mission, the program makes grants to:

- Identify policy levers that can achieve equity in health care access and quality and address concerns faced by vulnerable populations across the continuum of care;
- Identify promising care delivery practices and models and develop and disseminate policy recommendations to support such innovations so that care systems can better serve vulnerable populations;
- Encourage state and local planning efforts to achieve systems of care that meet the specific needs of vulnerable populations; and
- Document and track health care utilization and quality for vulnerable populations at the state level.

The program is led by Program Officer
Pamela Riley, M.D., M.P.H.

Cover: The Commonwealth Fund initiated the Vulnerable Populations program in 2011 to help ensure that disadvantaged minorities and individuals with low income can access care from high-performing health systems that meet their special needs. One of the program's missions is to identify and spread promising care delivery practices and models, like the patient-centered medical home, that can better respond to the needs of vulnerable populations.

Photo: Susie Fitzhugh

The Issues

In the United States, vulnerable populations, including low-income people, the uninsured, and racial and ethnic minorities, have greater difficulty accessing health care, receive worse care overall, and experience poorer health outcomes than the general population. Members of vulnerable populations also have disproportionately high special needs arising from personal, social, and financial circumstances, any of which may negatively affect health and hamper efforts to obtain care. High-performing health systems for vulnerable populations must be equipped to address these needs.

While the traditional safety-net health system is critical for providing care to vulnerable populations, many members of vulnerable groups do not rely on it as their main source of care. That is why improvements in health care delivery must be made not only within the safety net but across the broader health system as well. All patients should have access to high-performing health care systems capable of providing care that is patient-centered, population-based, comprehensive, high-quality, accountable, and integrated across the continuum of needed services.

Recent Projects

Promoting Integration of Safety-Net Systems

With continuing weakness in the economy, the number of people relying on publicly funded health care has grown, while the revenue states have available to support that care has shrunk. Simply put, safety-net providers are being forced to do more with less.

Public hospitals and community health centers that operate within integrated systems appear best equipped to handle the needs of vulnerable patients efficiently. Integrated health care systems offer vulnerable patient populations access to specialty services, continuity in relationships with providers, and better-coordinated care than smaller independent practices or hospitals typically do. Under the direction of Leighton Ku, Ph.D., George Washington University researchers have been examining the degree to which safety-net providers are part of larger systems of care, identifying examples of different approaches to integration, and analyzing policies that would facilitate greater integration of safety-net systems. In a Commonwealth Fund brief laying out the keys to greater integration, Ku and his team note that success will require flexible strategies that accommodate variations in community and state needs.

The use of federal safety-net funding to encourage the spread of integrated care systems has the potential to lower health care costs and ensure the sustainability of the safety net. Under the leadership of Barbara Wynn, M.A., at the RAND Corporation, project staff are researching the current and projected flow of federal safety-net funding to determine how those monies might be used to facilitate the integration of community health centers and hospitals. They will also identify policy levers that could promote integration of the care systems serving vulnerable populations.

The integration of federally qualified health centers—a critical source of comprehensive health care services for vulnerable populations—with each other and with public and private community hospitals has the potential to improve the quality and efficiency of care in urban and rural communities across the nation. The laws and regulations guiding the structure and financing of these organizations, however, may impede integration—among them, health centers' legal obligation to serve all community residents, regardless of income, insurance status, or ability to pay, as well as limits on affiliation. Led by Sara Rosenbaum, J.D., at the George Washington University, Commonwealth Fund–sponsored researchers analyzed these legal barriers and demonstrated how successfully integrated safety-net providers overcame them, whether through co-location of services or umbrella affiliations in which health centers remain independent partners yet agree to act collaboratively to achieve specific goals. Their report, *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers,* was published by the Fund in July 2011.

Identifying Shared Resources for Care Coordination and Delivery System Improvement for Vulnerable Populations

Federally qualified health centers are already experienced in providing a range of medical and support services to patients, many of which are required components of the medical home model. With the influx of $11 billion in new funding for health centers under the health reform law, states will have an opportunity to leverage the capabilities of their health centers to improve care delivery for all residents, including those in other primary care settings.

Under the direction of Mary Takach, M.P.H., and Neva Kaye at the National Academy for State Health Policy (NASHP), a Commonwealth Fund–supported project examined ways in which health centers can serve as community "utilities," fostering connections with other Medicaid primary care providers to help beneficiaries get the services they need to manage their health and reduce costly visits to the hospital. In a May 2011 report published by the Fund and NASHP, the team highlighted promising community

utility models involving partnerships between states and health centers, as well as the policy options available at the state level to replicate these models. The authors note that such partnerships could help states accommodate the needs of the 20 million additional Medicaid beneficiaries expected after health reform is fully implemented.

At the Center for Health Care Strategies, Inc., Nikki Highsmith, M.P.A., under a Commonwealth Fund grant, documented how some states are supporting small independent physician practices that serve Medicaid patients by establishing networks of shared resources. By sharing such services as coverage for evening and weekend appointments, patient registry reports and panel management, and electronic systems for ordering and tracking tests, these typically underresourced providers are able to ensure their patients have access to a wide range of medical home services. The project identified the types of organized practice supports that are most needed by high-volume Medicaid practices and produced a set of design considerations for state Medicaid agencies. Read the March 2011 Fund report *Driving Value in Medicaid Primary Care: The Role of Shared Support Networks for Physician Practices* to learn more.

Future Directions

Monitoring and Tracking to Guide Planning and Policy

States have a large role in ensuring access to health care for vulnerable populations. To understand the extent to which states are meeting this responsibility—and how they are going about it—The Commonwealth Fund plans to develop a state scorecard assessing health care access, utilization, and equity among vulnerable populations, as well as state policies, resources, and programs that address their needs. The Fund will also likely support projects that identify sources of care for vulnerable populations as part of broader efforts to assess and improve their access to quality care.

Promoting Statewide Planning Efforts for Care of Vulnerable Populations

Many states have not undertaken a systematic review of their policies and programs for vulnerable populations, and as such may be ill-prepared to seize new opportunities in the Affordable Care Act for strengthening their health care safety net. But in Iowa, health care leaders are preparing for a comprehensive planning effort to identify strategies that they and policymakers in other states could follow to achieve a high performance health

care system for their vulnerable populations. Under the leadership of the University of Iowa's Peter Damiano, D.D.S., M.P.H., this Commonwealth Fund–supported project will convene an advisory group of state officials and safety-net providers to determine the current funding, expenditures, and infrastructure of Iowa's safety net, and then develop strategies for improving its integration.

Establishing Sustainable Financing for Safety-Net Systems

Funded by a combination of patient care revenue, local and state taxes, and supplemental payments from disproportionate-share payment programs, public hospitals contend with wide fluctuations in their funding streams and near-constant financial uncertainty. Under the leadership of Nancy Kane, D.B.A., at Harvard University, researchers will collect audited financial statements from approximately 150 large, urban public hospitals to analyze their funding streams and financial sustainability, with the goal of setting a baseline for monitoring their viability over the next decade as reforms in the Affordable Care Act take hold.

Identifying Promising Models and Opportunities for Delivery System Reform

For vulnerable populations, accessing specialty care services is at least as great a problem as accessing primary care. Under the direction of Anna Sommers, Ph.D., at the Center for Studying Health System Change, a team will study existing and emerging models for financing specialty care for Medicaid enrollees—for example, using physician assistants to provide specialty care at lower cost—to identify those that are sustainable and to consider policy options for promoting their adoption.

Another Commonwealth Fund project, led by Wendy Holt, M.P.P., at DMA Health Strategies, will focus on the "enabling services"—transportation, interpretation, psychosocial support, and outreach, among others—that safety-net providers typically offer patients to overcome personal, social, geographic, financial, and environmental barriers to care. The DMA team will research current approaches to the financing and provision of enabling services and produce recommendations for ensuring that vulnerable individuals are able to take full advantage of their coverage, regardless of where they choose to seek care.

Mongan Commonwealth Fund Fellowhip Program in Minority Health Policy

(formerly Commonwealth Fund/Harvard University Fellowship in Minority Health Policy)

Moving toward a high-performance health care system requires trained, dedicated physician leaders who can transform health care delivery systems and promote policies and practices that improve access to high-quality care and health outcomes for vulnerable populations, including racial and ethnic minorities and economically disadvantaged groups. With the passage of the Affordable Care Act, it is more important than ever that the needs of vulnerable populations be represented by well-trained clinician leaders as the provisions of the new law are implemented. Since 1996, the Mongan Commonwealth Fund Fellowship Program in Minority Health Policy (formerly the Commonwealth Fund/ Harvard University Fellowship in Minority Health Policy) has played an important role in developing physician leaders who will address the health needs of vulnerable populations.

Based at Harvard Medical School under the direction of Joan Reede, M.D., Dean for Diversity and Community Partnership, the year-long fellowship offers intensive study in health policy, public health, and management for physicians committed to transforming delivery systems for vulnerable populations. Fellows also participate in leadership forums and seminars with nationally recognized leaders in health care delivery systems, minority health, and public policy. Under the program, fellows complete academic work leading to a master of public health degree at the Harvard School of Public Health, or a master of public administration degree at the Harvard Kennedy School of Government.

Beginning with the July 2012 entering class, the fellowship program will include an optional second year of practicum experience to supplement the fellows' academic and leadership development training, with practical experience creating high performance health care for vulnerable populations. Fellows chosen for the second-year practicum will spend one year in a health care delivery system setting, a federal or state agency, or a policy-oriented institution. The practicum is a competitive program open to first-year fellows, with a variable number of placements available per year.

For more information about the fellowship, including how to apply, visit the Mongan Commonwealth Fund Fellowship Program in Minority Health Policy page on www.commonwealthfund.org.

A total of 80 fellows have graduated from the program since it began. In 2011–12, five physicians were selected for the fellowship program. They are:

Monica Bharel, M.D.

Medical Director, Boston Health Care for the Homeless Program, Boston, Mass.

Monica Bharel, M.D., most recently served as medical director of the Boston Health Care for the Homeless Program. She is an instructor of medicine at Harvard Medical School/Massachusetts General Hospital and an assistant clinical professor of medicine at Boston University School of Medicine/Boston Medical Center. Dr. Bharel's principal area of interest is preventive health care and chronic disease management for underserved populations through system-based improvements. Her research has encompassed cervical cancer screening in homeless women, hepatitis C in vulnerable populations, and medical resident education. Dr. Bharel received her medical degree from the Boston University School of Medicine in 1994, and, in 1998, completed a residency and chief residency in internal medicine at Boston Medical Center.

Jay Bhatt, D.O., M.P.H.

Internal Medicine Physician and Resident and Clinical Fellow, Cambridge Health Alliance/Harvard Medical School, Cambridge, Mass.

Jay Bhatt, D.O., M.P.H., is an internal medicine physician currently completing a residency and clinical fellowship at Cambridge Health Alliance/Harvard Medical School. From 2005 to 2006, Dr. Bhatt was a legislative fellow for Congresswoman Donna Christensen, providing support on the Healthcare Equity and Accountability Act of 2005. The following year, he served as the national president of the American Medical Student Association, and currently he is chair-elect of the American College of Physicians Council of Associates. He led the development of the American Medical Student Association's PharmFree Scorecard, which assesses the content of medical school policies regulating the interactions between students and faculty and the pharmaceutical and device industries. Dr. Bhatt's main area of interest is innovation in community health delivery and chronic disease management and prevention. In 2008, Dr. Bhatt received both his medical degree, from the Philadelphia College of Osteopathic Medicine, and his master's degree in public health, from the University of Illinois, Chicago School of Public Health.

Denise De Las Nueces, M.D.

Former Resident, Internal Medicine/Primary Care, Brigham and Women's Hospital, Boston, Mass.

Denise De Las Nueces, M.D., completed a residency in internal medicine/primary care at Brigham and Women's Hospital in Boston. Dr. De Las Nueces aspires to work as a physician and leader in a community health center, providing longitudinal care to immigrant and racial/ethnic minority populations. She is interested in novel approaches to improving health care delivery and chronic care management through the use of community-based participatory research. Dr. De Las Nueces commitment to vulnerable populations is evidenced by her work caring for Latina women in her residency clinic as well as in a rural clinic in El Salvador prior to her residency. She received her medical degree from Harvard Medical School in 2008.

James Kennedye, M.D.

Former Emergency Physician, St. Francis Hospital, Tulsa, Okla.

James Kennedye, M.D., a member of the Kiowa Tribe of Oklahoma, most recently served as an emergency physician at St. Francis Hospital in Tulsa and a clinical assistant professor of emergency medicine at the University of Oklahoma College of Medicine–Tulsa. From 2000 to 2010, Dr. Kennedye served in the military, including most recently as Lieutenant Commander in the U.S. Naval Reserve Medical Corps. A longstanding member of the Association of American Indian Physicians and the Association of Native American Medical Students, he has served on the executive boards of both organizations. He is interested in working on a national policy scale that attempts to merge individual, community, state, and national desires into a coherent, reproducible, and sustainable health care system. Dr. Kennedye received his medical degree from the University of Oklahoma College of Medicine in 1998 and completed his emergency medicine residency at Washington University's St. Louis Barnes-Jewish Hospital and St. Louis Children's Hospital in 2002.

Elna Nagasako, M.D., Ph.D.

Instructor in Medicine, Department of Medicine, Division of Medical Education, Washington University, St. Louis, Mo.

Elna Nagasako, M.D., Ph.D., most recently served as instructor in medicine in the Department of Medicine, Division of Medical Education, at Washington University. She was also the director of the Global Health Scholars in Medicine program at the Washington University School of Medicine. As a Comparative Effectiveness Research Scholar, she is currently conducting research using administrative data to examine the effect of physician supply on health outcomes. She has also worked as a part-time hospitalist with Team Health at the Hilo Medical Center in Hawaii. Dr. Nagasako received her medical degree from Washington University School of Medicine in 2007 and her Ph.D. in optics from the University of Rochester in 2001. She completed her residency in internal medicine at Barnes-Jewish Hospital in St. Louis in 2010.

THE COMMONWEALTH FUND 2011 ANNUAL REPORT

AFFORDABLE HEALTH INSURANCE

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

AFFORDABLE HEALTH INSURANCE

Program Goals

As part of The Commonwealth Fund's efforts to inform health reform policy, the Program on Affordable Health Insurance envisions an equitable and efficient system of health coverage that makes comprehensive, continuous, and affordable coverage available to all Americans. The program supports activities to:

- provide timely analysis of changes in employer-based health insurance, health plans offered in the individual market, and public health coverage for people under age 65, and estimate the impact those changes will have on the numbers covered and the quality of coverage;
- document how being uninsured, or underinsured, affects personal health, finances and job productivity;
- inform federal and state policymakers and the media about the provisions of the health reform law—the Patient Protection and Affordable Care Act—and related federal regulations, along with their implications for people and employers;

The program is led by Vice President
Sara R. Collins, Ph.D.

Cover: Women are just one of the many groups in society that stand to benefit from the Affordable Care Act. When fully implemented, the law is expected to provide near-universal health coverage and make care far more affordable for women than it is today. In the meantime, the law is already yielding health benefits for women through free coverage of preventive services like mammograms and small-business tax credits to help women-owned businesses pay for their health insurance. Through publications, blog posts, and Web resources, The Commonwealth Fund's Affordable Health Insurance program is tracking Americans' health coverage and care and documenting the wide-ranging impact of health reform.

Photo: Martin Dixon

- inform implementation of the new law through analysis of its key provisions for achieving affordable, comprehensive, and near-universal insurance coverage; and
- analyze and develop new policy options for expanding and stabilizing health insurance coverage, making coverage more affordable, and optimizing administrative efficiency.

The Issues

The most recent census data reveal that 49.9 million people lacked health insurance in 2010, an increase of 13 million over the last decade. Moreover, new Commonwealth Fund research published in *Health Affairs* shows that in 2010, an additional 29 million nonelderly adults with health coverage had such high out-of-pocket costs relative to their income that they could be considered "underinsured"; this represents an increase of 13 million people since 2003. Both trends have had serious consequences for U.S. families. An estimated 73 million adults under age 65, both with and without health care coverage, reported problems paying their medical bills in 2010, and 75 million reported a time when they did not get needed care because of the cost.

Fortunately, help is on the way. The Affordable Care Act will significantly expand health insurance in the United States. To achieve near-universal coverage beginning in 2014, the law expands Medicaid eligibility and provides premium and cost-sharing subsidies that will make it easier for small businesses and individuals to afford private plans purchased through new insurance exchanges. In addition, new regulations will limit underwriting by insurers, prohibit exclusions from coverage based on preexisting health conditions, and establish a new standard for comprehensive health benefits—helping to protect against underinsurance. To ensure the law is implemented effectively, policymakers will need information about the likely impact of the reforms on the affordability and quality of coverage, as well as aspects of the law that might require modification.

Recent Projects

Disseminating Information About Health Insurance Reform

The Commonwealth Fund's Program on Affordable Health Insurance has been closely monitoring implementation of the Affordable Care Act and emerging federal regulations, assessing their impact on coverage, affordability, and access to care, and informing policymakers of its findings.

Once President Obama signed the act into law, the Fund launched an online interactive timeline to guide policymakers, the press, and the public through the law's provisions and dates of implementation—one of many tools available in the Health Reform Resource

Center on commonwealthfund.org. In posts to The Commonwealth Fund Blog, Fund staff and grantees are also providing analysis of the federal regulations as they are issued, including rules governing health insurance exchanges, risk adjustment for health plans, preventive services for women, student health plans, and plan medical loss ratio requirements.

The new Commonwealth Fund publication series, Realizing Health Reform's Potential, explains how the Affordable Care Act may benefit different populations and groups, as well as improve insurance coverage and overall health system performance. Among the topics covered in the series are young adults, small businesses, women, and baby boomers ages 50 to 64. Additional briefs in the series assessed the relative affordability of health insurance under reform, reviewed the law's essential benefit package and what it means for people with disabilities, and reported on enrollment in the new preexisting condition insurance plans.

As a complement to these briefs, Commonwealth Fund webinars on health reform provide a forum for state officials and other stakeholders to hash out implementation issues. Discussing the new state-based health insurance exchanges, for example, were Timothy Jost, J.D., of the Washington and Lee University School of Law, Illinois Department of Insurance director Michael McRaith, and Sandra Shewry of the California Health and Human Services Agency. A webinar on the federal Pre-Existing Condition Insurance Plan (PCIP) program featured Jean Hall of the University of Kansas, PCIP program director Richard Popper, and Amie Goldman and Deborah Armstrong, who direct the PCIPs in Wisconsin and New Mexico, respectively.

Analyzing Key Reform Implementation Issues

Health Insurance Exchanges

The centerpiece of the Affordable Care Act's private health insurance reforms, new state-based insurance exchanges are expected to provide coverage to up to 30 million individuals and small-business employees by 2020. In the September 2010 Commonwealth Fund report *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, Washington and Lee University School of Law professor Timothy Stoltzfus Jost, J.D., took on the thorny questions that federal and state policymakers will need to resolve to ensure the exchanges will be up and running in time.

One of the risks to the exchanges is that they will disproportionately enroll people in poorer health, a situation that could lead to higher premiums for everyone purchasing plans through the exchanges. To guard against this outcome, the Affordable Care Act

requires federal and state officials to construct a risk-adjustment mechanism that protects health insurers that attract a disproportionate share of patients with high health care needs. In a Commonwealth Fund issue brief synthesizing the views of leading experts in risk adjustment, Wake Forest University's Mark Hall, J.D., explored the challenges regulators will face and compared the merits of different strategies. Among the recommendations offered in the brief: use diagnostic risk measures in addition to demographic ones, and phase in the issuance of risk-transfer payments, to give insurers more time to predict and understand the full effects of risk adjustment.

In examining California's new health insurance exchange, the nation's first, the New America Foundation's Leif Haase and Micah Weinberg, Ph.D., found that state policymakers took advantage of flexibility in the reform law to ensure that the exchange will act as an active purchaser in the marketplace, as well as to combat adverse selection and allow Medicaid plans to be sold. Their study, supported by The Commonwealth Fund, was published in a May 2011 issue brief.

On The Commonwealth Fund Blog, the Fund's Sara Collins and Tracy Garber are tracking states' progress in establishing exchanges.

Affordability and Cost Protection of Coverage Under Reform

Sharp growth in U.S. health care costs, rising premiums and deductibles in both employer and individual market insurance plans, and stagnant household incomes have increased the number of people struggling with high health insurance and health care costs. In a March 2011 analysis of survey data, Fund staff reported that in 2010, nearly one-third of adults ages 19 to 64 spent 10 percent or more of their income on out-of-pocket costs and premiums, up from 21 percent in 2001. Since 2005, the share of people who reported having deductibles of $1,000 or more has nearly doubled, rising from 10 percent to 18 percent.

Meanwhile, the number of U.S. adults who had health insurance all year but were still "underinsured"—with very high medical expenses relative to their incomes—rose by 80 percent between 2003 and 2010, from 16 million to 29 million, according to a Commonwealth Fund study published in *Health Affairs* (Sept. 2011). The Fund's Cathy Schoen and colleagues have found that people who are underinsured are nearly as likely as those who are uninsured to skip needed health care and prescriptions and have problems paying medical bills.

Through a major expansion of health insurance coverage providing essential health benefits as well as premium and cost-sharing subsides, the Affordable Care Act should help diminish the medical cost burden faced by U.S. families. In a May 2011 Commonwealth

Fund issue brief, Jonathan Gruber, Ph.D., professor of economics at the Massachusetts Institute of Technology, found that under the new law, fewer than 10 percent of families would not have room in their budgets for premiums and typical out-of-pocket costs. The individuals most likely to lack sufficient resources for health care costs, Gruber found, would be the sickest—those with the highest medical expenses.

As reform moves forward, it will be critical for state and federal policymakers to understand the medical cost burdens U.S. families are facing. Such information will be needed to help ensure that people can afford timely health care and are protected from catastrophic health care costs.

Tracking the Uninsured and Underinsured

The 2010 Commonwealth Fund Biennial Health Insurance Survey, a nationally representative phone survey of 4,000 adults, enabled Fund researchers in the past year to examine the effects of the recent severe economic recession on insurance coverage, as well as to assess changes in coverage, access to care, and medical bill problems over a decade.

