



2012 ANNUAL REPORT





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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 2012 Annual Report offers highlights of the Fund's activities in the past year.

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HEALTH CARE REFORM:

A Journey

KAREN DAVIS



2012 ANNUAL REPORT
PRESIDENT'S MESSAGE

Health Care Reform: A Journey

President's Message

This year was a dramatic one for health care reform and, for several months around the Supreme Court's decision on the constitutionality of the Affordable Care Act, a time in which an unusually large number of Americans were closely following federal health policy. As we learned last summer, the Supreme Court ultimately upheld the law, enabling vital health care delivery and health insurance reforms to continue and an estimated 30 million Americans to gain health insurance coverage by the end of the decade.

It has been rewarding to see the United States finally on the path to joining all other major industrialized countries in ensuring near-universal health insurance coverage. This accomplishment is one that U.S. presidents have struggled to achieve over the past hundred years—and one that I've worked toward over the course of my entire career. Thanks to the health reform law, we as a nation will no longer have a health care system that allows so many Americans to suffer from treatable diseases because they cannot afford health care—or to lose their savings to pay for treatment.

This year has also served as a time to reflect on my 18 years as president of The Commonwealth Fund. As an economist with a background in both policy and academia, my overarching goal for The Commonwealth Fund has been to help improve U.S. health system performance by identifying and evaluating achievable solutions to systemic problems of access, quality, and efficiency, especially for the most vulnerable.

In many ways, the Affordable Care Act has been the fruition of work that The Commonwealth Fund and

others have conducted over the past 20 years. The law's principles were articulated a decade ago in such articles as “A 2020 Vision for American Health Care” (2000), which helped promote the concept of patient-centered primary care, and in “Creating Consensus” (2003) and “A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to Employees” (2005), which outlined an approach to coverage expansion that included individual and employer mandates, a purchasing pool for affordable coverage, and public program expansions.

Today, a number of these principles and recommendations are beginning to realize their promise: There has already been substantial progress in the first two years of the Affordable Care Act's implementation. An estimated 6.6 million young adults gained coverage in 2011 through their parents' health insurance, thanks to the provision guaranteeing dependent coverage up to age 26. And, after 12 years of increases in the uninsured, the number of people without coverage dropped by 1.3 million in 2011. As of December 2012, 18 states and the District of Columbia have submitted applications to HHS to operate a state-run exchange in 2014, and six states are pursuing a state-federal partnership exchange. In addition, seven states and the District of Columbia have used new federal matching funds to expand eligibility for adults through their Medicaid programs, covering 600,000 people.

Nearly all states have taken legislative or regulatory steps to implement the law's early [insurance market reforms](#),



President
Karen Davis

including a ban on gender and age discrimination, and coverage of preventive care services without cost-sharing. Over the course of 2012, insurers either lowered their premiums or paid consumers and small businesses rebates amounting to more than \$1 billion under the law's requirement that they spend at least 80 to 85 percent of their premium revenues on medical costs, as opposed to administration and profits. And nearly 94,000 uninsured people with preexisting health conditions have gained coverage through state-based preexisting condition insurance plans.

In addition, the Centers for Medicare and Medicaid Services (CMS) is supporting many innovative health care delivery and payment initiatives to help identify what strategies work best to improve care and lower spending. There is evidence that such federal initiatives, and others in place in states and in the private sector, are already beginning to slow health care spending growth. Although the fact that health care spending grew at the slowest rate in 50 years in 2009 and 2010 is partly attributable to more people skipping care because of costs, we may also be witnessing the early impact of the spread of new models of health care delivery, improved quality and safety, health information technology, and preventive care.

It is gratifying for me to reflect upon the fact that The Commonwealth Fund has—over the past 18 years—contributed significantly to these achievements in a number of ways:

- providing timely policy analysis
- identifying promising models of coverage and health care delivery and encouraging innovation
- creating comparative analyses, including national and international comparisons
- fostering the international exchange of information
- training future leaders
- communicating effectively.

PROVIDING TIMELY ANALYSIS

The Commonwealth Fund Commission on a High Performance Health System, established in 2005, has shaped a guiding and unifying vision for the work of the Fund. The Commission, first chaired by the late James Mongan, M.D., the former president and CEO of Partners HealthCare, and now by David Blumenthal, M.D., the Fund's incoming president, includes experts and leaders representing every sector of health care, including federal and state policy, business, and academia. Its landmark reports, including *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (2007), *A High Performance Health System—An Ambitious Agenda for the Next President* (2007) and *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (2009) substantially informed the debate leading up to enactment of the Affordable Care Act.

The predecessor to the Commission was the Task Force on the Future of Health Insurance, created in 1999 and chaired by Dr. Mongan. That body identified strategies for expanding and improving coverage for America's working families and informed Massachusetts' groundbreaking health reform plan. Task Force members included Kathleen Sebelius, current Secretary of the U.S. Department of Health and Human Services.

The Commonwealth Fund has since become known for measuring progress on issues related to health insurance coverage and access to care. We began the National Survey of Health Insurance in 1997, which later evolved into the Biennial Health Insurance Survey—an ongoing source of information on coverage trends, including high rates of uninsured young adults. In a 2004 report, we proposed extending the age for dependent coverage to address this problem; the idea was later realized in the Affordable Care Act.

The Biennial Health Insurance Survey also helped us identify the growing problem of “underinsurance,” which arises when people cannot afford their out-of-

pocket medical costs despite having health insurance. Last fall, Commonwealth Fund researchers found that the number of underinsured adults rose by 80 percent between 2003 and 2010, from 16 million to 29 million. The essential benefits provision in the Affordable Care Act will help reverse this trend over the coming decade.

Today, in addition to the Fund's new Health Insurance Tracking Surveys, which will help gauge the impact of the health reform law, the Affordable Health Insurance Program provides timely analyses on implementation of the law's coverage provisions, such as the state health insurance exchanges that will serve as marketplaces where individuals and small businesses can buy private coverage.

The Program on Medicare's Future (1997–2008) likewise provided analysis that informed the development of the Medicare Part D prescription drug benefit, helped flag the overpayments to private Medicare Advantage plans that were eliminated under the Affordable Care Act, and demonstrated the need for care coordination within Medicare and the health system at large.

The Fund has also been a pioneer in payment reform, supporting early work on what is now known as bundled payment; funding evaluations of pay-for-performance programs and other payment innovations; and, more recently, looking at shared savings programs. The Payment and System Reform program has also provided guidance to the new Center for Medicare and Medicaid Innovation.

HIGHLIGHTING INNOVATION

In 2000, The Commonwealth Fund created the first foundation-sponsored health care quality program. The program has supported important research on the causes and shortcomings in health care delivery, while highlighting innovative interventions to reduce hospital readmissions, enhancement of health care information technology infrastructure, and patient safety. The

program is also contributing to our understanding of the collaborative care models known as accountable care organizations, by identifying trends and keys to success.

Commonwealth Fund–supported analysis of the program's [State Action on Avoidable Rehospitalizations \(STAAR\)](#) shows that the initiative has led to statistically significant reductions in hospital readmissions within 30 days of discharge. A national survey of hospitals suggests that those participating in the STAAR program are more likely to have adopted interventions like enhanced assessments of patients before they leave the hospital, enriched patient education, and better contact with postacute care providers prior to discharge.

The Patient-Centered Primary Care program, launched in 2005, is largely dedicated to another promising model of care: the patient-centered medical home. This program is helping primary care practices around the country transform into medical homes, which provide around-the-clock access to coordinated care that meets patients' needs. [Preliminary results](#) from medical home studies suggest a 21 percent decrease in hospitalization and 31 percent decrease in emergency department use, leading to reduced health care expenditures per capita.

Other programs have focused on specific populations in need. The Fund's Program on Vulnerable Populations aims to improve care and identify models of care that meet the special needs of low-income, uninsured, and otherwise disadvantaged groups, as well as methods of assisting safety-net providers in becoming high-performing health systems.

Building on the foundation's long history in child health, the Program on Child Development and Preventive Care, which ran from 2001 to 2009, helped promote the healthy development of young children by encouraging routine developmental and behavioral screening of young children and screening for parental depression. The program also worked to coordinate pediatric practices with community services and specialized care.

In addition to strengthening primary and well-child care, The Commonwealth Fund has focused on improving the quality of long-term care services and supports. The Fund's Long-Term Care Quality Improvement program has been instrumental in the drive to transform nursing homes into resident-centered organizations that provide high-quality services. Advancing Excellence in America's Nursing Homes, a national campaign for which the Fund provides leadership, involves more than half of U.S. nursing homes in efforts to make them better places for residents and their caregivers.

CREATING COMPARATIVE ANALYSES

In an effort to help states and local areas achieve “the best,” the Fund has published a series of comprehensive scorecards that track measures of health system performance at the national, state, and local levels. We have created online comparative databases for commonwealthfund.org with some of these data to help generate the will and capacity to improve performance. Variation in care at the state, county, and hospital referral region or hospital levels can also be tracked on The Commonwealth Fund's robust quality improvement Web site for health professionals, www.WhyNotTheBest.org. The site offers custom performance reports and interactive maps.

Since 1998, the International Program in Health Policy and Innovation has conducted annual international surveys, which have brought international performance comparisons with other industrialized countries to bear on the U.S. health reform debate. The influential report *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*, which draws on the survey findings and the National Scorecard on U.S. Health System Performance, helped establish that the United States underperforms on the major dimensions of health care performance—quality, access, efficiency, equity, and healthy lives, despite spending twice what other countries spend per

capita on health care. These data were instrumental in making the case for health reform.

FOSTERING INTERNATIONAL COMPARISONS

By conducting its annual international health policy survey, establishing international partnerships, and hosting international forums for health ministers and their staff, the International Health Policy and Innovation program promotes cross-national learning on a number of levels. Learning about other countries' approaches to attaining a high performance health care system is of particular benefit to the United States, given the nation's relatively low return on its health care investment.

FUTURE LEADERS

Another goal of The Commonwealth Fund has been to promote future health care leaders. In 1997, the Fund launched what is now the Mongan Commonwealth Fund Fellowship Program in Minority Health Policy, based at Harvard Medical School, in an effort to prepare the next generation of minority physician leaders. And the Fund's international Harkness Fellowships, which date back to 1925, were refocused in 1996 to align with the Fund's emphasis on health care policy. Today, under the guidance of the International Health Policy and Innovation program, the fellowship enables policy researchers and practitioners in nine countries to spend up to 12 months in the United States conducting a health policy-oriented research study. The Picker/Commonwealth Fund Scholars program, which operated from 1991 to 1999, helped propel the patient-centered care movement.

EFFECTIVE COMMUNICATION

The publishing process has changed dramatically in the past 18 years, and The Commonwealth Fund's communications department swiftly adapted. Our approach to publication and dissemination went completely online during my tenure, and our subscribed

audience—thanks to our social media presence—has risen to nearly 40,000. We produce more than 100 publications annually, as well as an active blog, several successful online newsletters, and a podcast and video series.

NEXT STEPS

As the Affordable Care Act moves toward full implementation, we at The Commonwealth Fund will continue to provide needed analysis of the process and drive forward innovations in payment and delivery. It has been a great source of professional fulfillment to lead the Fund over this historic period in American health care.

In every organization, however, there comes a time for new leadership with new ideas. I look forward to returning to the Johns Hopkins Bloomberg School of Public Health and working on critical issues around Medicare and integrated care. It has been a privilege to lead work that is so important to ensuring that every American receives the best possible care and the opportunity to have a healthy, productive life.



THE ARCHIVES OF U.S. FOUNDATIONS

An Endangered Species

JOHN E. CRAIG, JR.



2012 ANNUAL REPORT
Executive Vice President–
Chief Operating Officer’s Report

The Archives of U.S. Foundations: An Endangered Species

Executive Vice President–Chief Operating Officer’s Report

A foundation’s archives preserve records of the programs, activities, products, governance, people, and history of the organization that may have enduring cultural, historical, research, or institutional value. Ideally, an archive should be part of a comprehensive records management program consisting of a records policy, a short-term records retention schedule, and an archive collection policy.

As important as archives can be, little has been written about them in the foundation management literature. In truth, the creation and maintenance of archives, if undertaken at all, is typically an afterthought, and rarely considered a key information management responsibility. As the U.S. foundation sector matures, more attention must be paid to the retention and safekeeping of records that are important to historians who document not only the work, people, and institutions that foundations support, but also the very foundations themselves.

Using data collected on the 300 largest U.S. foundations through a survey commissioned by The Commonwealth Fund in fall 2012, this essay reports on the current status of archiving in the foundation sector and recommends ways to improve policies and practices in an area that is too often overlooked.¹

PREVALENCE OF ARCHIVES OUTSIDE AND WITHIN THE FOUNDATION SECTOR

An archives is a place that people can visit—either in person or electronically—to gather facts, data, and evidence from business and program files, reports, letters, notes, memos, photographs, and other primary



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

sources on an organization’s activities from the time of its founding or a later date.² Archiving permanent records is an important function of most large institutions, including government agencies, universities and colleges, presidential libraries, religious organizations, and corporations. At the federal level, there is the National Archives and Records Administration, an independent agency with an annual budget of \$387 million, headed by the Archivist of the United States. Every state has an official archive as well, as do most universities and colleges and large corporations. Religious organizations, libraries, museums, and historical societies also play large roles in preserving important historical records.

The profession of archivist is thus a large one. The Society of American Archivists has over 5,000 institutional and individual members. Numerous university departments of library science and information studies offer a Ph.D. and other graduate degrees in archiving and preservation. And, in fact, the field has its own journal—*the American Archivist*, a respected, refereed periodical published semiannually, both in print and online that seeks to reflect thinking about theoretical and practical developments in the archival profession.

If most large organizations and many small ones regard their archives as important and worthy of management support, foundations in the United States—with some significant exceptions—historically have not. A 1988 survey of the 1,000 largest U.S. foundations (by asset size) undertaken by the Rockefeller Archive Center had a response rate of only 39 percent, a likely indicator

itself of the priority placed by foundation managers on archives at the time.³ Of the 225 respondents from the 500 largest foundations, only 32, or 14 percent, placed their records in an archive. The percentage was even lower—8 percent—for the 169 foundations that rank within the next 500 largest foundations.

Comments from many respondents to the 1988 survey revealed the low status that archives preservation generally had at that time among foundation managers. “We only keep subject files for three years,” wrote the executive director of one of the top 100 foundations.⁴

The reasons for and implications of this neglect were explored in a January 1990 Council on Foundations–Rockefeller Archive Center symposium attended by leading archivists and foundation managers with long interest and experience in the subject.⁵

- As reported in the 1988 foundation archives survey, many foundation executives regard their records of little importance or insufficiently worthy of preservation.
- Many foundations are thinly staffed and understandably focus their resources on responding to requests for grants and carrying out projects and programs, not on organizational infrastructure (beyond that essential for meeting current operational needs and regulatory requirements).
- Given the rapid growth in the number of foundations, the sector is a youthful one, with many institutions—including a number of large ones—being less than 25 years old. It is not uncommon for foundations in their early years to put off the question of archiving to a later date, “when things have settled down,” and to fail to revisit the question as time passes.
- In an effort to keep administrative expenses low, even foundations with archives often rank this function near the bottom of priorities when annual budgets are being set.

- The never-ending search for file storage space as a foundation ages puts files on past programs at risk for disposal or perilous warehousing.⁶
- Periodic office moves and changes in foundation leadership are often accompanied by a wholesale clearing out of files of discontinued programs or programs scheduled for discontinuation. James Allen Smith, a program officer at the Twentieth Century Fund (now the Century Foundation) from 1979 to 1987, reports, for example, that when the foundation was preparing for a new project to examine the history and long-range prospects of the nation’s social security system in 1981, staff members discovered that the deliberations of the foundation’s Committee on Social Security of the 1930s had been discarded—likely during an office move in the 1960s. The loss was a significant one, as the 1930s commission was a close equivalent to the Greenspan Commission on Social Security of the early 1980s, and, along with the subsequent 1950s Social Security Commission funded by the Twentieth Century Fund, helped influence the continuing debate on how best to ensure adequate incomes for the nation’s elderly population.⁷
- Archiving is a profession and, with the spread of digital technology, an increasingly specialized one requiring expertise that must continually be refreshed. Thus, it is beyond the scope of the staff of most foundations. Because relatively few foundations can justify hiring a professional archivist, there is usually no archival voice in decision-making about budget or information system design.

CURRENT ISSUES IN ARCHIVING

Two major issues have a large impact on foundations’ attitudes and practices regarding archiving: 1) the enormous growth, since the advent of word processing, of paper records in all organizations, and

the impossibility of traditional paper-based archiving practices keeping up with the increase, and 2) the emergence of digital electronic technology as the predominant means by which most records are now created and as a tool for preserving old paper-based records.

Leading archivists are virtually unanimous on the question of whether it is any longer possible for paper-based traditional archiving practices to meet modern day demands. As stated by Mark Greene and Dennis Meissner in an influential 2005 *American Archivist* article, “Processing is not keeping up with acquisitions, and has not been for decades, resulting in massive backlogs of inaccessible collections at repositories across the country.”⁸

Greene and Meissner bemoan the fact that “the archival profession has been unwilling or unable to change its processing practices in response to the greater quantities of acquisitions.” They point to overzealous standards and practices regarding what should be archived and how it should be archived—for example, focusing on the individual contents of file folders, rather than on organizing files as they are received by meaningful categories—which lead to high costs, a lack of administrative controls, and difficulties in meeting archiving timelines and projecting costs. Greene and Meissner also note the widespread inadequacy of finding aids, particularly Web-based ones, as well as a tendency of archivists to place preservation ahead of access for users.⁹ In addition, they and other leading archivists report that archiving practices are not keeping up with the changing nature of collection materials, particularly e-mail and other records that are “born digital.”

Online surveys in 2003–04 by Greene and Meissner of 100 archival repositories and their research users illustrate the extent of these problems, which are undoubtedly being exacerbated in state archives by recent budget cuts:¹⁰

- In 36 percent of the archives surveyed, more than 50 percent of received materials go unarchived; in 62 percent, more than 30 percent go unarchived.
- For 58 percent of the archives, backlog is regarded as a major problem.
- For 95 percent, no more than 36 months is considered a realistic and acceptable interval from accessioning through processing, but in actuality 52 percent take more than 36 months.
- Thirty-eight percent of archives reported collection donors being upset because donated materials had not yet been processed.
- At 40 percent of archives, researchers were upset at being denied access to, or lacking knowledge of, unprocessed collections.¹¹

With professional archival organizations facing performance challenges like these, there is little wonder that foundations with no professional archiving capacities or experience are prone to ignoring the issue altogether.

If traditional paper-based archiving practices are fighting a losing battle, the digital and information technology age offers a potential way out, though one fraught with technical and implementation challenges and professional disagreements. In theory, if agreement can be reached on safe ways to digitize existing archived paper-based records, filter and organize the mass of “born-digital” records (including e-mail) now flowing forth from every organization, and take advantage of cloud computing, with its limitless repository capacities, then the digital age should lead to a new era in archiving, making it feasible for any organization to participate.

Noted archivist Margaret L. Hedstrom and her colleagues report, however, that archivists have debated for more than 40 years the best strategies and methods for preserving digital information.¹² She explains that

“dramatic changes in electronic communications and data processing are transforming the business processes that archivists must document and overwhelming archives with new demands that few archivists feel competent to meet.”¹³

While it is not possible to summarize here even a portion of the literature on digital issues in archiving—or, for a non-technician like this author, to understand much of it—one is left with the impression that the profession will ultimately meet the challenge. In his cautiously optimistic presidential address to the Society of American Archivists in 2006, Richard Pearce-Moses argued:

[A]rchivists should become as comfortable working with digital records as they are working with traditional media. Instead of pen and paper, we will work with cursor and keyboard. Instead of sorters, we will work with sorting algorithms. Rather than weeding, we will filter. With few exceptions, all archivists will need what we now call technical skills, as the vast majority of contemporary and future records are and will be digital. Work with electronic records will not be a job for specialists, as the majority of records will be digital. No doubt some archivists will continue to specialize, but their specializations will be specific to the digital arena: databases, image and audio formats, and metadata, but also user interfaces, search systems, and digital preservation.¹⁴

It is notable also that the ferment in the archiving world caused by the information revolution has led to the entry of a number of commercial and not-for-profit business entities into the field that have introduced promising content management engines. These should strengthen organizations’ ability to design information systems that aid in archiving important records, and assist professional archives in absorbing those records into their electronic repositories.

WHY FOUNDATION ARCHIVES ARE IMPORTANT

If preserving foundation archives, under the circumstances just described, is not a task to be assumed lightly, is there a strong case for taking on the challenge? Foundations leaders and historians who have examined the question thoughtfully believe so, as do, not surprisingly, leaders in the archives field.

Historical Research on Social and Economic Developments and Influential Institutions and Individuals

The central argument for preserving foundation records derives from what these organizations do—their role in society. Private foundations are a very small piece of the action in the United States; their health care spending, for example, amounted to less than 0.5 percent of national health spending in 2010. Yet, as Joel Fleishman demonstrated in his book *The Foundation: A Great American Secret*, this small group of institutions is often instrumental in improving society.¹⁵ Fleishman calls attention to Paul Ylvisaker’s assessment that “philanthropy is America’s passing gear,” and foundations serve this purpose in numerous ways: by helping to launch movements (such as civil rights, environmental protection, or health care reform); by developing new institutions and strengthening existing ones; by making society more inclusive through support of programs to improve the lot of vulnerable populations; by building up the knowledge base for social improvements and scientific advancement and, through the support of individual researchers, contributing to the nation’s intellectual capital; and by strengthening the social fabric and physical capital of the communities in which foundations operate.

As James Allen Smith observed in his 1991 essay, “foundations often house material that is exceedingly important for understanding the nation’s social history, intellectual developments in various academic fields, as well as the genesis of many important public policy initiatives.”¹⁶ Because foundations are often intermediaries between the public and private sectors,

their records can be unique in helping to document the emergence of major social movements and economic developments. Foundation records are also frequently one of the few sources for historical research on small, relatively short-lived organizations (and their leaders) that had significant impact in their day.

In the hands of good researchers, the records of foundations can provide guidance for future generations in tackling new and continuing social problems. As examples, no history of the civil rights movement would be complete without access to the permanent records of the Ford Foundation; no history of the development of the “miracle” rice strains that sparked the Green Revolution, which helped transform Southeast Asian societies in the 1960s and 1970s, would be complete without the records of the Rockefeller and Ford foundations; and no history of the health care reform legislation of 2010 would be complete without the records of The Commonwealth Fund, the Kaiser Family Foundation, the Robert Wood Johnson Foundation, and other national and regional health care philanthropies.

Promoting Accountability in the Foundation Sector

A second reason that the permanent records of foundations are important is that they help foster accountability among this very privileged group of institutions, subject as they are to no elections, limited scrutiny by the press, minimal regulation, and no business test other than the management of their endowments and spending levels. Foundations, given their exemption from most federal and state taxes, owe it to the public to provide clear and accessible records of how they have conducted their business and what they have accomplished—records that enable rigorous independent assessments. Archives enable independent scholarly research on the impact of foundations’ strategies and programmatic investments.

Protecting the Foundation Sector and Defending Institutions from Misinformed Attacks

Related to archives’ function in promoting accountability is a third argument for preserving important records permanently: individual foundations and the sector as a whole periodically come under attack—by regulators, elected officials, the media, or academics. On the whole, the scrutiny that foundations receive from time to time is wholesome, as the sector and the individual institutions in question are almost invariably strengthened by having a spotlight cast upon them. But in the absence of good historical records, foundations are at risk of not being able to make their case for being tax-exempt convincingly, or they may simply be caught flatfooted in being able to produce records of their accomplishments and actual behavior.¹⁷ Historical records are also important on occasions when questions of donor intent arise.

Facilitating Strategic Planning and Fostering a Learning-from-Experience Culture

Archival records enrich the research base for consideration of foundations’ future directions and help ensure program continuity. The lessons from earlier experience that they hold can help prevent strategic and tactical mistakes by current and future foundation managers.

Writing in the *Harvard Business Review* about the importance of institutions celebrating landmark anniversaries, Rockefeller Foundation president Judith Rodin says of her organization’s 100th:

The pride and unity “an anniversary” inspires makes it an ideal time to ask people to think together about why their work matters and how it should move forward. A way to begin that process is to trace the historical trends that have affected the organization’s work and project how they might continue. This is the essence of strategic thinking.¹⁸

This kind of commemoration becomes very difficult in the absence of institutional archives.

Ensuring Institutional Memory and Sense of Accomplishment

Permanent archives are also a primary source for the institutional memory that is vital to learning organizations, and for the institutional pride that ensures the strong staff morale needed to achieve high performance. The staffs of most foundations are small, turnover in leadership is fairly frequent, and many new leaders come from outside the sector, with no management experience in it and limited or no prior contact with the organization they are summoned to lead. The speed with which successive leaders of The Commonwealth Fund, for example, have been able to take charge has been accelerated by the existence of a comprehensive history of the foundation—a history that was made possible by archival records going back to the organization's founding in 1918.¹⁹

Good Management and Administrative Efficiency

Finally, as in any other well-functioning organization, the care given to archives is a beneficial operational discipline, with orderly archives being a reflection of efficient office practices and good management. Inactive records are not allowed to pile up and get in the way of current files; information systems are designed to separate current from aging files and to preserve information in the latter that could be important for future managements and researchers; and information from inactive files can be achieved quickly when needed.