According to the Fund report *Help on the Horizon*, which drew from the survey findings, an estimated 9 million working-age adults in the last two years became uninsured after losing a job with health benefits. Most people who lost their jobs were unable to afford COBRA continuation coverage. And people who ventured into the individual market faced higher premiums or preexisting-condition exclusions; in fact, of all survey respondents who tried to buy health plans in the individual market during the last three years, 60 percent said it was very difficult or impossible to find affordable coverage. *Help on the Horizon* also described the significant increase in the prevalence of cost-related difficulties getting needed care and problems paying medical bills.

Commonwealth Fund researchers also used the Biennial Survey to explore the coverage and care experiences of working-age women, who have greater health care needs than do men. Together with colleagues, Ruth Robertson, a senior research associate, found that over the last decade coverage became less affordable and health care more costly for women under 65. Less than half of women in the survey were up to date on recommended preventive care services like mammograms and colon cancer screenings. Those lacking health insurance or in households with low incomes were the least likely to get the care they needed.

Another issue brief, published in May 2011, examined the crisis in health insurance coverage among young adults ages 19 to 29—the age group with the largest number of uninsured. Fund authors Collins and Garber reported the number of uninsured young adults climbed to nearly 15 million in 2009, up from 13.7 million the year before, in a continuation of a decade-long trend that also saw 45 percent forgo needed care in 2010 because of the cost.

Beyond reporting grim data, each of these reports also shows how the health reform law will make a difference for each of these groups, whether by enabling young men and women to remain under their parents' coverage until age 26, enroll in Medicaid if their incomes are low, and buy subsidized private coverage through the insurance exchanges. Recent federal data show, in fact, that the law may already be having an impact: for example, the Centers for Disease Control and Prevention recently estimated that in the first quarter of 2011 there were 900,000 fewer uninsured adults ages 19 to 25 than in 2010.

Closing Gaps in Insurance Coverage

Over the last several years, the Program on Affordable Health Insurance has examined gaps in Americans' coverage and the phenomenon of "churning" in plan enrollment, which occurs when people lose their source of coverage, as may happen through job loss, and transition to another source. A recent Commonwealth Fund–sponsored analysis led by Pamela Farley Short of Pennsylvania State University found that the Affordable Care Act will help limit the coverage gaps experienced by many people when their life circumstances change. To reduce gaps further, Short and her colleagues say policymakers will need to find ways to overcome four key challenges: 1) adjusting premium and cost-sharing subsidies when incomes change; 2) coordinating eligibility for insurance premium credits and public coverage; 3) facilitating continuous coverage; and 4) minimizing transitions between the individual and small-business insurance exchanges.

Redesigning Employer Benefits to Encourage Use of High-Value Treatments

Value-based insurance design (VBID) is a strategy that increasing numbers of employers and insurers are adopting to improve health care quality while controlling health spending. The basic idea is to promote use of services or treatments that provide high benefits relative to their cost and, alternatively, to discourage the use of services whose benefits do not justify their cost. To test whether VBID actually works, Commonwealth Fund grantee Niteesh Choudhry and colleagues at Brigham and Women's Hospital in Boston examined a program at Pitney Bowes that eliminated copayments for cholesterol-lowering statins and reduced them for clopidogrel, a

blood clot inhibitor. Their findings suggest that by reducing or eliminating copayments, patient adherence to prescribed medications can indeed improve. While the gains in adherence were relatively modest, the researchers believe these could be augmented through additional policies that address "suboptimal" use of health care services.

Future Directions

The Program on Affordable Health Insurance will continue to monitor the impact of the Affordable Care Act on the nation's uninsured and underinsured and inform policymakers and federal officials about ways to ensure the reforms achieve their goals.

- Timothy Jost, in collaboration with Mark Hall and Harvard University's Katherine Swartz, Ph.D., will monitor the creation of state insurance exchanges where individuals will be able to shop for their health coverage. Their Commonwealth Fund–supported work will provide recommendations to state and federal officials, legislators, and regulators for ensuring that these crucial components of health reform function as intended. Sara Rosenbaum, J.D., of George Washington University, meanwhile, will examine the structure and features of the different exchanges; her findings will be used to create an interactive tool on commonwealthfund.org to enable side-by-side comparisons.
- The Affordable Health Insurance program will also continue to track trends in the affordability of health coverage. With Fund support, the National Opinion Research Center's Jon Gabel will compare the affordability of health plans offered through the exchanges, and the cost protection these plans provide, with that of plans offered by employers and sold through the individual market. Using the federal Medical Expenditure Panel Survey, Peter Cunningham, Ph.D., of the Center for Health System Change is monitoring changes in the medical cost burden faced by Americans, including insurance premiums and out-of-pocket expenses; in particular, he will be looking at the health care impact on people with diabetes and asthma.
- Year-to-year changes in personal income will affect eligibility for the Affordable Care Act's insurance premium tax credits, which will be offered on a sliding, income-based scale. A decrease in income could result in a higher tax credit, while an increase in income means that someone might have to return all or part of the tax credit. Jonathan Gruber, Ph.D., of the Massachusetts Institute of Technology will use a microsimulation model to project the potential frequency of such adjustments and examine how policy changes might reduce costs for individuals and the government.

- To inform state and federal policymakers about the importance of continuity in insurance enrollment, researches led by Pamela Farley Shortwill estimate gaps in people's health coverage and the extent of churning in health plan enrollment over the period 2004 to 2007. The analysis will yield baseline data for evaluating the capacity of health reform to address the problem.
- At the University of Kansas Center for Research, Jean Hall, Ph.D., will continue to track state enrollment and patient experiences in the high-risk insurance pools created by the new law and offer recommendations to officials charged with their implementation.
- Finally, a new series of online longitudinal surveys will track the effects of the Affordable Care Act over the next three years as it is implemented and establish baseline measures prior to 2014, when the major provisions of the law go into effect. Throughout this transformational period in U.S. health care, the new surveys will provide a flexible, policy-relevant survey tool to supplement the Fund's long-standing national Biennial Health Insurance Survey.

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

The Commission's Goals

In establishing the Commission on a High Performance Health System in 2005, The Commonwealth Fund's Board of Directors recognized the need for national leadership to revamp, revitalize, and retool the U.S. health care system. The Commission's 17 members—distinguished experts and leaders representing every sector of health care, as well as the state and federal policy arenas, the business sector, and academia—are charged with promoting a high-performing health system that provides all Americans with affordable access to excellent care while maximizing efficiency in its delivery and administration. Of particular concern to the Commission are the most vulnerable groups in society, including low-income families, the uninsured, racial and ethnic minorities, the very young and the aged, and people in poor health.

The Commission's principal accomplishments have been to highlight specific areas where health system performance falls short of what is achievable, and to recommend practical, evidence-informed strategies for transforming the system. Many of the major ideas in the Affordable Care Act—among them, new insurance market regulations, requiring everybody to have coverage, the availability of premium and cost-sharing subsidies for low- and moderate-income families, and payment and delivery system reforms—were advanced by the Commission through the reports and statements it has issued.

The Commonwealth Fund Commission on a High Performance Health System is chaired by David Blumenthal, M.D. Fund staff members Stuart Guterman, Cathy Schoen, and Rachel Nuzum serve as executive director, research director, and senior policy director, respectively.

Cover: David Blumenthal, M.D., makes a point during the June 2011 meeting of The Commonwealth Fund Commission on a High Performance Health System, which he chairs. Over the coming months and years, the Commission will help inform implementation of the Affordable Care Act, assist health care leaders and the public with understanding the new legislation and what it means for them, and help lay the groundwork for future delivery system change and health policy action.

Photo: Martin Dixon

The Issues

The United States provides some of the best medical care in the world. Yet a growing body of evidence indicates that our health care system, as a whole, comes up short compared with what is achieved not only in other industrialized nations but also in some areas within the U.S. Although the nation's health spending is by far the highest in the world, we are the only industrialized nation that fails to guarantee universal health insurance, and millions of our citizens lack affordable access to primary and acute care. Moreover, the care that is provided is highly variable in quality and often delivered in a poorly coordinated fashion—driving up costs and putting patients at risk.

Recent health reform legislation provides policy tools that can be used to address many of these problems. In the coming year, the Commission will focus on reinforcing the principles and goals of a high performance health system, helping the nation realize the potential of health reform, and advancing the unfinished agenda to control costs, improve value, and ensure that all Americans have access to efficient, high-quality health care.

Recent Projects

Defining and Laying Out a Framework for a High Performance Health System

In its first report, *Framework for a High Performance Health System for the United States* (2006), the Commission outlined a vision of a uniquely American, high performance system. That report established high performance as an achievable objective for the U.S. health system and defined the key strategies necessary to reach that objective. Two years later, the report *Organizing the U.S. Health Care Delivery System for High Performance* highlighted the detrimental effects of the nation's fragmented health care delivery and payment systems and offered recommendations for establishing greater coordination across providers and care settings. Among other changes, the Commission favors moving away from fee-for-service payment and toward bundled-payment methods that reward coordinated, high-value care.

Making the Case for Reform

In 2007, the Commission on a High Performance Health System released *A Roadmap to Health Insurance for All: Principles for Reform,* making the case for achieving universal coverage by building on the current mix of private group plans and public programs—a course of action that would retain the best features of our current system while minimizing dislocation for Americans who currently have good insurance coverage.

The Commission believes that while ensuring that all Americans have health insurance is essential, doing so is alone not enough to drive the kind of reform our health system needs. In its report *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (2007), the Commission discussed concrete goals—and the strategies for achieving them—that should be on the national health care agenda, including: guaranteeing affordable health insurance for all; containing growth in health care costs and reforming provider payment; fostering greater organization and integration of care delivery; speeding adoption of health IT, evidence-based medicine, and other infrastructure; and setting and meeting national goals through strong national leadership.

Tracking Health System Performance

The Commission has issued two national and two state-level scorecards for the U.S. health system. These reports take a broad look at how well the health care system is doing, where improvements are needed, and what examples of good care exist that could serve as models for the rest of the country. They look at specific issues, including: Do people have access to the health care they need? Are they getting the highest-quality care? Are we spending money and using health care resources efficiently?

The 2011 edition of the *National Scorecard on U.S. Health System Performance* finds that despite pockets of improvement, the United States as a whole failed to improve when compared with the top 10 percent of U.S. states, regions, health plans, or health care providers, or the top-performing countries. The scorecard measures the health system across 42 key indicators of health care quality, access, efficiency, equity, and healthy lives. In particular, the report noted significant erosion in access to care and affordability of care, as health care costs have risen far faster than family incomes.

The bright spots in U.S. performance have largely been in areas on which public reporting or collaborative improvement initiatives have focused, such as blood pressure control, hospital treatment of heart attack and pneumonia, and prevention of surgical complications, all of which have improved substantially across the country.

The Commission's State Scorecard on Health System Performance, meanwhile, offers a metric for evaluating individual states on access to care, prevention and treatment quality, avoidable hospital use and costs, health outcomes, and equity—with the goal of spurring policymakers and private stakeholders to undertake efforts to improve their performance to benchmark levels and beyond. The second edition of *Aiming Higher: Results from a State Scorecard on Health System Performance,* released in 2009 along with an interactive map showing state-by-state comparisons, reported that the cost and quality of health care, as well as access to care and health outcomes, continue to vary widely.

Developing Policy Options

In its 2007 report, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, the Commission showed how policies that are designed to improve health system performance can also help reduce spending growth. The report estimated the likely effects of a set of specific policy options, finding that if they were to be implemented along with universal health coverage, national health expenditures would fall by $1.5 trillion over 10 years. At the same time, the nation would reap the benefits of improved access to health care, higher-quality care, and better health outcomes.

As the national health reform debate began taking shape in early 2009, the Commission unveiled an array of comprehensive insurance, payment, and system reforms that could help make affordable health coverage widely available, lead to improved health outcomes, and slow the growth of health spending by $3 trillion by the end of the next decade. Many of the policy options presented in *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* are similar to provisions later included in the Affordable Care Act.

Helping to Realize the Potential of Health Reform

One of the most important provisions in the health reform legislation was the creation of the Center for Medicare and Medicaid Innovation, which is tasked with developing and implementing new models of health care financing and delivery that will improve care and reduce cost growth. The Center will also monitor the impact of these models and help spread ones that demonstrate success. In the 2010 issue brief *Developing Innovative Payment Approaches: Finding the Path to High Performance*, the Commission proposed a set of principles to guide the new Innovation Center and facilitate innovation, while recognizing the need to maintain the fiscal integrity of the Medicare and Medicaid programs.

A model of health care financing and delivery reform that has attracted much attention is the accountable care organization (ACO), a group of health care providers that agree to take responsibility for the quality and cost of care delivered to a population of patients. In the 2011 report *High Performance Accountable Care: Building on Success and Learning from Experience*, the Commission provides a set of recommendations for ensuring the successful implementation and spread of the ACO model, which holds promise as an effective and efficient way to deliver care, especially to people with chronic or complex medical conditions.

Informing Policymakers

In addition to formulating options for improving health policy and recommendations for implementing reform, the Commission on a High Performance Health System engages and informs policymakers in the executive and legislative branches and key health care

stakeholders. The Commission sponsors bipartisan briefings and meetings for members of Congress and their staff, as well as key Administration officials. Its senior policy director, Rachel Nuzum, also directs The Commonwealth Fund's Federal and State Health Policy program and provides policymakers in the executive and legislative branches with information and technical assistance that draw upon both Commission and Fund work. In addition, staff from the Fund and the Commission are frequently called upon by federal and state legislators to lend expert testimony and assistance.

Future Directions

Even with the passage of comprehensive health care reform, the work of the Commission on a High Performance Health System is far from complete. Over the coming months and years the Commission seeks to: 1) inform implementation of the Affordable Care Act and assess its potential to move the U.S. along the path to a high performance health system; 2) help health care leaders and the American public understand the new legislation and what it means for them; and 3) lay the groundwork for future delivery system change and health policy action. In addition, the Commission will continue its efforts to assess national and state health system performance and to inform health policy at all levels.

FEDERAL AND STATE HEALTH POLICY

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

FEDERAL AND STATE HEALTH POLICY

Program Goals

The Commonwealth Fund's Program on Federal and State Health Policy is designed to strengthen the link between the work of the foundation, including the Commission on a High Performance Health System, and policy processes at the federal and state levels. As a key component of the Fund's efforts around health reform, the program focuses on the identification, development, evaluation, and spread of policies that expand access to affordable, high-quality, and efficient care—particularly for vulnerable populations—while reducing health spending growth. Specific activities include:

- convening federal and state policymakers, in both the executive and legislative branches of government, to discuss key health policy issues and to help identify policy solutions;
- producing written materials on timely issues relevant to federal and state policymakers and their staff, with particular emphasis on implementation of the Affordable Care Act;
- facilitating information exchange between federal and state policymakers, both to inform federal leaders of innovations in state health policy that have implications

The program is led by
Vice President Rachel Nuzum, M.P.H.

Cover: At the September 2011 release of a new state scorecard on long-term services and supports, Commonwealth Fund vice president Mary Jane Koren, M.D., distilled the report's key findings and policy implications for long-term care stakeholders, including federal and state policymakers. The Fund's Federal and State Health Policy program informs policymakers at every level about health system performance and the latest policy innovations, and works to facilitate dialogue leading to solutions to our most pressing health care issues.

Photo: Greg Gibson

for national health reform implementation and to inform state leaders about federal policies affecting the development of state health reform strategies; and
- fostering dialogue among policymakers, national stakeholders, and the research community on key health policy issues.

Recent Projects

Bipartisan Congressional Health Policy Conference for Members of Congress

A select group of members of the U.S. House of Representatives and Senate are invited each year to meet in an informal, off-the-record setting with leading health policy experts and health care practitioners from a variety of backgrounds. The Bipartisan Congressional Health Policy Conference gives members of Congress the opportunity to learn about timely health policy issues and engage in substantive discussion, all in an environment free from partisan politics and media pressures. In addition to serving as an opportunity to reach one of the Fund's most influential audiences, it also helps build working relationships with members who can advance the Fund's mission to achieve a high performance health system. Seventy-nine House and Senate members have attended the retreat since 1998, with strong bipartisan representation.

Health Reform Briefings and Roundtables

The health policy briefings and roundtables conducted jointly by the Alliance for Health Reform and The Commonwealth Fund are a valuable resource for congressional and agency staff, representatives of national organizations, the media, and other key stakeholders looking to stay abreast of the latest developments in health care policy. The briefings, held on Capitol Hill and open to the public, focus on timely health policy topics under discussion at the federal and state levels.

Dialogues for Congressional and Administration Staff

A series of off-the-record, invitation-only discussions provides a forum for senior congressional and administration staff to engage in dialogue with their peers and receive technical assistance from outside experts on key national health policy issues. In 2011, federal officials together with state experts and congressional staff discussed topics related to the implementation of the Affordable Care Act, such as the establishment of Pre-Existing Condition Insurance Plans and the formation of accountable care organizations.

Bipartisan Health Policy Retreat for Senior Congressional Staff

At this annual conference, invited senior congressional staff and senior staff from congressional support agencies meet in an informal setting with leading academics and

health care practitioners to learn about pertinent health policy issues, engage in open and off-the-record debate, and discover opportunities for bipartisan collaboration.

Supporting Medicaid Directors During Health Reform Implementation

This project supports a series of conference calls related to Medicaid-specific health reform implementation challenges and opportunities. Held in partnership with the Center for Health Care Strategies and the National Association of Medicaid Directors, the calls are focused on areas of most interest to both state and federal policymakers. The calls provide education, guidance, and a forum to exchange experiences and lessons learned on key implementation issues.

All-Payer Claims Databases: Resources for States

States need to have comprehensive information on disease incidence, treatment costs, and medical outcomes when formulating and evaluating health care policies. Because such information is often not readily available, a growing number of states are developing all-payer claims databases (APCDs), which combine data from public programs like Medicaid and Medicare, as well as from private insurance carriers and pharmacy benefit managers, to give policymakers statewide information on costs, quality, utilization, and access to care.

With Commonwealth Fund support, the National Association of Health Data Organizations (NAHDO) tracked the current status of state-based APCDs and provided technical guidance to state officials interested in developing APCDs. In the Fund issue brief, *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency*, NAHDO executive director Denise Love and colleagues showed how these databases are proving to be powerful tools for filling in long-standing gaps in health care information and providing essential trend data that will be needed to guide policymakers through the transitions that health reform will bring.

Future Directions

In the coming year, the Federal and State Health Policy Program will continue to examine the intersection of federal and state health policy in the implementation of the Affordable Care Act and in efforts to improve health care delivery in the United States. Program staff will furnish guidance and technical assistance to federal and state policymakers and congressional and administrative staff engaged in the law's implementation and in delivery and payment system reform. In addition, program staff will also inform federal and state policymakers about recent Commonwealth Fund research and analysis, policy recommendations from the Fund's Commission on a High Performance Health System, and case studies of innovative policies and programs around the country.

PAYMENT AND SYSTEM REFORM

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

PAYMENT AND SYSTEM REFORM

Program Goals

The Program on Payment and System Reform is a key component of The Commonwealth Fund's efforts to inform health reform policy. It supports the development and analysis of options for reforming how health care is paid for, focusing on incentives to improve the effectiveness and efficiency of care delivery while curbing spending growth. Activities sponsored by the program include:

- examining reforms that would align incentives and provide a base for more comprehensive payment reform;
- modeling the potential impact of alternative payment reform options within the Medicare program and throughout the health care system;
- studying how payment reform could stimulate new models of health care delivery that yield better, more coordinated care; and
- evaluating the potential for broader application of successful payment and delivery models.

The program is led by Vice President
Stuart Guterman
and Senior Policy Analyst
Mark A. Zezza, Ph.D.

Cover: Physicians at one of Signature Healthcare's hospitals in Brockton, Mass., that is participating in the Alternative Quality Contract (AQC), a new method for paying doctors and hospitals that was developed by Blue Cross Blue Shield of Massachusetts. Under this system, providers receive a comprehensive, global payment rather than being reimbursed on a fee-for-service basis. The payment covers the entire continuum of a patient's care, and providers are eligible for a performance bonus if they meet certain performance targets. Early results from a Commonwealth Fund–sponsored evaluation of the AQC show signs of lower medical spending and improved quality of care.

Photo: Mitch Selinger

The Issues

National spending on health care in the United States—which already has the most expensive health system of any country—is projected to nearly double over the next decade, from $2.6 trillion in 2010 to $4.6 trillion, or 20 percent of the gross domestic product, by 2020. Yet the resources spent on health care have failed to produce commensurate returns in access, outcomes, or value. There is growing agreement that many of the cost and quality problems in our health system today are caused, or at least exacerbated, by the way we pay for care. It has become clear that new approaches to paying for health care are needed so that providers are rewarded for the high value of their care rather than the volume of services they deliver, and so that working together to deliver more appropriate, coordinated, and effective care is rewarded, rather than punished—as it often is in the current system.

In addition to its provisions for making health insurance coverage available to millions of uninsured Americans, the Affordable Care Act establishes a foundation for identifying, developing, implementing, testing, and spreading new payment approaches. To aid this effort, policymakers will need information and analysis on the available alternatives, as well as the potential and actual impacts on health care utilization, spending, and quality.

Recent Projects

Developing Alternative Approaches to Health Care Payment and Delivery

Although a variety of payment reforms have been proposed, many are seen as either doing too little to make an appreciable impact, or changing payment too radically to implement without great disruption to health care providers. In *Transitioning to Accountable Care*, a 2011 report published by the Center for Health Care Quality and Payment Reform with Commonwealth Fund support, Harold Miller, Ph.D., calls for flexible, "middle ground" options that promote accountability for care yet do not force providers to take on more financial risk than they can manage or be held accountable for services they cannot effectively control. He identifies and describes three types of payment changes that could help primary care and specialty physician practices transition toward more global payment structures, and the central issues that must be addressed in implementing these changes.

The Affordable Care Act has been both a source and a catalyst for innovative approaches to payment reform and care delivery, as well as for new ways to measure performance and value and increase use of health information technology. One such innovation is the Medicare Shared Savings Program, which provides financial incentives for "accountable care organizations" (ACOs) to provide their patients with coordinated, well-integrated, and efficient care. Although many providers and payers are now preparing to participate

in ACOs, little known about what it takes for ACOs to succeed, including the payment models—from shared savings to shared risk—that will most appropriately support them. A July 2011 Commonwealth Fund report prepared by Catalyst for Payment Reform, in partnership with Booz Allen Hamilton, examined the formation of eight private accountable care organizations that use, or are planning to deploy, a shared payer–provider risk payment model. The study team, led by Suzanne Delbanco, Ph.D., emphasizes that continued experimentation with both shared-savings and shared-risk arrangements in the private sector will be critical in the search for successful ways to align incentives for high-value care.