THE CURRENT ARCHIVING PRACTICES OF LARGE FOUNDATIONS

As noted above, the last survey of U.S. foundations' archiving policies and practices was undertaken in 1988, when the digital age was still dawning in the sector. In the intervening 24 years, the universe of foundations has expanded by over 150 percent, from approximately

30,000 to more than 76,000. Given the maturation of older foundations, the sector's substantial expansion, and technological developments, it is timely to reassess the archiving policies and practices of foundations.

To this end, in the fall of 2012 The Commonwealth Fund commissioned Mathew Greenwald & Associates to undertake a confidential online survey of the 300 foundations with assets greater than \$240 million in the 2009–12 period—261 of which could be reached for surveying.²⁰ These institutions account for approximately 52 percent of the foundation sector's endowment assets, including private, community, corporate, and operating foundations.

As shown in Exhibit 1, the survey had an overall response rate of 37 percent, with larger foundations (\$700-million-plus endowments) responding at a higher rate than smaller foundations (\$240 million to \$299 million)—47 percent to 67 percent for the former, 27 percent for the latter.

Prevalence of Archives

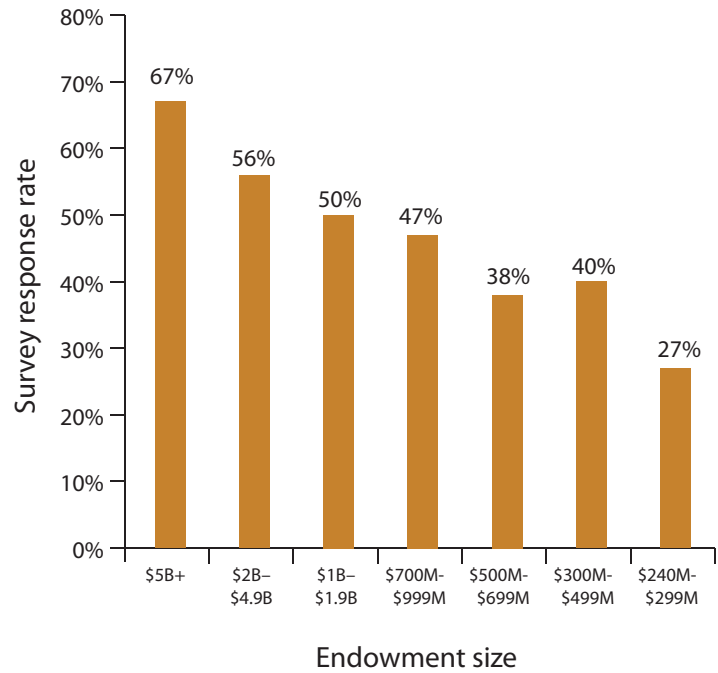
Of the 97 foundations responding to the survey, 48 have archives and 49 do not (Exhibit 2). But this almost certainly overstates the share of large foundations with archives. Since the unreachable foundations (13% of the universe of 300) are unlikely to have archives, and probably most of the nonresponding foundations (63% of those surveyed) also lack them, the actual share of large foundations with archives is unlikely to be more than 20 percent—probably not much greater than it was for foundations of this size in 1988. Among the responding foundations, those with larger endowments, those with larger staffs, and those that are older are more likely to maintain archives.

Comparison of Records Management Attitudes and Practices

Not surprisingly, 85 percent of archiving foundations believe permanent preservation of the foundation's historical records is “extremely” or “very” important,

Exhibit 1. Larger foundations were much more likely to respond to the 2012 archives survey than were smaller ones.

| | Total sample | Respondents |
|-----------------------|--------------|-------------|
| | 261 | 97 |
| Median endowment size | \$497M | \$618M |
| Response rate | | 37% |



Source: Commonwealth Fund 2012 Foundation Archives Survey.

while only 35 percent of nonarchiving foundations share this view. The fact that only 37 percent of the nonarchiving foundations have formal records-retention policies as required for nonprofits under the 2002 federal Sarbanes-Oxley legislation, however, suggests worrisome laxity or informality with respect to institutional recordkeeping within the sector.

The 2012 survey data reveal additional interesting facts about foundations that do not maintain archives. Most frequently, these foundations warehouse their historical records, at least for a time (48%), but many simply allow files to accumulate in their offices (Exhibit 3). When asked about their reasons for not archiving, the most frequently cited major reason was “lack of

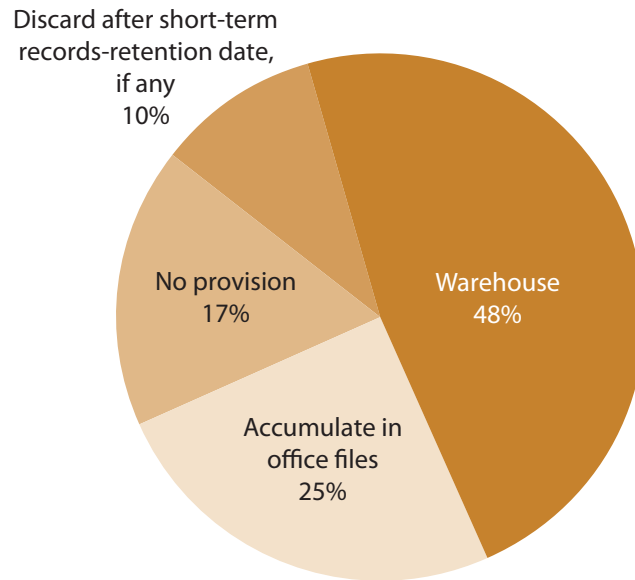
Exhibit 2. Of the universe of 300 foundations with assets greater than \$240 million, probably not more than 20 percent have archives.

Foundations with larger endowments and larger staffs, and older foundations are more likely to maintain archives.

| | Foundations with formal archives | Foundations without formal archives |
|--|----------------------------------|-------------------------------------|
| Foundations responding to survey | 48 (49%) | 49 (51%) |
| Median endowment size | \$1.061B | \$497M |
| Median age of foundation | 65 years | 34 years |
| Median staff size | 40 | 23 |
| Believe permanent collection of foundation's historical records is “extremely” or “very” important | 85% | 35% |
| Have formal records management and retention policies as required under Sarbanes-Oxley | 83% | 37% |

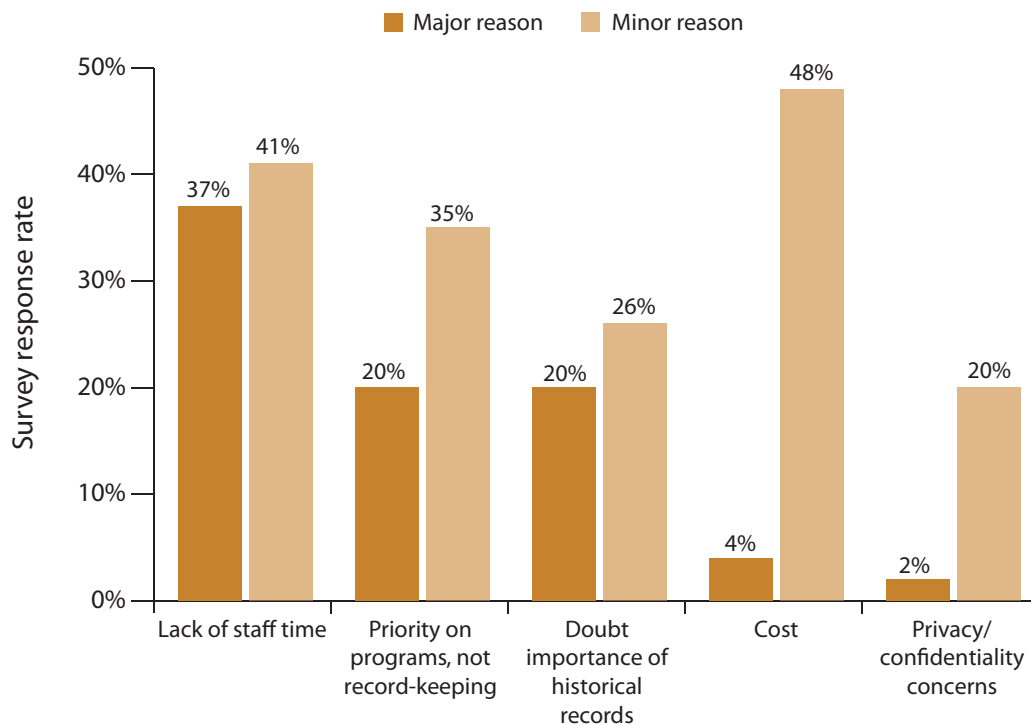
Source: Commonwealth Fund 2012 Foundation Archives Survey.

Exhibit 3. Foundations without archives most often warehouse old records or simply let them accumulate in office files until discarded.



Source: Commonwealth Fund 2012 Foundation Archives Survey.

Exhibit 4. Lack of staff time is cited most often as the major reason why a foundation does not establish archives—and even more often as a minor reason. Neither cost nor privacy/confidentiality concerns are a major reason.



Source: Commonwealth Fund 2012 Foundation Archives Survey.

staff time,” followed by “priority is on programs, not record-keeping” (Exhibit 4). Twenty percent of this group gave “doubt of the importance of historical records” as a major reason. Interestingly, neither cost nor privacy or confidentiality was identified as a major reason for not establishing archives. A sizeable number of foundations cited their youth as contributing to their failure to set up archives, explaining that the issue is either something they have not yet gotten to or have not needed to address thus far.

Somewhat encouragingly, approximately one-half of large foundations without archives are thinking about establishing them in the future, and information technology is regarded as helping to make the decision to archive (Exhibit 5).

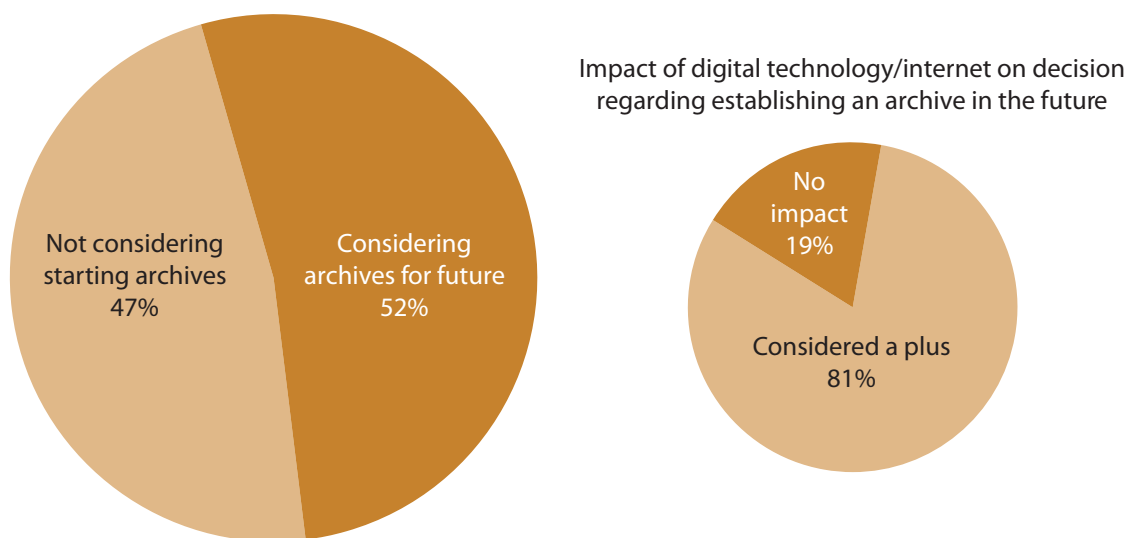
Different Archiving Models Pursued by Foundations

Turning to the foundations with archives, we find that the 2012 survey data reveal a rich variety of approaches to archiving. Two-thirds of large foundations with archives (28) manage them in-house; 17 percent place their historical records with independent, nonprofit

archive centers; 9 percent place records with a historical society, museum, or research library; and 7 percent place them with a university or college archive (Exhibits 6–8).

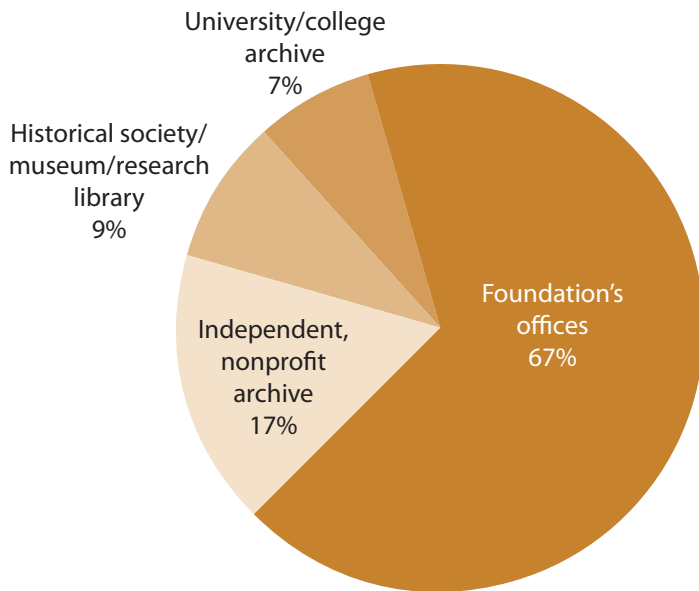
Because of resource differences and economies of scale, it might be expected that larger foundations would be prone to manage their archives internally, while smaller foundations would more often go the outsourcing route—but this is not routinely the case. The mean endowment size of foundations with intramural archives is \$1.7 billion, compared with \$2.0 billion for outsourcing foundations, and 12 foundations with assets between \$240 million and \$500 million have internal archives, compared with three in this size range using external centers. An example of a very large foundation that historically managed its archives internally but recently switched to the outsourced model is the Ford Foundation.²¹ Ford selected as its repository in 2012 the Rockefeller Archive Center, which is the independent archive organization most often used by large foundations, including, since 1985, The Commonwealth Fund.

Exhibit 5. Approximately one-half of large foundations without archives are thinking about establishing them in the future. And information technology is regarded as helping to make the decision to archive.



Source: Commonwealth Fund 2012 Foundation Archives Survey.

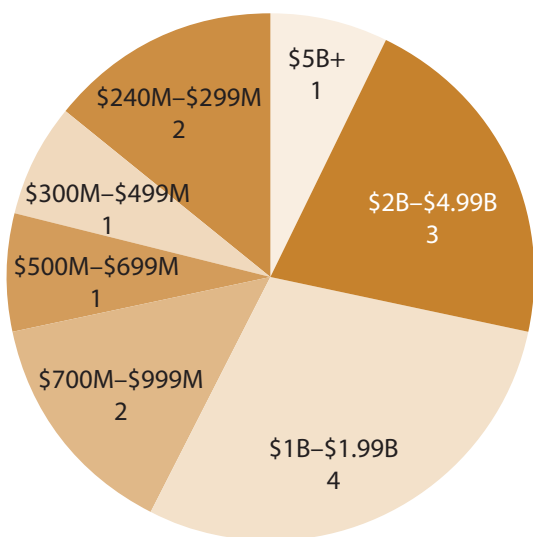
Exhibit 6. Two-thirds of large foundations with archives manage them internally; 17 percent use an independent, nonprofit archive center. Others use historical society, museum, research library, or university/college archives.



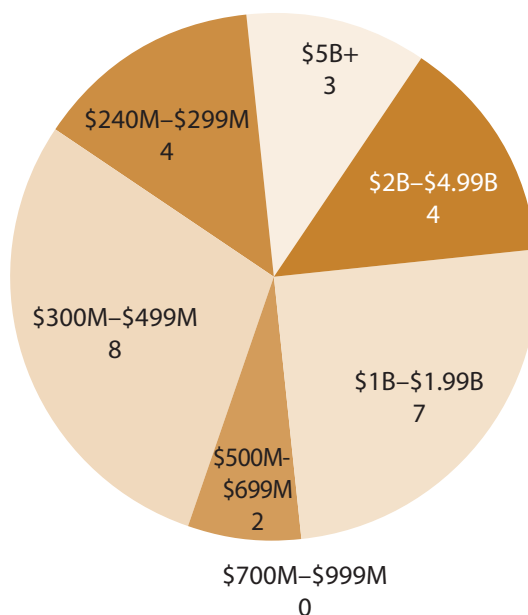
Source: Commonwealth Fund 2012 Foundation Archives Survey.

Exhibit 7. Among large foundations with archives, endowment size is not a strong predictor of who will use the intramural vs. outsourced model.

Number of foundations with OUTSOURCED archives, by endowment size



Number of foundations with INTRAMURAL archives, by endowment size



Source: Commonwealth Fund 2012 Foundation Archives Survey.

Exhibit 8. External Archive Organizations Used by Foundations

| Foundation | Primary Archive |
|----------------------------------|--|
| Carnegie Corporation | Columbia University Rare Book and Manuscript Library |
| Chicago Community Trust | Chicago Historical Society |
| Cleveland Foundation | Western Reserve Historical Society |
| Commonwealth Fund | Rockefeller Archive Center |
| Charles A. Culpepper Foundation | Rockefeller Archive Center |
| Geraldine R. Dodge Foundation | Drew University (Poetry Archive) |
| Doris Duke Charitable Foundation | Duke University—David M. Rubenstein Rare Book & Manuscript Library |
| Ford Foundation | Rockefeller Archive Center |
| William T. Grant Foundation | Rockefeller Archive Center |
| McKnight Foundation | Minnesota Historical Society |
| Open Society Foundations | Central European University |
| Pew Charitable Trust | Hagley Museum & Library |
| Rockefeller Brothers Fund | Rockefeller Archive Center |
| Rockefeller Foundation | Rockefeller Archive Center |

Source: Commonwealth Fund 2012 Foundation Archives Survey.

Nearly half the foundations with archives use a secondary archiving entity. For example, health policy and health services research survey data developed with Commonwealth Fund support is permanently archived at the University of Michigan Health and Medical Data Archive, as part of the International Consortium for Political and Social Research. Of note, a number of foundations hold inactive files in an in-house archive until they are transferred to the main repository.

Contents of Archives

Many foundations that maintain archives put all important records in them since the foundation's founding. Foundations generally follow traditional archiving practices in preserving program files, the foundation's publications, public relations documents, organizational records (for example, board and committee minutes), key administrative records, and, if they produce them, photographs, documentaries, and videos. Most institutions do not archive declined proposals and no longer attempt to keep traditional archival material like officers' calendars. External archive centers typically do not accept financial or human resources records, owing to lack of space and

to processing priorities. Most foundations (80%) with archives are not preserving important e-mail correspondence, and over half are not archiving Web site information.

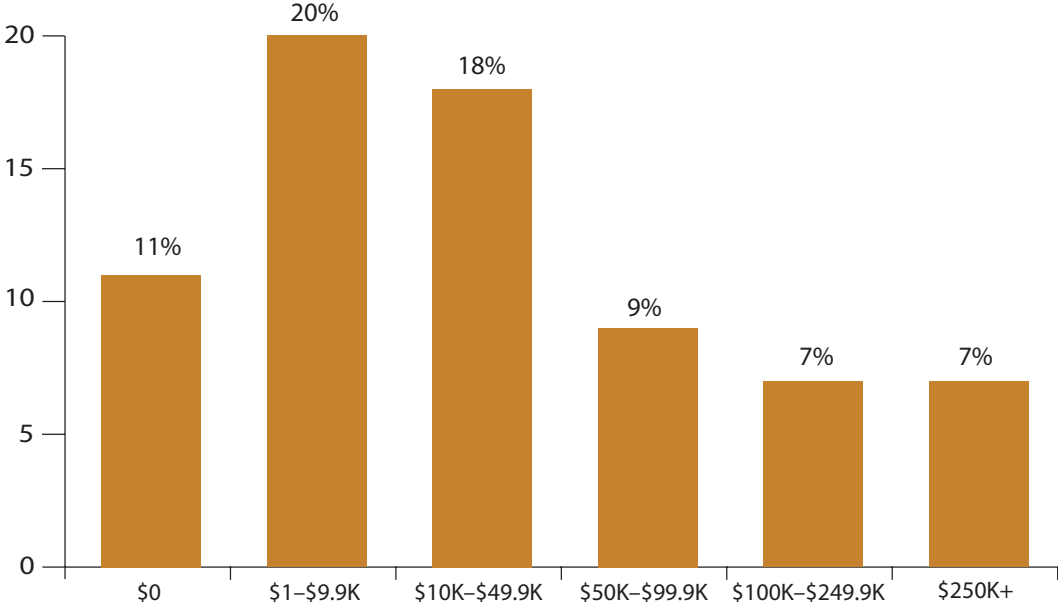
Costs of Archives

Twenty-nine percent of foundations with archives were unable to estimate their annual cost. For those providing estimates, costs varied with foundation size, age, and the nature of the foundation's work (Exhibit 9). For a 94-year old, \$650 million foundation with extensive intramural program operations and publications like The Commonwealth Fund, the annual costs of archives is about \$100,000. The mean annual cost reported in the survey was \$60,000.

Access to Archives

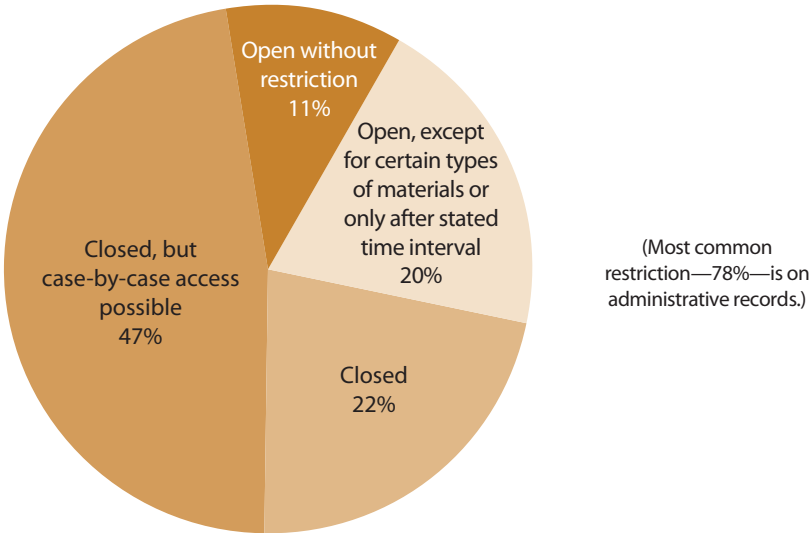
Most foundations restrict researchers' access to their archives, but nearly half will permit access if the research objective is deemed worthwhile (Exhibit 10). About a third (31%) routinely open their archives to researchers. The most common restriction is on access to administrative records.

Exhibit 9. For those providing estimates, archival costs varied with foundation size, age, and the foundation’s purpose.* For a 94-year-old, \$650 million foundation with extensive intramural program operations and publications like The Commonwealth Fund, the annual costs of archives is about \$100,000.



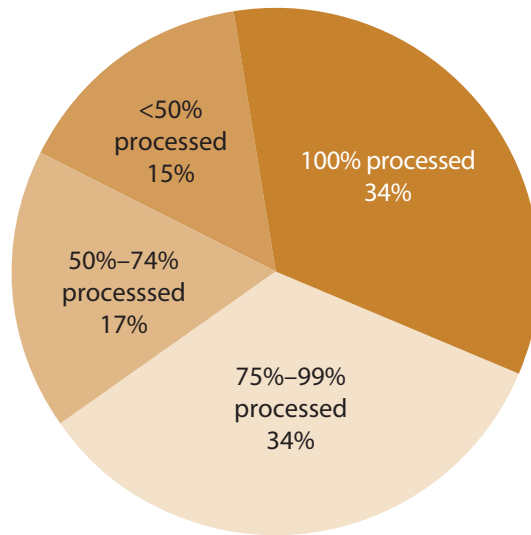
*29 percent of respondents could not provide a cost estimate.
 Source: Commonwealth Fund 2012 Foundation Archives Survey.

Exhibit 10. Most foundations restrict researchers’ access to their archives, but nearly half will allow access if the project is deemed worthwhile; 31 percent routinely open their archives to researchers.