In a complementary Fund-supported effort, Michael Bailit, M.B.A., and Christine Hughes, M.P.H., of Bailit Health Purchasing, interviewed payer and provider organizations and state agencies involved in shared-savings arrangements about their diverse approaches, including populations and services covered, assignment of providers, use of risk adjustment, and methods for calculating and distributing savings. In their issue brief, *Key Design Elements of Shared-Savings Payment Arrangements*, the authors identify the issues that payers and providers must still resolve, including how to determine whether savings were truly achieved, how to equip providers with the data, tools, and guidance they need, and what standard provider performance measures should be used.

Models for Transforming the Health Care System

The Physician Group Incentive Program (PGIP) is a collection of practice transformation and quality improvement initiatives in Michigan striving to improve the quality of patient care across the state. Developed collaboratively by Michigan physicians, their medical groups, and Blue Cross Blue Shield of Michigan, the PGIP works within the existing fee-for-service payment system to support, recognize, and reward practice performance and improvement among the more than 11,000 participating physicians. Incentive payments are tied to key outcome measures, including evidence-based recommendations for care processes and population-based cost measures, and support physician organizations' efforts to acquire patient-centered medical home capabilities. The Commonwealth Fund is supporting an evaluation of the PGIP by a team at the University of Michigan, led by Christy Lemak, Ph.D. The study is examining the initiatives developed as part of the program, the implementation of those initiatives, how providers are responding, and the impacts on the quality and costs of care.

In Massachusetts, meanwhile, Blue Cross Blue Shield—the state's largest commercial payer—is trying out a global payment model called the Alternative Quality Contract (AQC), which pays health care providers a comprehensive, global payment rather than

reimbursing them on a fee-for-service basis. The payment covers the entire continuum of a patient's care, including inpatient, outpatient, rehabilitation, long-term care, and prescription drugs, and providers are eligible for a performance bonus if they meet certain quality targets. With Commonwealth Fund support, a team led by Michael Chernew, Ph.D., of Harvard Medical School is evaluating the AQC's impact on health care utilization, spending, and quality of care. Initial findings of the evaluation indicate somewhat lower medical spending and improvements in both chronic and pediatric care.

The Premier Healthcare Alliance offers another model for health care organizations seeking to control costs and improve patient care. Premier, which began as a hospital purchasing collaborative, has formed a collaborative of 25 health systems that are forming accountable care organizations and pursuing the goals of better health, better care, and lower costs. For ACOs to flourish nationally, health care organizations will need guidance in designing and implementing ACOs while achieving those objectives. Under the direction of Eugene Kroch, Ph.D., and Danielle Lloyd, M.P.H., Premier is helping providers undergo the transformation by demonstrating how the more than 60 candidate members of its accountable care collaborative are seeking to acquire the infrastructure and capabilities of a successful ACO, including payment mechanisms, data systems, and performance measurement and improvement strategies. The project team is also performing an inventory of members' core capabilities as part of an assessment of ACO readiness.

Transformative health system change is also occurring on a statewide scale. In May 2011, Vermont became the first state to enact a law mandating a single-payer health care financing system—a system intended to achieve both universal health insurance coverage and greater control over costs. Supported in part by The Commonwealth Fund, William Hsiao, Ph.D., of Harvard University and his research team modeled alternative health care financing options for Vermont's legislature. In a July 2011 article in *Health Affairs,* Hsiao and colleagues provide estimates of savings, costs, and impacts of the historic legislation. According to their projections, the law will produce annual savings of 25.3 percent compared with current spending, cut employer and household spending by $200 million, create 3,800 jobs, and boost the state's overall economic output by $100 million. The article also recounts the political, legal, fiscal, and institutional hurdles that had to be surmounted, the strategies used to overcome them, and the factors that were integral to the law's passage.

Future Directions

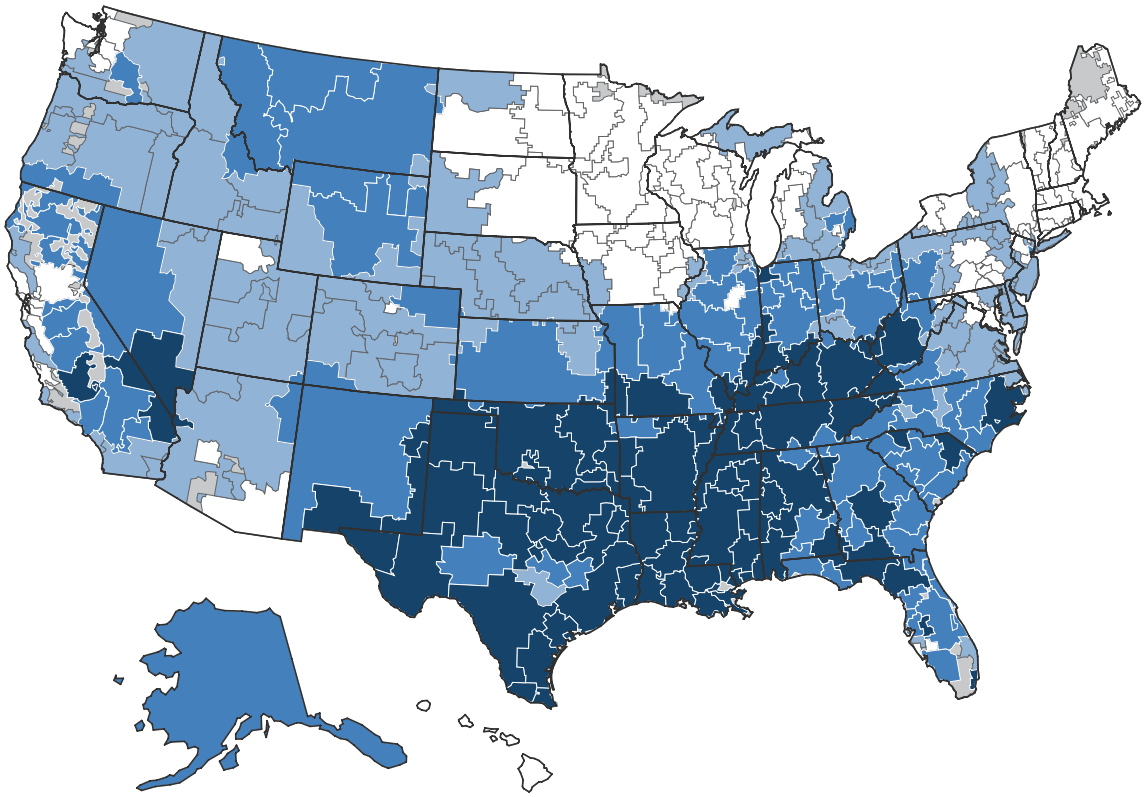
In the coming year, the Program on Payment and System Reform will further develop the capacity to model the potential provider- and system-level impact of changes to health care payment and delivery, including those called for in the Affordable Care Act. The projects it supports will also identify ways to improve the process of rapid-cycle development, testing, and implementation of payment and system improvements, with which the new Center for Medicare and Medicaid Innovation is charged, and evaluate local initiatives to restructure payment incentives and improve health care delivery.

Commonwealth Fund–supported work also will examine how public and private initiatives can help reinforce each other. For example, the Affordable Care Act contains several provisions designed to make private Medicare Advantage insurance plans more efficient and effective in providing beneficiaries with coordinated care. In addition to lowering reimbursement for these plans so that per-beneficiary costs are more in line with traditional fee-for-service Medicare, the law rewards plans that perform well on measures of quality and patient experience and strengthens protections for beneficiaries. Brian Biles, M.D., and his colleagues at the George Washington University are analyzing the impact that the new policies have on these plans and their enrollees.

Researchers also will investigate factors that drive increases in health care costs. While it is well known that care utilization and spending by Medicare beneficiaries vary from region to region, patterns of use and spending in commercial insurance markets are not as well understood. Under a Commonwealth Fund grant, Harvard Medical School's Michael Chernew, Ph.D., is examining geographic variation in commercial spending and the correlation between commercial and Medicare spending across hospital referral regions.

Other projects will focus on modeling the impact of alternative payment system approaches, identifying examples of ACOs and similar organizations in practice, and examining public and private sector initiatives to support accountability in health care provision.

HEALTH SYSTEM PERFORMANCE ASSESSMENT AND TRACKING



THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

HEALTH SYSTEM PERFOMANCE ASSESSMENT AND TRACKING

Program Goals

To advance its goal of a high performance U.S. health care system, The Commonwealth Fund gathers and disseminates evidence of excellence in health care from across the country and the world. This work is intended both to show what is possible and to stimulate health care providers, policymakers, and stakeholders to take action to improve performance in all facets of care.

The Fund's capacity for Health System Performance Assessment and Tracking enables it to:

- track and compare health system performance, by identifying benchmarks for patient care experiences, health outcomes, and cost that states, health care providers, and others can use to set improvement targets;
- assess trends in health insurance coverage, access to care, and patient-reported quality of care; and
- monitor public and private actions to transform health care delivery, including payment innovations, health information technology adoption, and the organization of care.

These activities are closely coordinated with Commonwealth Fund initiatives in the areas of delivery system innovation and improvement, health reform policy, and international health policy and innovation.

The program is led by:

Senior Vice President for Policy, Research, and Evaluation Cathy Schoen

Vice President of Survey Research and Evaluation Michelle M. Doty, Ph.D.

Senior Analyst and Project Director, Health System Scorecard and Research Project, David C. Radley, Ph.D., M.P.H.

Senior Research Adviser Douglas McCarthy, M.B.A.

Senior Research Associate, Health System Scorecard and Research Project, Jacob A. Lippa, M.P.H.

Performance Assessment and Tracking Activities

Health System Performance Scorecards

Since 2006, The Commonwealth Fund and its Commission on a High Performance Health System have tracked the performance of U.S. health care through a series of national and state scorecards. The National Scorecard on U.S. Health System Performance (2006, 2008, and 2011), focuses on health care outcomes, quality, access, efficiency, and equity. The State Scorecard on Health System Performance (2007 and 2009) assesses states' performance on health care relative to achievable benchmarks for 38 indicators of access, quality, costs, and health outcomes.

Two new reports were added to the scorecard series in 2011. The first, *Securing a Healthy Future: The State Scorecard on Child Health System Performance, 2011,* examines states' performance on 20 key indicators of children's health care access, affordability of care, prevention and treatment, the potential to lead healthy lives, and health system equity. The second, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers,* reports on care delivered by America's nursing homes, assisted-living facilities, home health agencies, and other long-term care providers. An upcoming "local" scorecard will focus on variations in health and health care delivery among smaller, sub-state communities.

WhyNotTheBest.org

The Commonwealth Fund's benchmarking and quality improvement Web site for health care providers, WhyNotTheBest.org, enables users to compare hospitals within and among states, download case studies of top performers and innovative programs, and access a variety of quality improvement resources.

Surveys

The Commonwealth Fund conducts a wide range of surveys, both in the United States and abroad, to monitor trends in health care access and quality, explore public views on health care matters, and assess the policy perspectives of health care leaders. Recent and ongoing surveys include:

- Longitudinal surveys tracking the effect of health reform on coverage for young adults, low-income families, and older adults (Commonwealth Fund Biennial Health Insurance Survey). Over the years, these surveys have produced a wealth of information about the extent and quality of health care coverage in the U.S. Topics covered in past surveys include: the stability and quality of adults' health insurance coverage, the underinsured, cost-related difficulties in accessing care, medical bill problems, and medical debt.

- Commonwealth Fund International Health Policy Survey (annual). Now including 11 industrialized countries, these annual surveys explore such topics as health system performance and responsiveness from the perspective of seriously ill adults and primary care physicians. Visit the Fund's online International Health Policy Center for more information.

- Commonwealth Fund Survey of Public Views of the U.S. Health Care System (2006, 2008, and 2011). Results from the 2011 survey suggest the health system is not serving the public well—a large majority of adults surveyed say it needs to be fundamentally changed or rebuilt. Many adults reported difficulties accessing care, poor care coordination, and struggles with costs and health insurance administrative requirements.

- Commonwealth Fund Survey of Young Adults (2009). Young adults ages 19 to 29 are one of the largest uninsured segments of the population. This nationally representative survey found that nearly half have gone without insurance at some time during the year.

- Commonwealth Fund National Survey of Federally Qualified Health Centers (2009). With the likely increase in demand for community health center services following enactment of health reform legislation, this survey explored these clinics' ability to provide access to care, coordinate care across settings, engage in quality improvement and reporting, adopt and use health information technology, and serve as patient-centered medical homes.

- Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey. Conducted quarterly from 2004 to 2011, these surveys sampled leaders in the fields of health care and health care policy about key challenges and the options for addressing them.

To access all Commonwealth Fund surveys, visit Surveys at www.commonwealthfund.org.

Multinational Comparisons of Health System Data

Comparing the health care system in the United States with the systems of other industrialized countries reveals striking differences in spending, availability and use of services, and health outcomes. Each year, The Commonwealth Fund produces a chartbook depicting key health data for the 30 member nations of the Organization for Economic Cooperation and Development (OECD), as well as analyses based on those data. Visit the Fund's online International Health Policy Center for more information.

INTERNATIONAL PROGRAM IN HEALTH POLICY AND INNOVATION

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

INTERNATIONAL PROGRAM IN HEALTH POLICY AND INNOVATION

Program Goals

Sponsoring activities ranging from high-level international policy forums to the Harkness Fellowships and an annual health policy survey, The Commonwealth Fund's International Program in Health Policy and Innovation promotes cross-national learning by:

- sparking high-level creative thinking about health policy among industrialized countries;
- encouraging comparative research and collaboration among industrialized nations;
- building an international network of health care researchers devoted to policy; and
- showcasing international innovations in policy and practice that can inform U.S. health reform.

The program is led by
Vice President Robin Osborn, M.B.A.

Cover: During a roundtable meeting at The Commonwealth Fund's offices in New York, 2011–12 Harkness Fellows in Health Care Policy and Practice Walter Wodchis of Canada (speaking) and Ewout van Ginneken of the Netherlands, along with other current fellows, discuss plans for their research projects and share insights on each other's work. The Harkness Fellowship program is a major component of the Fund's International Program in Health Policy and Innovation, which, among other goals, seeks to build an international network of health care researchers devoted to policy.

Photo: Roger Carr

The Issues

Across the industrialized world, health care policymakers face mounting pressure to provide access to expensive new drugs and medical technologies, improve the quality and safety of care, and ensure that the care patients receive is responsive to their needs and preferences. Learning about other countries' approaches to attaining a high performance health care system—one that provides comprehensive health insurance coverage and delivers cost-effective, timely, high-quality health services—is of particular benefit to the United States, which continues to spend far more on health care per capita than any other nation and yet receives less in return than most.

Recent Projects

2011 International Symposium on Health Care Policy

For the past 14 years, The Commonwealth Fund has hosted an annual international health care policy symposium in Washington, D.C., organized in collaboration with the leading U.S. health policy journal, *Health Affairs*. The 2011 symposium, "Achieving a High Performing and Sustainable Health Care System: Bending the Cost Curve," brought together health ministers and 65 leading policy thinkers from Australia, Canada, France, Germany, New Zealand, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

Kicking off the symposium was Annette Widmann-Mauz, Parliamentary State Secretary for Health for Germany, who outlined her vision of a 21st-century health care system. In the annual John M. Eisenberg International Lecture, David Blumenthal, M.D., Samuel O. Thier Professor of Medicine and Health Policy at Harvard Medical School and chair of The Commonwealth Fund Commission on a High Performance Health System, noted the "performance improvement imperative" in the U.S. and laid out general principles to guide strategic use of the new tools provided by health reform to raise health system performance. Guest speaker Naoki Ikegami, M.D., Ph.D., a health economist from Keio University in Japan, described how prices are controlled in Japan's multipayer health system. Japan, which celebrated 50 years of universal coverage in 2011, has been successful in restraining health spending while providing good access to care and producing excellent patient outcomes. Japan spends less than half as much per capita on health care as the U.S.

A highlight of the symposium was the presentation of findings from the 2011 Commonwealth Fund International Health Policy Survey, which found that adults with complex medical conditions benefit from receiving their care from a medical home. According to the survey, which focused on the care experiences of "sicker" adults in the U.S. and 10 other high-income countries, patients connected with primary care practices that have medical home characteristics were less likely to report medical errors, test duplication, and other care coordination failures. Moreover, they reported better relationships with their doctors and rated their care more highly. An article based on the survey findings was published by *Health Affairs* (Nov. 9, 2011). The survey was conducted in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

Harkness Fellowships in Health Care Policy and Practice

Targeted toward promising health care policy researchers and practitioners in nine countries, the Harkness Fellowships provide a unique opportunity to spend up to 12 months in the United States conducting a policy-oriented research study, gaining firsthand exposure to innovative models of health care delivery, and working with leading health policy experts. In 2011, Sweden joined Australia, Canada, Germany, the Netherlands, New Zealand, Norway, Switzerland, and the United Kingdom as participants in the program.

Harkness alumni continue to generate important research based on their fellowship work and move into high-profile positions back home. For example:

- In a feature article in *Milbank Quarterly* (March 23, 2011), Geraint Lewis (U.K., 2007–08), Rhema Vaithianathan (U.K., 2007–08), Peter Hockey (U.K., 2007–08), and coauthors identified lessons from the aviation industry that could be applied to patient safety improvement efforts.
- In a piece in the *New England Journal of Medicine* (April 14, 2011), Adam Elshaug (Australia, 2010–11) and colleagues examined the budget impact of two medical procedures commonly covered by insurers (percutaneous vertebroplasty and kyphoplasty) that recent comparative-effectiveness research suggests may not only be ineffective but also raise safety concerns.
- Stephanie Stock (Germany, 2007–08) reported in *Health Affairs* (Dec. 28, 2010) the successes of German diabetes management programs in lowering mortality, complications, and costs for diabetics.

As they do each year, the 2011–12 Harkness Fellows represent a diversity of policy experiences and research interests. The new fellowship class is:

Rachael Addicott, Ph.D. (United Kingdom)
Senior Policy Research Fellow
The King's Fund
Project: Physician Receptivity and Readiness to Participate in Accountable Care Organizations
Placement: University of California, Berkeley
Mentors: Steven Shortell, University of California, Berkeley; Francis J. Crosson, Permanente Federation

Sarah Derrett, Ph.D. (New Zealand)
Senior Research Fellow
Department of Preventive and Social Medicine
University of Otago
Project: Complex Chronic Conditions: Patient Pathways, Processes, and Engagement
Placement: University of Chicago
Mentor: Marshall Chin, University of Chicago

Robert Fowler, M.D. (Canada)
Critical Care Physician
Associate Professor
Department of Medicine
University of Toronto
Project: Comparison of Intensity of Care Received at the End of Life in the U.S. and Canada for Patients over Age 65

Atle Fretheim, M.D. (Norway)
Research Director, International Health Care Unit
Norwegian Knowledge Centre for the Health Services
Associate Professor
University of Oslo
Project: Alternative Methods for Evaluating Health System Innovations
Placement: Harvard Medical School
Mentors: Stephen Soumerai, Harvard Medical School; Meredith Rosenthal, Harvard School of Public Health; Dennis Ross-Degnan, Harvard Medical School

Tom Frusher (United Kingdom)
Policy Director
NHS Cooperation and Competition Panel (CCP)
Project: Competition Regulation and the Delivery of Health Reform: What Are the Lessons to be Learned from the U.S. Experience for U.K. Policymakers?
Placement: University of Pennsylvania Wharton School of Business
Mentors: Lawton R. Burns, University of Pennsylvania Wharton School of Business; Sharis A. Pozen, U.S. Department of Justice

Lars Hemkens, Dr.med. (Germany)
Research Fellow
German Institute for Quality and Efficiency in Health Care (IQWiG)
Project: The Reliability of Health Care Utilization Databases for Decision-Making to Improve Health of Priority Populations and Patient Safety
Placement: Stanford University
Mentor: John Ioannidis, Stanford University

Matthew Inada-Kim, M.B.B.S. (United Kingdom)
Lead Consultant in Acute Medicine
Emergency Medical Assessment Unit
Winchester Hospital
Project: What Can Be Learned from Organizations That Have Improved Their 30-Day Readmission Rates?
Placement: Harvard School of Public Health/Brigham and Women's Hospital
Mentors: David W. Bates, Harvard School of Public Health/ Brigham and Women's Hospital; Ashish Jha, Harvard School of Public Health

Philip Van Der Wees, Ph.D. (Netherlands)
Manager, Quality Improvement Research Program
Radboud University Nijmegen Medical Center, Royal Dutch Society for Physical Therapy, and Maastricht University
Chair, Guidelines International Network
Project: Implications of Medicaid Reforms on Health Care Disparities: The Example of Health Care Reform in Massachusetts
Placement: Harvard Medical School
Mentor: John Ayanian, Harvard Medical School

Ewout Van Ginneken, Ph.D. (Netherlands)
Senior Researcher
European Observatory/WHO Collaborating Centre for Health Systems Research and Management
Berlin University of Technology
Project: Implementing State-Based Health Insurance Exchanges: Key Issues and Evidence
Placement: Harvard School of Public Health
Mentors: Katherine Swartz, Harvard School of Public Health; Timothy Jost, Washington & Lee University

Walter Wodchis, Ph.D. (Canada)
Associate Professor
Department of Health Policy, Management and Evaluation
University of Toronto
Adjunct Scientist
Institute for Clinical Evaluative Sciences
Project: Managing Risk Among Older Adults with Medical and Home Care Needs

To learn more about the Harkness Fellowships and about alumni fellows, visit the Harkness Fellowships page on commonwealthfund.org.

In collaboration with the Australian Department of Health and Ageing, The Commonwealth Fund also offers the Australian–American Health Policy Fellowship, a "reverse Harkness Fellowship" designed to enable midcareer U.S. policy researchers or practitioners to spend six to 10 months in Australia conducting research and gaining an understanding of that country's health care system.