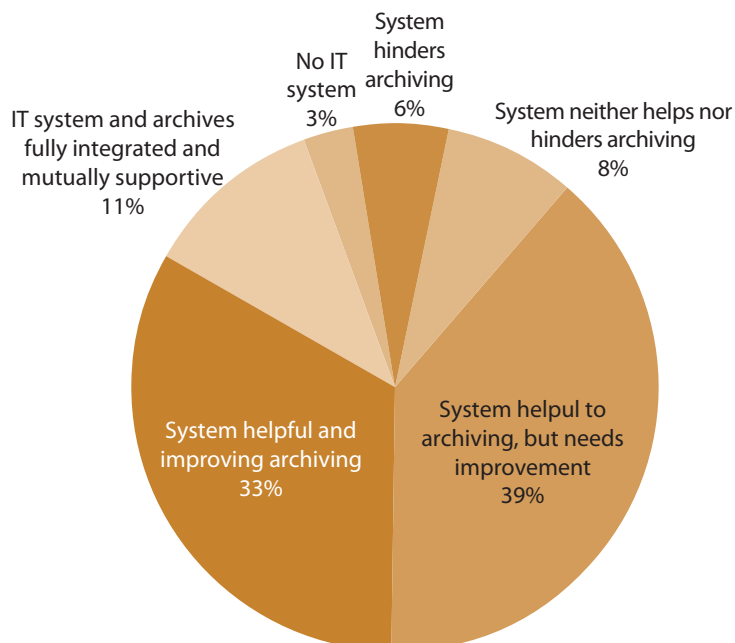
Source: Commonwealth Fund 2012 Foundation Archives Survey.

Exhibit 11. Foundations with archives are staying on top of paper flow relatively well: two-thirds report that 75 percent of records sent to archives have been processed.



Source: Commonwealth Fund 2012 Foundation Archives Survey.

Exhibit 12. Many foundations with archives are using their own information technology systems to advance archiving objectives, and some are quite advanced in doing so. But for over half, improvements in the foundation’s IT system could improve archiving performance.



Source: Commonwealth Fund 2012 Foundation Archives Survey.

Staying on Top of the Paper Flow

Like other institutions, foundations see their archiving system at risk of being overwhelmed with the influx of materials. Even so, foundations with archives are staying on top of the paper flow relatively well: two-thirds say that at least 75 percent of records sent to archives have been processed (Exhibit 11).

Harnessing Information Technology to Advance Archiving Objectives

Many foundations with archives are using their own information technology systems to advance archiving objectives, and some are quite advanced in doing so (Exhibit 12). But for over half, IT system improvements could improve archiving performance. Half of the foundations that currently have archives expect that, over time, their archives will be primarily electronic, and another 40 percent foresee a growing role for IT in their archiving practices (Exhibit 13). Less than 20 percent of foundations that currently have archives regard the principle obstacles to harnessing

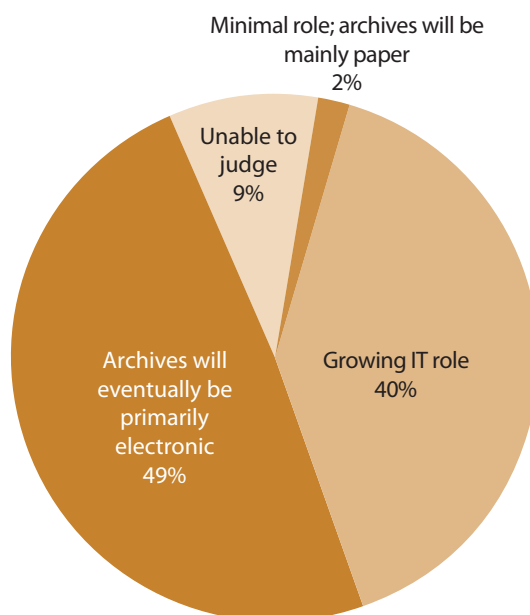
IT to enhance their archiving objectives as major; the primary issue being keeping up with rapidly evolving information storage technology (Exhibit 14).

Performance of External Archive Centers

Most foundations with assets under several billion dollars find that outsourcing their archives to an external center is more efficient than attempting to build a professional internal archives unit. As noted above, one-third of large foundations take this route, and it is the only feasible one for the majority of smaller foundations. The question of the performance of independent archives centers used by foundations is therefore an important one.

The survey found that half of foundations using external archives centers find the services, overall, to be “very good” to “excellent,” and another 35 percent rate the services “satisfactory” (Exhibit 15). Echoing challenges facing the archiving profession, the chief areas of concern are timeliness in processing materials and

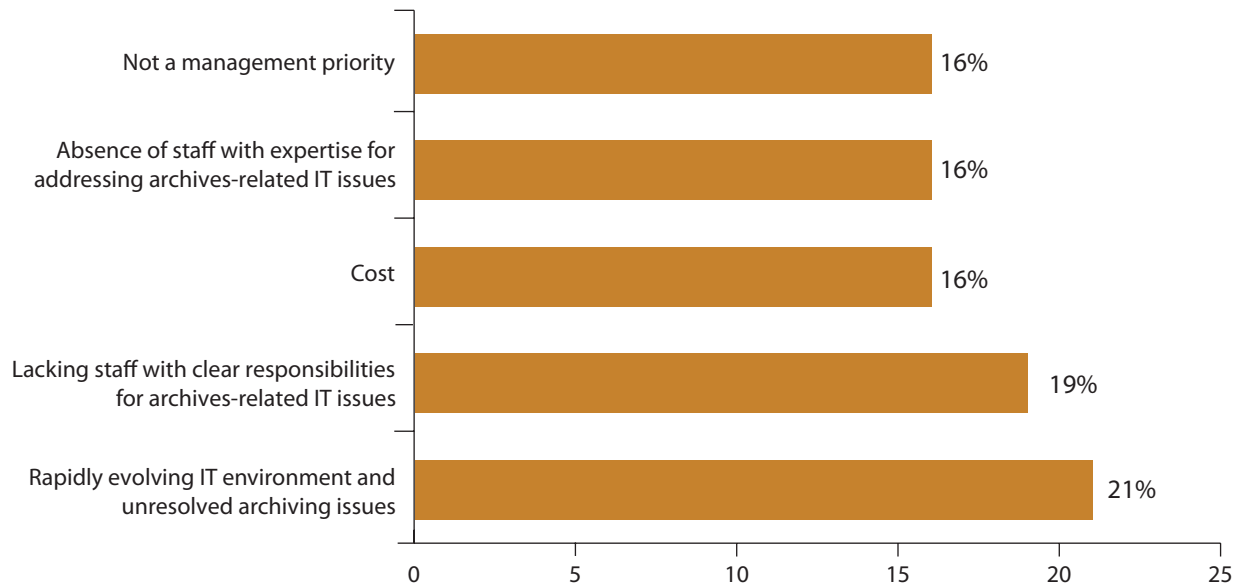
Exhibit 13. Half the foundations that currently have archives expect that, over time, their archives will be primarily electronic, and another 40 percent foresee a growing role for information technology in their archiving practices.



Source: Commonwealth Fund 2012 Foundation Archives Survey.

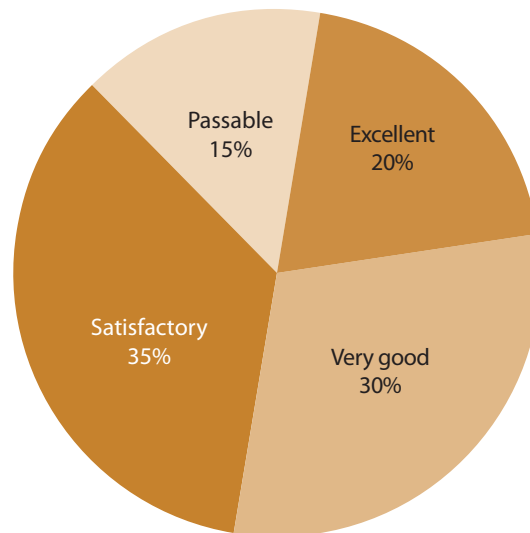
Exhibit 14. Most foundations with archives do not regard as major the expected obstacles to harnessing information technology to enhance their archiving.

Percent of foundations with archives that identified the following as major obstacle to harnessing IT for archiving purposes:



Source: Commonwealth Fund 2012 Foundation Archives Survey.

Exhibit 15. Half of foundations using external archive centers say that the services, overall, are "very good" to "excellent." Another 35 percent say services are "satisfactory."



Source: Commonwealth Fund 2012 Foundation Archives Survey.

using information technology to maximum advantage. Researchers are well served by external archive centers, but some foundations express dissatisfaction with services provided to their own staff (Exhibit 16).

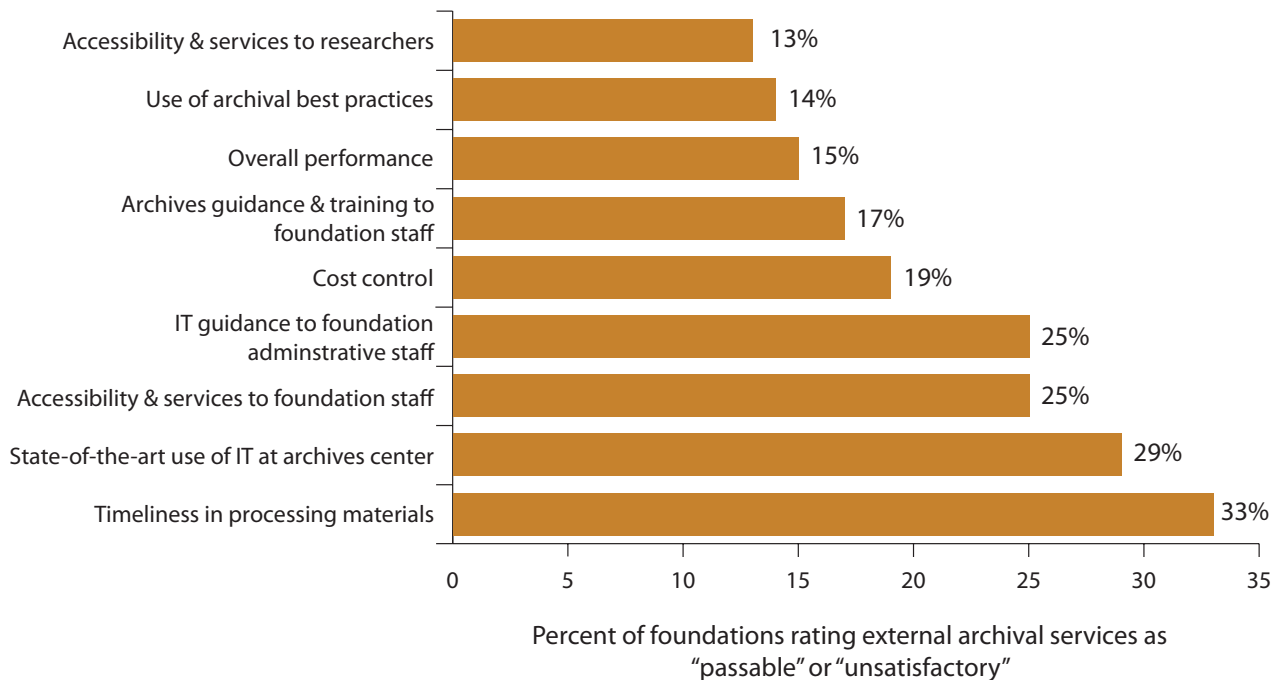
In sum, the 2012 survey reveals that archives are not a high priority for most foundations, but that those that have them find them valuable and not excessively costly. Most large foundations with archives are optimistic (probably more so than the archivist profession) that advances in information technology will improve systems, and large foundations currently lacking archives foresee that information technology advances could well bring them within their reach.

RECOMMENDATIONS

A review of the literature, the 2012 foundation archives survey findings, and conversations with leading archivists and foundation officers suggest the following recommendations for advancing the state of archiving in the foundation sector:

- The number of foundations currently maintaining archives is far fewer than it should be, and foundation boards and executives should give more attention to the issue than they do now. Audit and compliance committees of foundation boards should ensure that the short-term records-retention policy required by Sarbanes-Oxley is developed and enforced, and should take an active role in seeing that the question of archiving is addressed at the board level. For foundations above some minimum endowment size—say, \$50 million—the burden of the argument should fall on those opposed to archiving.

Exhibit 16. Foundations’ chief areas of concern with their outsourced archive centers are timeliness in processing materials and using information technology to maximum advantage. Researchers are well served by archive centers.



Source: Commonwealth Fund 2012 Foundation Archives Survey.

- Chief executive officers of foundations should see one of their responsibilities as assessing the foundation's need for archives and, if the decision is affirmative, delegating clear responsibility for their development and maintenance.
- The experience of foundations with archives is generally positive, and the undertaking is not a costly one. Indeed, with most records now originating in digital form and with rapidly advancing information storage technology, archiving is within reach of virtually any foundation. Boards and managements should see that resources are set aside as needed to achieve archiving objectives.
- Every foundation should have a stated archiving policy—even if it is “none”—to ensure that the question has been addressed. Policies should specify what records are to be preserved, the archiving model to be pursued (in-house vs. outsourced), access guidelines and restrictions, and guidelines for paper and electronic preservation. Archiving policies should ensure that the intensity of the archiving effort varies with the potential value of materials to users. The policy should be reviewed every five years to ensure that it keeps up with advances in information storage technology.
- The Council on Foundations should be encouraged to include maintenance of archives among its best-practice guidelines for foundations above some minimum endowment size.
- Outsourcing the archiving function to an external archive center is a viable option that many foundations, including multibillion dollar ones, should consider. The choice of external center, however, must be made with care, and performance monitored regularly. In selecting an external archive, key considerations should include the following:
 - Are the external center's archiving philosophy, objectives, and practices in sync with those of the foundation? Greene and Meissner caution, for example, that “grantors have compounded the industry-wide problem of backlog by insisting on or naively being sold a level of processing intensity that is unnecessary or inappropriate to their collections.”²²
 - Do the foundations or other organizations that are currently donating archival records to the external center share similar objectives and expectations?
 - Does the external center have other significant collections that provide a valuable context for the foundation's archive?
 - Can the center meet the foundation's expectations regarding the speed with which records are processed, provided with online finding aids, and opened to researchers?
 - Does the archival institution have the capacity to manage the long-term preservation of digital records and to provide access to them?
 - Is the foundation willing to assist the external center in tackling the big archiving issues of managing the massive inflow of digital records and generally harnessing the possibilities of the digital revolution, and is the center prepared to take full advantage of such assistance?
- Many foundations, especially small and newer ones, may find that their archiving objectives going forward can be met with cloud-based content management systems (now spreading throughout the foundation community) that can be adapted in various ways for use by external researchers.
- Two-thirds of larger foundations were established after 1989, but youth should be no excuse for postponing the question of whether to archive

or not.²³ Indeed, young foundations are in the enviable position of being on the ground floor on the technology front, typically starting out with state-of-the-art information systems in which virtually all of their records have always been kept digitally. Under these circumstances, archives are almost a natural byproduct of a good information system, with minimal marginal cost.

- Important institutional anniversary events (e.g., a young foundation's 20th birthday) provide an opportunity on which to capitalize for raising the question of archives.
 - Spend-down foundations are prone to establish archives, but they often confront the issue only as the date of their sunset becomes imminent. Ideally, the question should be addressed early in their life.
 - Information technology staff of foundations should have as one of their major responsibilities the development of systems within the foundation that advance archiving objectives. They should work closely with external centers to coordinate and promote IT initiatives. Above all, they should take pains to see that archiving questions are not an afterthought, but are on the table throughout any system redesign or improvement.
 - A learning collaborative of foundation officers with responsibility for archives (both in-house and outsourced) would greatly advance the spread of best practices in the sector. Affinity groups of foundation officers are frequently formed, to good effect, to improve practices—either programmatic or administrative—in a sector that operates in many respects as a cottage industry. Foundations without archives reported in the 2012 survey that if there were a foundation-led group developing archiving standards and guidelines and providing information on consultants and experienced-based advice on technical issues, they would be better equipped to activate nascent plans for establishing archives.
- The formation of a foundation archives affinity group would therefore likely advance the spread of archives in the sector. The responsibilities of the members of two existing Council on Foundations-affiliated groups—the Technology Affinity Group and the Consortium of Foundation Libraries—include in many cases their foundations' archives, and the best-situated of these groups could possibly serve as incubator for the affinity group needed to develop concerted leadership on archiving issues in the foundation sector.
- As suggested by one 2012 survey respondent, thought should be given to development of an archive cooperative by a consortium of foundations with common interests and archiving objectives. Thus far, foundations have turned to existing external archive centers, generally accepting the archiving approaches and services agreed to with preexisting clients. In some cases, the fit with the available external archive is not a natural one, and long-established centers can be slower to take advantage of technological changes than newer organizations are. Additionally, it is doubtful that existing archive centers have the capacity to take on large numbers of new foundation clients.
- Just as groups of foundations banded together to create The Foundation Center in 1956 and The Investment Fund for Foundations (TIFF) in the early 1990s—both enormously successful enterprises that meet a congregate service need in the foundation sector—so a group of foundations could form *de novo* a repository serving foundations with common archiving objectives and committed to up-to-date use of technology and best practices. Given the enormous number of foundations, interregional differences, and frequent commonality of interests at the regional level, multiple foundation archive coops might well be easier to launch and operate than a single national one.

Exploration of the concept of regional foundation archive cooperatives, led potentially by the archiving affinity group proposed above, by an existing regional association of grantmakers, or by one or more very large foundations in a given region, would be worthwhile even if found to be unworkable. If the concept were to be judged promising, it could be piloted and capitalized by a few very large foundations in an “early adopter region”—with spread of the model to other regions to follow, if justified by the experience of the pilot.

Writing in 1991, James Allen Smith, now vice president and director of research and education at the Rockefeller Archive Center, said “the most telling record of deeds attempted and done will only be available to future generations if those who now labor in foundations understand the importance of history’s evaluation, are convinced that their work matters enough to be worthy of a future generation’s judgment, and act to preserve the documents that tell their story.”²⁴ It is to be hoped that Smith’s admonition will be taken to heart and acted upon by a greater number of foundations than is currently the case.

NOTES

- ¹ I am indebted to Diana Davenport, Vice President for Administration, and Andrea Landes, Vice President for Grants Management, at The Commonwealth Fund, for their contributions to this essay and to the conduct of the survey. Anne Elmlinger and Rachel Forcino at Mathew Greenwald & Associates also played key roles in carrying out the survey and analyzing the results. Jack Meyers, president of the Rockefeller Archive Center, provided helpful comments on a draft of the paper.
- ² More formally, using the definition of the Society of American Archivists (<http://www2.archivists.org>):

Archives are the non-current records of individuals, groups, institutions, and governments that contain information of enduring value. Formats represented in the modern archival repository include photographs, films, video and sound recordings, computer tapes, and video and optical disks, as well as the more traditional unpublished letters, diaries, and other manuscripts. Archival records are the products of everyday activity....The primary task of the archivist is to establish and maintain control, both physical and intellectual, over records of enduring value.
- ³ Kenneth W. Rose, "The State of Foundation Archives: Results from the Rockefeller Archive Center's Survey," in Kenneth W. Rose and Darwin H. Stapleton (eds.), *Establishing Foundation Archives: A Reader and Guide to First Steps* (Washington, D.C.: Council on Foundations, 1991), 23–32. The response rate among the 500 largest foundations at the time was higher, as might be expected, than that for smaller foundations (45% vs. 34%), but even so, was disappointingly low.
- ⁴ *Ibid.*, 26.
- ⁵ *Ibid.*, 1–3. The symposium was entitled, "Foundation Archives: Information, Access, and Research."
- ⁶ In the literature search and interviewing process for preparing this report, I encountered repeated reports of warehoused records being destroyed by fire, water, and other physical damage, or disappearing through misplacement—a reminder that warehousing is not an acceptable archiving option.
- ⁷ James Allen Smith, "Why Foundation Archives Matter," in *Establishing Foundation Archives*, 7–12.
- ⁸ Mark Greene and Dennis Meissner, "More Product, Less Process: Revamping Traditional Archival Processing," *The American Archivist*, Fall/Winter 2005 68(2):208–63. Greene is director of the American Heritage Center at the University of Wyoming, and Meissner is head of collections management at the Minnesota Historical Society.
- ⁹ A finding aid is a document containing detailed information about a specific collection of papers or records within an archive. Such aids are used by researchers to determine whether information within a collection is relevant to their research.
- ¹⁰ Kim Severson, "Budget Cuts to Archives Put History Out of Reach," *New York Times*, Sept. 29, 2012.
- ¹¹ Greene and Meissner, "More Product, Less Process," 257–61.
- ¹² Margaret L. Hedstrom et al., "'The Old Version Flickers More': Digital Preservation from the User's Perspective," *The American Archivist*, Spring/Summer 2006 69(1):159–87.
- ¹³ David Bearman and Margaret L. Hedstrom, "Reinventing Archives for Electronic Records: Alternative Service Delivery Options," in Margaret L. Hedstrom (ed.), *Electronic Records Management Program Strategies*, Archives and Museum Informatics Technical Report #18 (Pittsburgh: Archives & Museum Informatics, 1993), 549.
- ¹⁴ Richard Pearce-Moses, "Janus in Cyberspace: Archives on the Threshold of the Digital Era," Society of American Archivists, www.archivists.org/governance/presidential/pearce-moses.asp.
- ¹⁵ Joel Fleishman, *The Foundation: A Great American Secret* (PublicAffairs, 2007), 56.
- ¹⁶ Smith, "Why Foundation Archives Matter," 8.

- ¹⁷ Short-term records retention policies, required for nonprofit organizations since 2002 under Sarbanes-Oxley, are the first line of defense on administrative and operational practices, but the documents typically saved for three to 10 years under such policies are inadequate for revealing a foundation's long-range impact or level of institutional performance. Note: Sarbanes-Oxley was enacted by the U.S. Congress in 2002 in reaction to a series of corporate accounting and fraud scandals in the 1990s. While the legislation is intended mainly to improve accounting and reporting practices of public corporations and decrease the potential for fraudulent activities in the corporate sector, two of its provisions apply to nonprofits: requirements for 1) a records retention policy, and 2) a whistleblower policy.
- ¹⁸ Judith Rodin, "Anniversaries Are Not to Be Wasted," *Harvard Business Review*, Nov. 2012 90(11):36.
- ¹⁹ McGehee Harvey and Susan L. Abrams, *For the Welfare of Mankind: The Commonwealth Fund and American Medicine* (Baltimore: Johns Hopkins University Press, 1986).
- ²⁰ The date for the valuation of each foundation's endowment was its fiscal year-end, and ranged from December 31, 2009, to June 30, 2012. Data provided by The Foundation Center.
- ²¹ Sam Roberts, "Foundation Files Reveal Insights on Culture," *New York Times*, April 8, 2012, http://www.nytimes.com/2012/04/09/arts/ford-foundation-records-move-to-rockefeller-archive-center.html?_r=0.
- ²² Greene and Meissner, "More Product, Less Process," 240.
- ²³ *Foundation Growth and Giving Estimates*, 2009 edition, The Foundation Center.
- ²³ Smith, "Why Foundation Archives Matter," 9.

Cover: Left: In Depression-ravaged rural America, such problems as poor sanitation, infected water, and contaminated milk were particularly acute. During the 1930s, The Commonwealth Fund launched programs in partnership with a number of states, predominantly in the South, to send teams of physicians, nurses, and public health workers to rural communities to treat families and carry the message of good health practice. These programs would help set the standard for professionally run and staffed public health departments.

Right: In 2005, the Board of Directors of The Commonwealth Fund established and charged the Commission on a High Performance Health System with promoting a health system that provides all Americans with affordable access to excellent care while maximizing efficiency in its delivery and administration. Chaired over its first six years by the late James J. Mongan, M.D. (second row, center) and, since 2011, by David Blumenthal, M.D., 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 system transformation. Many of the major ideas in the Affordable Care Act of 2010—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 its reports and statements.

Photo: Left photo © The Commonwealth Fund Archives, right photo © Jason Smith.



THE FUND'S MISSION, GOALS, AND STRATEGY



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

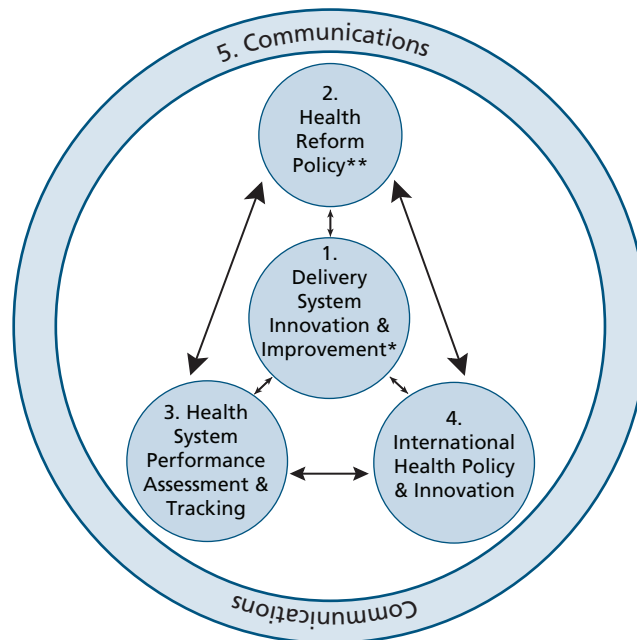
- delivers high-quality, patient-centered care
- is affordable and efficient
- promotes the health of the entire population
- continuously innovates and improves.

STRATEGY

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 care organizations.

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.

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 for health system leaders and policy officials on reform implementation issues, and effectively communicate and disseminate the results produced by the Fund’s grants and research programs.

The Commonwealth 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.

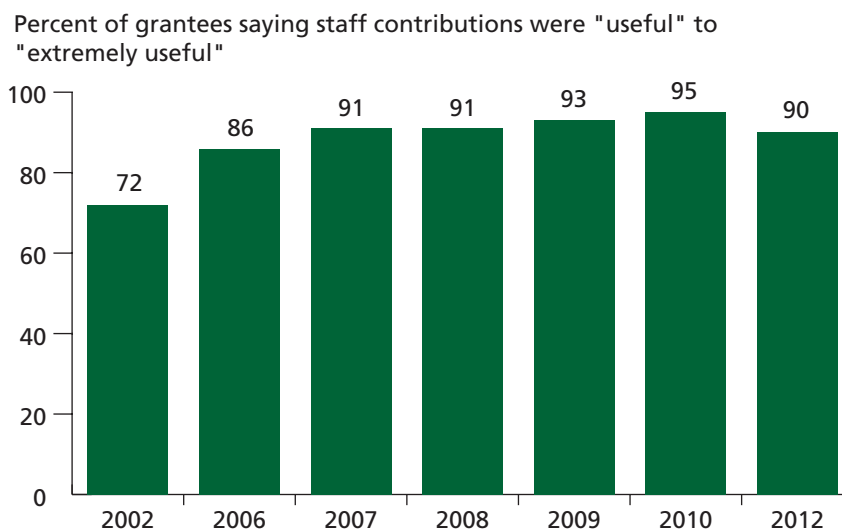
PROGRAMS

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

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

- The **Patient-Centered Coordinated Care** program, which 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. 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

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



Source: 2002 Harris Interactive Survey of Fund Grantees and 2006–2012 Mathew Greenwald Audience and Grantee Surveys.

Exhibit 3. In the 2012–17 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: \$162 Million

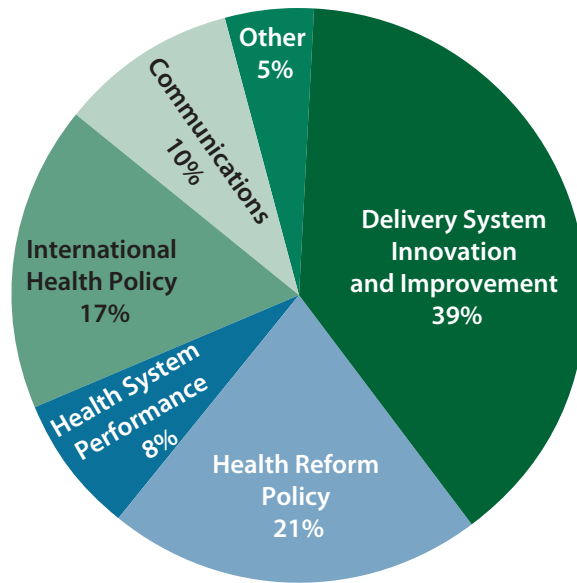
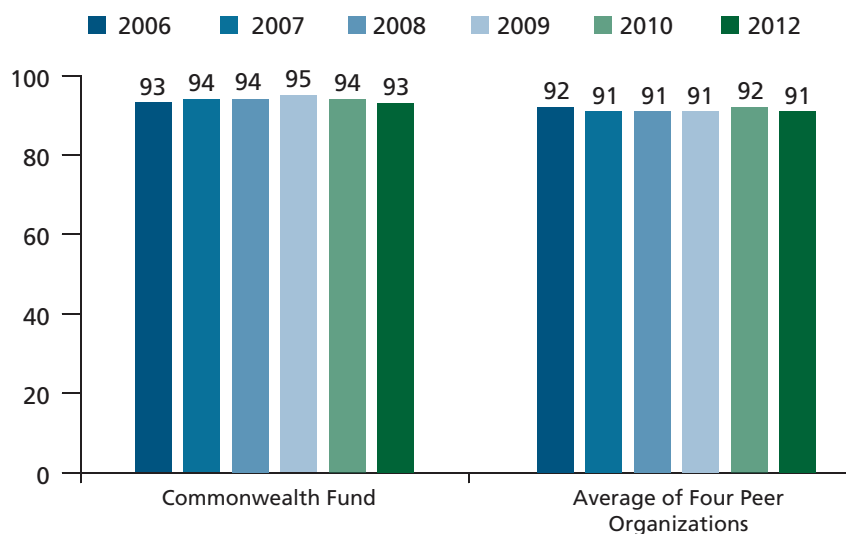


Exhibit 4. The Commonwealth Fund’s Performance Scorecard: Reaching Change Agents Effectively

Percent of Commonwealth Fund audience saying institution "effective" to "extremely effective" in reaching change agents



Source: 2003 Harris Interactive and 2006–2012 Mathew Greenwald Commonwealth Fund Audience Surveys.

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 **Health System Quality and Efficiency** program aims 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 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 **Long-Term Care Quality Improvement** program aims to raise the quality of postacute and long-term care services and supports, and to improve care transitions for patients by integrating these services with the other care they receive. The program makes grants to identify, test, and spread measures, practices, models, and tools that will lead to person-centered, high-performing long-term care; build strong stakeholder networks 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 care services are an integral part of any care system and incorporated into provider payment, health information technology, and delivery system reforms. The program also makes grants to improve the care and care experiences of

the particularly vulnerable individuals who are dually eligible for Medicare and Medicaid, as well as to reduce the costs of their care through better coordination of services.

- The **Vulnerable Populations** program aims to ensure that low-income, uninsured, and racial and ethnic minority populations are able to obtain care from high-performing health systems capable of meeting their special needs. The program makes grants to identify policy levers that can advance 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. **Mongan Commonwealth Fund Fellowship Program in Minority Health Policy** at Harvard 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 following:

- The program on **Affordable Health Insurance** works toward 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 insurance programs for people under age 65, and estimate the impact those changes

will have on the number of people 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 reform law at the federal and state levels through tracking surveys of key population groups, Web-based interactive tools that monitor state progress, and analysis of key reform provisions and regulatory guidance; and analyzes and develops new policy options for expanding and stabilizing health insurance coverage, making coverage more affordable, and optimizing administrative efficiency.

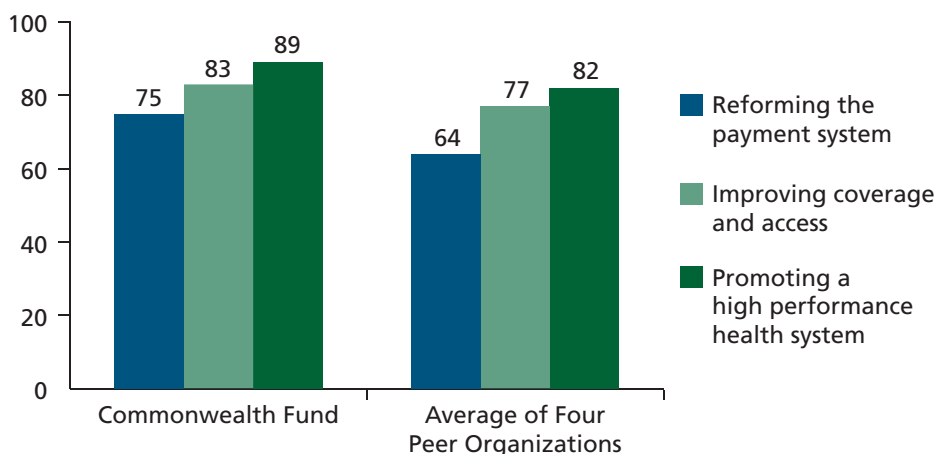
- The program on **Payment and System Reform** supports the development and analysis of options for reforming how health care is paid for, focusing on incentives to improve the effectiveness and efficiency of care delivery while curbing spending growth. Activities sponsored

by the program include examining reforms that would align incentives with higher-quality health care 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 **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, helps inform implementation of the Affordable Care Act and assesses its potential to move the U.S. along the path to a high performance health system; helps health care leaders and the American public understand the new legislation and what it means for them; and lays the groundwork for future delivery

Exhibit 5. The Commonwealth Fund’s Performance Scorecard: Improving Health Care Access, Reforming the Payment System, and Enhancing Delivery System Performance

Percent of Fund audience saying institution “effective” to “extremely effective” in improving health care access, reforming the payment system, and advancing a high performance health system



Source: 2012 Mathew Greenwald Commonwealth Fund Audience Survey.

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.

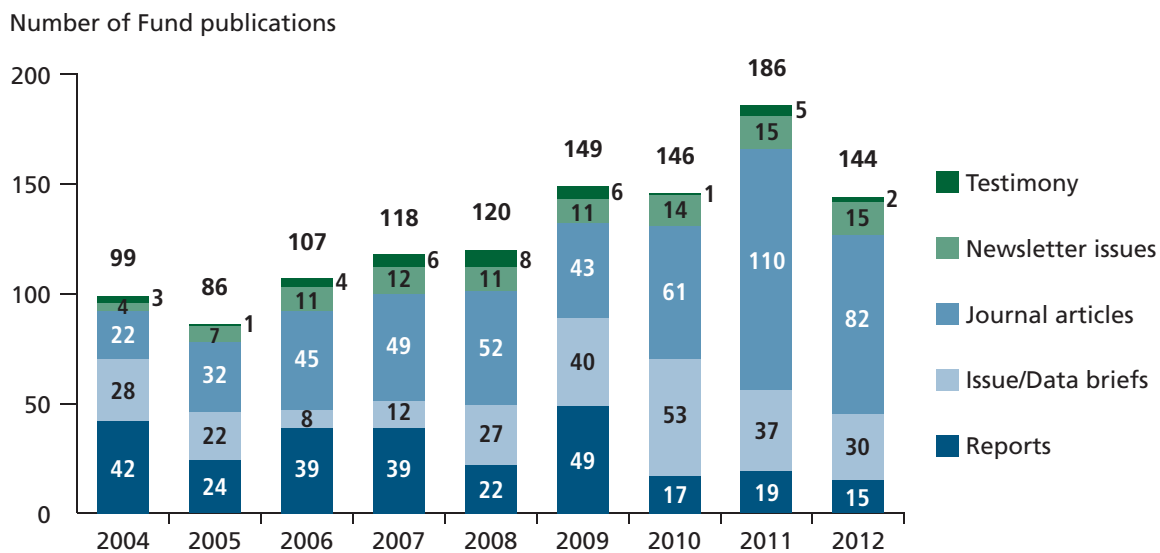
- The **Federal and State Health Policy** program aims to identify, develop, evaluate, and spread policies that expand access to affordable, high-quality, and efficient care—particularly for vulnerable populations—while reducing health spending growth. Specific activities include convening federal and state policymakers, in both the executive and legislative branches of government, to discuss key health policy issues and to help identify policy solutions; facilitating information exchange between federal and state policymakers, both to inform federal leaders of innovations in state health policy that have implications for national health reform implementation and to raise awareness among state leaders about federal policies that will affect state health reform strategies; 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; and fostering dialogue among policymakers, national stakeholders, and the research community on key health policy issues.

Other programs include the following:

- The **Health System Performance Assessment and Tracking** program gathers and disseminates evidence of excellence in health care from across the country and the world. Work carried out by the program 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, affordability, access to care, and patient-reported quality of care; and monitors public- and private-sector 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 promotes cross-national learning among industrialized countries about

Exhibit 6. The Commonwealth Fund Focuses from the Beginning of Projects on Producing Publishable Products and Ensuring Their Harvesting and Dissemination to a Wide Audience



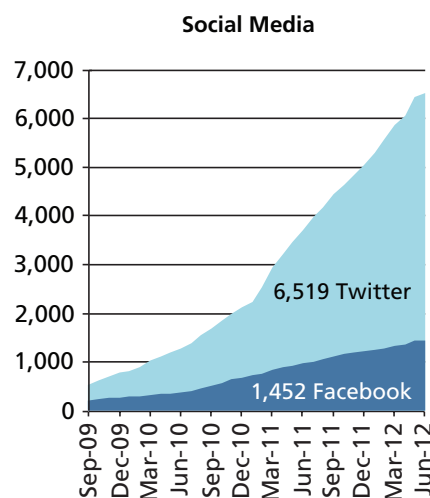
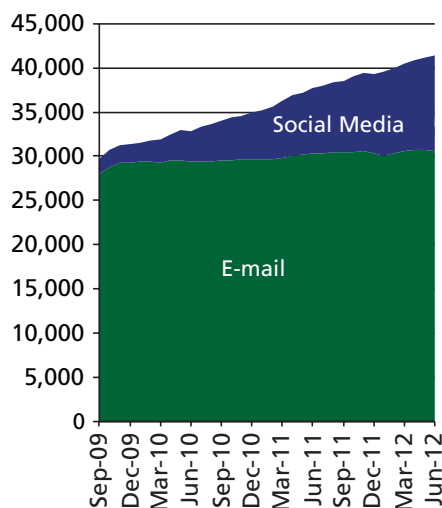
ways to improve the performance of health systems. It does this by supporting creative thinking about health policy; encouraging comparative research and collaboration on quality improvement and other reform initiatives; building an international network of health care researchers devoted to improving health policy; and showcasing international innovations in policy and practice that can inform U.S. health reform. 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.

- 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 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, 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 states' progress in implementing exchanges. 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.

Exhibit 7. The Commonwealth Fund's Social Media Subscriptions Continue to Climb

Total Subscribed Audience, as of June 2012, Was 41,189



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

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 no higher than 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
- 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 2012–17, The Commonwealth Fund expects to spend \$162 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 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 40 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 24 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 2011–12 were as follows:

- setting out options for controlling health care costs, achieving federal budget savings, and reforming Medicare
- informing the presidential campaign debate on policy concerning the future of health insurance coverage and health care payment and delivery system reform
- accelerating and spreading health care delivery innovation and performance improvement
- promoting understanding of the incoherence of health care prices in the private market and setting out options for payment reform across private and public payers
- ensuring successful transition in the Fund's leadership.

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. The foundation'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. In December 2012, the Fund was one of two foundations featured by the Center for Effective Philanthropy as case studies of foundations achieving high levels of staff satisfaction.¹

¹ Ellie Buteau and Ramya Gopal, *Employee Empowerment: The Key to Foundation Staff Satisfaction*, Center for Effective Philanthropy, 2012.



HEALTH SYSTEM QUALITY AND EFFICIENCY

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 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 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 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. Given the nation's standing as the world's biggest spender on health care, our system is clearly inefficient as well. Supporting efforts that 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



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

care in the U.S. Many of these are readmissions for conditions that could have been prevented had patients received proper discharge planning, education, and support. In 2009, the Institute for Healthcare Improvement (IHI), with Commonwealth Fund support, initiated 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 sustain improvements. As reported in *Health Affairs* (July 2011), the most important rehospitalization-reduction strategies used so far include: improving patient education; ensuring timely follow-up with patients after hospital discharge; creating “cross continuum” care teams comprising staff from hospitals, skilled nursing facilities, home health agencies, and primary care practice; and using universal patient transfer or discharge forms. To date, 167 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.

Nearly one-quarter of patients hospitalized with heart failure and one-third of patients hospitalized with acute myocardial infarction are readmitted within 30 days of discharge, despite evidence that a substantial portion of readmissions may be preventable. While these and other readmissions increase Medicare costs by an estimated \$17 billion per year, little is known about the extent to which hospitals have employed recommended strategies to reduce readmission risk. As part of a Commonwealth Fund–supported study, Elizabeth Bradley, Ph.D., and her team at Yale University surveyed more than 500 U.S. hospitals enrolled in the American College of Cardiology and

the Institute for Healthcare Improvement’s “Hospital to Home” initiative to determine their use of 10 practices associated with lower readmission rates.

The results, published in the *Journal of the American College of Cardiology* (July 2012), show that hospitals’ use of recommended practices to reduce readmission rates varies significantly. On average, hospitals used five of 10 key practices, while only 3 percent of hospitals used all 10 practices. Such infrequent use of best practices may reflect insufficient resources, constraints on staff time, and the complexity of coordinating efforts among physicians, pharmacists, nurses, and other staff.

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 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.

Significant variability in 30-day readmission rates across U.S. hospitals suggests that some are more successful than others at providing safe, high-quality inpatient care and promoting smooth transitions to follow-up care. A Commonwealth Fund report by Sharon Silow-Carroll of Health Management Associates offers a synthesis of findings from case studies of four hospitals with exceptionally low readmission rates. The four are all part of integrated health systems, and each has responded effectively to local health care market conditions and the policy environment.

Douglas McCarthy, senior research adviser to The Commonwealth Fund, has also profiled health care organizations that have produced exemplary results in improving care transitions and reducing hospital readmissions. In a new case study series, McCarthy highlights the efforts of [UCSF Medical Center](#) in San Francisco, part of the University of California system, which demonstrate what an organization can achieve in the absence of explicit

financial incentives to reward desired behavior; Cincinnati Children’s Hospital Medical Center, which is scaling up a program for children with asthma to the community level; and the Visiting Nurse Service of New York’s CHOICE program, which is integrating health care services for Medicare/Medicaid dual eligibles.

Accountable Care Systems

As the nation moves toward health care delivery systems that are accountable for the health outcomes and costs of caring for their patient populations, The Commonwealth Fund is sponsoring efforts to ensure the success of this model for achieving coordinated, patient-centered, efficient care. With Fund support, Elliott Fisher, M.D., and his 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 to assess quality of care and to determine payments to accountable care organization (ACO) providers and the shared savings for which they are eligible. The team has also recommended testing a more advanced set of measures, including clinical outcomes measures and patient-reported measures of care experience and health status.

In the project’s second phase, the team developed a framework for evaluating ACOs and applied it to a [series of case studies](#) of four diverse health care organizations—from integrated health systems to a community hospital—that are collaborating 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 address issues of governance, patient attribution, payment, patient and provider engagement, and benefit design.

For ACOs to succeed, payment methods need to foster greater organizational accountability for patient care quality and cost. The Commonwealth Fund is supporting a multiyear evaluation to compare changes in spending

and quality for providers participating in one such payment model: the Alternative Quality Contract (AQC), a global payment system developed by Blue Cross Blue Shield of Massachusetts (BCBS) to replace fee-for-service reimbursement and counter rising health care spending. Under the contract, Blue Cross Blue Shield makes a comprehensive payment to health care providers that covers the entire continuum of a patient’s care for a specific illness—including inpatient, outpatient, rehabilitative, and long-term care services, 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 patients whose primary care providers participated in the AQC, and did the same for a control group of patients whose providers did not take part. In a [Health Affairs](#) paper (July 2012), Song and colleagues reported that Massachusetts physician groups signed on to the AQC were able to reduce the rate of increase in health care spending over two years by an average of 2.8 percent. The savings and improvements in quality appear to be sustained, and were even greater in year 2 compared with year 1. Savings accrued largely from reduced spending for procedures, imaging, and lab tests.

The ACO programs implemented by the Centers for Medicaid and Medicare Services (CMS)—the Shared Savings Program, the Pioneer Program, and the Advanced Payment Program—are intended to improve quality and slow cost growth. The ACO model is based on an earlier pilot, the Medicare Physician Group Practice Demonstration, in which 10 physician groups were eligible for up to 80 percent of any savings they generated if they were also able to demonstrate improvement on 32 quality measures. Although evidence indicates the groups in the demonstration improved quality, uncertainty remains about the impact on costs. Writing in the [Journal of the American Medical Association](#) (Sept. 12, 2012), Fisher, together with Carrie Colla, Ph.D., and colleagues, reported that nearly all the aggregate savings were concentrated among Medicare/Medicaid dual eligibles.

The Fund also supported the Hospital Research and Education Trust (HRET) to conduct the first national survey of hospital readiness to form ACOs. The survey asked leaders of nearly 1,700 hospitals about their care management, financial management, information systems, and performance improvement practices. The HRET report, based on the results, provides hospital leaders with a tool to gauge their organizations' relative preparedness for ACO participation.

Survey data was also the basis of a Commonwealth Fund [issue brief](#) (Aug. 2012) that describes the start of the ACO adoption curve. The findings suggest that ACOs are embarking on a paradigm shift, moving away from an acute care focus and toward primary and preventive care. The authors, led by Fund vice president Anne-Marie J. Audet, M.D., also find that aspiring ACOs must develop the infrastructure to take on financial risk and manage population health.

In partnership with Stephen Shortell, Ph.D., of the University of California, San Francisco, the Dartmouth team is currently conducting the first national survey of ACOs to obtain information about the characteristics and circumstances that influence their formation, structure, contracts, and capabilities.

Meeting and Raising Benchmarks for Quality

Today, nearly 7,500 hospital executives, quality improvement professionals, medical directors, business coalitions, state health agencies, and others use [WhyNotTheBest.org](#), The Commonwealth Fund's online resource for health care quality benchmarking, to compare their organization's performance against 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.

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 new functionalities so that users can compare performance by various categories—for example, safety-net, rural, or urban. Users can also examine aggregated hospital performance by state, county, or hospital referral region. Additional efforts this year will focus on outreach to new audiences, such as employers, and health services researchers.

Publicly available data can also drive improvement in health care. Physician and hospital “report cards” have proliferated in recent years. While consumers seem to value them, they can be difficult to understand and use, and so far they seem to have had little influence on people's health care provider choices. For a Fund-sponsored *Health Affairs* [study](#) (March 2012), researchers at the Harvard School of Public Health, led by Anna Sinaiko, Ph.D., and Meredith Rosenthal, Ph.D., synthesized the views of experts and stakeholders about what needs to be done to make provider report cards more useful. There was broad consensus that report cards should offer a greater number of consumer-oriented measures, be more clear and accessible, and contain a wider range of data, including information on cost.

Assessing Providers' Capacity to Improve Care

Although deaths from heart attack have decreased significantly over the past decade, there is still substantial variation across U.S. hospitals in the number of patients who die within 30 days of hospitalization for acute myocardial infarction. Certain variables, such as medication adherence, can improve these rates, but less is known about strategic factors like communication and problem-solving. Based on a survey of more than 500 acute care hospitals, a Fund-supported research team led by Yale's Elizabeth Bradley, Ph.D., identified low-cost, low-risk strategies that together could lower risk-standardized mortality by more than 1 percent and save thousands of lives

annually. Among the strategies described in the authors' May 2012 *Annals of Internal Medicine* article are: holding monthly meetings with hospital clinicians and staff who transported patients to the hospital; having on-site cardiologists; and encouraging clinicians to engage in creative problem-solving.

Disseminating Best Practices and Innovative Models

Case studies and evaluations of high-performing provider organizations can be a highly effective in educating health care stakeholders about best practices for managing chronic diseases, reducing hospitalizations, increasing patient satisfaction, and achieving other important performance goals. A recent Commonwealth Fund–sponsored study undertaken by Geoffrey Lamb, M.D., of the Medical College of Wisconsin sought to assess the link between public reporting on diabetes care and physicians' activities to improve the quality of care they provide to patients. His research team focused on primary care doctors participating in the Wisconsin Collaborative for Healthcare Quality, a designated Chartered Value Exchange Network and leader in public reporting and best-practice sharing. According to survey results reported in *Health Affairs* (March 2012), public reporting helped drive early adoption of diabetes care improvement activities in clinics participating in the collaborative, including patient registries and care reminders, and also seems to have led to clinics adopting multiple improvement interventions over time.

At the Group Health Cooperative in Washington State, David Arterburn, M.D., led the first large-scale observational study to assess the effectiveness of patient-decision aids on the use of elective surgical procedures, total health care use, and total costs. The results, published in *Health Affairs* (Sept. 2012), show that the introduction of decision aids was associated with 26 percent fewer hip replacement surgeries, 38 percent fewer knee replacements, and 12 percent to 21 percent lower costs over six months.

Future Directions

A number of projects sponsored by the Health System Quality and Efficiency program will begin yielding results over the coming year:

- Karen Donelan, Sc.D., of Massachusetts General Hospital and Catherine DesRoches, Ph.D., of Mathematica Policy Research recently fielded 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., is evaluating 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 IT 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. Two forthcoming Fund case studies will describe what selected Beacon Communities are learning, how they are evaluating their efforts, and what implications can be drawn from their experience for policy and practice.

Cover: At Fairview Health Services in Minneapolis, Minn., Commonwealth Fund–supported researchers are identifying the specific behaviors of clinicians that are linked to higher levels of patient engagement, improved health outcomes, and greater efficiency. Recent studies show that patients who are more involved in their own care experience better health outcomes and use less costly services.

Photo: © Michael Malyszko



LONG-TERM CARE QUALITY IMPROVEMENT

LONG-TERM CARE QUALITY IMPROVEMENT

PROGRAM GOALS

The Picker/Commonwealth Fund Program on Long-Term Care Quality Improvement, a key component of the foundation's efforts to improve health care delivery and spur innovation, aims to raise the quality of postacute and long-term care services and supports, and to improve care transitions for patients by integrating these services with the other care 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 stakeholder networks 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
- ensure that long-term care services are an integral part of any care system and are incorporated into provider payment, health information technology, and delivery system reforms.