International Meeting on Quality of Health Care

Since 1999, The Commonwealth Fund and The Nuffield Trust have sponsored annual symposia bringing together senior government officials, leading health researchers, and practitioners from the United States and the United Kingdom for an exchange on quality improvement policies and strategies. The 12th conference in this series, held in July 2011 at Pennyhill Park, England, compared country reform strategies for transforming the delivery system and bending the cost curve through accountable care organizations

in the U.S. and clinical commissioning groups in the U.K. The discussion centered on getting the right balance between competition, collaboration, and regulation to drive quality and integration; using institutional payment mechanisms as drivers of quality and accountability; and creating a policy environment that enables models of excellence and innovation to thrive.

Since its inception, this meeting has underpinned a cross-national collaboration on quality led in the U.S. by Carolyn Clancy, director of the Agency for Healthcare Research and Quality (AHRQ), and, until 2011, in the U.K. by Sir Liam Donaldson, former chief medical officer for England's Department of Health.

Capitol Hill Briefings

In November 2011, The Commonwealth Fund and the Alliance for Health Reform cosponsored a Capitol Hill briefing for congressional staff, policymakers, and journalists to highlight the policies other countries use to improve value in pharmaceutical purchasing. The panelists, who included the directors of the U.K.'s National Institute for Health and Clinical Excellence (NICE), Germany's Federal Joint Committee, and France's National Authority for Health, discussed the roles of such tools as comparative effectiveness research, limited-entry agreements, and reference pricing.

Harkness Alumni Policy Forum

At a Washington, D.C., forum held in May 2011, senior U.S. policymakers and alumni of the Harkness Fellowships program gathered to share information about international innovations in health care delivery and lessons for health reform. Fellows presented findings on such topics as shared services in primary care, after-hours care arrangements, mobile health interventions, and patient safety strategies. Among the U.S policymakers taking part in the event were Donald M. Berwick, M.D., former head of the Centers for Medicare and Medicaid Services; Jeanne Lambrew, Ph.D., Deputy Assistant to the President for Health Policy; David Blumenthal, M.D., former director of the Office of the National Coordinator for Health Information Technology; and Carolyn Clancy, director of the Agency for Healthcare Research and Quality.

Partnerships with International Foundations

The Commonwealth Fund has more than 20 ongoing international partnerships with health ministries, research organizations, and health care foundations whose cofunding and collaboration support the expansion of the Harkness Fellowships and the Fund's annual International Health Policy Survey, in addition to important cross-national research on comparative health system performance (see table).

Country	Partner Organization: *International Survey*	Partner Organization: *Harkness Fellowships*
Australia	Bureau of Health Information	
Canada	Health Council of Canada Health Quality Council of Alberta Ontario Health Quality Council Québec Commissioner of Health and Welfare	Canadian Health Services Research Foundation
France	National Health Authority (HAS) National Fund for Health Insurance for Employees (CNAM)	
Germany	German National Institute for Quality Measurement in Health Care (BQS)	B. Braun Foundation Robert Bosch Foundation
Netherlands	Ministry for Health, Welfare, and Sport Scientific Institute for Quality of Healthcare (IQ Healthcare)	Ministry for Health, Welfare, and Sport
Norway	Knowledge Centre for the Health Services	Research Council of Norway
Sweden	Ministry of Health and Social Affairs	
Switzerland	Federal Office of Public Health Swiss Medical Foundation	Careum Foundation
United Kingdom	Health Foundation	Nuffield Trust NHS National Institute for Health Research/SDO

Future Directions

The 2012 International Health Policy Survey will assess health care system performance from the perspective of primary care physicians, focusing on practices' capacity to serve as medical homes and coordinate care, deployment of care teams for chronically ill patients, use of electronic health records with information exchange capabilities, payment arrangements, and job satisfaction. The findings will be released at the Fund's 15th annual International Symposium on Health Care Policy in November 2012.

Most of the International Program's unrestricted grant money is for small grants up to $50,000 and for issue briefs and case studies. Topics of particular interest include health care delivery system integration; patient-centered primary care models; governance structures for ensuring quality, cost-containment, and competition; and comparative pricing and utilization for pharmaceuticals, medical imaging, and medical devices.

THE COMMONWEALTH FUND

2011 Annual Report

TREASURER'S REPORT

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

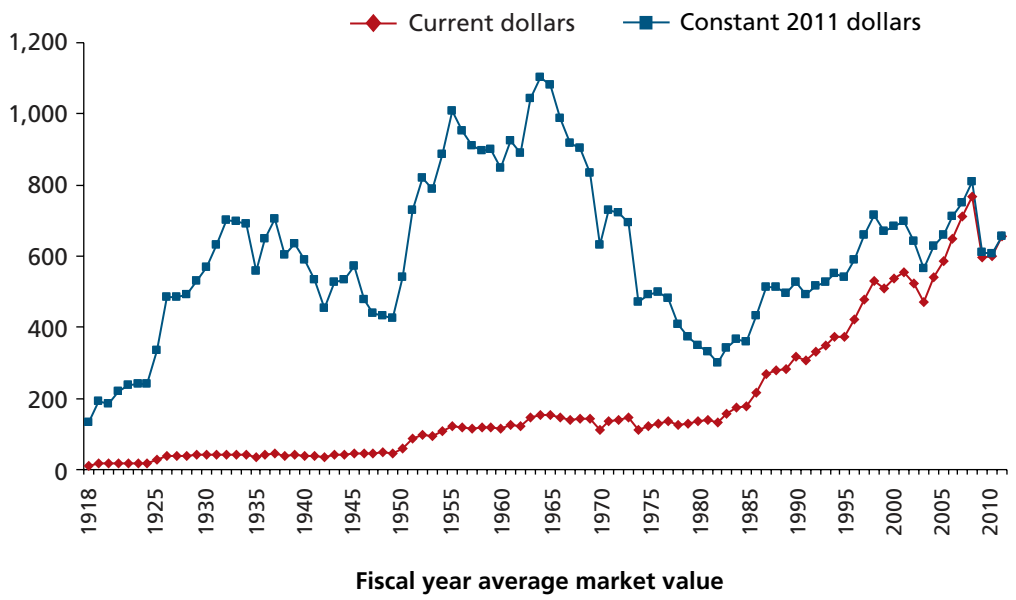
In the fiscal year ending June 30, 2011, the value of The Commonwealth Fund's endowment continued to recover from the losses arising from the major global financial crisis and stock market crash of 2008–09 (Exhibit 1). The market value of endowment assets had risen from $503 million at the depths of the market crisis in March 2009, to $598 million on June 30, 2010. During the fiscal year, further advances brought the market value on June 30, 2011, to $686 million. At the same time, the foundation expended $30.2 million during the year in pursuit of its mission of advancing a high performance health system (Exhibit 2).

The net return on the Fund's endowment over the 12 months ending June 30, 2011, was 20.9 percent (Exhibit 3). Because of the defensive asset-class allocation of the endowment, it underperformed the market benchmark during the year (20.9% vs. 26.7%). But the foundation's average annual returns through June 30, 2011, for the last five-, seven-, and 10-year periods are well above those of the market benchmark.

The performance of the Fund's endowment is also quite competitive with that of peer institutions (Exhibit 4). For example, in the 12 months ending June 30, 2011, the Fund's return of 20.9 percent was greater than the 19.3 percent earned by 84 peer university and foundation endowments with assets between $250 million and $999 million monitored by Cambridge Associates. The average annual return on the Fund's endowment over the last five, seven, and 10 years was also greater than that of peer institutions.

The salient features of the Fund's current investment strategy are summarized in Exhibit 5. Key among these are an overall target commitment of 88 percent of the portfolio to equities (publicly traded and private) and 12 percent to fixed-income securities; an 18 percent commitment to publicly traded U.S. equities, paired with a 20 percent commitment to international equities, including a 5 percent to 8 percent allocation to emerging markets; active large capitalization value stock managers; assignment of responsibility for 20 percent of the endowment to marketable alternative equity (hedge fund) managers; a 12 percent commitment to nonmarketable alternative equities (venture capital and private equities); and an 18 percent allocation to inflation hedges, including oil and gas, commodities, gold, and TIPS.

Exhibit 1. The Commonwealth Fund's endowment, in millions, 1918–2011



A CHANGE IN THE FUND'S APPROACH TO MANAGING ITS ENDOWMENT

With the uncertainties arising from the 2008–09 market crash, the continuing major economic contraction that resulted from it, the recurring crises that threaten the global financial system, and evermore complicated investment markets, foundations face more challenges in managing their endowments than at any time since the Great Depression. In response, The Commonwealth Fund's Investment Committee and Board devoted a great deal of attention during the year to the best model for managing the Fund's endowment over the long term and, in the end, decided to make a significant change.

As discussed in an essay in the *2009 Commonwealth Fund Annual Report,* foundations have a choice of five basic models for managing their endowments (Exhibit 6).[1] The first four models are:

- **Solo investment committee.** In this common approach, typically employed by very small foundations but also by many small and even midsize ones, the board's investment committee has virtually all strategic and operational responsibility for the endowment—working with little or no internal staff or consultant support, although generally delegating portfolio management to a brokerage firm, mutual funds, or external investment managers (typically using commingled funds shared with other investors).
- **Investment committee–investment consultant.** As foundation size and investment strategy complexity increase, many investment committees recognize the need for an investment consultant to help inform and guide their decisions, and sometimes to help implement them. The amount of responsibility delegated by the committee is higher under this model than under the solo investment committee model.

Exhibit 2. The Commonwealth Fund's annual spending, in millions, 1919–2011: Total spending of $870 million over 92 years, or $2.6 billion in constant 2011 dollars

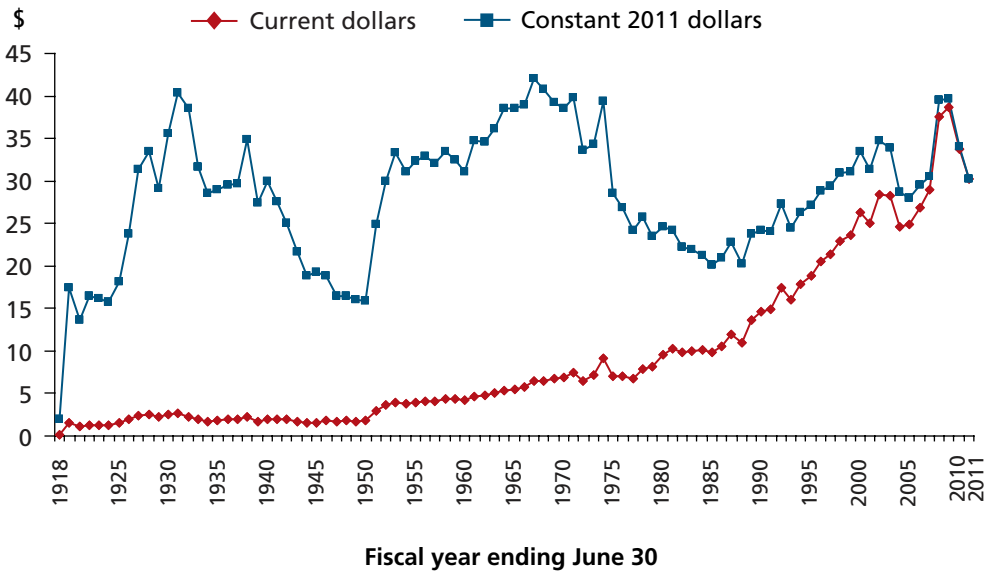


Exhibit 3. Because of the defensive asset-class allocation of The Commonwealth Fund's endowment, it underperformed the market benchmark over the 12 months ending June 30, 2011, but average annual returns through June 30, 2011, for the last five-, seven-, and 10-year periods are well above those of the market benchmark.

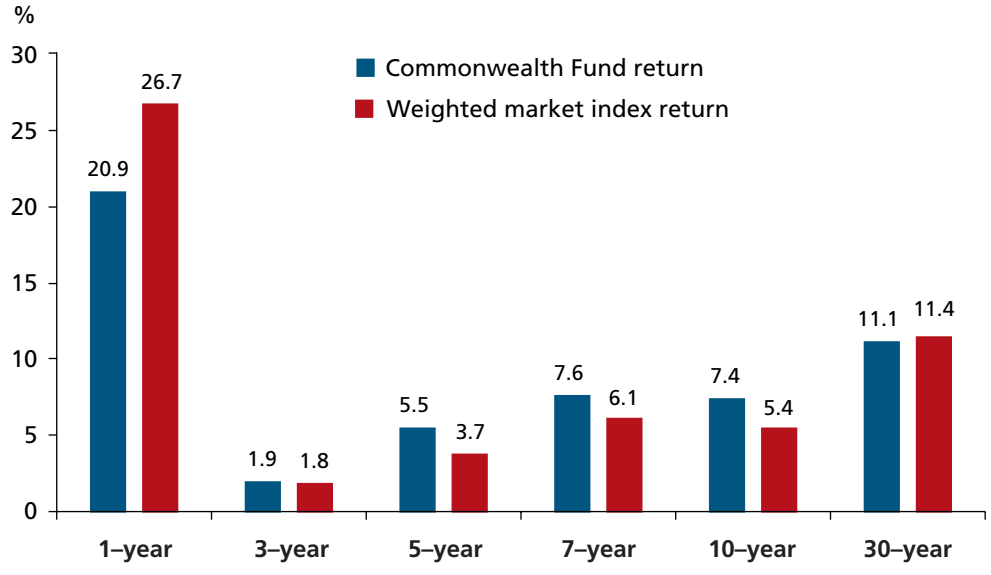
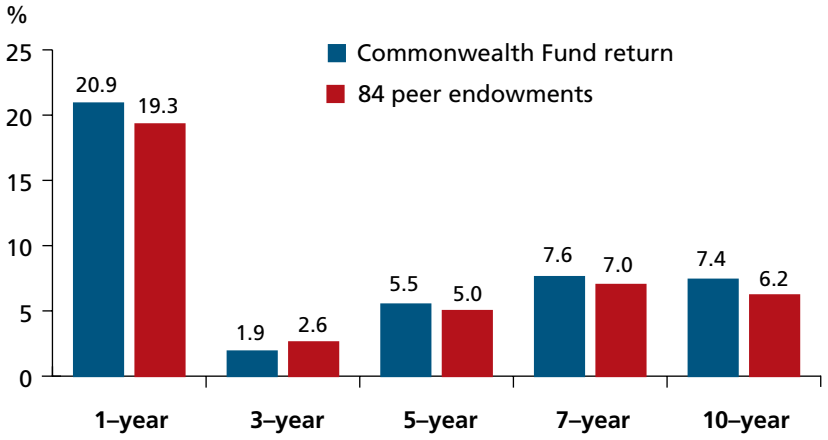


Exhibit 4. The Commonwealth Fund's returns are very competitive with those of peer foundations and universities/colleges.

Endowment average annual investment returns, years ending June 30, 2011



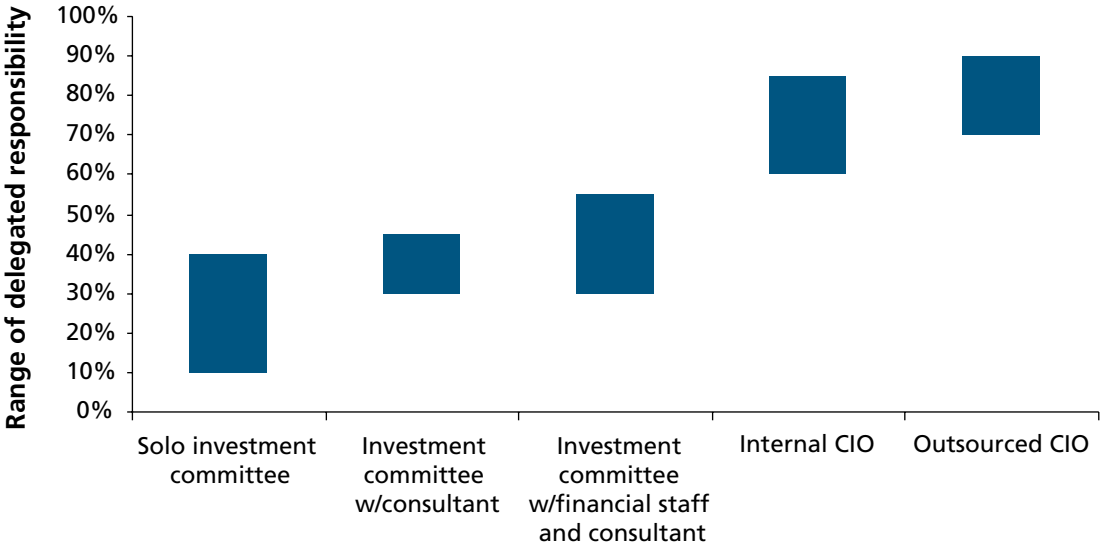
Source: Peer endowment (endowments with assets between $250 million and $999 million) comparisons provided by Cambridge Associates.

Exhibit 5. The Commonwealth Fund's endowment management strategy

	Allocation on October 31, 2011	Long-term target	Permissible range
Total endowment	100%	100%	
Asset class			
Total equity	84%	88%	75%–90%
U.S. equity marketable securities	18%	18%	15%–30%
Non-U.S. equity marketable securities	17%	20%	15%–30%
Marketable alternative equity	18%	20%	15%–30%
Nonmarketable alternative equity	14%	12%	5%–15%
Inflation hedges	17%	18%	5%–20%
Fixed income	16%	12%	10%–25%

Exhibit 6. The internal-CIO model of endowment management is unavailable to all but the largest foundations, but the outsourced-CIO model addresses many of the weaknesses of alternative models.

The larger the foundation, the more responsibility investment committees must delegate to consultants, internal chief investment officers, or outsourced CIOs.



- **Investment committee–internal financial staff–investment consultant.** Any foundation with assets of $250 million or more is likely to pursue a sophisticated, diversified investment strategy like that of The Commonwealth Fund (Exhibit 5). Under these circumstances, the day-to-day responsibilities of managing the endowment require qualified staff; moreover, barring an investment committee member with the time, inclination, and expertise for working closely with the consultant on strategic and operational issues like manager searches, a professional staff member is needed to ensure best use of the time and skills of the consultant and committee members. Thus, this model entails still higher de facto (if not formal) levels of responsibility delegation by the investment committee.

The Commonwealth Fund has used this model since 1981. Under it, the committee determines the allocation of the endowment among asset classes and hires external managers, who do the actual investing. Day-to-day responsibility for the management of the endowment rests with the Fund's executive vice president and COO/treasurer, who with the assistance of Cambridge Associates consultants, is also responsible for researching investment strategy questions to be addressed by the committee. The committee meets at least three times a year to review the performance of the endowment and individual managers, reassess the allocation of the endowment among asset classes and managers and make changes as appropriate, deliberate investment issues affecting the management of the endowment, and consider new undertakings.

- **Internal CIO.** Once a foundation reaches the $3 billion or so level in endowment assets, it becomes economic and feasible for it to hire a full-time, highly trained, experienced chief investment officer (CIO) and recruit a sizeable, dedicated professional investment team, compensated at the necessary competitive levels. As described by Lawrence E. Kochard and Cathleen M. Rittereiser, a number of very large foundations including the Carnegie Corporation and William and Flora Hewlett Foundation use this model and have achieved considerable success.[2]

The primary strength of the solo investment committee model is that it leaves, in theory, no doubt regarding where accountability for the management of the endowment lies. All too often, however, foundations employing this model shy away from the investments-performance tracking that would help tell them how well their investment committee is functioning. Even when a record of below-market performance is clear, some boards are unwilling to hold the investment committee accountable for it. Small and even midsize foundations can find it difficult to attract board members with sufficient investment experience and expertise and the time or inclination to direct their skills fully to management of the endowment.

Committee members, furthermore, are likely to develop a very limited set of investment managers from which to choose and may favor those they know—with attendant potential conflicts of interest. Indeed, board member conflicts of interest in the management of endowments arise all too frequently and require firm attention by board and audit committee chairs. Even with effective leadership, investment committees operating alone are sometimes challenged in reaching consensus and taking action, or fall into the trap of groupthink. As a result of these weaknesses, the solo investment committee model is prone to being suboptimal.

Adding a qualified investment consultant to the investment committee model helps address many, but not all, of these issues. The chief weakness of the investment-committee-with-consultant model is that responsibility for decision-making is muddied, and it is difficult for the board to hold either the committee or consultant accountable if things go wrong. While investment consultants bring research, experience, and contacts that are extremely valuable in building consensus, setting strategy, and hiring and firing managers, they can be more passive in providing advice than is desirable. Additionally, the quality of investment consulting firms can range widely, as can the value-adding capacity of any single consultant within even a strong firm.

The investment committee-with-consultant model has other weaknesses as well. First, the performance record of investment consultants is reputational, not statistical, which presents a challenge in the hiring decision. Second, consultants have many clients competing for their best ideas and access to the best firms in their pools of investment managers. Third, consultants are unlikely to recommend partially tested, rising-star managers or cutting-edge products—although achieving above-market performance virtually depends on beating other investors to new investment approaches. Finally, as with any consultant, investment consultants provide their best work through a strong working relationship with, and guidance from, the client; yet many investment committee chairs lack the time required to provide such guidance.

Foundations with assets of roughly $150 million or more find it economical to seek to enrich

the potential of the investment committee–consultant model by assigning a qualified foundation staff member responsibility for managing the consultant and orchestrating investment committee meetings. With the right experience, training, and judgment, an internal chief financial officer can greatly strengthen the committee's ability to make the most of the investment consultant's skills, ward against any problematic conflicts of interest, ensure firmer daily oversight of endowment operations and their integration with the foundation's operating needs, and bring helpful investment insights to program strategy and grantmaking.

Even so, while accountability can be enhanced by the addition of qualified staff, it remains an issue. More seriously, staff in these roles typically have multiple and substantial other responsibilities within the foundation and may lack either or both the time or expertise to produce all the benefits of this approach. Foundations employing this model, moreover, often face a major challenge in identifying and adequately compensating a staff person able to meet the many demands of the assigned role.

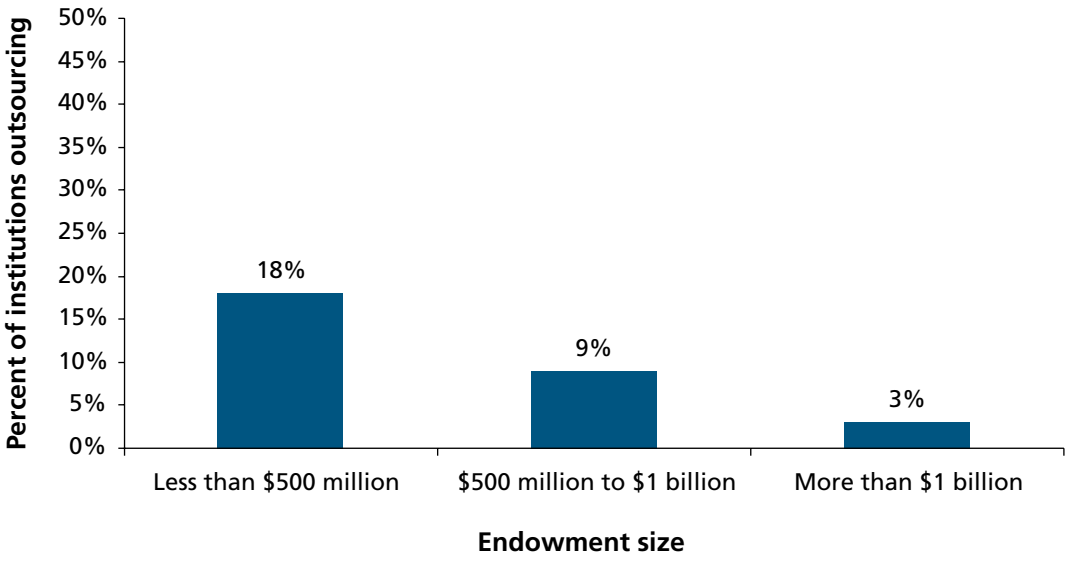
The vitally missing piece in the first three models is a chief investment officer—a role which should arguably be assigned, at least de facto, to someone in any organization totally dependent on an endowment for income. Well executed, the internal CIO model addresses most of the shortcomings of the first three models. Besides being unaffordable for all but about 30 of the largest private foundations, however, the chief weaknesses of this approach are the challenges of recruiting and retaining a highly qualified CIO, particularly given the compensation such individuals draw in other settings. While CIOs can add value to the foundation's programs, culture clashes between programmatic and investment staffs do arise, and the foundation needs to take care that the values of the foundation and the CIO are fully aligned, and that the strong personality that is typically a CIO trait fits into the foundation's management structure.

Given the shortcomings of the solo investment committee, committee-consultant, and committee-financial staff-consultant models of endowment management, smaller foundations in recent years have turned toward an alternative model:

- **Outsourced CIO (O-CIO).** Under this model, foundations with under around $2 billion in assets fully outsource the management of their endowment to a firm that essentially offers a packaged set of services comparable to those that very large foundations obtain with an in-house CIO (Exhibit 7). The O-CIO firm—the best being the creation of a stellar former CIO of a large university endowment or pension fund—assumes most of the responsibility for managing the endowment. While the amount of delegated authority varies from foundation to foundation, most investment committees using this model have an essentially advisory role and, beyond consultation on broad strategy, leave decisions on managers and tactical moves to the O-CIO. The spectrum of actual services offered by O-CIOs is wide, ranging from somewhat customized portfolios to one-size-fits-all proprietary portfolios.[3]

Small foundations are leading the trend toward the O-CIO model, but foundations in the $250 million to $2 billion range are also attracted to it—in large part, because of their increased use of "alternative" investments like hedge funds, private equity, venture capital, real estate, and timberland, and the difficulties of identifying and gaining access to top-ranked managers of this type on their own.

Exhibit 7. Increasingly, nonprofits are fully outsourcing the management of their endowments.



Source: Casey Quirk & Associates, *The New Gatekeepers: Winning Business Models for Investments Outsourcing*, 2008.

Contributing to the trend also is the disappointment of many midsize and large foundations with their existing investment committee- or consultant-driven management model in the recent financial crisis.[4]

The outsourced-CIO model addresses most of the weaknesses of alternative management approaches available to foundations too small to hire their own CIO team. The constraint here is the number of highly qualified individuals and firms to which such responsibility can be safely delegated. As predicted in a study by Casey Quirk and Associates, many former large university or pension fund heads will set themselves up as O-CIOs in the coming years—but not all will be true investment stars.[5] The ability of the largest group of entrants into this business—established investment consultants—to deliver high-quality O-CIO services stands a substantial risk of being compromised by their responsibilities to existing consulting clients and their questionable ability to attract truly outstanding investment professionals. There are also concerns that while existing O-CIO firms restrict the number of clients to the small number needed to ensure above-market returns, they will be pressured over time to grow the firm beyond an asset level that is optimal for clients.

The largest risk of the O-CIO model, however is "key person"—the viability and strength of the firm should it lose its star CIO. This risk is real, as most outstanding O-CIO firms are small. At the same time, given the newness of this model, few such firms are likely to face a transition in leadership for the foreseeable future.

The Commonwealth Fund's endowment, which is in the $600 million–$700 million range, is of a size where the foundation cannot afford, or realistically build, a CIO unit with the requisite team that is needed to carry out the sophisticated investment strategy that an endowment of such size merits. While the investment committee–internal financial staff–investment consultant model used by the Fund over the last 30 years has produced

competitive results, the investment committee of the foundation's board has increasingly appreciated its limitations and fragility as the investment world has grown more complicated and financial markets more volatile and prone to crisis. In the fall of 2011, following consideration of some 20 outsourced-CIO firms and then very close inspection of three finalist firms, the investment committee hired Investure to serve as the foundation's O-CIO, with the formal change to begin on July 1, 2012.

Investure, founded in 2003 by Alice Handy, formerly CIO of the University of Virginia endowment, currently has 13 clients and over $9 billion under management. The firm offers its O-CIO services exclusively to endowments with similar investment objectives and level of sophistication and expects to add no more than one client per year over the next three years. The firm requires clients to place all of their endowment with the firm, with the minimum client asset size being $500 million.

Investure aims to be tightly integrated with its clients' investment committees and in-house finance teams, working closely with each client to establish portfolios that fit its individual risk profile—primarily using pooled investment vehicles to create efficiencies and scale. The firm covers all asset classes and backs start-up investment teams emerging from existing investment management firms. It provides back-office support, which includes performance reporting, custodian selection and interface, cash management, and audit support. Investure's investment strategy takes into account its clients' 5 percent payout requirement, and liquidity for meeting operating expenses is available as needed. The firm regards its client base as its "board" and convenes regular client meetings to support that role.

Investure's clients include such institutions as Barnard College, the Carnegie Endowment for International Peace, the Edna McConnell Clark Foundation, the Colonial Williamsburg Foundation, Dickenson College, the Henry Luce Foundation, the Houston Endowment, Middlebury College, Rockefeller Brothers Fund, Smith College, Trinity College, and the University of Tulsa.

In hiring Investure as the Fund's O-CIO, the Fund's board hopes to lower the risk profile of the endowment and enhance the probability of achieving the 5-percent-plus-inflation annual return that will ensure the foundation's continued financial strength while meeting the regulatory annual payout requirement.

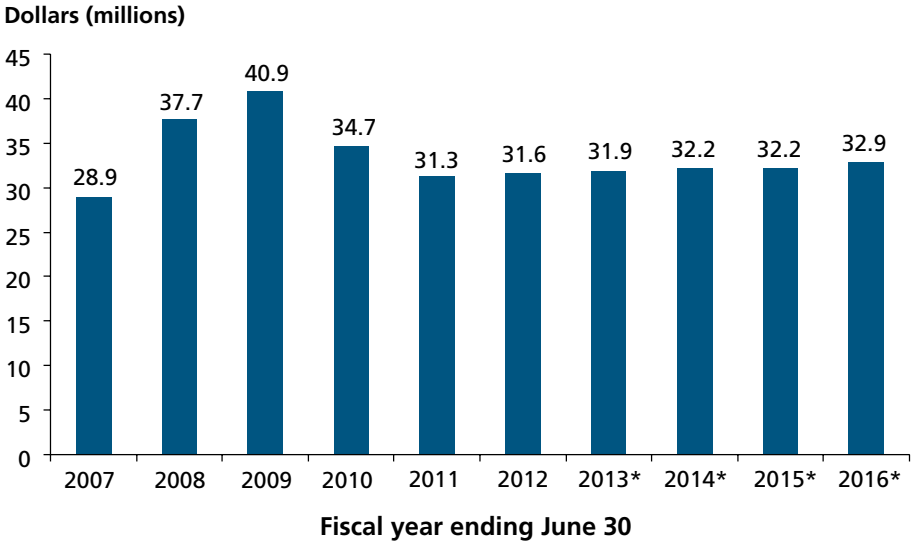
COMMONWEALTH FUND SPENDING TO ADVANCE ITS MISSION

Three considerations determine The Commonwealth Fund's annual spending policy: the aim of providing a reliable flow of funds for programs; the objective of preserving the real (inflation-adjusted) value of the endowment and funds for programs; and the need to meet the Internal Revenue Service requirement of distributing at least 5 percent of the endowment for charitable purposes each year.

Like most other institutions whose sole source of income is their endowment, the Fund had to adjust spending plans to the new realities resulting from the 2008–09 financial markets crisis (Exhibit 8). Following a 15 percent reduction in the Fund's budget in 2009–10, the Board of Directors approved a further 10 percent reduction in 2010–11. Improved endowment performance over the last two years, however, enabled an increase in the budget of 1 percent in 2011–12, to $31.6 million. The Board hopes to maintain such modest annual increases over the next five years.

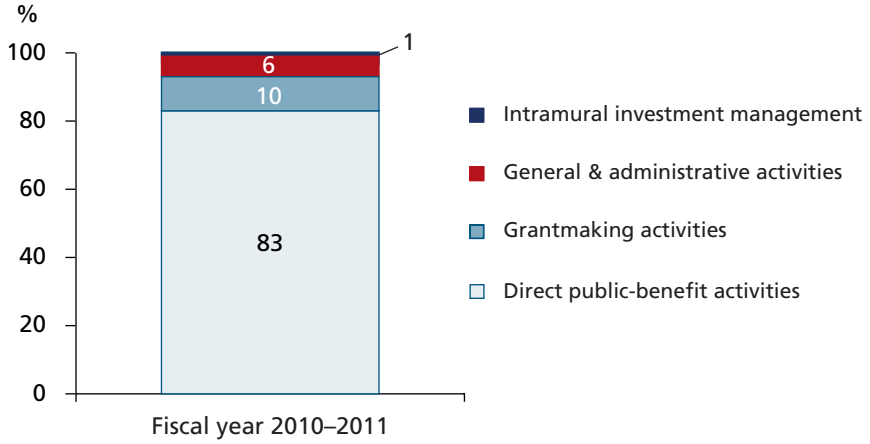
As a value-adding foundation, the Fund seeks to achieve an optimal balance between

Exhibit 8. With significant recovery in the market value of the endowment, The Commonwealth Fund's annual budget has stabilized at around $32 million.



* Projected

Exhibit 9. The Commonwealth Fund's total direct public-benefit activities—including extramural grants and intramural research, communications, and programs conducted by the foundation—account for 83 percent of its annual expenditures. Value-adding oversight of grants takes up 10 percent of the Fund's budget.



its grantmaking and intramural research, communications, and program management activities, while minimizing purely administrative costs. Recognizing that data on expenditures reported in the IRS 990-PF annual tax return inadequately reflect the purpose of many expenditures,[6] the analysis in Exhibit 9 sorts out the foundation's 2010–11 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 2010–11, the Fund's total direct public-benefit activities accounted for 83 percent of its annual expenditures. Value-adding oversight of grants took up 10 percent of the Fund's budget, and the intramural costs of managing the endowment, 1 percent. Appropriately defined, the Fund's administrative costs amounted to 6 percent of its budget.

Throughout the recent period of belt-tightening and, at best, modest budget increases, staff has demonstrated creativity in achieving cost-savings and reordering spending priorities to maximize the impact of the foundation's resources. As painful as the budget constraints may be, given still subdued inflation, the Fund is fortunate in continuing to have the resources needed to maintain its role in helping inform health policy debates and promote a high performance health system.

Notes

[1] John E. Craig, Jr., "Rethinking the Management of Foundation Endowments," in *2009 Commonwealth Fund Annual Report,* http://www.commonwealthfund.org/Publications/Annual-Report-Essays/2010/March/Rethinking-the-Management-of-Foundation-Endowments.aspx.

[2] Lawrence E. Kochard and Cathleen M. Rittereiser, *Foundation and Endowment Investing* (Hoboken, N.J.: John Wiley & Sons, Inc., 2008).

[3] Casey Quirk & Associates, *The New Gatekeepers: Winning Business Models for Investments Outsourcing*, 2008. Lawrence Kochard and Cathleen Rittereiser describe the business models and investment strategies of such leading O-CIO firms as Investure and Morgan Creek Capital in *Foundation and Endowment Investing*.

[4] Cambridge Associates, *"Fiduciary Fatigue" CIO Outsourcing: Leaner Times Increase Demand, and Raise New Questions,* 2009.

[5] Casey Quirk & Associates, *The New Gatekeepers,* 2008.

[6] John E. Craig, Jr., "Modernizing the 990-PF to Advance the Accountability and Performance of Foundations: A Modest Proposal," in *2010 Commonwealth Fund Annual Report,* http://www.commonwealthfund.org/Publications/Annual-Report-Essays/2011/Modernizing-the-990-PF.aspx.

2011 Annual Report

INDEPENDENT AUDITORS' REPORT FINANCIAL STATEMENTS

Years Ended June 30, 2011 and 2010

2011 Annual Report

Independent Auditors' Report

The Commonwealth Fund

We have audited the accompanying statements of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2011 and 2010 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, 2011 and 2010 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.

November 7, 2011

THE COMMONWEALTH FUND
STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2011 AND 2010

	2011	2010
ASSETS		
CASH	$ 1,286,376	$ 1,300,500
INVESTMENTS - At fair value (Notes 1 and 2)	679,363,908	597,134,926
INTEREST AND DIVIDENDS RECEIVABLE	45,124	74,177
PROCEEDS RECEIVABLE FROM SECURITY SALES - NET	3,493,372	492,525
TAXES REFUNDABLE	755,008	609,945
PREPAID INSURANCE AND OTHER ASSETS	311,622	324,088
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 $2,152,492 at June 30, 2011 and $1,848,540 at June 30, 2010 (Note 1)	4,662,659	4,313,804
TOTAL ASSETS	$690,193,069	$604,524,965
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable and accrued expenses	$ 2,041,355	$ 1,362,171
Program authorizations payable (Note 3)	20,308,399	24,418,124
Accrued postretirement benefits (Note 4)	4,776,443	4,539,962
Deferred tax liability (Note 5)	2,734,441	1,339,221
Total liabilities	29,860,638	31,659,478
NET ASSETS:		
Unrestricted	660,332,431	572,865,487
Total net assets	660,332,431	572,865,487
TOTAL LIABILITIES AND NET ASSETS	$690,193,069	$604,524,965

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2011 AND 2010

	2011	2010
REVENUES AND SUPPORT:		
Interest and dividends	$ 8,353,660	$ 7,876,340
Contribution and other revenue	587	43,645
Total revenues and support	8,354,247	7,919,985
EXPENSES:		
Program authorizations and operating program	27,984,516	31,612,976
General administration	1,836,709	1,869,540
Investment management	3,821,723	3,670,564
Taxes (Note 5)	1,888,005	1,199,562
Retirement and other postretirement (Note 4)	628,950	2,809,234
Total expenses	36,159,903	41,161,876
EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS	(27,805,656)	(33,241,891)
NET INVESTMENT GAINS		
Net realized gains on investments	45,511,613	27,160,110
Change in unrealized appreciation of investments	69,760,987	44,259,135
Total net investment gains	115,272,600	71,419,245
CHANGES IN UNRESTRICTED NET ASSETS	87,466,944	38,177,354
Net assets, beginning of year	572,865,487	534,688,133
Net assets, end of year	$660,332,431	$572,865,487

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2011 AND 2010

	2011	2010
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash provided by interest, dividends, and other	$ 8,383,300	$ 7,961,340
Cash used to pay grants and program expenses	(31,415,057)	(26,252,893)
Cash used to pay administrative expenses	(1,520,291)	(1,907,392)
Cash used to pay investment expenses	(3,821,723)	(3,670,564)
Cash used to pay taxes (refunds)	(637,848)	889,527
Cash used to pay unfunded retirement expenses	(392,469)	(463,454)
Net cash used by operating activities	(29,404,088)	(23,443,436)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of furniture, equipment, and building improvements - net	(652,807)	(147,461)
Purchase of investments	(109,230,230)	(125,170,744)
Proceeds from the sale of investments	139,273,001	150,004,758
Net cash provided by investing activities	29,389,964	24,686,553
NET INCREASE (DECREASE) IN CASH	(14,124)	1,243,117
CASH, BEGINNING OF YEAR	1,300,500	57,383
CASH, END OF YEAR	$ 1,286,376	$ 1,300,500
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Change in net assets for the year	$ 87,466,944	$ 38,177,354
Depreciation	303,952	286,236
Net investment gains	(115,272,600)	(71,419,245)
Decrease in interest and dividends receivable	29,053	41,355
Decrease (increase) in taxes refundable - net	(145,063)	1,203,907
Decrease (increase) in prepaid insurance and other assets	12,466	(324,088)
Increase in accounts payable and accrued expenses	679,184	263,471
Increase (decrease) in program authorizations payable	(4,109,725)	5,096,612
Increase in accrued post retirement benefits	236,481	2,345,780
Increase in deferred tax liability	1,395,220	885,182
Net cash used in operating activities	$(29,404,088)	$(23,443,436)

See notes to financial statements.

THE COMMONWEALTH FUND
Notes to Financial Statements
Years Ended June 30, 2011 and 2010

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.

The Fund records derivative instruments in the statements of financial position at their fair value, with changes in fair value being recorded in the statement of activities. The Fund does not hold or issue financial instruments, including derivatives, for trading purposes. Both realized and unrealized gains and losses are recognized in the statements of activities.

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

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

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

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

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

2. Investments

Investments at June 30, 2011 and 2010 comprised the following:

	2011		2010	
	Fair Value	Cost	Fair Value	Cost
U.S. Equities	$ 92,323,471	$ 76,145,579	$ 80,387,617	$ 83,534,330
Non-U.S. Equities	130,999,782	107,278,926	104,167,492	91,678,376
Fixed income	71,003,503	61,925,158	94,489,324	87,488,048
Short-term	15,528,170	15,527,549	15,087,701	15,087,701
Marketable alternative equity	160,233,469	92,113,165	134,247,901	79,872,435
Nonmarketable alternative equity	75,214,657	78,017,648	61,307,334	67,855,885
Inflation hedge	134,060,856	111,634,027	107,447,557	104,657,084
	$679,363,908	$542,642,052	$597,134,926	$530,173,859

At June 30, 2011, the Fund had total unexpended investment commitments of approximately $75.2 million ($26.0 million for private equity, $17.9 million for venture capital, $13.2 million for natural resources, $9.7 million for real estate and $8.4 million for inflation hedge).

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, 2011 and 2010, the Fund had no outstanding derivative positions.

Fair value of an investment is the amount that would be received to sell the investment in an orderly transaction between market participants at the measurement date.

Accounting guidance establishes a hierarchal disclosure framework which prioritizes and ranks the level of market price observability used in measuring investments at fair value. Market price observability is impacted by a number of factors, including type of investment and the characteristics specific to the investment. Investments with readily available active quoted prices or for which fair value can be measured from actively quoted prices generally will have a higher degree of market price observability and a lesser degree of judgment used in measuring fair value.

Investments measured and reported at fair value are classified and disclosed in one of the following categories.

Level 1 Inputs – Quoted prices in active markets for identical investments. In the case of funds, a reported NAV and full liquidity.

Level 2 Inputs – Other significant observable inputs (including quoted prices for similar investments, interest rates, etc.). Hedge funds with reported NAV are included in this category. The Fund requires investments classified as level two to have at least quarterly liquidity.

Level 3 Inputs – Prices determined using significant unobservable inputs. Unobservable inputs reflect the Fund's own assumptions about the factors market participants would use in pricing an investment and would be based on the best information available. Investments included in this category generally include private equity, venture capital, real estate, natural resources, gas and oil, and hedge

fund investments with limited liquidity. The fund invests in these investments to diversify its portfolio. The level three illiquid investments only have redemptions when underlying investments are sold. The Fund expects the terms of these investments to last up to twelve years.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an investment's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

Investments are categorized as follows:

	2011			
	Total	**Level 1**	**Level 2**	**Level 3**
U.S. Equities				
Growth fund	$ 18,843,475	$ 18,843,475		
U.S. equity fund	17,184,600	17,184,600		
Consumer goods	10,802,029	10,802,029		
Services	10,310,580	10,310,580		
Finance	8,086,628	8,086,628		
Equipment	7,766,879	7,766,879		
Energy	7,628,074	7,628,074		
Other	11,701,206	11,701,206		
Non-U.S. Equities	130,999,782	130,999,782		
Fixed income				
Corporate	1,663,340		$ 1,663,340	
Funds	69,340,163	42,338,160	27,002,003	
Short-term	15,528,170	15,528,170		
Marketable alternative equity	160,233,469	5,299,788	154,849,054	$ 84,627
Nonmarketable private equity	37,062,297			37,062,297
Nonmarketable venture capital	38,152,360			38,152,360
Inflation hedge				
Diversified	39,488,392	39,488,392		
Gold funds	16,328,630	16,328,630		
Energy	45,117,240	20,429,396		24,687,844
Real estate	25,685,408			25,685,408
TIPS	7,441,186	7,441,186		
	$679,363,908	$370,176,975	$183,514,397	$125,672,536

	2010			
	Total	Level 1	Level 2	Level 3
U.S. Equities	$ 80,387,617	$ 80,387,617		
Non-U.S. Equities	104,167,492	104,167,492		
Fixed income	94,489,324	71,273,790	$ 23,215,534	
Short-term	15,087,701	15,087,701		
Marketable alternative equity	134,247,901	5,156,944	128,978,131	$ 112,826
Nonmarketable alternative equity	61,307,334			61,307,334
Inflation hedge	107,447,557	72,369,988		35,077,569
	$597,134,926	$348,443,532	$152,193,665	$96,497,729

The change in level three assets for 2011 is as follows:

	Balance 6/30/2010	Capital Additions	Distributions	Income	Balance 6/30/2011
Marketable alternative equity	$ 112,826		$ 28,199		$ 84,627
Nonmarketable private equity	34,069,718	$ 7,230,679	11,235,511	$6,997,411	37,062,297
Nonmarketable venture capital	27,237,616	6,942,053	4,139,343	8,112,034	38,152,360
Inflation hedge - energy	21,989,034	4,075,284	6,311,535	4,935,061	24,687,844
Inflation hedge - real estate	13,088,535	8,428,454	1,369,484	5,537,903	25,685,408
	$96,497,729	$26,676,470	$23,084,072	$25,582,409	$125,672,536

The change in level three assets for 2010 is as follows:

	Marketable Alt. Equity	Nonmarketable Alt. Equity	Inflation Hedge	Total
Balance 6/30/09	$ 84,218	$53,148,235	$29,086,428	$82,318,881
Net additions	(853,681)	4,874,223	3,863,698	7,884,240
Investment return	(19,179)	3,284,876	2,127,443	5,393,140
Transfers between levels	901,468			901,468
Balance	$112,826	$61,307,334	$35,077,569	$96,497,729

3. Program Authorizations Payable

At June 30, 2011, program authorizations scheduled for payment at later dates were as follows:

July 1, 2011 through June 30, 2012	$16,038,324
July 1, 2012 through June 30, 2013	4,125,285
Thereafter	217,120
Gross program authorizations scheduled for payment at a later date	20,380,729
Less adjustment to present value	72,330
Program authorizations payable	$20,308,399

A discount rate of 1.75% was used to determine the present value of the program authorizations payable at June 30, 2011.