The program also oversees a Commonwealth Fund initiative targeting the particularly vulnerable group of individuals who are enrolled in both the Medicare and Medicaid programs—the so-called “dual eligibles.” The effort seeks to bring about better care, improved care experiences, and reduced costs for these beneficiaries through better coordination of services.

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 can also jeopardize our ability to remain independent.

That's why access to high-quality, affordable postacute care and long-term services and supports (LTSS) is so critical. Patients and their families know it is one of the keys to getting well, staying well, and remaining functional. Policymakers, however, have generally been slow to recognize how integral LTSS are to an effective and efficient health care system.

As implementation of the Affordable Care Act proceeds, The Commonwealth Fund's Program on Long-Term Care Quality Improvement is supporting work with nursing homes and other long-term care providers to ensure successful care transitions and better patient outcomes overall.



Vice President for Long-Term
Care Quality Improvement
Mary Jane Koren, M.D., M.P.H.

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 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 important quality-related issues such as reducing staff turnover—a problem endemic within the industry and a barrier to high performance—or improving the care planning process to address patients' goals for care. Participating providers must also set performance targets and measure change. The campaign works with stakeholder coalitions in each state, 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 8,800, representing over 56 percent of all U.S. nursing facilities—and in making measurable progress toward quality goals. Through the campaign's Web site, nhqualitycampaign.org, nursing homes can access free tools for tracking improvement and comparing facilities' performance, such as in safely reducing hospitalizations and addressing inappropriate use of antipsychotic medications in people with dementia. Nursing home leaders can also learn about evidence-based practices through training webinars. Consumers, meanwhile, can find information that will help them get good care.

The Fund's longstanding commitment to person-centered long-term care, particularly in nursing homes, is evident in a number of other recent grants. For example:

- Fund support to the Pioneer Network, a leading force behind culture change in nursing homes and the move to person-centered care, has enabled the coalition to advise state and federal agencies on nursing home payment and policy. Pioneer leaders have been working with CMS to implement a provision of the Affordable Care Act designed to strengthen quality assurance and performance improvement efforts in nursing homes. They have also worked with officials in Colorado, Kansas, and New Hampshire on pay-for-performance mechanisms that promote culture change.
- The University of Wisconsin's Barbara Bowers, Ph.D., investigated the lack of strong evidence to support consistent nurse assignment in facilities, despite general acceptance of this practice as a key to person-centered care. Bowers concluded that previous studies failed to define consistent assignment objectively—thus complicating attempts to quantifiably measure it—and applied it in variable ways.
- In collaboration with the National Center for Assisted Living, Sheryl Zimmerman, Ph.D., of the University of North Carolina convened 37 stakeholder organizations to recommend ways of optimizing the seven psychosocial components of the new version of the nursing home resident assessment tool known as the Minimum Data Set.
- Mathy Mezey, Ed.D., of the Hartford Center for Geriatric Nursing at New York University developed recommendations for academic nurse training programs to incorporate the principles of person-centered care into their curricula.
- Edward Miller, Ph.D., of the University of Massachusetts and Cynthia Rudder, Ph.D., of the Long-Term Care Community Coalition conducted a case study of consumer participation in the formulation of Medicaid nursing home payment policies in New York and Minnesota. The researchers also developed informational materials for consumers in other states.

Long-Term Services and Supports State Scorecard

With the growing demand for LTSS and continuing pressures on government budgets, states are being forced to do more with less. One solution is to establish a better balance between nursing home care and services delivered in the home or through community-based providers, such as adult day health care programs. As states embark on this new era in long-term care, they will need the means to assess progress in making affordable, high-quality services and supports available to all who need them.

Following on the success of The Commonwealth Fund's national and state health system scorecards, Susan Reinhard, R.N., Ph.D., and her team from AARP collaborated with the Fund and the SCAN Foundation to develop the first-ever state performance scorecard focused on long-term services and supports. The report, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, examined 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 assessed each state's performance overall as well as on the 25 individual indicators within the four domains. It found that all states have a long way to go to create a high-performing LTSS system, and that state Medicaid policies dramatically affect consumer choice and affordability. One of the most sobering findings is that the cost of LTSS, especially those provided in nursing homes, is unaffordable for most middle-income families. The scorecard, along with related state case studies, has served as a blueprint for action, with many states now working to address problem areas.

The Dual Eligibles Initiative

About 9 million Americans are eligible for benefits from Medicare, the federal program that provides health coverage for older adults and younger people with severe disabilities, as well as Medicaid, the joint federal–state program that pays for both medical care and long-term services and supports for

low-income individuals. Often referred to as the “dual eligibles,” this group represents a relatively small share of Medicare and Medicaid beneficiaries (16% and 15%, respectively). Because of their needs for a mix of medical care, behavioral health, and long-term care services, however, dual eligibles incur exceptionally high costs and account for disproportionate shares of spending in both programs. Some of the costs result not just from high use of services but also from inefficiencies caused by a lack of coordination in both payment and service delivery.

The Medicare–Medicaid Coordination Office within CMS, in conjunction with the new Center for Medicare and Medicaid Innovation, is authorized to study and address issues pertaining to dual eligibles. Its aim is to serve these beneficiaries better, assist health care providers, and help states develop an integrated approach to delivering and paying for the complex care beneficiaries need.

The Commonwealth Fund has also launched an initiative to help dual eligibles, with the goals of improving quality of care and care experiences and reducing overall costs. Several projects are already under way. Under the leadership of Eric Carlson, J.D., the National Senior Citizens Law Center is examining the experiences of states that received a waiver from the federal government so they may use Medicaid funds to pay for assisted-living services for dual eligibles. While the waivers are intended to allow beneficiaries to avoid the institutionalized settings of nursing homes, there are considerable downsides. Most important is that federal nursing home standards do not apply to assisted-living facilities, meaning consumer protections are comparatively slight. In an [article](#) in *ElderLaw Report* (Dec. 2011), Carlson outlined strategies that elder law attorneys can use to advocate for assisted-living clients when their rights are compromised, such as when facilities require residents to pay the private-pay rate for a period before accepting Medicaid reimbursement—a clear violation of federal Medicaid law.

With support from The Commonwealth Fund and the SCAN Foundation, the Center for Health Care Strategies is continuing to provide technical assistance to 12 states as they develop plans for an integrated system of care for dual-eligible beneficiaries and submit them for CMS approval. Through face-to-face meetings, conference calls, and Web-based educational sessions, state officials are able to share ideas, discuss common challenges, and learn about ways to deliver seamless care.

A number of states are turning to capitated managed care as a way to contain costs and integrate care systems for dual eligibles. While the potential for better care coordination is significant, an already vulnerable population may be at risk if strong beneficiary protections for independence and choice of service setting are lacking. Recognizing the importance of consumer input, CMS requires states to involve consumers in the implementation of managed care programs. Fund grantee Kevin Prindeville, from the National Senior Citizens Law Center, has created a Web site (www.dualsdemoadvocacy.org) to provide consumer groups with informational resources and concrete recommendations that will enable them to engage constructively with state governments to ensure adequate safeguards.

Future Directions

In addition to continuing its support for person-centered care and performance improvement in nursing homes, the Fund's Program on Long-Term Care Quality Improvement is supporting a number of projects aimed at improving care coordination and transitions for patients. For example:

- David Casserett, M.D., of the University of Pennsylvania is working with 14 hospices to identify best practices in the care of seriously ill nursing home residents. His goal is to pinpoint strategies and methods that strengthen the nursing home–hospice relationship and ensure that residents receive the best care possible, without being transferred to a hospital.
- Over the next year, the Fund will closely coordinate its work on dual eligibles with the Medicare–Medicaid Coordination Office, the Center for Medicare and Medicaid Innovation, and individual states in order to identify, evaluate, and spread innovations that improve care and lower costs—without putting beneficiaries in jeopardy. Attention will be given to smaller providers that are recognized for delivering high-quality care; keeping the essential features of these high-performing plans intact while they are brought to scale may represent the most feasible way to improve dual-eligible care and lower its cost. Carol Raphael, former CEO of the Visiting Nurse Service of New York, and Penny Feldman, Ph.D., director of its Center for Home Care Policy, will form a learning collaborative for plan and provider leaders to address the organizational challenges that must be resolved for this to occur.

Cover: Elderly residents of the Hebrew Home at Riverdale, in Bronx, NY, doing pool exercises. Quality long-term care services can be provided in a numbers of settings, including nursing homes, assisted living facilities, and home care. The Commonwealth Fund sponsors efforts to assess, track, and compare the performance of long-term services and supports and to ensure that these vital services are an integral part of any care system.

Photo: © Martin Dixon



PATIENT-CENTERED COORDINATED CARE

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 both become more patient-centered and coordinate more closely with hospitals, specialists, and other public and private health care providers in their communities
- inform the development of policies to encourage patient- and family-centered care in medical homes.

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 built upon a strong primary care foundation deliver higher-quality, lower-cost care overall and greater equity in health outcomes. Research also suggests that patient-centered primary care is best delivered in a medical home—a physician practice or health center that offers enhanced access to clinicians, coordinates all of a patient's health care services, and engages 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 Edward Wagner, M.D., of the MacColl Institute for Healthcare Innovation, the initiative involves 65 clinics in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania. The Qualis/MacColl team



Vice President for Patient-Centered Coordinated Care
[Melinda K. Abrams, M.S.](#)

provides technical assistance to local quality improvement organizations that, in turn, help the clinics achieve benchmark levels of performance in quality and efficiency, patient experience, and clinical staff experience. Eight foundations have joined the Fund in support of the initiative.

To help extend the reach and impact of the demonstration, the project team is developing an online curriculum for quality improvement coaches who are supporting the efforts of the nation's 1,300 community health centers to become effective medical homes. The Safety Net Medical Home Initiative is serving as a blueprint for the Center for Medicare and Medicaid Innovation's three-year medical home demonstration for federally qualified health centers, which provides technical assistance and enhanced payment to over 500 health centers in 44 states.

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 that are getting 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.

The Commonwealth Fund has supported 10 evaluations of medical home demonstrations. To align evaluation methods, share best practices, and exchange information on ways to improve evaluation designs, the Fund in 2008 established the [Patient-Centered Medical Home Evaluators' Collaborative](#), co-chaired by Meredith Rosenthal, Ph.D., of the Harvard

School of Public Health and the Fund's Melinda Abrams. A key objective of the collaborative is to reach consensus on a core set of standardized measures in each of the main areas under investigation, such as use of health services, cost savings, clinical quality, patient experience, and clinic staff experience. In 2012, the evaluators' collaborative announced recommendations for standardized measures of cost, utilization, and technical quality outcomes in medical home evaluations. The Centers for Medicare and Medicaid Services has encouraged its prospective medical home evaluation contractors to use the metrics, described in a Commonwealth Fund [issue brief](#), in their federally funded studies.

[Building Capacity for Patient-Centered Medical Home Implementation and Spread](#)

The Commonwealth Fund is supporting a number of efforts to help guide implementation of the medical home model's defining features, including team-based care, care management for high-risk patients, availability of after-hours care, and care coordination. For example, Timothy Ferris, M.D., and Clemens Hong, M.D., of Massachusetts General Hospital are comparing primary care-based care management programs that have been shown to improve quality of care and health outcomes for high-risk patients. The study will compare the programs on operational features, such as training of care manager, panel size, patient eligibility criteria, and use of information technology to monitor care. The Fund also is supporting Lawrence Casalino, M.D., Ph.D., of Weill Cornell Medical College to assess the value of e-mail as a means of communication between patients and providers.

To gain a better understanding of what facilitates the spread of patient-centered medical homes, the Fund is supporting researchers at Pennsylvania's Geisinger Health System to examine how its medical home program has reduced costly hospital admissions and readmissions. In particular, the study team is looking at ways to streamline and standardize the implementation of medical homes in primary care sites.

Helping Smaller Physician Practices Share Patient Care Resources

Because of their limited resources and capacity, small primary care practices often struggle to meet the functional requirements of a patient-centered medical home, which range 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 or expertise—such as care coordinators or quality improvement coaches—they enhance their capacity to provide care and improve their performance.

With Commonwealth Fund support, the University of Montana’s Stephen Seninger, Ph.D., is evaluating a statewide shared care management program where nurses working out of the local community health center provide support exclusively to high-risk Medicaid patients served by private, community-based physician practices in Montana. Dr. Seninger is examining the impact of the program on cost and quality of care as well as its viability in other rural communities. Under another Fund grant, Tara Bishop, M.D., at Weill Cornell Medical College is evaluating a pilot program in New York City that enables safety-net practices to share the services of a patient-panel manager, who helps ensure that patients receive recommended routine services and chronic disease care.

Improving Policy and Financing to Promote Patient-Centered Care

Forty-two states are developing patient-centered medical home programs for their Medicaid and Children’s Health Insurance Program enrollees. With Commonwealth Fund support, the National Academy for State Health Policy (NASHP) has been working with state Medicaid officials and other key stakeholders to ensure that beneficiaries have access to a medical home. Since 2011, NASHP has worked with 23 states to strengthen, expand, and sustain medical home initiatives, providing guidance on payment models, evaluation metrics, and technical assistance approaches. In a *Health Affairs* article (Nov. 2012), NASHP’s Mary Takach reviewed the variety of reforms taking shape, including new fee structures that enable physician practices to be reimbursed for the care management services they provide; support for smaller practices to share the services of registered nurses, behavioral health specialists, and other health professionals; and the alignment of payment with quality standards. For more information about states’ efforts to promote medical homes, see the Commonwealth Fund/NASHP report *Building Medical Homes: Lessons from Eight States with Emerging Programs* and NASHP’s interactive [medical home map](#).

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 methods for financially rewarding primary care sites that function as 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—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 features 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 spread medical homes, health system leaders, clinicians, and policymakers need information on the factors that lead to improved quality of care, greater efficiency, and lower costs. Future work will need to help providers implement the medical homes in ways that are sustainable, economical, and patient-centered.

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 more commonly

provided by larger practices. The Fund is supporting research into models for sharing clinical support services and health information systems, so that practices are able to provide coordinated care, after-hours appointments, and other services expected from medical homes

Policy implementation. As the Affordable Care Act's primary care provisions take effect, a Fund priority will be to synthesize and disseminate findings from the many medical home evaluations that are in progress for local, state, and federal policymakers.

Integrating the medical home with the "medical neighborhood." Commonwealth Fund support is aiding efforts to understanding how medical homes can integrate and partner with the other providers in their community—for example, specialists, hospitals, and mental health care providers in both safety-net and commercial settings—to ensure high-quality, efficient care.

Cover: At the Community Health Partners health center in Livingston, Mont., nurse care manager Libby Frederickson, R.N. (left) works with high-risk chronically ill patients to ensure they get the services they need to manage their condition successfully. Sharing care management services can bolster small physician practices' capacity to serve as medical homes. The Commonwealth Fund is supporting an evaluation to determine the effect of Montana's care management program on use of health care, quality, and costs.

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VULNERABLE POPULATIONS

VULNERABLE POPULATIONS

PROGRAM GOALS

As part of The Commonwealth Fund's mission to promote delivery system improvement and innovation, the Program on Vulnerable Populations supports efforts to ensure that low-income, uninsured, and racial and ethnic minority populations are able to obtain care from high-performing health systems with the capacity to meet 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 Issues

Equity is a core goal of a high performance health care system. In the United States, however, vulnerable populations—low-income people, the uninsured, and disadvantaged racial and ethnic minorities—experience greater difficulty obtaining health care, receive worse care, and experience poorer health outcomes than other groups. They also are more likely to have special needs arising from their personal, social, and financial circumstances, any of which may negatively affect health and hamper efforts to obtain care. The health care systems where vulnerable populations seek treatment 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's 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 health services.



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

Recent Projects

Establishing a Policy Framework for Equity in Health Care

The Affordable Care Act provides a number of opportunities to improve the health of vulnerable Americans, primarily by expanding insurance coverage and bolstering the health care safety net. Much work remains to be done, however, to ensure that these opportunities are fully realized. In October 2011, The Commonwealth Fund Commission on a High Performance Health System issued a [framework](#) for achieving equity in health care and ensuring that vulnerable populations receive care from well-functioning health systems. The report puts forward three strategies: 1) ensure that health coverage provides adequate access to care and financial protection; 2) strengthen the care delivery systems serving vulnerable populations; and 3) coordinate medical care with other community-based services, including public health.

Promoting Sustainable Funding for Safety-Net Hospitals

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 other providers serving large numbers of low-income and uninsured patients play a central role in the health care delivery systems that treat vulnerable populations. Several provisions in the Affordable Care Act—including the expansion of Medicaid and the reduction of disproportionate share hospital (DSH) payments, which help cover the costs of uncompensated care—will alter traditional revenue streams for safety-net hospitals. It will be critical to develop funding mechanisms that not only sustain the operations of safety-net facilities in a post-reform environment, but also promote delivery of high-performance health care.

Under the direction of Deborah Bachrach, J.D., Manatt Health Solutions analyzed current revenue streams of safety-net hospitals and how they are expected to change under health reform. The resulting [report](#), issued by the Fund's Commission on a High Performance Health System in March 2012,

offers policy options that target existing funds so that hospitals serving the most vulnerable patients would continue to thrive once the Affordable Care Act is fully implemented.

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

Safety-Net Providers' Role in Health Reform Implementation and Accountable Care

For safety-net providers, health reform implementation presents unique challenges, given the financial constraints and the complex needs of their low-income and uninsured patients. Under a Commonwealth Fund grant, Catherine Hess of the National Academy for State Health Policy (NASHP) convened a workgroup of state and federal officials, health care providers, and health policy experts to examine the impact of health reform on the safety net and develop policy recommendations for including these providers in reform implementation plans and policies.

One area of focus for the workgroup was the role of safety-net providers in integrated health care delivery systems. Public hospitals and community health centers operating within integrated systems—which offer greater access to specialty services, more continuity in provider relationships, and better-coordinated care than smaller independent practices or hospitals typically do—appear best equipped to handle the needs of vulnerable patients efficiently, the participants agreed. An [issue brief](#) published jointly by NASHP and the Fund in August 2012 explores key considerations for incorporating

safety-net providers into integrated delivery systems and discusses the roles of state and federal agencies in supporting and testing models of integrated care delivery.

Accountable care organizations (ACOs) represent a model of integrated care delivery with the potential to provide comprehensive, coordinated, and efficient care that meets the needs of vulnerable populations. There are concerns, however, that ACOs may unintentionally exacerbate existing inequities in health and health care—for example, many safety-net providers may not have the resources needed to participate in these new organizations. Under the direction of Valerie Lewis, Ph.D., Commonwealth Fund–supported researchers at the Dartmouth Institute for Health Policy and Clinical Practice conducted an [analysis](#) of the particular challenges facing would-be safety-net ACOs and suggested policy options for overcoming these obstacles. The Dartmouth team also will assess the extent to which ACOs are forming in socioeconomically disadvantaged communities and undertake a case study of a safety-net ACO—work that will inform policy options to maximize the benefits and minimize the risks of ACO formation for vulnerable populations.

Future Directions

Monitoring and Tracking to Inform Planning and Policy. States have a large role to play in ensuring that vulnerable patients have access to high-performing health care systems. To understand the extent to which states are embracing this role—and how they are going about it—The Commonwealth Fund is developing a scorecard of state performance on health care access, utilization, and equity for vulnerable populations, as well as state policies, resources, and programs that address their needs.

Promoting High-Performing, Integrated Delivery Systems. The Affordable Care Act’s expansion of Medicaid eligibility in 2014 for up to 17 million additional low-income Americans presents an opportunity for new accountable care organizations serving Medicaid patients to transform the way care is delivered

to vulnerable populations. The Commonwealth Fund will make grants to advance the development of ACOs in Medicaid. For example, support to the Center for Health Care Strategies and Tricia McGinnis has enabled creation of a multistate Medicaid ACO learning collaborative.

Another grant, to the Camden Coalition of Healthcare Providers, in Camden, N.J., will support creation of a “hotspotting” toolkit that will enable high-risk communities to identify the biggest users of emergency department and inpatient hospital care and devise targeted interventions to improve care coordination and quality and reduce costs.

Meeting the Varied Needs of Vulnerable Patients. Inadequate transportation, language interpretation, and outreach services are some of the many nonmedical causes of poor health outcomes in underserved communities. Over the next year, the Fund will support efforts to improve coordination among medical care, behavioral health, and community-based social service providers.

Leveraging Medicaid’s Role in Driving Delivery System Reform. Fund–supported researchers are also investigating ways that Medicaid can help drive transformation of the health care systems serving vulnerable populations. A November 2012 [report](#) by Deborah Bachrach and colleagues with Manatt Health Solutions examined how state Medicaid agencies can align with and build on the Medicare Shared Savings Program, which supports the development of ACOs for Medicare beneficiaries, to catalyze cost containment and quality improvement in their programs.

Laura Summer and Jack Hoadley of the Georgetown Health Policy Institute are examining possible changes in care delivery spurred by Medicaid managed care plans, which states are increasingly turning to as a means of controlling public health care costs. The findings will inform policymakers, state Medicaid administrators, and plan sponsors about the plan designs that are most likely to promote high-value—not just low-cost—care for vulnerable populations.

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

A health system that delivers high performance care to all Americans, including the most vulnerable among us, requires trained, dedicated physician leaders capable of addressing the health and social needs of disadvantaged minority populations and low-income individuals. 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 these leaders.

Based at Harvard Medical School under the direction of [Joan Reede, M.D., M.P.H., M.S., M.B.A.](#), 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 class, the fellowship program includes an optional second year of practicum experience to supplement the fellows' academic and leadership development training. Fellows chosen for the practicum spend one year in a health care delivery system setting, federal or state agency, or policy-oriented institution acquiring real-world experience in bringing high performance health care to vulnerable populations. The practicum is a competitive program open to first-year fellows, with a variable number of placements available per year.

For more information on the fellowship and how to apply, visit the [Mongan Commonwealth Fund Fellowship Program in Minority Health Policy](#) page on www.commonwealthfund.org.

A total of 85 fellows have graduated from the program. The four physicians selected for the 2012–13 class are:

Talita Jordan, M.D.

Dr. Jordan was most recently a pediatric chief resident at Children's National Medical Center in Washington, D.C. Her passion for the prevention of childhood obesity led her to Disciples Summer Camp, where she served as director for several years. In her role as child advocate, she developed a teen pregnancy workshop in Forestville, Md., and was involved in programs encouraging teen abstinence. While completing her medical degree at the University of Maryland School of Medicine, Dr. Jordan was awarded a National Heart, Lung, and Blood Institute Research fellowship for her scholarship and leadership skills.



Robert P. Marlin, M.D., Ph.D.

Dr. Marlin is an instructor in medicine at Harvard Medical School and a primary care physician in the school's Department of Medicine and at the East Cambridge Health Center. He has dedicated his career to improving health and health care of immigrants and refugees and, in particular, to developing coordinated care programs for survivors of political violence. Dr. Marlin, who holds a Ph.D. in anthropology from Rutgers University, received his medical degree from the State University of New York–Stony Brook School of Medicine in 2003 and completed his internal medicine residency at the Cambridge Health Alliance in 2006.



Anne Newland, M.D.

Most recently Dr. Newland was acting clinical director for the Kayenta Health Center of the Navajo Area Indian Health Service, and since 2004 has held the positions of medical officer and chief of medical staff. Her work at the center has helped to ensure community access to emergency care and expanded outpatient services. In 2010, she traveled to Kabul, Afghanistan, to collaborate with the medical arm of the Afghanistan Higher Education Project to improve clinical preceptorship. Dr. Newland received her medical degree from the University of Nebraska Medical Center in 1999. In 2003, she completed her residency in pediatric internal medicine at the University of Tennessee–Memphis, where she was chief resident in internal medicine (2004).



Oluseyi Ojeifo, M.D.

Dr. Ojeifo was most recently an internal medicine resident at Massachusetts General Hospital in Boston, Mass. Committed to the creation of a diverse medical workforce, she was engaged in residency recruitment during her tenure. Among her other interests are innovative approaches to improving health care delivery and reducing disparities in cardiovascular care. Dr. Ojeifo's dedication to vulnerable populations can be seen in her work as an Albert Schweitzer Fellow in an underserved neighborhood in Pittsburgh, Pa., and as a volunteer on the cardiology ward at Groote Schuur Hospital in Cape Town, South Africa. She received her medical degree from the University of Pittsburgh School of Medicine in 2009.



Cover: Cambridge Health Alliance (CHA), a leading safety-net provider in the Boston metropolitan area, has begun the process of transforming its primary care sites into patient-centered medical homes and testing new "global payment" arrangements. Under a Commonwealth Fund grant, researchers are studying CHA's approach in order to document the organization's progress in becoming an accountable care provider and identify lessons that will help other safety-net providers deliver efficient, patient-centered population-based care.

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AFFORDABLE
HEALTH INSURANCE

AFFORDABLE HEALTH INSURANCE

PROGRAM GOALS

As part of The Commonwealth Fund's efforts to inform health reform policy and implementation, 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 to employer-based health insurance, health plans in the individual market, and public insurance programs for people under age 65, and estimate the impact of those changes on the number of people insured 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 Affordable Care Act and related federal regulations, along with their implications for people and employers
- inform implementation of the reform law at the federal and state levels, through tracking surveys of key population groups, interactive tools to monitor state progress, and analysis of key reform provisions and regulatory guidance
- 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 U.S. census data reveal that the number of people without health insurance in the United States climbed steadily over the last decade, rising from 36.6 million in 2000 to 50 million in 2010. By 2011, however, the number had fallen by 1.3 million, to 48.6 million people, the largest one-year drop in the past decade. This improvement was likely driven by an increase in the number of young adults with coverage, a result of the Affordable Care Act's provision allowing those under age 26 to enroll in a parent's health plan. The nearly four-point decline in the uninsured rate for young adults (ages 19 to 25), from 31.4 percent to 27.7 percent in 2009, foreshadows the expected gains in coverage for many other Americans once all of the law's provisions are rolled out over the next few years.

Trends in insurance coverage and consumer spending on health care underscore why these reforms are so important. Rising health care costs and sluggish income growth have made health insurance less protective for millions of Americans. Deductibles for employer-based plans doubled between 2003 and 2010, while an estimated 29



Vice President for
Affordable Health Insurance
Sara R. Collins, Ph.D.

million insured adults under age 65 were underinsured, given their high out-of-pocket costs relative to income, compared with 16 million people in 2003. Both trends have had serious financial and health consequences for U.S. families.

By 2022, the Affordable Care Act reforms are expected to reduce the number of uninsured people from a projected 60 million, in the absence of the law, to 27.1 million. This will be achieved through a substantial expansion in Medicaid eligibility and through 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 ban insurers from charging people more based on health or gender, prevent insurers from barring enrollment because of a preexisting health condition, and establish a new standard for essential health benefits. To ensure the law is implemented effectively, policymakers will need information about the impact these and other reforms have on the affordability and quality of coverage, as well as about 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, the associated federal regulations, and state activity. Once President Obama signed the act into law, the Fund launched an online interactive timeline to guide policymakers, the media, 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 federal regulations as they are issued, including rules governing health insurance exchanges, premium tax credits, the essential health benefit standard, medical loss ratio requirements for insurers, and state and federal review of premium increases in the individual and small-group markets.

The program continued to contribute to The Commonwealth Fund's *Realizing Health Reform's Potential* issue brief series, explaining how provisions of the Affordable Care Act may benefit different groups, improve insurance coverage, and boost overall health system performance. Among the topics covered in the past year were: the health care experiences of U.S. women compared with those in other industrialized countries; the loss health benefits among the newly unemployed; and Pre-existing Condition Insurance Plans.

The Affordable Health Insurance program has also contributed to a new Commonwealth Fund publication series, *Tracking Trends in Health System Performance*. Briefs in the series highlighted results from the Fund's new online longitudinal health care tracking surveys of young adults and people with low and moderate incomes, documenting a substantial income-based divide in insurance and health care use, coverage gaps that lead to difficulties getting timely care, and the enrollment of millions of young men and women in their parents' health plans shortly after the reform law was enacted.

Analyzing Key Reform Implementation Issues

The new health insurance exchanges are the centerpiece of the Affordable Care Act's private health coverage reforms. By 2022, more than 20 million individuals and small-business employees will obtain their coverage through these managed marketplaces. State officials are currently drawing up plans to demonstrate to the Department of Health and Human Services how they intend to operate their exchanges or whether they are electing to partner with the federal government to implement them.

Drawing from research by grantee Sara Rosenbaum, J.D., of George Washington University, The Commonwealth Fund launched an interactive Web tool to enable side-by-side comparisons of state insurance exchange laws and executive orders. Users of the tool can find information about each state's approach to governance and board membership, standards for certifying health plans, strategies for combatting adverse selection, and coordination

with public insurance programs. The tool will be updated over time. In a [Fund issue brief](#), Rosenbaum and colleagues report that the exchanges established thus far are designed as publicly accountable entities with flexibility in how they operate.

In another [Fund issue brief](#), Wake Forest University School of Law professor Mark Hall, J.D., and Harvard School of Public Health economist Katherine Swartz, Ph.D., examine the activities of exchanges in California, Colorado, and Maryland, three states that have made significant progress but that now face a challenging set of decisions related to exchange financing and mitigating gaps in coverage and care among people who change their source of coverage. In July 2012, Commonwealth Fund vice president Sara Collins co-moderated a panel discussion at an Alliance for Health Reform briefing on insurance exchanges and the upcoming Medicaid expansion in the wake of the Supreme Court decision on the Affordable Care Act.

Earlier in the year, the Fund sponsored a set of papers in the journal *Health Affairs* (Feb. 2012) that dealt with implementation of the Small Business Health Options Program, more commonly known as the SHOP exchanges. Articles by [Timothy Jost, J.D.](#), of the Washington and Lee University School of Law, [Jon Kingsdale, Ph.D.](#), former director of the Massachusetts Commonwealth Health Insurance Connector Authority, [Terry Gardiner](#) of the Small Business Majority, and [William Kramer](#) of the Pacific Business Group on Health, among others, examined the potential of SHOP exchanges to provide affordable options for small employers, who currently face high premiums and administrative costs when they insure their employees. A related [webinar](#) moderated by Sara Collins drew an audience of more than 400 small and large employers, state policymakers, and industry stakeholders. On *The Commonwealth Fund Blog*, the Fund's Sara Collins and Tracy Garber continue to update states' progress in establishing exchanges.

Affordability and Cost Protection of Coverage Under Reform

For years, many U.S. households have faced sharp growth in their health care costs. Even for those who are continuously covered, it can be difficult to afford medical expenses when they are very high relative to income. Cathy Schoen and her Commonwealth Fund colleagues have found that people who are “underinsured” in this way are nearly as likely as those who are uninsured to skip needed health care and to have problems paying medical bills. According to a [Fund study](#) published in *Health Affairs* (Sept. 2011), the number of underinsured adults rose by 80 percent between 2003 and 2010, from 16 million to 29 million.

Numerous health reform provisions, some of which have already gone into effect, are aimed at making health insurance coverage more comprehensive and controlling growth in premiums. For example, insurance carriers selling policies in the individual and small-group insurance markets are required to spend at least 80 percent of their premiums on medical care and quality improvement, as opposed to administration and profits. Starting this year, insurers that do not meet these thresholds must pay rebates to enrollees. With Commonwealth Fund support, Wake Forest's Mark Hall and Michael McCue, D.B.A., of Virginia Commonwealth University [estimated the amount of rebates](#) expected in each state if the new rules had been in effect a year earlier. The researchers found that nationally, consumers would have received nearly \$2 billion in rebates if the new “medical loss ratio” rules had been in effect in 2010. Ultimately, many insurance carriers reduced spending on administrative costs in 2011, paying out a total of \$1 billion in rebates to policyholders.

Consumer protections enumerated in the “Patient Bill of Rights” have also been put in place. Insurers may no longer impose lifetime limits on benefits; retroactively cancel, or rescind, coverage when an individual gets sick; or impose preexisting condition exclusions on children. In an [issue brief](#) published in March 2012, Georgetown University's Kevin Lucia, J.D., and

colleagues reported that 49 states and the District of Columbia had taken legislative or regulatory action to implement these reforms in their states.

Tracking the Uninsured and Underinsured

To track changes in health insurance coverage and health care experiences as health reform is implemented, the Fund's Affordable Health Insurance program launched a series of three longitudinal, nationally representative online surveys in 2011 to follow randomly selected panels of adults over the next several years. The first issue brief from the surveys, *The Income Divide in Health Care*, which drew on findings from the Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, focused on the health care experiences of adults with low incomes. According to the brief, nearly three of five adults in families earning less than \$30,000 for a family of four were uninsured for a time in 2011, and two of five were uninsured for one or more years. Low- and moderate-income adults who were uninsured during the year were much less likely to have a regular source of health care than people in the same income range who had coverage all year.

A second Fund brief based on data from that survey, *Gaps in Health Insurance* (April 2012), found that compared with adults who had continuous coverage, those who were not covered for even a short period were less likely to have a regular doctor and less likely to be up-to-date with recommended preventive care screenings. Losing or changing jobs was the primary reason people experienced a gap in coverage. A separate Fund-sponsored [analysis](#), led by Pamela Farley Short, Ph.D., of Pennsylvania State University, found 89 million people—36.3 percent of Americans ages 4 to 64—were uninsured for at least one month between 2004 and 2007, including 23 million who lost coverage more than once. Starting in 2014, health insurance options provided by the Affordable Care Act should substantially reduce the chance that people will experience gaps in health coverage when their employment circumstances change.

The Health Insurance Tracking Survey of Young Adults yielded a third issue brief, *Young, Uninsured, and in Debt* (June 2012). The researchers found that as a result of the Affordable Care Act's provision permitting children to remain on their parent's private insurance plans until their 26th birthday, 13.7 million Americans between 19 and 25 stayed on or enrolled in their parent's health plan in 2011, including 6.6 million who likely would not have been able to do so prior to the passage of the law.

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 populations and inform policymakers and federal officials about ways to ensure the reforms achieve their goals.

- Timothy Jost, in collaboration with Mark Hall and Katherine Swartz, will continue to examine the creation of state insurance exchanges in six key states. Their work will provide recommendations to state and federal officials, legislators, and regulators for ensuring that these crucial components of health reform function as intended.
- States have considerable discretion in shaping the health plans qualified to be sold through the exchanges, in terms of how the plans meet population needs, the dynamics of insurance markets, and health system performance goals. To learn what health plans in the new state insurance exchanges will look like, Sara Rosenbaum and her team at George Washington University will analyze new state legislative activity in 2012, state and federal requests-for-proposals for the qualified health plans that will be sold through the exchanges, and health plan contracts.
- To inform federal efforts for ensuring that the law's health coverage provisions are being implemented consistently and with the best interests of consumers in mind, Georgetown University's Kevin Lucia

and his team will track and analyze how states are implementing their exchanges and planning to enforce compliance with the new rules through legislation, regulation, and guidance.

- The Fund's Affordable Health Insurance program will continue to track trends in the affordability of health coverage. Using the federal Medical Expenditure Panel Survey, Peter Cunningham, Ph.D., of the Center for Health System Change is monitoring the level of medical cost burden faced by Americans, including insurance premiums and out-of-pocket expenses.
- The Fund's Biennial Health Insurance Survey has been tracking trends in insurance coverage and quality for over a decade. The sixth biennial survey was fielded in 2012, and the results, including important data on trends in coverage and health care spending, will be published early in 2013. At the same time, the Fund's new series of

longitudinal tracking surveys will continue to provide timely data on the experiences of low-income adults, young adults, and older adults as health reform is implemented.

- At the University of Kansas Center for Research, Jean Hall, Ph.D., will continue tracking state enrollment and patient experiences in Pre-existing Condition Insurance Plans during their final year of operation. The research team will develop policy options to ease the transition of enrollees into coverage offered through the insurance exchanges.
- The National Opinion Research Center's Jon Gabel will administer a survey to small employers about their experience in providing health insurance benefits and their needs and preferences regarding the purchase of coverage. Understanding the perspectives of small firms should aid policymakers as they set up the SHOP exchanges.

Cover: Under the Affordable Care Act, small-business owners will have increased access to affordable health insurance coverage, both for themselves and their employees. Commonwealth Fund-supported researchers are tracking and documenting the implementation of the reform law's insurance provisions, including the new Small Business Health Options Program, and their effectiveness in making lower-cost yet comprehensive health coverage available to employers and their workers.

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COMMISSION ON 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 16 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 the need for improvement in health system performance, identify areas where improvements can be achieved, and 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, the requirement for everyone 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 its reports and official statements.

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 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 high-income 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.

The Affordable Care Act and other recent legislation offer policy tools that can be used to address many of these problems. But much work remains. In the coming year, the Commission will seek to reinforce the principles and goals of a high performance health system, helping the nation to advance the unfinished agenda to control health care costs, improve value, and ensure that all Americans have access to affordable, efficient, high-quality care.

Commission on a High Performance Health System

Stuart Guterman, executive director

Cathy Schoen, research director

Rachel Nuzum, senior policy director

Commission Projects

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 nation's longstanding mix of private group insurance plans and public programs—a course of action intended to retain the best features of our current system while minimizing dislocation for Americans who currently have good coverage. While ensuring that everyone has health insurance is essential, the Commission believes that 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 set forth 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. The Affordable Care Act was designed with many of these same goals in mind.

Tracking Health System Performance

The Commission has issued three national and two state-level [scorecards](#) for the U.S. health system, and in March 2012 released a new scorecard for health system performance at the local level. These reports take a broad look at how the health care system is doing and where improvements are needed, as well as models of exemplary care from which others may learn. They look at such issues as: 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?

Rising to the Challenge: Results from a Scorecard on Local Health System Performance, the first-ever scorecard to focus on health system performance within the nation's hospital referral regions, provides U.S. communities with comparative data that they can use to assess the performance of their health systems, establish priorities for improvement, and set achievement targets. The findings show clearly that when it comes to health care access and care experiences, where one lives matters. On many of the key health system indicators measured, including insurance coverage, preventive care, mortality rates, potentially avoidable hospital use, and costs, the scorecard finds significant differences between leading and lagging localities, and wide disparities among major cities. An [interactive map](#) accompanying the report allows comparison of cities and communities across the U.S.

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 notes 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 been in blood pressure control, heart attack and pneumonia care in hospitals, and prevention of surgical complications—all of which have been the focus of public reporting or collaborative improvement initiatives.

The Commission's [State Scorecard on Health System Performance](#) 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 the state scorecard, released in 2009 along with an [interactive map](#) showing state-by-state comparisons, identified continued wide variations in health care quality, access, costs, and outcomes.

Developing Policy Options

In its 2007 report, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, the Commission demonstrated how policies that are designed to improve health system performance can also reduce spending growth. In fact, the set of policies examined by the Commission would, if combined with universal health insurance coverage, lead to a decline in national health expenditures of more than \$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. A number of 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 that were later part of the Affordable Care Act.

Helping to Realize the Potential of Health Reform

A central piece of 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 are successful. In the 2010 issue brief *Developing Innovative Payment Approaches: Finding the Path to High Performance*, the Commission proposed a set of principles that would facilitate innovation while helping to maintain the fiscal integrity of the Medicare and Medicaid programs.

An approach to health care financing and delivery reform that has attracted much attention is the accountable care organization (ACO), a group of health care providers that, in partnership with payers, agrees to take responsibility for the quality and cost of care delivered to a defined population. 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.

A 2012 report from the Commission called on the federal government to develop a comprehensive, disciplined strategic plan to take full advantage of the new opportunities in recent health care legislation. In *The Performance Improvement Imperative: Utilizing a Coordinated, Community-Based Approach to Enhance Care and Lower Costs for Chronically Ill Patients*, the Commission lays out a strategy for addressing one of the greatest health system challenges:

improving the coordination of health services provided to people with multiple chronic health conditions. Five percent of the U.S. population accounts for 50 percent of all health care costs, and most in this group have chronic diseases like congestive heart failure, coronary artery disease, and diabetes. The report argues that the nation should be able to achieve substantial improvements in care for these patients, while saving billions in health care costs, through coordinated, locally based efforts.

Providing Access for Vulnerable Populations

The Commission also has released a series of reports focusing on the need to ensure access to a high-performing health system for vulnerable populations, including people without health insurance, families with low incomes, and disadvantaged minorities. In *Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations*, the Commission examines the challenges and offers strategies to close the health care divide. In *Toward a High Performance Health System for Vulnerable Populations: Funding for Safety Net Hospitals*, the Commission recommends ways to shore up safety-net hospitals so they are able to serve their communities effectively.

Informing Policymakers

In addition to formulating options for improving the health system and recommendations for implementing reform legislation, the Commission on a High Performance Health System seeks to engage and inform lawmakers and staff in the executive and legislative branches, as well as key health care stakeholders, through bipartisan briefings and meetings. The Commission's senior policy director, Rachel Nuzum, who also directs The Commonwealth Fund's Federal and State Health Policy program, provides policymakers in both branches of government with information and technical assistance that draw upon the work of the Commission and the Fund. Staff from the Fund and the Commission are also frequently called upon by federal and state legislators to provide expert testimony and assistance.

Future Directions

Despite the gathering momentum for meaningful health system reform in both the private and public sectors, the work of the Commission on a High Performance Health System is far from complete. Over the coming months, the Commission will work to:

- 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
- help health care leaders and the American public understand the legislation and what it means for them
- lay the groundwork for future delivery system change and health policy action.

The Commission will also continue its efforts to assess national and state health system performance and inform health policy at all levels.

Cover: Michael Chernew, Ph.D., of Harvard Medical School discusses promising innovations in health care payment policy with fellow members of The Commonwealth Fund Commission on a High Performance Health System at the June 2012 meeting in Cambridge, Mass. Seated next to him are commissioner Maureen Bisognano of the Institute for Healthcare Improvement, commission executive director Stuart Guterman of The Commonwealth Fund, and chairman David Blumenthal, M.D., incoming Fund president.

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Chris Jennings



**FEDERAL AND STATE
HEALTH POLICY**

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
- facilitating information exchange between federal and state policymakers, both to inform federal leaders of innovations in state health policy that have implications for national health reform implementation and to raise awareness among state leaders about federal policies that will affect state health reform strategies
- 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
- fostering dialogue among policymakers, national stakeholders, and the research community on key health policy issues.

Recent Projects

Bipartisan Congressional Health Policy Conference

Each year, members of the U.S. House of Representatives and Senate are invited 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 pressure. In addition to providing an opportunity to reach one of The Commonwealth Fund's most influential audiences, the meeting also fosters 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 retreats since 1998, with strong bipartisan representation.



Vice President for Federal Health Policy
Rachel Nuzum, M.P.H.

Bipartisan Congressional Staff Retreat

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.

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.

Medicaid as a Lever for Health System Reform

Passage of the Affordable Care Act strengthens Medicaid's position as both a platform for expanding insurance coverage and for initiating health care payment and delivery reforms. As state Medicaid agencies pursue initiatives in this area, Commonwealth Fund support to the National Association of Medicaid Directors is providing opportunities for agency heads to learn from one another and become familiar with a broad range of policy options. The project also facilitates dialogue between state and federal officials on key reform implementation activities.

Educating and Informing State Policymakers

State officials and legislators play a central role in implementing the Affordable Care Act, from passing laws that shape the health insurance exchanges to making health care budgeting decisions. To fulfill that role, state policymakers need tools and resources to understand the options available. Through a partnership with the Progressive States Network and the National Working Group of State Legislators for Health Reform, The Commonwealth Fund supports a series of meetings for state legislators that also involves policy experts and federal officials. The meetings have focused on using Medicaid as a lever for payment and delivery system reform, cost-containment options, and state Medicaid programs' interaction with health insurance exchanges.

Future Directions

In the coming year, the Program on Federal and State Health Policy will continue to examine the intersection of federal and state health policy in 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 to congressional and administrative staff working on the law's implementation and other delivery and payment system reforms. Program staff will also inform policymakers of recent Commonwealth Fund research and analysis, policy recommendations from the Fund's Commission on a High Performance Health System, and innovative policies and programs around the country.

Cover: At an October 2012 Commonwealth Fund briefing hosted by the Alliance for Health Reform in Washington, D.C., Chris Jennings of the Bipartisan Policy Center and health attorney and policy expert Dean Rosen discuss key differences between the Democratic and Republican health care platforms ahead of the November elections.

Photo: © James Ryder



PAYMENT AND SYSTEM REFORM

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 with higher-quality health care 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
- evaluating the potential for broader application of successful payment and delivery models.

The Issues

Health care spending in the United States—the nation with the most expensive health system—is projected to grow from \$2.7 trillion in 2011 to \$4.8 trillion, or 20 percent of gross domestic product, by 2021. 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 are needed to reward providers for delivering high-value care rather than a high volume of services, as is too often the case in our current system.



Vice President for
Payment and System Reform
Stuart Guterman



Senior Policy Analyst
Mark A. Zezza, Ph.D.

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 carry out this effort, policymakers require information and analysis on the alternatives available, as well as the potential and actual impacts on health care use, spending, and quality.

Recent Projects

Exploring Alternative Payment and Delivery Models

The Affordable Care Act has been a source as well as a catalyst for innovative approaches to payment reform and care delivery. One such innovation is the Medicare Shared Savings Program, which provides financial incentives for accountable care organizations, or 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 is known about what it takes for these organizations to succeed, including the payment models—from shared savings to shared risk—that will 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 ACOs that use, or are planning to deploy, a payment arrangement in which payers and providers share risk. The study team, led by Suzanne Delbanco, Ph.D., argues 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 Commonwealth Fund–supported effort, Michael Bailit, and Christine Hughes, of Bailit Health Purchasing interviewed stakeholders in shared-savings arrangements—payers, providers, and state agencies—to learn about the populations covered, the assignment of providers, risk adjustment mechanisms, and methods for calculating and distributing savings. According to their Fund issue brief, *Key Design Elements of Shared-Savings Payment Arrangements* (Aug. 2011), among the key issues that payers

and providers must still resolve are how to determine whether savings were truly achieved, how to equip providers with the data, tools, and guidance they need, and which standard provider performance measures should be used. Their follow-up study, *Shared-Savings Payment Arrangements in Health Care: Six Case Studies*, suggests that shared-savings programs will eventually need to incorporate shared risk to be effective in the long term.

Premier, the national performance improvement alliance of U.S. hospitals and other health care sites, offers another model for health care organizations seeking to control costs and improve patient care. Premier, which began as a hospital purchasing coalition, has created a large-scale collaborative to develop an effective accountable care model that could be replicated across hospitals, health systems, and physician practices. In an August 2012 [report](#), Eugene Kroch, Ph.D., Danielle Lloyd, and others from the Premier Research Institute provided an overview of strategies for implementing ACOs that effectively balance cost control with efforts to improve health outcomes and enhance satisfaction with care. The report also describes a model for a successful ACO, payment options and performance metrics, examples of ACOs in action, early challenges faced, and policy recommendations that would support formation of these organizations across the nation. The Premier project team is also performing an inventory of members' core capabilities as part of an assessment of ACO readiness.

Evaluating Payment and Delivery System Reform

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 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 14,000 participating doctors. 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, 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. Evaluation of the first two years of the program indicates somewhat lower medical spending and improvements in both chronic and pediatric care.

Informing Payment Reform Policies

Payment reform can also elevate the role of primary care as a driver of health system improvement. With Commonwealth Fund support, James Reschovsky, Ph.D., and colleagues from the Center for Studying Health System Change simulated the impact of turning the temporary 10 percent bump in Medicare fees for primary care services, a policy authorized by the Affordable Care Act, into a permanent increase. In a Fund [issue brief](#), the authors demonstrate that the fee increase would raise both the number and cost of primary care visits. The cost increase, however, would be offset by lower Medicare costs for other services—mostly inpatient and postacute care—once the full effects on treatment patterns are realized.

Under a Fund grant to the University of Massachusetts Medical School, Arlene Ash, Ph.D., and Randall Ellis, Ph.D., developed a bundled payment model that accounts for the cost of all services that primary care practitioners provide. The intent is to promote not only the delivery of more efficient care but also the use of appropriate primary care services. The model has already been adopted by the Capital District Physician's Health Plan, a nonprofit network-model health plan in New York. In an [article](#) in *Medical Care* (Aug. 2012), Ash and Ellis demonstrated the applicability of the approach to a variety of providers and populations, as long as risk is adjusted to reflect variations in patient complexity and treatment costs.

Future Directions

In the coming year, the Program on Payment and System Reform will further develop the capacity of researchers to model the 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—the mission of the new Center for Medicare and Medicaid Innovation—and evaluate local initiatives to restructure payment incentives and improve health care delivery.