4. Retirement and Other Postretirement Benefits

The Fund has a noncontributory defined contribution retirement plan, covering all employees, under arrangements with Teachers Insurance and Annuity Association of America and College Retirement Equities Fund and Fidelity Investments. This plan provides for purchases of annuities and/or mutual funds for employees. The Fund's contributions approximated 17% of the participants' compensation for the years ended June 30, 2011 and 2010. Pension expense under this plan was approximately $1,013,000 and $983,000 for the years ended June 30, 2011 and 2010, 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.

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 $148,000 and $118,000 for each of the years ended June 30, 2011 and 2010.

Expected contributions under the postretirement medical plan for the fiscal year ended June 30, 2012 are expected to be approximately $179,000. Additional required disclosure on the Fund's postretirement medical plan for the years ended June 30, 2011 and 2010 is as follows:

	2011	2010
Benefit obligation at June 30	$4,776,443	$4,539,962
Fair value of plan assets at June 30	—	—
Status - unfunded	4,776,443	4,539,962
Actuarial loss	—	—
Accrued benefit cost recognized	$4,776,443	$4,539,962
Net periodic expense	$973,334	$2,463,956
Employer contribution	$148,380	$118,176

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

	2011	2010
Discount rate	7.7%	2.7%
Health care cost trend rates – Initial	6.3%	7.3%
Health care cost trend rates – Ultimate	6.3%	7.1%

At June 30, 2011, benefits expected to be paid in future years are approximately as follows:

Year ended June 30, 2012	$166,000
Year ended June 30, 2013	$175,000
Year ended June 30, 2014	$185,000
Year ended June 30, 2015	$185,000
Year ended June 30, 2016	$172,000
Five years ended June 30, 2021	$836,000

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% (depending if certain criteria are met) Federal excise tax on net investment income. For the years ended June 30, 2011 and 2010, that excise tax rate was 1%. 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, 2011, distributions approximating $1.6 million are required to be made by June 30, 2012 to satisfy the minimum requirements of approximately $32.2 million for the year ended June 30, 2011.

In the Statements of Financial Position, the deferred tax liability of $2,734,441 and $1,339,221 at June 30, 2011 and 2010, respectively, resulted from expected Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2011 and 2010, the tax provision was as follows:

	2011	2010
Excise taxes - current	$ 492,785	$ 314,380
Excise taxes - deferred	1,395,220	885,182
Unrelated business income taxes - current	—	—
Total Taxes	$1,888,005	$1,199,562

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, 2011 and 2010, Picker program grants totaled approximately $1,960,000 and $1,960,000, 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 years ended June 30, 2011 and 2010, grants in the amount of $224,000 and $414,000 were awarded.

During the year ended June 30, 2002, the Fund received a bequest of $3,001,124 from the estate of Professor Frances Cooke Macgregor as a contribution to the general endowment, with the amount of annual grants generated by this addition to the endowment to be governed by the Fund's overall annual payout policies. An additional amount of $100,000 was received during the year ended June 30, 2004. This gift was made with the provisions that in at least the five-year period following its receipt, grants made possible by it will be used to address iatrogenic medicine issues, and that grants made possible by the gift be designated "Frances Cooke Macgregor" grants. During the years ended June 30, 2011 and 2010, the Frances Cooke Macgregor grants totaled approximately $390,000 and $350,000, respectively.

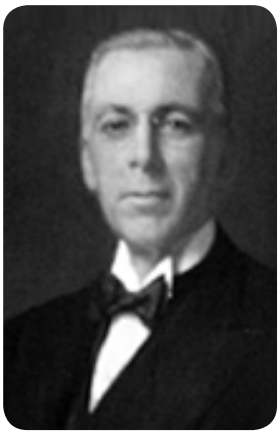
8. Uncertain Tax Position

The Fund has not entered into any uncertain tax positions that would require financial statement recognition. The Fund is no longer subject to audits by the applicable taxing jurisdiction for periods prior to June 30, 2008.

9. Subsequent Events

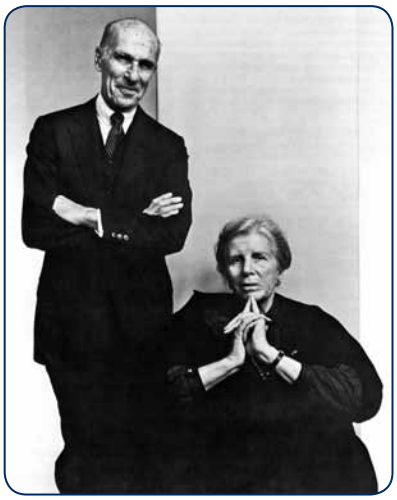
In connection with the preparation of the financial statements, the Fund evaluated subsequent events after the statement of financial position date of June 30, 2011 through November 7, 2011, which was the date the financial statements were available to be issued.

Founders and Benefactors



Anna Harkness and Edward Stephen Harkness

The story of The Commonwealth Fund begins with the family of Stephen V. Harkness, an Ohio businessman who began his career as an apprentice harnessmaker at the age of 15. His instinct and vision led him to invest in the early refining of petroleum and to make a further investment at a critical moment in the history of the fledgling Standard Oil Company. After her husband's death in 1888, Anna Harkness, Stephen's wife, moved her family to New York City, where she gave liberally to religious and welfare organizations and to the city's major cultural institutions. In 1918, she made an initial gift of nearly $10 million to establish a philanthropic enterprise with the mandate "to do something for the welfare of mankind," a broad and compelling challenge. Anna Harkness placed the gift in the wise hands of her son Edward Stephen Harkness, who shared her commitment to building a responsive and socially concerned philanthropy. During his 22 years as president of the foundation, Edward Harkness added generously to the Fund's endowment and led a talented and experienced staff to rethink old ways, experiment with fresh ideas, and take chances, a path encouraged by successive generations of leadership.



Jean and Harvey Picker

In 1986, Jean and Harvey Picker joined the $15 million assets of the James Picker Foundation with those of The Commonwealth Fund. James Picker, a prime contributor to the development of the American radiologic profession, had founded the Picker X-ray Corporation, an industry leader in its field. Recognizing the challenges faced by a small foundation, the Pickers chose the Fund as an institution with a common interest in improving health care and a record of effective grantmaking, management, and leadership. The Commonwealth Fund strives to do justice to the philosophy and standards of the Picker family by shaping programs that further the cause of good care and healthy lives for all Americans.

THE COMMONWEALTH FUND

2011 Annual Report

DIRECTORS AND STAFF

At the April 2011 Commonwealth Fund Board of Directors retreat in Boston, Board members Benjamin Chu, M.D., William Yun, Glenn Hackbarth, and James Tallon learned about health care delivery and payment system innovations in the New England region. Such annual retreats are important to the Board's deliberations over the foundation's program strategy for advancing a high performance health system.

Photo by Michael Malyzsko

DIRECTORS AND STAFF

The Commonwealth Fund's Board of Directors has fiduciary responsibility for the foundation and is charged with ensuring its accountability and effective pursuit of mission. Throughout the foundation's history, its Board has been a policy-setting body, with responsibility for overseeing the overall mission, hiring and assessing the performance of the president/chief executive officer, advising on and approving program strategies, approving spending policy (including allocations of resources among programs and between extramural and intramural work, the Fund's annual budget, and Board-level grants), guiding the management of the Fund's endowment, and assessing the performance of the institution.

In Memory of James J. Mongan

Commonwealth Fund Director James J. Mongan, M.D., passed away on May 3, 2011, after a lengthy battle with cancer. Dr. Mongan joined The Commonwealth Fund Board in 2006, shortly after taking on the role of founding chairman of the Fund's Commission on a High Performance Health System. As a member of the Board, Dr. Mongan was never anything less than crisply insightful, constructive, and supportive of the Fund's mission. But it was in his role as Commission chair that Dr. Mongan's unique gift as a consensus builder, and his sparkling wit and wisdom, really shone.

Over the last five years, under Dr. Mongan's visionary leadership, the Commission established itself as a source of some of the most significant and relevant analysis and advice to policymakers as they debated health care reform. The Commission's national and state health system performance scorecards, in addition to such reports as *An Ambitious Agenda for the Next President* and *Path to a High Performance U.S. Health System* reports (to name just a few of the Commission's many important products), have not only been widely cited as critically important to those discussions, but they also rank among the most widely read publications in Commonwealth Fund history.

Dr. Mongan came to the Fund's Board with a long and distinguished record of leadership in health care policy and delivery system improvement, and with an almost unmatched commitment to ensuring that all Americans—especially the most vulnerable in our society—have access to high-quality health care and full insurance coverage. He was a professor of health care policy and social medicine at Harvard Medical School, and served as president and CEO of Partners HealthCare from 2003 to 2010. From 1996–2002, Dr. Mongan also was president of Massachusetts General Hospital (MGH), the largest and oldest teaching affiliate of Harvard Medical School. Before his tenure at MGH, he served for 15 years as executive director of the Truman Medical Center in Kansas City and as dean of the University of Missouri–Kansas City School of Medicine. Prior to that, he spent 11 years in Washington as a staff member of the Senate Committee on Finance, working on Medicare and Medicaid legislation, and as deputy assistant secretary for health in the Carter administration, before becoming associate director of the domestic policy staff at the White House. He was also a member of the Institute of Medicine of the National Academy of Sciences. Dr. Mongan's history of contributions to The Commonwealth Fund dates back to his chairmanship of our earlier Task Force on the Future of Health Insurance (1999–2005).

Dr. Mongan's presence and intellectual firepower will be greatly missed on the Fund's Board

and on the Commission. To commemorate his dedication to addressing the health care needs of vulnerable populations, the Board has approved the renaming of the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy as the Mongan Commonwealth Fund Fellowship Program and has expanded the program by adding a competitive second-year practicum experience, beginning in 2013.

William R. Brody, Jr., Retires from Board

William R. Brody, Jr., M.D., stepped down from The Commonwealth Fund Board of Directors in April 2011, owing to the many commitments stemming from his responsibilities as CEO of the Jonas Salk Institute. Dr. Brody applied his enormous range of experience and expertise extremely well in his 11 years of service on the Fund's Board.

Dr. Brody encouraged boldness in taking chances on large initiatives, and thereby helped the foundation make a mark in the movement to improve the quality of nursing home care. As a physician, inventor, investor, and university president, he brought unique insights to Board discussions that helped shape the Fund's contributions to the health care reform debate. He encouraged asking tough questions about the performance of programs, and in doing so, strengthened them. His oversight helped ensure that the foundation's research is of the highest quality and targeted on issues where there is likely to be the highest payoff.

His service on the Board's Investment Committee was also invaluable, as he brought unique perspective and experience on endowment management to the Committee's deliberations. His voice during the tumultuous 2008–09 financial crisis was especially important in helping steer the foundation through uncommonly rough waters, by contributing to decisions to make difficult short-term adjustments that will ensure the financial health of the Fund for the long term.

In sum, Dr. Brody was a model Board member in exercising his fiduciary responsibilities: always thoughtful, supportive, and constructively provocative. He, too, will be missed.

Maureen Bisognano Elected to Board

At its July 12, 2011, meeting, the Board elected Maureen Bisognano as a Director of The Commonwealth Fund. Ms. Bisognano is president and chief executive officer of the Institute for Healthcare Improvement (IHI) and a leading authority on improving health care systems.

At IHI, she has worked with health care providers and leaders throughout the world to achieve safe and effective health care, with a focus on motivating and building the will for change, identifying and testing new models of care in partnership with patients and health care professionals, and ensuring the broadest possible adoption of best practices and effective innovations. Ms. Bisognano was IHI's executive vice president and chief operating officer for 15 years before being named president and CEO in 2010.

Ms. Bisognano brings to the Fund's Board a wealth of practical knowledge about the elements of a high performance health system and how to acquire them. Her insights regarding the innovations needed to move the nation's health care system from one that is fragmented and inefficient to one that is well coordinated and efficient for patients and providers will be a valuable asset to the Fund as it works to attain the goal of access to high-quality health care for all Americans.

Ms. Bisognano, an elected member of the Institute of Medicine and a member of the

Commonwealth Fund Commission on a High Performance Health System, is also an instructor of medicine at Harvard Medical School and a research associate in the Division of Social Medicine and Health Inequalities at Brigham and Women's Hospital in Boston.

Remembering Former President Margaret E. Mahoney

Margaret E. Mahoney, former president of The Commonwealth Fund and the first woman to head a major U.S. philanthropic foundation, passed away on December 22, 2011, after a long illness.

As president from 1980 to 1995, Ms. Mahoney revitalized The Commonwealth Fund, which was founded in 1918 and today has assets of $680 million. Previously she had played a key role in the transition of the Robert Wood Johnson Foundation from a family foundation to one of the largest philanthropies in the United States.

Under her leadership, the Fund became a significant force for improving the delivery of health care, addressing the health and developmental needs of vulnerable populations, and strengthening key health care institutions. By bringing about the merger of the James Picker Foundation with The Commonwealth Fund in 1986, she assembled resources that were integral to the emergence of the patient-centered care movement. Other major Fund initiatives carried out under Ms. Mahoney—the Commission on Women's Health (1993–98), Task Force on Academic Health Centers (1996–2003), Commission on Elderly People Living Alone (1985–1990), and a national program promoting mentoring of vulnerable adolescents—were based on her ability to spot emerging issues, engage national and local leaders in bringing attention to them, and mobilize the Fund and other philanthropies' resources to help address them in practical ways.

Upon her retirement from The Commonwealth Fund in 1995, Ms. Mahoney worked with the Fund and other organizations to create Healthy Steps for Young Children, a national initiative to encourage pediatricians to pay more attention to developmental issues in the first three years of life. Some 50 Healthy Steps practices are in operation around the country, serving as models for integrating health care and social services needed by vulnerable children.

A native of Nashville, Tennessee, and a graduate of Vanderbilt University, Ms. Mahoney received honorary degrees from many colleges and universities and served on numerous nonprofit boards. She was also a member of the National Academy of Science's Institute of Medicine, a body she helped create in the 1970s.

Margaret Mahoney left an indelible impression on the field of philanthropy and on The Commonwealth Fund in particular. She will truly be missed.

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Jane E. Henney, M.D.
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William Y. Yun

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1 Current as of January 1, 2012.

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Shreya Patel, *Program Associate, Health System Quality and Efficiency*
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Michelle G. Ries, *Senior Program Associate, International Health Policy and Innovation*
Jennie Smith, *Program Assistant, Payment and System Reform*
David Squires, *Senior Research Associate, International Health Policy and Innovation*

2 Current as of January 1, 2012.

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Christine F. Haran, *Assistant Vice President, Online Information*
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Deborah L. Lorber, *Senior Editor*
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Martha Hostetter, *Consulting Editor and Web Content Developer*

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Jordana Williams, *Executive Assistant to the Executive Vice President and Chief Operating Officer*
Steve Boxer, *Director of Information Technology*
Edwin Antonio Burke, *Assistant Dining Room Manager*
Maureen Deboo, *Manager of Meeting and Administrative Services*
Dane N. Dillah, *Manager of Information Technology*
Trupti Patel Doshi, *Grants Manager*
Paul W. Engel, *Harkness House Curator*
Lauren Hildreth, *Office Services Coordinator and Communications Assistant*
Matthew E. Johnson, *Dining Room Manager*
Leslie K. Knapp, *Financial Associate*
Jamie Sellers, *Receptionist*
Annie Shek, *Grants Assistant*
Shelford Thompson, *Building Manager*

Health System Performance Assessment and Tracking Unit (at the Institute for Healthcare Improvement, Cambridge, Mass.)

David C. Radley, *Senior Analyst and Project Director, Health System Scorecard and Research Project*
Douglas McCarthy, *Senior Research Advisor*

White & Case, *Counsel*
Owen J. Flanagan and Company, *Auditors*

DELIVERY SYSTEM INNOVATION AND IMPROVEMENT

Health System Quality and Efficiency

AcademyHealth
$340,000
Establishing a New Beacon Community Learning Network to Accelerate Local Delivery System Redesign

The federal Beacon Community Program has awarded 17 localities across the United States with three-year grants to build and strengthen their health information technology infrastructure and data exchange capabilities, with the goals of improving care coordination, reducing costs, and accelerating development of accountable care systems. With the understanding that success will depend in part on rapid learning and knowledge dissemination, the project team will establish a learning network for Beacon Communities to help them demonstrate the impact of their community-level health system reforms and to disseminate this information rapidly to local, state, and federal stakeholders. More broadly, this work is expected to inform policymakers about progress in spreading accountable care systems.

Lisa Simpson, MB, BCh, M.P.H.
President and Chief Executive Officer
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Trustees of Dartmouth College
$356,562
Advancing Pilot Tests of Accountable Care Organizations

The spread of accountable care organizations (ACOs) in a multipayer environment faces numerous barriers and requires significant technical work. In phase 1 of this project, the investigative team developed a "starter set" of health care claims-based measures that could be used to assess quality of care as well as determine payments to ACO providers and the shared savings for which they are eligible. In phase 2, the team will develop and test a more advanced set of measures with pilot sites, including clinical outcomes measures and patient-reported measures of care experience and health status. A framework for evaluating the implementation and sustainability of new ACOs will also be created. This work will be of great interest to the Centers for Medicare and Medicaid Services and other organizations as they prepare for nationwide implementation of the ACO model.

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Director, Center for Population Health
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Health Research and Educational Trust
$106,425
Surveying Hospitals and Health Systems About Their Readiness to Be Accountable for the Continuum of Patient Care

Although the Affordable Care Act encourages the establishment of accountable care organizations (ACOs), it is not clear that health care providers are ready to participate in ACOs or will be able to develop the capabilities to do so. In the first study of its kind, researchers will profile U.S. hospitals and health systems for their readiness to be accountable for the continuum of patient care. The project team will survey system leaders about their organizations' ability to: 1) provide integrated primary, acute, and post-acute care services; 2) enable communication and clinical information exchange among all providers involved in a patient's care; and 3) manage financial risk, receive bundled payment, and calculate and distribute shared savings to providers. As the Centers for Medicare and Medicaid Services implements its ACO program, the survey findings will provide the agency with information about hospital system capabilities that may need to be strengthened.

Maulik S. Joshi, Dr.P.H.
President
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Institute for Healthcare Improvement
$268,780
Examining the Potential of Statewide and Local Initiatives to Transform Health Care Delivery

Wide geographic variations in U.S. health system performance highlight opportunities for states and communities to improve the quality and efficiency of care in concert with the anticipated expansion of health insurance coverage. One way The Commonwealth Fund seeks to stimulate higher performance is to identify promising approaches for surmounting challenges. Under this grant, Douglas McCarthy will launch a series of case studies to generate evidence for policymakers and practitioners interested in learning how particular approaches, adopted under various conditions, are helping to meet policy goals and improve health care delivery.

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Institute for Healthcare Improvement
$750,000
The State Action to Avoid Rehospitalizations (STAAR) Initiative

In year 1 of the five-year State Action to Avoid Rehospitalizations (STAAR) initiative, the project team at the Institute for Healthcare Improvement identified effective strategies for reducing the need to rehospitalize patients soon after discharge and recruited three states—Massachusetts, Michigan, and Washington—to commit to reducing readmissions by 20 percent within three years. In year 2, 69 hospitals in those states collaborated in redesigning the care transition process for patients leaving the hospital. The project also supported a state-level leadership coalition to address systemic barriers. In the next year, the project team will identify top-performing hospitals from the first cohort and train them to mentor a sec-

ond cohort of up to 20 new hospital teams in the three states. State leadership groups will focus on: 1) the financial implications of fewer readmissions; 2) improving coordination across care settings; 3) creating measurement systems to track readmission rates; and 4) developing recommendations for regulatory and payment reform.

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Massachusetts General Hospital
$317,162
Surveying Physician Practices About Their Capacity to Provide Coordinated, Patient-Centered Care

A number of federal programs are being implemented to help physician practices transform themselves into providers of patient-centered, coordinated, and efficient care. The proposed survey will assess physicians' capacity to deliver this high level of care. Questions will explore: the organizational settings and local health care markets in which primary and specialty care physicians practice; relationships with other providers; care coordination processes; type of reimbursement; and the use of health information technology to tailor health care interventions based on clinical need, make care safer, support clinical decisions, and exchange clinical information. To assess progress over time, the survey will be conducted first in 2011 and again in 2013.

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Parkland Health and Hospital System
$396,037
Developing a Clinical Decision Support Tool to Prospectively Identify Patients at High Risk for Hospital Readmission

Common, costly, and often preventable, readmissions to the hospital continue to be a major problem within our health care system. The ability to identify quickly which patients are at high risk for readmission and then tailor interventions for those patients would enable hospitals to reduce readmissions in a cost-effective manner. This project will develop an electronic clinical decision support tool, using data obtained from electronic health records, to help hospitals predict which patients are at heightened risk of readmission within one month. After validating the tool with seven hospitals in the Dallas-Fort Worth metropolitan area, it will be made freely available to all U.S. hospitals. The model could also be used to risk-adjust hospital payment under new reimbursement approaches.