A few examples of research that will yield results in the near future include:

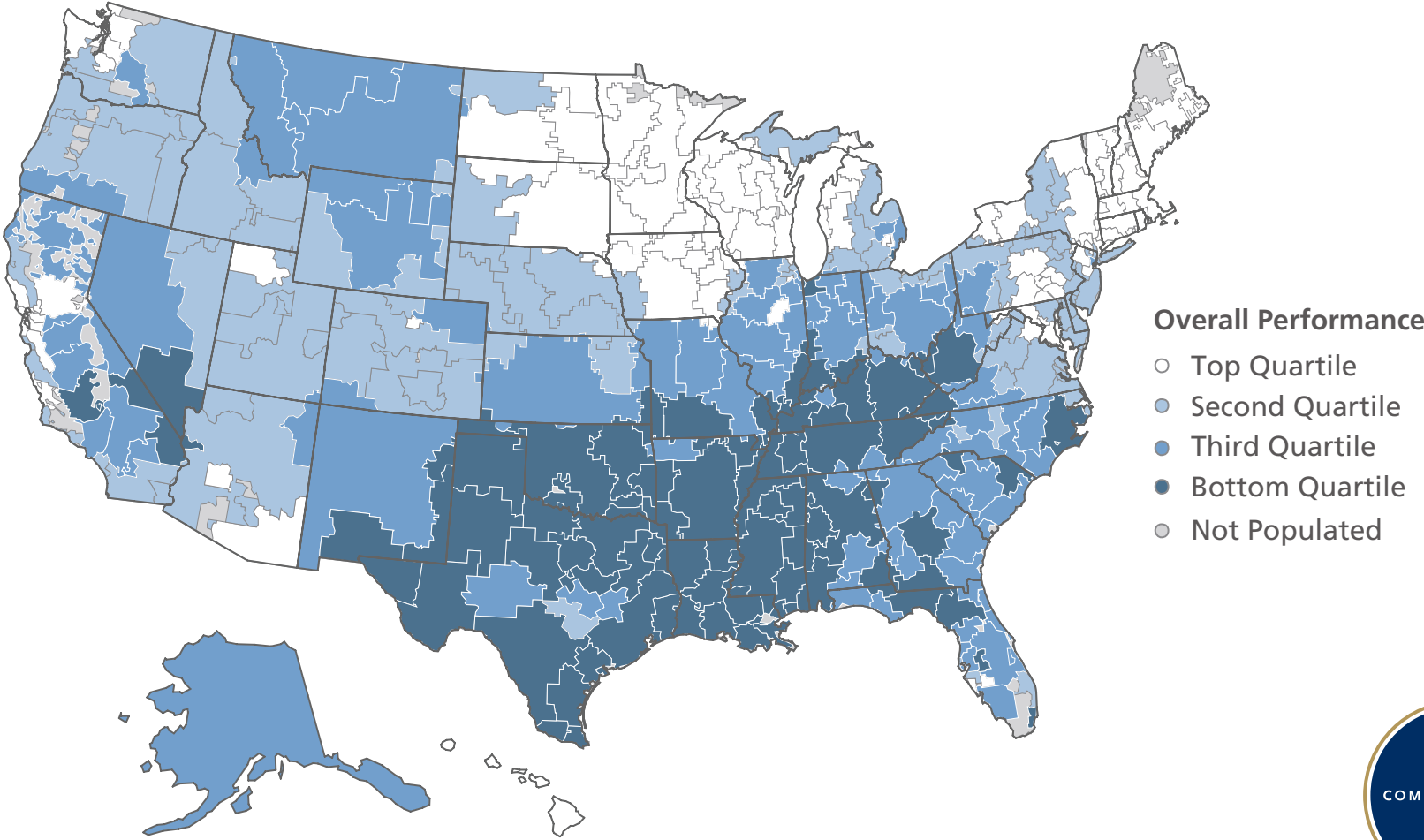
- An analysis of the impact of new federal policies that reduce longstanding overpayments to private Medicare Advantage plans and, for the first time, reward plans that perform well on measures of quality and patient experience. The grant to George Washington University and Brian Biles, M.D., will also address topics that are likely to be the subject of continued intense debate: proposals to transform Medicare into a “premium support” program, and interest on the part of the federal government and the states in enrolling Medicare/Medicaid dual eligibles into private plans.

- An investigation by Harvard Medical School’s Michael Chernew, into geographic variation in commercial health care spending and the correlation between commercial and Medicare spending across hospital referral regions. While it is well known that Medicare spending and service use vary from region to region, patterns in commercial insurance markets are not as well understood.
- A study of how a tiered hospital network affects choice of hospital, use of services, and prices. Michael Chernew will focus on Blue Cross Blue Shield of Massachusetts’ hospital network, which features large differences in cost-sharing between tiers. The results will inform insurers and policymakers about the effectiveness of tiered networks as a tool for reducing overuse and lowering prices.

Cover: Partly because of the piecemeal approach to health care payment in the United States, physician offices typically spend significant time dealing with administrative paperwork—time that could be better spent on patient care. The Commonwealth Fund supports research into better ways of paying for care that not only benefit providers but, more importantly, help ensure that their patients are getting the “right care.”

Photo: © Michael Malyzsko

Overall Health System Performance



HEALTH SYSTEM PERFORMANCE ASSESSMENT AND TRACKING

HEALTH SYSTEM PERFORMANCE ASSESSMENT AND TRACKING

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 to show what is possible to achieve, 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, affordability, access to care, and patient-reported quality of care; and
- monitor public- and private-sector actions to transform health care delivery, including payment innovations, health information technology adoption, and the organization of care.

The Fund's Health System Performance Assessment and Tracking activities are closely coordinated with Fund initiatives in [Delivery System Innovation and Improvement](#), [Health Reform Policy](#), and [International Health Policy and Innovation](#).

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, state, and, starting in 2012, local scorecards. The [National Scorecard on U.S. Health System Performance](#) (2006, 2008, and 2011), focuses on health care outcomes, quality, access, efficiency, and equity and compares U.S. average performance to benchmarks set within the U.S. and internationally. 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, avoidable hospital use/costs, and health outcomes, and the potential gain if each state reached levels of performance achieved by leading state. The [Scorecard on Local Health System Performance](#) (2012) examines performance of 306 local areas across 43 indicators related to access, prevention and treatment, potentially avoidable hospital use and cost, and healthy lives. This scorecard enables comparison of performance within and across states. Profiles, that compare each area to

benchmarks set by top performing communities, and data are available on an interactive map on the Fund Web site.

The [State Scorecard on Long-Term Services and Supports](#) (2011) assesses performance of nursing homes, home health agencies, and state programs across four dimensions: access and affordability, choice of setting and provider, quality of life and quality of care, and support for family caregivers.

The [State Scorecard on Child Health System Performance](#) (2011) examines states' performance on 20 key indicators of children's health care access, health system equity, affordability of care, prevention and treatment, and the potential to lead healthy lives.

WhyNotTheBest.org. 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 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.

Surveys. The Fund conducts a wide range of surveys, both in the United States and abroad, to monitor trends in health care access and affordability, the delivery of patient-centered coordinated care, and the spread of health information technology with information exchange in physician practices. Fund surveys also explore public views on health care matters, and assess the policy perspectives of health care leaders. Recent and ongoing surveys include:

- [Commonwealth Fund Biennial Health Insurance Survey](#) (2001, 2003, 2005, 2007, 2010, 2012). Over the years, these surveys have produced a wealth of information about the extent and quality of

health care coverage in the United States. Specific topics covered in past surveys include: the stability, affordability, and quality of adults' health insurance coverage; cost-related difficulties in accessing care; experiences in the individual market; medical bill problems; and medical debt.

- [The Commonwealth Fund Health Insurance Tracking Surveys of U.S. Adults](#). This series of online longitudinal surveys tracks the effects of the Affordable Care Act over the next three years as it is implemented and establishes baseline measures prior to 2014, when the major provisions of the law go into effect. Throughout this transformational period in U.S. health care, these surveys will provide a flexible, policy-relevant survey tool to supplement the Fund's long-standing national Biennial Health Insurance Survey.
- [Commonwealth Fund International Health Policy Survey](#) (annual). Now including 11 industrialized countries, this rotating series of annual surveys explore such topics as health system performance; access, coordination, and responsiveness from the perspective of the general population; seriously or chronically ill adults; and primary care physicians. The 2012 survey focused on 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, 2011). The public views survey assessed the public's experiences and perspectives on the organization of the nation's health care system and ways to improve patient care.
- [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 2009 Survey of Clinic Patients in New Orleans.** One of the many things Hurricane Katrina devastated when it hit New Orleans in 2005 was the city's health care system. To find out how well community clinics were serving their high-need populations, The Commonwealth Fund conducted interviews with patients at 27 clinics in 2009. The [findings](#) were encouraging.

To access all Fund surveys, visit [Surveys](#) at 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 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.

State Trends in Private Insurance Premium and Deductibles (2009, 2010, 2011, 2012). The Commonwealth Fund also produces an annual report that tracks employer-sponsored health insurance plan costs and benefits in each state. The report focuses on premiums, employee shares of premiums, and plan deductibles. The [newest analysis](#), released in December 2012, covers the period 2003 to 2011. An accompanying [data brief](#) focuses on insurance cost trends in major metropolitan areas.

Cover: One of the many map views available from The Commonwealth Fund's Scorecard on Local Health System Performance. The Fund produces an array of scorecards to assess U.S. health system performance nationally, by individual state, and by hospital referral region, as well to measure the quality and accessibility of long-term care services and children's health care. All the scorecards can be accessed through the Fund's online Health System Data Center.



INTERNATIONAL HEALTH POLICY AND INNOVATION

HANS OLAV MELBERG
(Norway)

INTERNATIONAL 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 among industrialized countries about ways to improve the performance of health systems. It does this by:

- sparking creative thinking about health policy
- encouraging comparative research and collaboration on quality improvement and other reform initiatives
- building an international network of health care researchers devoted to health policy
- showcasing international innovations in policy and practice that can inform U.S. health reform.

The Issue

Across the industrialized world, health care policymakers face mounting pressure to bend the cost curve while providing access to expensive new drugs and medical technologies, improving the quality and safety of care, and ensuring 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

2012 International Symposium on Health Care Policy

For the past 15 years, The Commonwealth Fund has hosted an annual international health care policy symposium in Washington, D.C., organized in collaboration with the journal *Health Affairs*. The 2012 symposium, “International Lessons for the Financial Sustainability of Health Systems,” brought together health ministers and more than 60 leading policy thinkers from Australia, Canada, France, Germany, New Zealand, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom, and the United States.



Vice President for International
Health Policy and Innovation
[Robin Osborn, M.B.A.](#)

In the opening keynote address, New Zealand minister of health Tony Ryall outlined his vision for a high-performing 21st-century health care system and “better, sooner, more convenient care,” citing examples of his nation’s efforts to ensure patient-centered care, better access, and the provision of services closer to home. In the annual John M. Eisenberg International Lecture, Commonwealth Fund president Karen Davis reflected on 15 years of cross-national learning and highlighted innovations in policy and practice that have contributed to high performance in many of the nations’ health care systems.

During the symposium, international experts compared the strategic choices countries make for containing health care costs; the ways that different health systems have responded to the current economic downturn; and how countries use primary care as a driver of performance to achieve better care, higher quality, and lower costs. Presenters at a session on “frugal innovations” described how some low-income countries have used mobile phones and community workers to provide vulnerable populations with essential care in ways that are cheaper and sometimes achieve better clinical outcomes than those in high-income countries.

In an inspiring closing address to symposium participants, Ontario Minister of Health Deb Matthews shared her vision for Ontario’s health care system and the province’s bold agenda to transform primary care through use of multidisciplinary family health teams, greater transparency and public reporting, and an overall focus on wellness and care coordination.

A highlight of the symposium was the presentation of findings from the 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, conducted in the U.S. and 10 other countries. According to the survey, primary care doctors increasingly use electronic medical records in their practice, particularly in the U.S. and Canada, which have both seen a 50 percent increase in uptake since 2009. However, majorities of doctors in all countries reported failures of, and delays in, communication between

specialists and hospitals. The survey was conducted in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the U.K., and the U.S. An [article](#) discussing the survey results was published by *Health Affairs* in November 2012.

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 U.S. 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. For example in August 2012, Harkness Fellows published perspectives in the *New England Journal of Medicine*. Philip Van der Wees (Netherlands, 2011–12) and his Harkness mentor John Ayanian, M.D., of Harvard Medical School [described](#) Massachusetts’ ambitious efforts to limit the growth of health care spending and support delivery system reform toward accountable care organizations and patient-centered medical homes. Ewout van Ginneken (Netherlands, 2011–12) and his mentor Katherine Swartz, Ph.D., of the Harvard School of Public Health [offered lessons](#) for states from European countries’ experiences with health insurance exchanges. In *Milbank Quarterly* (June 2011), Ruth Thorlby (U.K., 2008–09) and her Harkness mentors John Ayanian and Bruce Siegel, M.D., of the National Association of Public Hospitals and Health Systems [examined](#) how health care organizations are using patients’ race and ethnicity to improve quality of care.

Returning to their home country, Harkness alumni continue to move into positions of influence. Based on a recent 10-year review of the Harkness Fellowships, one of three Harkness alumni was rated as a national leader

within academia, government, or the health care delivery system in their home country. To learn more about the Harkness Fellowships and about alumni fellows, visit the [Harkness Fellowships](#) page.

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.

2012–13 Harkness Fellows in Health Care Policy and Practice

Peter Alders, Ph.D., M.Sc. (Netherlands)

Commonwealth Fund/VWS Harkness Fellow in Health Care Policy and Practice

Acting Head of the Department of Social Support Act
Ministry of Health, Welfare, and Sport

Placement: Harvard Medical School

Mentor: Richard Frank, Ph.D., Harvard Medical School

Project: Policy Strategies to Improve Use of Long-Term Care Services



Matthew Anstey, M.B.B.S., M.P.H. (Australia)

Specialist Intensive Care Physician

Department of Anesthesia, Critical Care and Pain Medicine

Beth Israel Deaconess Medical Center

Placement: Kaiser Permanente

Mentor: Murray Ross, Ph.D., and Elizabeth McGlynn, Ph.D., Kaiser Permanente

Project: Improving Resource Use in the Intensive Care Unit



Nikola Biller-Andorno, M.D., Ph.D. (Switzerland)

Harkness/Careum Fellow in Health Care Policy and Practice

Professor and Chair, Biomedical Ethics

Founding Director, Institute of Biomedical Ethics

University of Zurich

Placement: *New England Journal of Medicine*

Mentor: Greg Curfman, *New England Journal of Medicine*

Co-Mentor: Thomas Lee, M.D., Partners Community Healthcare, Inc.

Project: Evaluating and Monitoring the Ethical Implications of Health Care Reform



Joan Costa-Font, Ph.D., M.Sc. (United Kingdom)

Senior Lecturer

Department of Social Policy and European Institute
London School of Economics and Political Science

Placement: Harvard School of Public Health

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

Co-Mentor: Richard Frank, Ph.D., Harvard Medical School

Project: Policy Approaches to Long-term Care Insurance



Gerdien Franx, M.Sc. (Netherlands)

Manager of Health Care Innovation

Trimbos Institute/National Institute for Mental Health and Addiction

Placement: Columbia University

Mentor: Lisa Dixon, Columbia University

Co-Mentor: Harold Pincus, M.D., Columbia University

Project: Policies and Models for Integrating Mental Health and Primary Care



Simona Grassi, Ph.D., M.Sc. (Switzerland)

Harkness/Careum Fellow in Health Care Policy and Practice

Assistant Professor of Health Economics

University of Lausanne

Placement: Harvard Medical School

Mentor: Joseph Newhouse, Ph.D., Harvard Medical School

Project: Use of Behavioral Economics to Understand Consumer Choice of Insurance



Hans Olav Melberg, Ph.D. (Norway)

Associate Professor of Economics

University of Oslo

Placement: University of Pennsylvania

Mentor: Mark Pauly, Ph.D., University of Pennsylvania

Project: High End-of-Life Spending in the United States and Norway: Causes and Trends



Daniela Koller (Germany)

Harkness/Robert Bosch Stiftung Fellow in Health Care Policy and Practice

Researcher

Department for Health Economics, Health Policy, and Outcomes Research

Centre for Social Policy Research

University of Bremen

Placement: Dartmouth University

Mentor: Julie Bynum, M.D., Dartmouth University

Co-Mentor: Elliott Fisher, M.D., Dartmouth University

Project: Regional Variation in Dementia Patients' Health Services Utilization



Julia Murphy, M.Sc. (United Kingdom)

Deputy Head of Knowledge and Intelligence

Performance Directorate

NHS London Strategic Health Authority

Placement: University of California, San Francisco

Mentor: Andrew Bindman, M.D., University of California, San Francisco

Co-Mentor: Kenneth Kizer, M.D., University of California, Davis

Project: Improving Quality and Lowering Costs Through Health System Integration in Medi-Cal



Douglas Noble, B.M.B.Ch., M.P.H., F.R.S.P.H.

(United Kingdom)

Public Health Registrar and Honorary Clinical Lecturer

Healthcare Innovation and Policy Unit

Bars and the London School of Medicine and Dentistry

University of London

Placement: Weill-Cornell Medical College

Mentor: Lawrence Casalino, M.D., Ph.D., Weill-Cornell Medical College

Project: Public Health Role of Accountable Care Organizations



Alexandra Norrish, M.St. (United Kingdom)
Deputy Director of Financial Policy and Strategy
Directorate of Policy, Strategy, and Finance
U.K. Department of Health

Placement: Harvard School of Public Health

Mentor: Thomas Lee, M.D., Partners Community
Healthcare, Inc.

Co-Mentor: Dana Safran, Sc.D., Blue Cross Blue Shield

Project: Balancing the Priorities of Different Stakeholders in a
Value-Based Health Care System



Nadine Reibling (Germany)

Doctoral Fellow
Mannheim Centre for European Social Research
University of Mannheim

Placement: Harvard School of Public Health

Mentor: Meredith Rosenthal, Ph.D., Harvard
School of Public Health

Project: Reducing Disparities Through Patient-
Centered Medical Homes



Jason Sutherland, Ph.D. (Canada)
Harkness/CHSRF Fellow in Health Care Policy and
Practice

Assistant Professor

Centre for Health Services and Policy Research
School of Population and Public Health
University of British Columbia

Placement: Center for Medicare and Medicaid
Innovation

Mentor: William Shrank, M.D., Center for Medicare and Medicaid
Innovation

Project: Funding Across the Continuum: Does It Work to Improve
Care and Reduce Cost?



**Susan Wells, M.B.Ch.B., Dip.Obs., M.P.H., Ph.D.,
FRNZCGP, FNZCPHM** (New Zealand)
Senior Lecturer of Clinical Epidemiology and Quality
Improvement

University of Auckland

Placement: Harvard School of Public Health

Mentor: David Bates, M.D., Harvard School of
Public Health

Project: Use of Electronic Health Records to Improve Quality and Care
Coordination



Expanding the OECD Health Systems Database

Since 2004, the Commonwealth Fund has provided support for the Organization for Economic Cooperation and Development (OECD) Health Care Quality Indicators project to enable policymakers to benchmark and compare country performance. Two current initiatives sponsored by the Fund are seeking to develop and pilot cross-national indicators to measure patient experiences as well as health systems' adoption and use of health information technology. Both projects aim for the measures to be routinely collected in all 34 OECD member countries and included in the OECD database of health indicators, providing a new window on how national health systems compare.

The organization's 2011 *OECD Health at a Glance* report included, for the first time, patient safety indicators developed by the Fund-supported Health Care Quality Indicators Project. The indicators are: obstetric trauma, foreign body left in during procedure, accidental puncture or laceration, postoperative pulmonary embolism or deep vein thrombosis, and postoperative sepsis.

Building a Go-To Online Resource for International Health System Comparisons

Over the past year, The Commonwealth Fund has expanded the online resources for learning about and comparing industrialized health systems. In addition to Fund-supported publications and chartpacks, information on the Harkness Fellowships and Alumni, and the [International Health Policy](#)

[Center](#)—which allows users to generate their own graphs and tables—the Fund launched the new publication series *Issues in International Health Policy* to report on major health reform initiatives from around the world. Topics covered in 2012 include strengthening access to after-hours care, bundling payments, and using no-fault administrative systems, or health courts, for compensating injured patients. The Fund also re-launched a monthly online newsletter, *International Health News Briefing*, with summaries of health policy news in Canada, France, Australia, New Zealand, Netherlands, and the U.K.

To reach out to a global audience and showcase findings from the 2011 international survey, the Fund held a webinar in January 2012. Moderated by Robin Osborn, the webinar featured Fund senior vice president Cathy Schoen presenting the 2011 survey findings, followed by reactions from international experts.

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 |
|----------------|--|--|
| Canada | Health Council of Canada Health Quality Ontario Quebec Health Commission Health Quality Council of Alberta Canada Health Infoway | Canadian Health Services Research Foundation |
| France | National Health Authority (HAS) National Fund for Health Insurance for Employees (CNAM) | |
| Germany | Federal Ministry of Health 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 | Norwegian Knowledge Centre for the Health Services | Research Council of Norway |
| Sweden | Ministry of Health and Social Affairs | Ministry of Health and Social Affairs |
| Switzerland | Federal Office of Public Health Swiss Medical Foundation | Careum Foundation |
| United Kingdom | | Nuffield Trust NHS National Institute for Health Research |

Future Directions

The Commonwealth Fund's 2013 international health policy survey will assess health care system performance from the perspective of the general population. Conducted in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States, the study will include questions about health care access and affordability, coordination and communication between clinicians, patient engagement and care for chronic conditions, and health system views. Survey findings will be released at the Fund's 2013 International Symposium.

In July 2013, The Commonwealth Fund and the Nuffield Trust will hold their 14th annual trans-Atlantic policy forum in Washington, bringing together senior government policymakers and experts from the U.K. and

the U.S. for a policy forum focused on improving health care system quality and efficiency. Lessons learned from the 2012 meeting were highlighted in a [paper](#) published in *Lancet* (Oct. 2012) by David Blumenthal, M.D., of Harvard Medical School and Partners HealthCare System, and Jennifer Dixon, director of the Nuffield Trust, who compared the sweeping health reforms under way in the English and U.S. health care systems.

Most of the unrestricted grant money disbursed by the International Program in Health Policy and Innovation is for small grants of 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.

Cover: During a roundtable meeting at The Commonwealth Fund's offices in New York, Hans Olav Melberg of Norway and Daniela Koller of Germany discuss their research projects with other 2012–13 Harkness Fellows in Health Care Policy and Practice 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.

Photos: © Roger Carr

2011–12 TREASURER'S REPORT

The average market value of The Commonwealth Fund's endowment fell from \$655.3 million to \$647.0 million in the fiscal year ending June 30, 2012 (Exhibit 1). In constant 2012 dollar terms, however, the average market value of the Fund's endowment in the 2011–12 fiscal year was well above its average value in 1994–95 (\$560.1 million), when Karen Davis became president of the foundation. During the 2011–12 fiscal year, the foundation expended \$31.1 million in pursuit of its mission of advancing a high performance health system (Exhibit 2). This compares with \$28.1 million, in constant 2012 dollars, in the 1994–95 fiscal year. Thus, as she steps down as Fund president at the end of December 2012, Karen Davis leaves the foundation in measurably stronger financial circumstances than those in which she found it.

In 1949–50, the last fiscal year before the Fund had its final major infusion of capital from the founding Harkness family, the foundation's spending in constant 2012 dollars was \$16.5 million. With current spending at \$31.1 million, the Fund is therefore more than meeting its objective of maintaining the purchasing power of the dollars available for advancing its mission.

The net return on the Fund's endowment over the 12 months ending June 30, 2012, was –2.9 percent (Exhibit 3). The endowment's return during the year was essentially that of its weighted benchmark (–2.9% vs. –2.7%), but because of substantial allocations to foreign equities (especially emerging markets), energy, and commodities, and the defensive posture of U.S. marketable equities managers, the Fund underperformed many other

endowments during the year. The median return of 35 college, university, and foundation endowments monitored by Investure, for example, was 1.5 percent (Exhibit 4).

As a result of subpar performance in 2011–12, the three-year average annual return on the Fund's endowment on June 30, 2012, was somewhat below that of the market benchmark (10.2% vs. 11.1%). But the foundation's average annual returns through June 30, 2012, for the last five-, seven-, 10-, and 15-year periods are well above those of the market benchmark. Moreover, the volatility of returns on the Fund's endowment was about 50 percent below that of the market over the last three years, and 25 percent below that of the market over the last 15 years. Over the last 10 years, the Fund's endowment performance approximated the performance of the median in its peer universe.

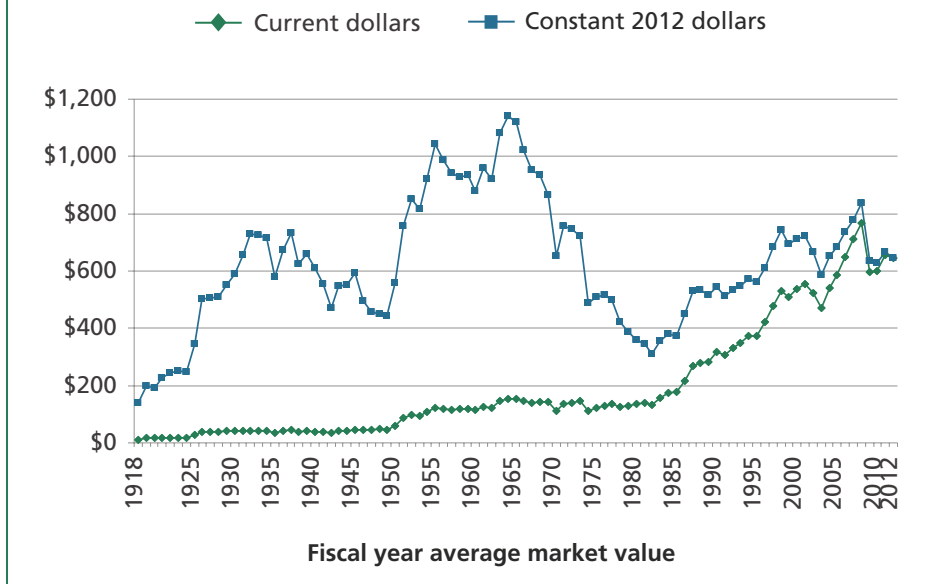


Executive Vice President—
COO John E. Craig, Jr.