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Premier Research Institute
$225,610
Learning What It Takes to Form Successful Accountable Care Organizations

The Affordable Care Act authorizes the creation of accountable care organizations (ACOs)—groups of providers that take responsibility for the cost and quality of the care they provide to patients—and their participation in the new Medicare Shared Savings Program. The Premier Healthcare Alliance has established an accountable care collaborative involving 28 health systems that are ready to function as ACOs, and 58 systems that are developing that capacity. In this project, the Premier team will help other health care organizations become successful ACOs by demonstrating how it has developed its own initiative, how it assesses core capabilities, and how it determines the readiness of members to become an ACO. The team will also develop case studies illustrating how health systems representing a range of organizational models have transformed themselves into this new breed of health care provider.

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Yale University
$390,850
Identifying Hospital Practices That Help Prevent All-Cause Readmissions for Heart Failure Patients
Frances Cooke Macgregor Grant

Hampering efforts to reduce avoidable hospital readmissions is a lack of information about the extent to which hospitals are implementing evidence-based practices and about which practices have the most impact in different settings. The national Hospital to Home (H2H) campaign, which aims to lower readmission rates for cardiovascular patients by 20 percent by 2012, provides an opportunity to get answers to these questions. The project team will first conduct a baseline survey of 600 participating hospitals to identify their current practices for reducing readmissions. These same hospitals will then be resurveyed one year later, allowing the researchers to track the spread and speed of adoption of best practices promoted in the campaign. In addition, the team will examine the associations between reported practices and various hospital characteristics with readmission rates to pinpoint which practices lead to lower readmission rates.

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Small Grants—Health System Quality and Efficiency

Brandeis University
$48,842
Survey of Capitation Contracting and Physician Compensation in Organized Delivery Systems

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President and Fellows of Harvard College
$34,893
A Quarter Century of Public Reporting in Health Care: What Have We Learned?

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Health Care Without Harm
$49,940
Bending the Cost Curve Through Energy and Waste Reduction: Lessons from the Healthier Hospitals Initiative

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Johns Hopkins University
$50,000
Exploring Approaches to Developing a Valid Standard Measure of Rehospitalizations

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National Partnership for Women and Families
$40,000
Assessing Trends in Patient Expectations and Understanding of Health Information Technologies

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Society of General Internal Medicine
$14,300
Association of Chiefs and Leaders of General Internal Medicine Annual Leaders Summit

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Patient-Centered Coordinated Care

American Academy of Family Physicians
$96,668
A Rapid Evaluation of Illinois's Medicaid Medical Home Program

In 2006, state officials in Illinois established a program to link 2 million Medicaid beneficiaries with a medical home, where treatment and patient referrals are coordinated centrally to improve quality and lower health care costs. The program saved the state an estimated $560 million between 2007 and 2009, largely by increasing use of primary and preventive care and reducing emergency department visits and unnecessary hospitalizations. This project will support an analysis of the Illinois program's cost and quality outcomes, together with the rapid submission of findings to a peer-reviewed journal. In light of the severe budget deficits that many states are facing, it is important to promote public awareness of effective medical home initiatives like Illinois's that strengthen primary care while also lowering costs.

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Center for Health Care Strategies, Inc.
$200,000
Using Medicaid Rate Increases as a Lever for Reform of Primary Care Delivery and Payment

The coming increase in Medicaid's reimbursement for primary care providers, as called for in the Affordable Care Act, presents an opportunity to align payments to providers with the improvements they achieve in quality and access to care. Enhanced reimbursement rates should also expand the heavily stretched network of Medicaid primary care providers. This project aims to inform the implementation of the rate increase, maximize coordination between federal and state officials, and minimize the technical burden. The research team will work with at least five state Medicaid agencies and the Centers for Medicare and Medicaid Services, providing guidance on how to implement the change in a way that promotes primary care payment approaches which place a premium on quality and efficiency.

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Center for Health Policy Development, National Academy for State Health Policy
$179,459
A National Workgroup on Integrating a Safety Net into Health Reform Implementation

Vulnerable populations, both those who will gain insurance under health reform and those who will not, require health care providers that are able to meet their needs. Safety-net providers can play important

roles, but those implementing state and federal health reform need to take into consideration these providers' unique characteristics. The National Academy for State Health Policy proposes to convene state and federal officials and safety-net leaders to discuss the major issues and develop policy solutions to facilitate integration of these providers into reform implementation. Some of the topics to be explored by the national workgroup include: the organizational barriers to provider integration, the need for compatible health information technology, and the roles that safety-net providers can play in the forthcoming Medicaid expansion.

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Center for Health Policy Development, National Academy for State Health Policy
$367,226
Sustaining, Strengthening, and Expanding State Medical Home Initiatives

Over the past three years, National Academy for State Health Policy (NASHP) staff have provided technical assistance to Medicaid officials in 16 states that are designing and launching medical home demonstrations targeting low-income populations. With the passage of the Affordable Care Act, even states with the most successful medical home programs will need continued support to strengthen those efforts and capitalize on the Affordable Care Act's numerous opportunities for creating a strong primary care foundation. In particular, state officials will need guidance on how to turn pilots into permanent programs, expand multipayer support, and create systems of integrated care. In this project, NASHP will help up to 17 experienced states sustain, strengthen, and expand their medical home initiatives and create useful models for all states.

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Geisinger Clinic
$170,033
What Makes Medical Homes Work: Lessons for Implementation and Spread

Patients enrolled in the medical home program launched by Pennsylvania's Geisinger Health System receive higher-quality, more-efficient care than those receiving care elsewhere within the system. Interest has now turned to understanding factors associated with successful spread of the model and identifying which features are most associated with greater efficiency. In this project, a team of Geisinger researchers will study the 26 medical home sites and rank practice attributes according to their correlation with a reduction in hospital admissions, readmissions, and total medical costs. The results will guide health system leaders, payers, and policymakers as they target investments to support primary care transformation and national dissemination of the medical home model.

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The George Washington University
$137,309
Assessing Legal Barriers to Clinical Integration Experienced by Health Centers and Public and Private Community Hospitals

The integration of federally qualified health centers (FQHCs) with each other and with public and private community hospitals has the potential to improve the quality and efficiency of health care provided to low-income populations. However, the legislative framework guiding the structure and financing of these organizations presents some barriers to integration. This project will: 1) analyze how the laws regulating FQHCs and safety-net hospitals might impede health center integration; and 2) highlight examples of successfully integrated safety-net providers and document how they were able to overcome legal barriers. The findings will be targeted to members of FQHC and hospital boards and to policymakers.

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President and Fellows of Harvard College
$97,630
Current Financial Status and Funding Sources of Major Urban Public Safety-Net Hospitals: Establishing a Baseline

Public hospitals form a critical component of the country's health care safety net. Funded by a combination of patient care revenue, local and state taxes, and supplemental payments from disproportionate-share payment programs, these institutions contend with wide fluctuations in their funding streams and near-constant financial uncertainty. This project will collect audited financial statements from up to 158 large, urban public hospitals to analyze their funding streams and financial sustainability, with the goal of setting a baseline for monitoring their viability over the next decade as reforms in the Affordable Care Act take hold.

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University of Iowa
$169,766
Strategies in Iowa for Improving Performance of the Health Care Safety Net in the Era of Health Reform

Responsibility for ensuring that vulnerable populations have access to quality health care falls largely to states. Many states have not analyzed their policies and programs systematically, however, and thus may be ill-prepared to seize new opportunities in the Affordable Care Act for strengthening their health care safety nets. Health care leaders in Iowa have proposed to undertake a comprehensive planning effort to identify strategies that they and policymakers in other states could follow to achieve a high performance health care system for their vulnerable populations. This project will convene an advisory group of state officials and safety-net providers to determine the current funding, expenditures, and infrastructure of Iowa's safety net, and then develop strategies for improving integration of the safety net.

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Joan and Sanford I. Weill Medical College of Cornell University
$223,881
Evaluating a Shared Patient-Panel Manager Program in New York City's Primary Care Information Project
Health Services Improvement Award

Most small, independent physician practices have difficulty offering the full range of services that medical homes provide. Patient-panel management, which helps ensure that patients are receiving recommended routine services and chronic disease care, is an example of a core medical home function that many small practices with limited resources cannot fulfill. This project will evaluate a pilot program in New York City in which safety-net practices will share the services of a patient-panel manager. Six panel managers will each assist up to six primary care sites in identifying and reaching out to patients with unmet needs. The evaluation will assess if the quality of care provided to chronically ill patients served by panel managers improves relative to patients not receiving this additional clinical support. The assessment will also identify factors associated with successful program implementation.

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University of New Mexico
$220,945
Spreading New Mexico's Model for Helping Primary Care Practices Become Medical Homes

New Mexico's nationally recognized Health Extension Rural Offices enable independent primary care practices in the state to share clinical resources and receive technical assistance in becoming patient-centered medical homes. These extension centers provide onsite coaching on quality improvement, connect practices with specialists to comanage complex patients, link patients to off-hours nurse triage services, and provide other resources smaller practices lack. This grant will enable a University of New Mexico team to provide technical assistance to three states—Kansas, Kentucky, and Oregon—that are interested in replicating New Mexico's program. The project team will also create an online resource to help state and local policymakers, provider organizations, health plans, and academic health centers across the country adapt the New Mexico model. Cofunding will be provided by the County of Bernalillo, New Mexico, and the Robert Wood Johnson Foundation.

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Qualis Health
$1,499,255
Transforming Safety-Net Clinics into Patient-Centered Medical Homes, 2011–12
Picker Program Grant

In April 2009, 65 safety-net clinics in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania were selected to participate in The Commonwealth Fund's Safety Net Medical Home Initiative, which provides clinics with assistance in becoming patient-centered medical homes and achieving benchmark performance in clinical quality, efficiency, and patient experience. In the past year, the clinics have reduced the time that patients wait to see a clinician, created care teams to enhance communication and efficiency among staff, developed in-house call centers to respond to patients' questions, and established patient–provider panels to improve continuity of care. Moreover, University of Chicago analysts evaluating the initiative report evidence suggesting that clinician staff morale and job satisfaction are higher at clinics with a greater number of medical home attributes. In the year ahead, the project team will continue to: 1) support practice transformation through meetings, webinars, site visits, and a variety of other means; 2) help several clinics achieve formal national recognition as medical homes; and 3) promote a "learning laboratory" for the clinic teams and state leaders through peer-to-peer events.

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RAND Corporation
$161,591
Financial Levers to Promote Integrated Health Care Systems for Low-Income Populations

Integrated health care systems offer vulnerable patient populations access to specialty services, continuity in relationships with providers, and more-coordinated care than smaller independent practices or hospitals typically do. The use of federal safety-net funding to encourage the spread of integrated care systems has the potential to lower health care costs and ensure the sustainability of the safety net. Project staff will research the current and projected flow of federal safety-net funding to determine how that funding might be used to facilitate the integration of community health centers and hospitals. Based on the findings, project staff will identify policy levers that could promote integration of the care systems serving low-income populations.

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Small Grants—Patient-Centered Coordinated Care

American Academy of Family Physicians
$49,984
International Learning on Increasing the Value and Effectiveness of Primary Care

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Regents of the University of California
$39,375
The History, Typology, and Landscape of Extension Service "Practice Coaching"

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Center for Health Policy Development, National Academy for State Health Policy
$9,947
Accountable Care Organizations and Safety Net Health Systems: Assessing Design Issues

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The George Washington University
$50,000
State Policy Incentives to Promote Collaboration and Cooperation Among Hospitals and Other Community Providers

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Issues Research, Inc.
$18,960
Case Study of the Veterans Health Administration's Implementation of Medical Homes

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Board of Regents of the University of Oklahoma
$20,411
Second Summit on Urban Health

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Picker/Commonwealth Fund Long-Term Care Quality Improvement Program

Center for Health Care Strategies, Inc.
$234,822
State Planning for a High Performance Health System for Medicare/Medicaid Dual Eligibles
Picker Program Grant

Medicare and Medicaid have long suffered from misaligned coverage and payment policies and conflicting incentives, leading to inefficient practices and high costs. Among those most hurt by these deficiencies are individuals qualifying for both Medicare and Medicaid—the "dual eligibles"—who often contend with fragmented care and confusing rules. The creation of the new Federal Coordinated Health Care Office and the Center for Medicare and Medicaid Innovation provides an unprecedented opportunity to align the two insurance programs, provide better care to beneficiaries, and slow spending growth. The Center for Health Care Strategies is proposing to work with 10 to 15 states that are ready to implement integrated-care demonstration models. The team will facilitate communication between the states and federal government to ensure these demonstrations meet the goals of both programs and their beneficiaries.

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LeadingAge, Inc.
$154,458
New Goals, New Partnerships: Next Steps for a National Effort to Advance Excellence in Nursing Homes
Picker Program Grant

Advancing Excellence in America's Nursing Homes, a coordinated, coalition-based nationwide effort to improve the quality of nursing home care, has demonstrated its effectiveness over the last two years. In addition to consolidating and updating the eight current goals, the campaign's national steering committee has recommended the pursuit of two new goals: promoting advance care planning and gauging job satisfaction among nursing home staff. In addition, the committee has recommended aligning goals with the Medicare-sponsored Quality Improvement Organizations' new work objectives, which include improving care transitions. This grant will enable Advancing Excellence to develop new metrics for measuring progress toward goals, test the practicability of new goals in three states prior to national rollout, and prepare for goal implementation. It will also support collaboration with the Institute for Healthcare Improvement's Fund-supported effort to reduce rehospitalizations.

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LeadingAge, Inc.
$123,094
Promoting Effective Long-Term Care Transitions in Health Reform Implementation
Picker Program Grant

Historically, long-term supports and services, such as nursing home and home-based care, have not been well integrated with other health care services. This fragmentation of care delivery drives up costs and

compromises outcomes for the millions of Americans who depend on long-term services. Led by the Long-Term Quality Alliance—a broad-based coalition to improve transitional care and promote best practices in the field—this project will explore ways to improve the coordination of transitional care, foster development of better measures of quality and efficiency, and promote adoption of effective practices through a learning network.

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Pioneer Network in Culture Change
$149,977
Seizing the Moment: Nursing Home Culture Change and Health Reform
Picker Program Grant

With Commonwealth Fund support, the Pioneer Network has established itself as the leading force behind culture change in nursing homes and the move to person-centered care. This year, the Pioneer Network, under Bonnie Kantor's leadership, will take advantage of opportunities presented by the new health reform law to spread person-centered care, advise the Centers for Medicare and Medicaid Services on the reframing of the regulatory process to support culture change, and help states, through their culture change coalitions, use payment reform to promote person-centered care and improve transitional care. Pioneer will provide cofunding from its revenues.

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Small Grants—Picker/Commonwealth Fund Long-Term Care Quality Improvement Program

AcademyHealth
$22,567
Building Bridges: Making a Difference in Long-Term Care 2011 Policy Seminar
Picker Program Grant

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Altarum Institute
$17,316
Web Content Delivery for Improving Care Transitions
Picker Program Grant

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University of Massachusetts Foundation, Inc.
$49,995
Increasing Consumer Involvement in Medicaid Nursing Home Reimbursement
Picker Program Grant

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University of North Carolina at Chapel Hill
$27,491
An Assisted Living Consensus Process: Using Expert Collaboration to Inform Public Policy and Practices
Picker Program Grant

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Pioneer Network in Culture Change
$13,500
Environments of Culture Change: A Comparison of THE GREEN HOUSE MODEL® and Retrofitted Culture Change Environments
Picker Program Grant

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The Board of Regents of the University of Wisconsin System
$40,000
Evidence for Consistent Assignment: A Critical Evaluation of the Literature and Current Practices
Picker Program Grant

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HEALTH REFORM POLICY

Affordable Health Insurance

Center for Studying Health System Change
$110,440
The Affordability of Medical Care: Recent Trends at the National and State Level and the Potential Effects of Health Reform

The Affordable Care Act substantially expands health insurance coverage and introduces more affordable and comprehensive private and public health insurance options, in combination with premium and cost-sharing tax credits. How these reforms will affect health-related spending, however, is likely to vary from person to person and from state to state. The project team will analyze trends in the level of financial burden that health care places on U.S. families and the potential impact health reform will have on those trends. This research will inform the work of federal policymakers currently engaged in drafting regulations for the health reform law and state officials who are, or will be, implementing provisions related to the insurance exchanges, tax credits, Medicaid expansion, and the individual requirement to have health coverage.

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The Commonwealth Fund
$300,000
Analysis and Modeling of Health Care Reform and Implementation

With the passage of the Affordable Care Act, it will be beneficial for The Commonwealth Fund to have increased flexibility in approving grants to take advantage of unique opportunities to inform the legislation's implementation. This appropriation for analysis and modeling opportunities will authorize the Fund's president to underwrite projects that will inform policymakers about issues critical to successful implementation of the law's major provisions. Possible projects include: modeling different options to ensure affordability of premiums and reduce the costs of health care and the size of federal budget outlays, including insurance market reforms, new plan choices offered through insurance exchanges, and changes to the individual and employer mandates; legal analysis of the law and regulations as they are issued; and a policy brief series on effective implementation of the coverage provisions, insurance rules, and insurance exchanges.

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Consumers Union of United States, Inc.
$75,000
Consumer Testing of Insurance Coverage Disclosure Forms Under the Affordable Care Act

The Affordable Care Act calls for new insurance coverage disclosure forms and the use of standard terms and definitions which will allow consumers to compare and understand the terms of health plans including premiums, covered benefits, and out-of-pocket cost responsibilities. The disclosures are to be used by all insurance plans beginning in 2012 as well as those sold inside and outside the insurance exchanges by

2014. The law calls for the Departments of Health and Human Services (HHS) and Labor (DOL) to draft the regulations for the forms after consulting with the National Association of Commissioners (NAIC). Though one of the most important steps in developing an effective form is consumer testing, neither NAIC or HHS have the resources to conduct such testing. Consumers Union (CU) is thus proposing formal focus group testing of the form. While the initial form will be in English, HHS is required to eventually develop a form in Spanish and other languages, which may be the subject of a second-phase project. Insurance commissioners from Oregon and Maine, who lead the NAIC working group on the forms, support CU's proposed testing effort, and have expressed interest in leveraging the findings as they prepare their final recommendations to HHS. Likewise, officials from HHS and DOL have expressed support for the proposed project and their intention to incorporate the findings into their final rule.

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Knowledge Networks, Inc.
$363,900
Tracking Health Reform's Impact on Insurance Coverage for Young Adults, Older Adults, and Low-Income Families

Although the Affordable Care Act's key provisions for expanding and improving health insurance coverage will not take effect until 2014, starting this year millions of families will see improvements in their coverage, while the groundwork for implementing the major reforms will be laid. To track the Affordable Care Act's impact as it is implemented and to establish baseline measures prior to 2014, this project will launch three longitudinal online surveys of young adults (ages 19 to 29), older adults (ages 50 to 70), and low-income adults (ages 19 to 64). The surveys' nationally representative sample will be drawn from a pool of over 50,000 individuals who previously agreed to participate in various surveys. As a supplement to the Fund's Biennial Health Insurance Survey, the new survey tool will yield timely information over the coming years on the public's experience with, and views of, health reform.

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RAND Corporation
$235,017
Current Health Benefits for Workers with Low and Moderate Incomes and Potential Effects of the Affordable Care Act

The Affordable Care Act includes a range of provisions intended to improve the accessibility and affordability of health insurance for workers with low and moderate incomes. Using a microsimulation model, a RAND team will predict the effects of these provisions, which take effect in 2014, on workers' insurance status, source of coverage, and out-of-pocket health spending. The team will also analyze the law's impact on health coverage in the event the individual requirement to have health insurance is waived or repealed. The findings will inform the federal rule-writing process and the work of state policymakers charged with establishing insurance exchanges and expanding Medicaid eligibility.

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Small Grants—Affordable Health Insurance

The Commonwealth Fund
$20,285
Conference on Risk-Adjustment Under the Affordable Care Act

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The George Washington University
$50,000
State Health Insurance Exchange Legislative Comparison Study: Phase One Analytic Framework

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President and Directors of Georgetown College for Georgetown University
$84,943
Massachusetts Health Insurance Reform: Promise and Results

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Medicare Rights Center, Inc.
$14,325
The Need for Seamlessness: Ensuring Smooth Transitions from Health Insurance Exchanges to Medicare

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National Opinion Research Center
$46,104
How Will 2010 Insurance Reforms Affect Health Insurance Premiums in 2011?

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New America Foundation
$17,500
Report on the California Health Benefit Exchange

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Small Business Majority Foundation Inc.
$48,500
Key Issues in Implementing the Consumer Operated and Oriented Plan (CO-OP) Program Under the Affordable Care Act

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Payment and System Reform

The George Washington University
$254,710
Medicare Private Plans in the Era of Health Care Reform

The Affordable Care Act contains several provisions designed to make private Medicare Advantage (MA) insurance plans more efficient and more effective in providing Medicare beneficiaries with coordinated care. First, the legislation lowers reimbursement for MA plans so that per-beneficiary costs are more in line with traditional fee-for-service Medicare. It also rewards plans that perform well on measures of quality and patient experience and strengthens protections for beneficiaries in MA plans. This project will analyze the impact that the new policies have on these plans and their enrollees, examine the MA program's potential for developing new models of coordinated care, and offer insight on how private plans might compete in the new health insurance exchanges.

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President and Fellows of Harvard College
$290,270
Understanding Geographic Variation in Health Care Costs for Privately Insured Patients and Medicare Beneficiaries

Medicare utilization and spending are known to vary from region to region and have been the subject of extensive analysis. Patterns of use and spending in commercial insurance markets, however, are not as well understood—and even less is known about the relation between Medicare and private spending, and how and why that relationship varies across geographic areas. Using claims data from Medicare and commercial claims data from large employers, this project will examine the factors related to variation in Medicare and private spending across hospital referral regions. Understanding more about these factors will enhance policymakers' ability to develop more effective policies to constrain health spending and align payment incentives across the health system.

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Small Grants—Payment and System Reform

Bailit Health Purchasing, LLC
$38,000
Current Experience with Shared Savings Payment Models

Michael H. Bailit
President
56 Pickering Street
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mbailit@bailit-health.com

Brandeis University
$15,000
Where Do We Go From Here? The Future of Health Care Reform

Stuart H. Altman, Ph.D.
Professor and Chairperson, Council on Health Care Economics and Policy
The Florence Heller Graduate School
Institute for Health Policy - MS035
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Health Research and Educational Trust
$49,977
Engaging Providers in the Design and Implementation of Innovative Demonstration Projects

Maulik S. Joshi, Dr.P.H.
President
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Pacific Business Group on Health
$43,000
Identifying Promising Payment Reform Models

Suzanne F. Delbanco, Ph.D.
Executive Director
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San Francisco, CA 94105
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Vermont State Legislature
$48,020
Enhanced Modeling of Baseline Federal Reform and Impact on Vermont Economy

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POLICY DEVELOPMENT AND CONVENING

Alliance for Health Reform
$338,479
Commonwealth Fund Bipartisan Congressional Retreat, 2011

The Commonwealth Fund's annual Bipartisan Congressional Retreat offers members of Congress the opportunity to engage in substantive dialogue about timely health policy issues in an environment free from partisan politics, jurisdictional debates, and media pressures. The conference is a direct way to reach one of the Fund's most influential audiences, and it helps build working relationships with those members who can advance the Fund's mission. Given the passage of the Affordable Care Act in 2010, the retreat will enable participants to take stock of progress made in the first year of implementation, examine political and policy challenges, and discuss provisions requiring technical corrections or areas where additional reforms might be needed.

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Alliance for Health Reform
$297,229
Health Policy Seminars, Roundtables, and a Retreat for Congressional and Support Agency Staff, 2010–11

Alliance for Health Reform briefings are a valuable resource for congressional staff, journalists, and members of the broader Washington policy community who are seeking the latest health policy information and analysis. In the coming year, the Alliance will conduct seven Commonwealth Fund-sponsored briefings or roundtables on Capitol Hill. The sessions will focus on topics most relevant to policymakers, particularly areas pertinent to implementation of health reform in 2010 and 2011. The annual Congressional Staff Retreat provides an opportunity for 50 to 75 senior health staff from both parties to engage in an informal, off-the-record exchange of ideas. The retreat is a partnership with the Catholic Health Association of the United States, which provides cofunding.

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Center for Health Policy Development, National Academy for State Health Policy
$282,000
ABCD III: Improving Care Coordination, Case Management, and Linkages to Support Healthy Child Development, Year 3

The Commonwealth Fund
$300,000
Authorization to Support the Initiative in Five States

Directed by the National Academy for State Health Policy, the current Commonwealth Fund-supported Assuring Better Child Health and Development (ABCD) initiative selected five states through a competitive process to test transformative models of care coordination—a critical component of high-quality, efficient health care. The two previous ABCD projects resulted in states' adoption of developmental screening policies and the incorporation of screening measures into the National Survey of Child Health and the Child Health Insurance Program. The current ABCD initiative is helping Arkansas, Illinois, Minnesota, Oklahoma, and Oregon develop integrated, community-based systems of care coordination for children. In the third year of ABCD, the project team will evaluate the care coordination pilot programs and disseminate findings. With this grant, the Fund concludes its support for state ABCD projects.

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The Commonwealth Fund
$122,400
Commonwealth Fund Commission on a High Performance Health System: Meetings

Over the coming months and years, the Commonwealth Fund Commission on a High Performance Health System will closely monitor implementation of the health reform package, focusing on payment system and delivery system reform issues, options for slowing cost growth and filling remaining gaps in insurance coverage, and lessons from reforms undertaken abroad. In addition, the Commission will continue to issue periodic health system performance scorecards and inform such Fund-sponsored activities as the Bipartisan Congressional Health Policy Conference, Congressional Staff Retreat, and Alliance for Health Reform briefings and roundtables. This grant will support the Commission's three annual meetings, at which the group discusses current projects and decides on future undertakings.

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The Commonwealth Fund
$250,000
Seizing Opportunities to Facilitate State Health Care Reform

Among its many reforms, the Affordable Care Act will expand eligibility for state Medicaid programs and confer on states new responsibilities for operating health insurance exchanges and all-payer claims databases. As a result, states will soon have much greater influence within the health care marketplace than before. At the same time, the November gubernatorial elections will likely yield a raft of newly appointed state officials in need of information and guidance on health reform implementation. With this special opportunities authorization, a set of small grants will enable The Commonwealth Fund to support efforts to convene state officials to discuss health reform issues. Grantees will produce a series of reports focused on ways to expand public–private collaboration within health care delivery to achieve higher levels of care coordination, chronic care management, and preventive care.

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Harris Interactive, Inc.
$53,000
Health Care Opinion Leaders Survey, Year 6

The Commonwealth Fund's Health Care Opinion Leader surveys contributed important information to the health reform debate, and they are likely to continue to play a key role during implementation of the Affordable Care Act. The surveys, conducted by Harris Interactive, explore a range of key health policy issues and the options for addressing them. The findings are published in *Modern Healthcare* and on the Fund's Web site, along with data briefs prepared by Fund staff and original commentaries written by top policy experts. Building on the success to date with this project, the Fund will support an additional year of surveys to cover major issues closely aligned with the work of the Fund's Commission on a High Performance Health System.

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Small Grants—Policy Development and Convening

AcademyHealth
$25,000
Support for the 2011 Activities of AcademyHealth's State Health Research and Policy Interest Group

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Alliance for Health Reform
$40,000
Additional Costs for 2011 Bipartisan Congressional Health Policy Conference

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Center for Health Care Strategies, Inc.
$49,560
Preparing Medicaid for Increasing Primary Care Rates

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Center for Health Care Strategies, Inc.
$25,541
Supporting the National Association of Medicaid Directors' Health Reform Efforts

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The George Washington University
$50,000
Analysis of Health Reform Implementation Issues Likely to be Revisited in the 112th Congress

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Greater New York Hospital Association
$1,200
22nd Annual Symposium on Health Care Services in New York: Research and Practice

Tim Johnson
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Oregon Health and Science University
$7,369.95
Measure Stewardship for the CHIPRA Core Measure Focused on Standardized Screening

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Child and Adolescent Health Measurement Initiative
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Virginia Commonwealth University
$48,956
Financial and Quality Care Assessment of Medicaid Managed Care Plans

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HEALTH SYSTEM PERFORMANCE ASSESSMENT AND TRACKING

AARP Foundation
$349,504
Producing a State Long-Term Care Scorecard

In the first phase of this project to develop a state scorecard focused on long-term care, the project team articulated a vision for a high-performing long-term care system and developed a conceptual framework for the scorecard, and soon it will finalize a set of performance indicators. With continued input from national experts and a technical workgroup, the team will create the scorecard, drawing from publicly available data sets as well as findings from an AARP state survey. Feedback from state officials and federal policymakers suggests that the new scorecard, along with subsequent updates, will be a highly useful resource in implementing and evaluating new federal reforms related to long-term care.

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Health Management Associates, Inc.
$308,759
Case Studies of Innovation and High Performance for WhyNotTheBest.org

In addition to presenting publicly available data on a wide range of quality-of-care and process measures, the Fund Web site WhyNotTheBest.org offers health care providers a number of other resources,

including case studies of high-performing hospitals and health systems. The proposed grant will support a new series of case studies and synthesis reports focusing on high-priority areas such as integrated health delivery, care coordination, patient safety, and health information technology. These timely publications, along with companion webinars, will inform leaders in health care delivery as they strive to fulfill their roles in health reform.

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Health Research and Educational Trust
$215,944
Tracking Progress in Health Care Integration and Adoption of Best Practices for High Performance: A Data Brief Series

The U.S. health care system is entering a phase during which dramatic changes—both planned and unanticipated—will occur more rapidly than at any time in the past. This project will produce four to six data briefs for WhyNotTheBest.org and The Commonwealth Fund's main Web site that summarize information about the nature and impact of these structural and organizational changes. Drawing from the data "warehouse" maintained by the Health Research and Educational Trust, the briefs, which will reflect national health reform priorities, will cover such topics as: the wider use of health information technology by providers and its impact on quality and efficiency; how hospitals' efforts to reduce readmissions are affected by external factors like population health; and how the level of service integration relates to performance. The new publications will identify for health system leaders and policymakers the new interventions that produce results, while also illuminating unanticipated effects that may result.

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IPRO, Inc.
$524,702

Pear Tree Communications, Inc.
$168,120

Raising the Bar for Web Resources on Health Care Performance Benchmarking and Improvement: Upgrades for WhyNotTheBest.org

In 2010, The Commonwealth Fund's quality improvement resource for health care providers, WhyNotTheBest.org, was enhanced with new data sets and maps that provide regional views of performance. This year's grant, in addition to supporting the site's hosting and maintenance, will enable IPRO and Fund staff to update data sets, add new information on physician performance and prevention, and highlight hospital systems' structural features, which will enable comparisons among systems with varying degrees of integration. The grant also will support the development of tools for estimating the improvement in patient outcomes and health care costs if organizations were to raise their performance to "best in class." Through a unique partnership with states that publicly report hospital safety and quality indicators, WhyNotTheBest.org will continue to supply health care leaders with cutting-edge information needed for performance improvement.

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Cleveland Heights, OH 44118-2033
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Small Grants—Health System Performance Assessment and Tracking

Harris Interactive, Inc.
$27,500
Public Views on Health System Performance

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Project HOPE—The People-to-People Health Foundation, Inc.
$25,000
Innovations Across the Nation: Case Studies on Improving Health and the Delivery of Health Care While Reducing Costs

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INTERNATIONAL HEALTH POLICY AND INNOVATION

The Commonwealth Fund
$1,682,500
Harkness Fellowships in Health Care Policy and Practice, 2012–13

Support for a 15th class of Harkness Fellows in Health Care Policy and Practice will allow the Fund to continue development of promising policy researchers and practitioners from Australia, Canada, Germany, the Netherlands, New Zealand, Norway, Switzerland, and the United Kingdom. In 2011, a Swedish Harkness Fellowship will be launched, made possible with funding from the Swedish Ministry of Health. Building on the partnership model that has enabled the European expansion of the Harkness Fellowships, sponsorship will be sought to expand the program to Denmark and France in 2012. A Harkness Alumni Policy Forum will be held in May in Washington, D.C., and the 10-year review of the Harkness

Fellowships in Health Care Policy and Practice will be published in July 2011. In the year ahead, the Fund will continue to leverage the program, drawing on alumni expertise to identify and highlight international policy and delivery system innovations relevant to U.S. health reform implementation.

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The Commonwealth Fund
$365,000
International Symposium on Health Care Policy, Fall 2011

The Fund's 14th annual International Symposium on Health Care Policy will compare policies and strategies across industrialized countries for reducing the growth of health care expenditures, as aging populations drive increasing demand for health services. Of particular interest are international approaches to provider payment reform; the use of comparative effectiveness research in insurance benefit design; best practices for pricing pharmaceuticals, medical imaging, and medical devices; and disease management and delivery system redesign. In bringing together leading policymakers and researchers from 12 countries, the symposium will highlight for U.S. policymakers the strategies that other nations have employed to ensure high-level performance and sustainability. The Fund and the Alliance for Health Reform will also cosponsor a briefing on Capitol Hill showcasing international reforms relevant to the U.S. The journal *Health Affairs* will consider online publication of papers commissioned for the symposium.

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Harris Interactive, Inc.
$435,000
International Health Policy Survey, 2011

The Commonwealth Fund's 2011 International Health Policy Survey will assess health care system performance and responsiveness from the perspective of adults who have chronic disease or other serious health problems, or who have had recent surgery or been hospitalized. Conducted in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States, the survey will focus on such topics as access to patient-centered care, safety of care, collaborative care approaches, and patient engagement. The analysis of the findings, which will be presented at the Fund's 2011 International Symposium and discussed in an article submitted to *Health Affairs,* will examine the extent to which variations in experiences reflect different systems of care and insurance. Within the U.S., the survey findings will help track the nation's progress in creating patient-centered accountable care systems. Cofunding is expected from foundation and government partners within the survey countries.

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London School of Economics and Political Science
$201,630
International Lessons for Bending the Curve: Achieving a High Performance Health Care System While Reducing Growth in Health Expenditures

Following passage of the Affordable Care Act, there is renewed debate over the best way to curtail the steady climb in health care costs. This grant, the fourth in a series to the London School of Economics and Political Science, will support the work of an international advisory group that will identify and compare best practices for maximizing value and containing costs, and then assess their potential applicability to the United States. The group's target areas will include value-based insurance benefit design, payment for chronic disease management, and pharmaceutical and medical device pricing and policy. Project results will be presented at the Fund's 2011 International Symposium on Health Care Policy and summarized in four papers to be submitted to *Health Affairs.* A Commonwealth Fund/Alliance for Health Reform briefing on Capitol Hill will further disseminate findings.

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The Nuffield Trust
$75,000
Commonwealth Fund/Nuffield Trust International Conference on Health Care Quality Improvement, 2011

The 12th conference in the series of annual transatlantic forums on quality improvement sponsored by The Commonwealth Fund and the United Kingdom's Nuffield Trust will examine how sweeping health reforms in the U.S. and U.K. aim to transform health care delivery and achieve cost savings. Sessions will focus on: accountable care organizations in the U.S. and general practitioner–commissioning consortia in England; the relative roles of competition and regulation in driving quality and integration; the organizational environments that motivate and engage young physicians; and the policy environments that allow models of excellence in health care delivery to thrive. Insights gained from the meeting will inform thinking on U.S. health care reform as well as the work of the Fund's Commission on a High Performance Health System. The Nuffield Trust will provide cofunding.

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Urban Institute
$125,000
Enhancing the International Program's Communications and Publications Capacity, Year 3

To strengthen the impact of The Commonwealth Fund's International Program and spark creative health policy thinking in the United States, the Urban Institute's Bradford Gray will work with Fund staff to produce a series of issue briefs highlighting innovations in health policy and practice from abroad that might be of interest to U.S. audiences. These publications will provide a much-needed vehicle for bring-

ing fresh ideas from abroad to the attention of U.S. policymakers, journalists, and researchers. Gray will serve as the series' coeditor, helping to identify topics and working with international authors to present information in an accessible format.

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Small Grants—International Health Policy and Innovation

The Commonwealth Fund
$27,200
Commonwealth Fund/Alliance for Health Reform International Briefing on Electronic Medical Records: Lessons from Abroad on Implementation and Meaningful Use

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Harris Interactive, Inc.
$30,100
Inclusion of Germany in the 2011 Commonwealth Fund International Health Policy Survey

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Health Services Research Association of Australia and New Zealand
$5,000
7th Australia–New Zealand Health Services and Policy Research Conference

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Professor in Health Economics
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Keio University
$13,000
Lessons Learned from Japan as a Model for Containing Health Care Costs

Naoki Ikegami, M.D., Ph.D.
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Organisation for Economic Cooperation and Development (OECD)
$49,982
Initiating International Comparisons of Health IT Use

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Scientific Institute for Quality of Healthcare
$36,384
Expansion of the 2011 Commonwealth Fund International Health Policy Survey to Include the Netherlands

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Ulm University
$3,000
Forum on Health Policy Management: Harkness Fellowship Marketing Lunch

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OTHER CONTINUING PROGRAMS

Communications

The Commonwealth Fund
$985,000
Supporting the Fund's Communications and Publishing Capacity to Reach Change Agents and Inform Public Discourse

The Commonwealth Fund's communications department partners and contracts with numerous organizations and individuals to disseminate the foundation's work to policymakers, stakeholders, and the public at large. At its April 2010 meeting, the Board of Directors, recognizing that these relationships constitute extramural expenses, approved packaging the costs as an annual authorization to the Fund beginning in July 2010. This authorization will provide support to continue and enhance our communications activities and partnerships in four main areas in fiscal year 2010–11: publications development and dissemination; Web design and content development; media services; and licensing.

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The Commonwealth Fund
$100,000
Authorization to Support Additional Publishing Projects

The Commonwealth Fund's online publishing partnership with the policy journal *Health Affairs* has provided opportunities to publish Fund-supported research faster and more frequently than traditional means allow, while also raising the Fund's professional and public profile. This grant will provide the journal with an additional year of funding for Web operations as well as the development of new media and social-networking capabilities online. A separate authorization to the Fund will support additional special publishing opportunities with Health Affairs or other organizations.

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Project HOPE—The People-to-People Health Foundation, Inc.
$200,000
Web Publishing Alliance with Health Affairs

The Commonwealth Fund's online publishing partnership with the policy journal *Health Affairs* has provided opportunities to publish Fund-supported research faster and more frequently than traditional means allow, while also raising the Fund's professional and public profile. This grant will provide the journal with an additional year of funding for Web operations as well as the development of new media and social-networking capabilities online. A separate authorization to the Fund will support additional special publishing opportunities with *Health Affairs* or other organizations.

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Small Grants—Communications

Center for Excellence in Health Care Journalism
$35,000

Support for the Association of Health Care Journalists' Annual Conference and European Health Journalism Conference, and Support for a New Aging and Long-Term Care Online Learning Center

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Trustees of Columbia University in the City of New York
$28,000
2011 Educational Insert in Columbia Journalism Review

Louisa Kearney
Advertising Director
2950 Broadway
New York, NY 10027
ldkpub@aol.com

CUNY TV Foundation
$48,000
"Talking Health" TV Series on CUNY TV

Robert Isaacson
President and Treasurer
365 Fifth Avenue, Suite 1400
New York, NY 10016
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MINORITY HEALTH POLICY FELLOWSHIP

President and Fellows of Harvard College
$800,000
The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: Support for Program Direction and Fellowships, 2011–12

Since 1996, the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy has played an important role in reducing pervasive racial and ethnic disparities by building a cadre of dedicated physicians who are trained to lead efforts to improve minority Americans' access to quality medical care. During the year-long program at Harvard University, physicians enrolled in the master's program in public health or public administration undertake intensive study in health policy, public health, and management, all with an emphasis on minority health issues. Fellows also participate in special program activities over the course of the year.

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Dean for Diversity and Community Partnership
Minority Faculty Development
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Small Grants—Minority Health Policy Fellowship

President and Directors of Georgetown College for Georgetown University
$50,000
Assessing the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy

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Organizations Working with Foundations and Institutional Support

AcademyHealth
$18,000
General Support

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Addison County Home Health and Hospice, Inc.
$2,500
Donation to Addison County Home Health and Hospice on Behalf of Governor James Douglas

Larry Goetschius
Executive Director
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Middlebury, VT 05753

American Legion Hospital
$3,000
Gift to The American Legion Hospital in Memory of Ezra Breaux, Jr.

Terry W. Osborne
Chief Executive Officer
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The Center for Effective Philanthropy
$10,000
General Support

Phil Buchanan
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The Communications Network
$3,500
General Support

Bruce S. Tratchenberg
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Fluxx Labs, Inc.
$25,000
Grants Database Implementation Support

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Foundation Center
$15,000
General Support

Bradford K. Smith
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Grantmakers in Aging, Inc.
$6,500
General Support

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Grantmakers In Health
$15,000
General Support

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Grants Managers Network, Inc.
$2,000
General Support

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HHC Foundation of New York City, Inc.
$3,000
STAT! For New York City's Public Hospitals!

Susan Jacobs
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International Society for Quality in Health Care, Inc.
$1,300
General Support

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National Medical Fellowships
$6,000
National Medical Fellowships 65th Anniversary New York Gala

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Nonprofit Coordinating Committee of New York
$35,000
General Support

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Trustees of the University of Pennsylvania
$22,731
The Commonwealth Fund's Child Development and Preventive Care Program, 1999–2011

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Philanthropy New York
$15,100
General Support

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Primary Care Development Corporation
$6,000
Primary Care Development Corporation 2011 Annual Spring Gala

Ronda Kotelchuck
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Rockefeller Archive Center
$90,000
Transfer and Maintenance of The Commonwealth Fund's Archives, Year 15

This grant will support the transfer, processing, and storage of additional Commonwealth Fund materials at the Rockefeller Archive Center, which has housed the Fund's archives since 1985 and continues to be an important research center on the history of philanthropy. In addition, this grant will support one year of archiving services from Internet Archive for the Fund's two Web sites, www.commonwealthfund.org and www.whynotthebest.org.

Lee R. Hiltzik, Ph.D.
Assistant Director and Head of Donor Relations and Collection Development
15 Dayton Avenue
Sleepy Hollow, NY 10591-1598
lhiltzik@rockarch.org

San Antonio Area Foundation
$25,000
Establishment of a Fund for Public Health in San Antonio

Clarence R. Williams
President and Chief Executive Officer
110 Broadway, Suite 230
San Antonio, TX 78205
crwilliams@saafdn.org

United Hospital Fund of New York
$15,000
2010 United Hospital Fund Gala

James R. Tallon, Jr.
President
1411 Broadway, 12th Fl.
New York, NY 10018
jtallon@uhfnyc.org

SUMMATION OF PROGRAM AUTHORIZATIONS

Year ended June 30, 2011

	Major Program Grants	Small Grants Fund Grants	Total Authorizations
Program Grants Approved			
Delivery System Innovation and Improvement	$7,111,950	$548,108	$7,660,058
Health System Quality and Efficiency (see Note 1)	$2,925,816	$213,554	$3,139,370
Patient–Centered Coordinated Care (see Notes 2 and 3)	$3,523,763	$163,685	$3,687,448
Picker/Commonwealth Long–Term Care Quality Improvement Program (see Note 2)	$662,371	$170,869	$833,240
Health Reform Policy	$3,498,055	$663,831	$4,161,886
Affordable Health Insurance	$1,084,357	$196,714	$1,281,071
Payment and System Reform	$770,590	$180,000	$950,590
Policy Development and Convening	$1,643,108	$287,117	$1,930,225
Health System Peformance Assessment and Tracking	$1,217,525	$52,500	$1,270,025
International Program in Health Policy and Innovation	$2,884,130	$189,658	$3,073,788
Communications	$1,285,000	$136,000	$1,421,000
Other Continuing: Minority Health Policy Fellowship	$800,000		$800,000
Organizations Working with Foundations and Institutional Support	$236,400	$133,231	$369,631
Total Program Grants Approved	$17,033,060	$1,723,328	$18,756,388
Grants Matching Gifts by Directors and Staff			$383,654
Program Authorizations Cancelled or Refunded and Royalties Received			($224,439)
Total Program Authorizations			$18,915,603

NOTES:
(1) Frances Cooke Macgregor Award of $390,850 in 2010–11.
(2) Picker Program Grants totalled $2,332,495 in 2010–11.
(3) Health Services Improvement Award of $223,881 in 2010–11.