CHANGE IN ENDOWMENT MANAGEMENT MODEL

In the fall of 2011, following consideration of some 20 outsourced chief investment officer (O-CIO) firms and then very close inspection of three finalist firms, the investment committee of the Fund's board of directors hired Investure to serve as the foundation's O-CIO, with the formal change

Exhibit 1. The Commonwealth Fund's endowment, in millions, 1918–2012

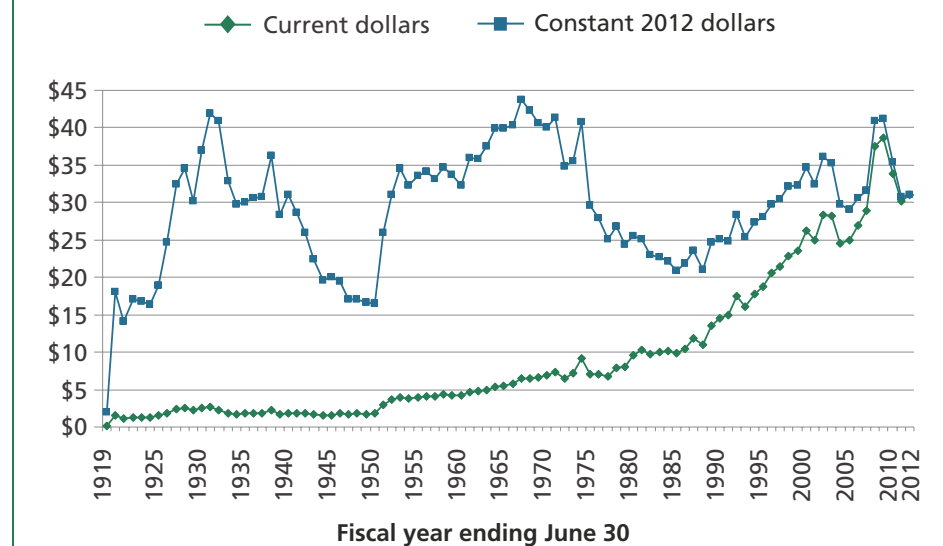


commencing July 1, 2012. By the end of December 2012, the transition process to Investure will be completed, with the exception of the Fund's preexisting private partnership investments and commitments, which will be worked down as they mature over a number of years.

Investure, founded in 2003 by former University of Virginia endowment chief investment officer Alice Handy, currently has 15 clients and approximately \$10 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 very few, if any, clients over the next several 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

Exhibit 2. The Commonwealth Fund's annual spending, in millions, 1919–2012: Total spending of \$902 million over 93 years, or \$2.8 billion in constant 2012 dollars



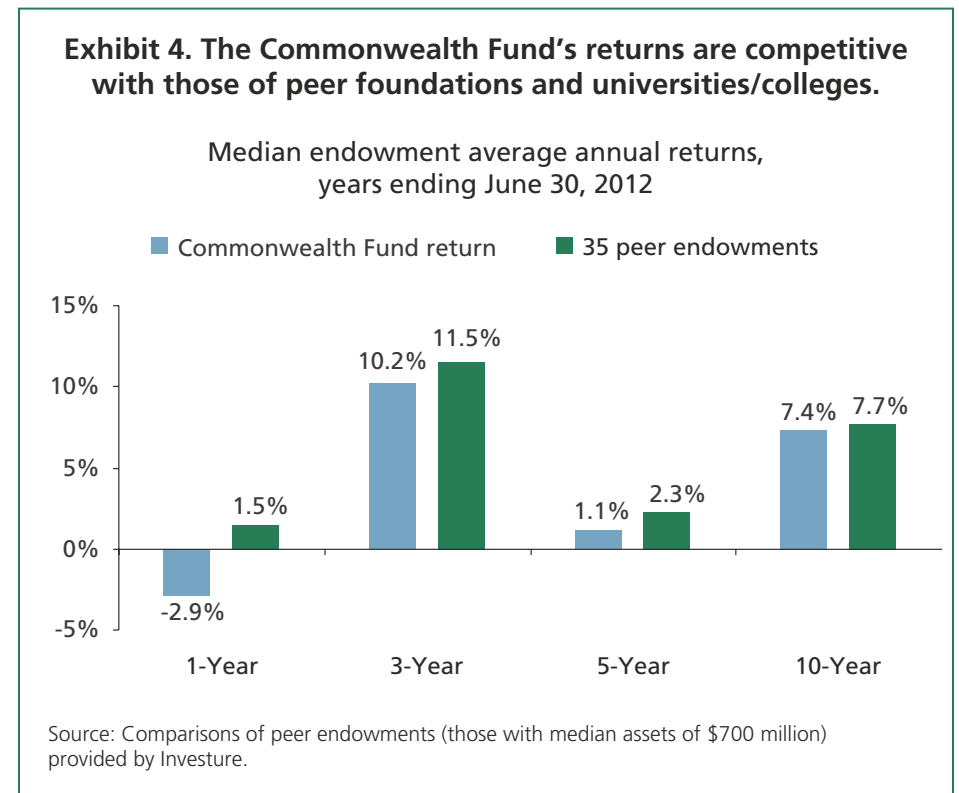
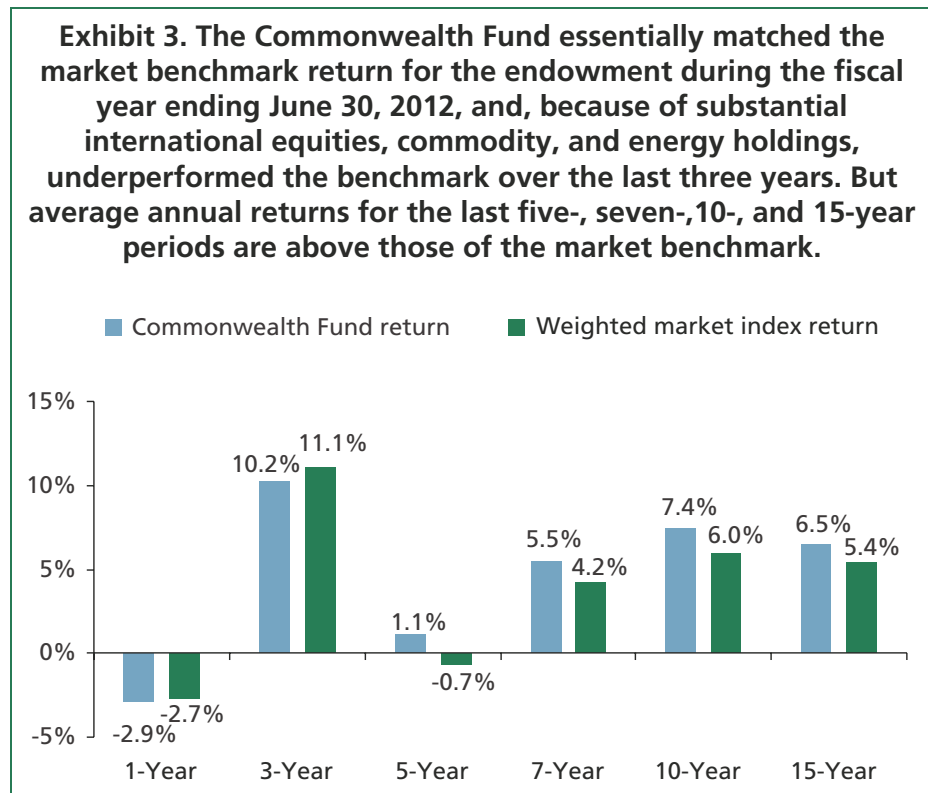
investment vehicles to create efficiencies and scale. The firm regards its client base as its “board” and convenes regular client meetings to support that role. In addition to The Commonwealth Fund, Investure's foundation clients include the Carnegie Endowment for International Peace, the Colonial Williamsburg Foundation, the Edna McConnell Clark Foundation, the Henry Luce Foundation, the Houston Endowment, and Rockefeller Brothers Fund.

Investure covers all asset classes and provides back-office services, which include 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.

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.

For 2013, Investure has set target asset class allocations for the Fund's endowment as follows: 37 percent to global marketable equities; 25 percent to hedge funds; 28 percent to private partnerships; and 10 percent to fixed income, including cash (Exhibit 5). Investure aims to maximize annual

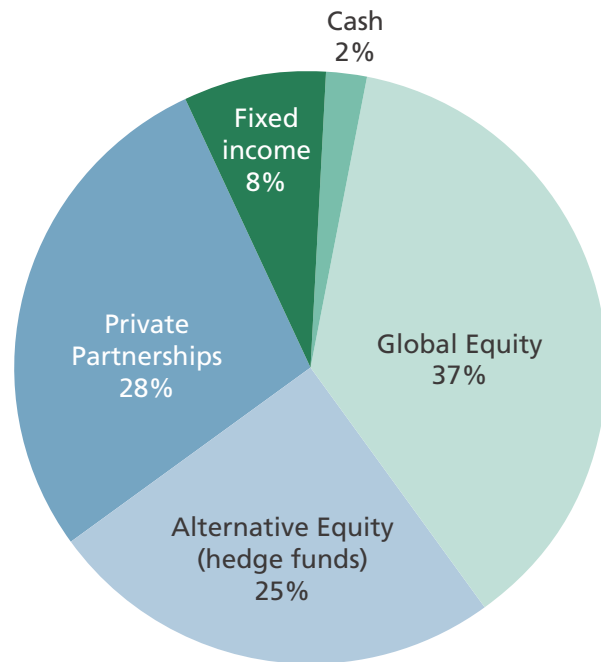
returns net of all costs over rolling 10-year periods while adhering to the risk guidelines provided by the Fund's investment committee. The firm regularly monitors five risk metrics for the Fund's portfolio: geographic net exposure, leverage, liquidity, private partnership exposure, and capital structure (asset class allocation). At least 30 percent of the Fund's portfolio is to be held in investment vehicles with lock-ups of 12 months or less, and 60 percent with lock-ups of 60 months or less. Under normal circumstances, the net asset value of private partnership holdings plus unfunded capital commitments to partnerships is not to exceed 65 percent of the endowment.



Under Investure’s management, performance of the endowment is measured against a passive benchmark reflecting target portfolio allocations and against a benchmark consisting of the Fund’s spending rate plus inflation. The firm seeks to avoid annualized performance shortfalls exceeding 3 percent, relative to the mean return of large endowments (\$1 billion and higher) reporting to the National Association of College and University Business Officers (NACUBO), over rolling 10-year periods.

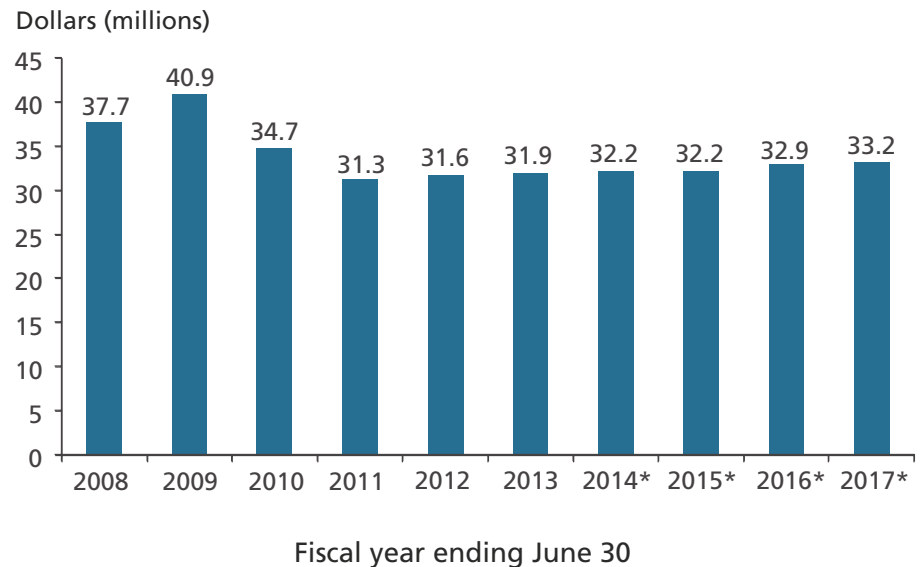
In addition to the careful selection of managers within its global equities, alternatives (hedge fund), and private equities pools, Investure has achieved strong returns in recent years through concentration with top managers, directly executed investments (beginning with fixed income and broadened to include passive equity, currency trades, and rate options), reducing fees and improving terms in both its public equities and private partnership portfolios, and pursuing co-investment opportunities with private partnership managers. The firm also opportunistically backs start-up investment teams emerging from existing investment management firms.

Exhibit 5. The Commonwealth Fund’s endowment management strategy in 2013 under Investure as outsourced chief investment officer



Allocation of endowment

Exhibit 6. With significant recovery in the market value of the endowment, The Commonwealth Fund’s annual budget has stabilized at around \$32 million.



* Projected

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 6). 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. Despite improved returns in the 2009–10 and 2010–11 fiscal years, continued concerns about the market

outlook have led the board to hold expected budget increases to an average of 1 percent annually over the next five years.

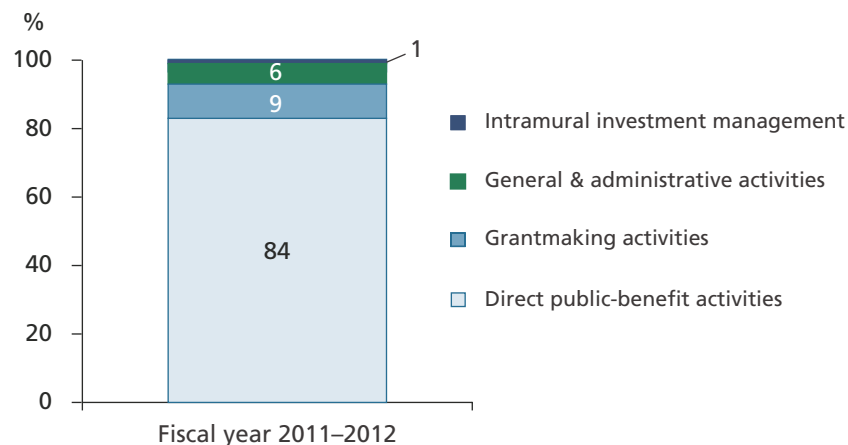
As a value-adding foundation, the Fund seeks to achieve an optimal balance between its grantmaking and intramural research, communications, and program management activities, while minimizing purely administrative costs. Recognizing that data on expenditures reported in the IRS 990-PF annual tax return inadequately reflect the purpose of many expenditures,¹ the analysis in Exhibit 7 sorts out the foundation’s 2011–12 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 2011–12, the Fund’s total direct public-benefit activities accounted for 84 percent of its annual expenditures. Value-adding oversight of grants took up 9 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. 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.

¹ John E. Craig, Jr., “Modernizing the 990-PF to Advance the Accountability and Performance of Foundations: A Modest Proposal,” in *2009 Commonwealth Fund Annual Report*.

Exhibit 7. Properly measured, The Commonwealth Fund’s administrative expenses amount to 6 percent of its total budget. Direct public-benefit activities—including extramural grants, intramural research, communications, and programs conducted by the foundation—and value-adding grantmaking work make up 93 percent of the budget.



INDEPENDENT AUDITORS' REPORT FINANCIAL STATEMENTS

Years Ended June 30, 2012 and 2011

The Commonwealth Fund

We have audited the accompanying statements of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2012 and 2011 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 audits.

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, 2012 and 2011 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.



December 4, 2012

THE COMMONWEALTH FUND
 STATEMENTS OF FINANCIAL POSITION
 JUNE 30, 2012 AND 2011

| | 2012 | 2011 |
|---|-----------------------------|-----------------------------|
| ASSETS | | |
| CASH | \$ 3,347,522 | \$ 1,286,376 |
| INVESTMENTS - At fair value (Notes 1 and 2) | 629,441,692 | 679,363,908 |
| INTEREST AND DIVIDENDS RECEIVABLE | 129,042 | 45,124 |
| PROCEEDS RECEIVABLE FROM SECURITY SALES - NET | 6,000,000 | 3,493,372 |
| TAXES REFUNDABLE | 292,583 | 755,008 |
| PREPAID INSURANCE AND OTHER ASSETS | 57,690 | 311,622 |
| 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 \$2,471,257 at June 30, 2012 and \$2,152,492 at June 30, 2011 (Note 1) | <u>4,520,017</u> | <u>4,662,659</u> |
| TOTAL ASSETS | <u>\$644,063,546</u> | <u>\$690,193,069</u> |
| LIABILITIES AND NET ASSETS | | |
| LIABILITIES: | | |
| Accounts payable and accrued expenses | \$ 2,109,807 | \$ 2,041,355 |
| Program authorizations payable (Note 3) | 19,842,731 | 20,308,399 |
| Accrued postretirement benefits (Note 4) | 4,602,212 | 4,776,443 |
| Deferred tax liability (Note 5) | <u>1,539,655</u> | <u>2,734,441</u> |
| Total liabilities | <u>28,094,405</u> | <u>29,860,638</u> |
| NET ASSETS: | | |
| Unrestricted | <u>615,969,141</u> | <u>660,332,431</u> |
| Total net assets | <u>615,969,141</u> | <u>660,332,431</u> |
| TOTAL LIABILITIES AND NET ASSETS | <u>\$644,063,546</u> | <u>\$690,193,069</u> |

See notes to financial statements.

THE COMMONWEALTH FUND
 STATEMENTS OF ACTIVITIES
 YEARS ENDED JUNE 30, 2012 AND 2011

| | 2012 | 2011 |
|--|----------------------|----------------------|
| REVENUES AND SUPPORT: | | |
| Interest and dividends | \$ 8,331,057 | \$ 8,353,660 |
| Contribution and other revenue | <u>866</u> | <u>587</u> |
| Total revenues and support | <u>8,331,923</u> | <u>8,354,247</u> |
| EXPENSES: | | |
| Program authorizations and operating program | 28,830,493 | 27,984,516 |
| General administration | 1,908,510 | 1,836,709 |
| Investment management | 5,239,404 | 3,821,723 |
| Taxes (Note 5) | (430,611) | 1,888,005 |
| Retirement and other postretirement (Note 4) | <u>(163,462)</u> | <u>628,950</u> |
| Total expenses | <u>35,384,334</u> | <u>36,159,903</u> |
| EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS (LOSSES) | <u>(27,052,411)</u> | <u>(27,805,656)</u> |
| NET INVESTMENT GAINS | | |
| Net realized gains on investments | 42,428,162 | 45,511,613 |
| Change in unrealized appreciation of investments | <u>(59,739,041)</u> | <u>69,760,987</u> |
| Total net investment gains (losses) | <u>(17,310,879)</u> | <u>115,272,600</u> |
| CHANGES IN UNRESTRICTED NET ASSETS | <u>(44,363,290)</u> | <u>87,466,944</u> |
| Net assets, beginning of year | <u>660,332,431</u> | <u>572,865,487</u> |
| Net assets, end of year | <u>\$615,969,141</u> | <u>\$660,332,431</u> |

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2012 AND 2011

| | 2012 | 2011 |
|---|------------------------|------------------------|
| CASH FLOWS FROM OPERATING ACTIVITIES: | | |
| Cash provided by interest, dividends, and other | \$ 8,248,005 | \$ 8,383,300 |
| Cash used to pay grants and program expenses | (29,057,087) | (31,415,057) |
| Cash used to pay administrative expenses | (1,506,435) | (1,520,291) |
| Cash used to pay investment expenses | (5,239,404) | (3,821,723) |
| Cash used to pay taxes | (301,750) | (637,848) |
| Cash used to pay unfunded retirement expenses | <u>(10,769)</u> | <u>(392,469)</u> |
| Net cash used by operating activities | <u>(27,867,440)</u> | <u>(29,404,088)</u> |
| CASH FLOWS FROM INVESTING ACTIVITIES: | | |
| Purchase of furniture, equipment, and building improvements - net | (176,123) | (652,807) |
| Purchase of investments | (153,382,225) | (109,230,230) |
| Proceeds from the sale of investments | <u>183,486,934</u> | <u>139,273,001</u> |
| Net cash provided by investing activities | <u>29,928,586</u> | <u>29,389,964</u> |
| NET INCREASE (DECREASE) IN CASH | 2,061,146 | (14,124) |
| CASH, BEGINNING OF YEAR | <u>1,286,376</u> | <u>1,300,500</u> |
| CASH, END OF YEAR | <u>\$3,347,522</u> | <u>\$1,286,376</u> |
| Adjustments to reconcile change in net assets to net cash used in operating activities: | | |
| Change in net assets for the year | \$(44,363,290) | \$87,466,944 |
| Depreciation | 318,765 | 303,952 |
| Net investment (gains) losses | 17,310,879 | (115,272,600) |
| Decrease (increase) in interest and dividends receivable | (83,918) | 29,053 |
| Decrease (increase) in taxes refundable - net | 462,425 | (145,063) |
| Decrease in prepaid insurance and other assets | 253,932 | 12,466 |
| Increase in accounts payable and accrued expenses | 68,452 | 679,184 |
| Decrease in program authorizations payable | (465,668) | (4,109,725) |
| Increase (decrease) in accrued post retirement benefits | (174,231) | 236,481 |
| Increase (decrease) in deferred tax liability | <u>(1,194,786)</u> | <u>1,395,220</u> |
| Net cash used in operating activities | <u>\$ (27,867,440)</u> | <u>\$ (29,404,088)</u> |

See notes to financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

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

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, 2012 and 2011 comprised the following:

| | 2012 | | 2011 | |
|----------------------------------|----------------------|----------------------|----------------------|----------------------|
| | Fair Value | Cost | Fair Value | Cost |
| U.S. Equities | \$104,728,125 | \$ 87,882,832 | \$ 92,323,471 | \$ 76,145,579 |
| Non-U.S. Equities | 105,878,302 | 107,278,926 | 130,999,782 | 107,278,926 |
| Fixed income | 59,223,356 | 48,902,302 | 71,003,503 | 61,925,158 |
| Short-term | 33,795,029 | 33,794,615 | 15,528,170 | 15,527,549 |
| Marketable alternative equity | 131,013,663 | 89,121,056 | 160,233,469 | 92,113,165 |
| Nonmarketable alternative equity | 84,727,145 | 89,584,012 | 75,214,657 | 78,017,648 |
| Inflation hedge | 110,076,072 | 102,139,701 | 134,060,856 | 111,634,027 |
| | <u>\$629,441,692</u> | <u>\$558,703,444</u> | <u>\$679,363,908</u> | <u>\$542,642,052</u> |

At June 30, 2012, the Fund had total unexpended investment commitments of approximately \$53.0 million. (\$19.4 million for private equity, \$12.0 million for venture capital, \$8.3 million for natural resources, \$5.6 million for real estate and \$7.7 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, 2012 and 2011, 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 hierarchical 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 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.

Investments are categorized as follows:

| | 2012 | | | |
|-------------------------------|----------------------|----------------------|----------------------|----------------------|
| | Total | Level 1 | Level 2 | Level 3 |
| U.S. Equities | | | | |
| Growth fund | \$ 18,010,607 | \$ 18,010,607 | | |
| U.S. equity fund | 37,562,570 | 37,562,570 | | |
| Direct stock holdings | 49,154,948 | 49,154,948 | | |
| Non-U.S. Equities | 105,878,302 | 68,006,689 | \$ 37,871,613 | |
| Fixed income | | | | |
| US Treasury | 14,308,231 | 14,308,231 | | |
| Corporate | 1,126,401 | | 1,126,401 | |
| Funds | 43,788,724 | 5,937,879 | 37,850,845 | |
| Short-term | 33,795,029 | 33,795,029 | | |
| Marketable alternative equity | 131,013,663 | 3,768,602 | 125,813,460 | \$ 1,431,601 |
| Nonmarketable private equity | 44,426,205 | | | 44,426,205 |
| Nonmarketable venture capital | 40,300,940 | | | 40,300,940 |
| Inflation hedge | | | | |
| Diversified | 30,082,287 | 30,082,287 | | |
| Gold funds | 10,479,918 | 10,479,918 | | |
| Energy | 41,417,172 | 14,446,283 | | 26,970,889 |
| Real estate | 28,096,695 | | | 28,096,695 |
| | <u>\$629,441,692</u> | <u>\$285,553,043</u> | <u>\$202,662,319</u> | <u>\$141,226,330</u> |

The change in level three assets for 2012 is as follows:

| | Balance 6/30/2011 | Capital Additions | Distributions | Income | Balance 6/30/2012 |
|-------------------------------|----------------------|----------------------|---------------------|---------------------|----------------------|
| Marketable alternative equity | \$ 84,627 | \$ 1,395,820 | \$ 48,846 | | \$ 1,431,601 |
| Nonmarketable private equity | 37,062,297 | 9,102,387 | 10,271,202 | \$8,532,723 | 44,426,205 |
| Nonmarketable venture capital | 38,152,360 | 6,206,051 | 4,961,073 | 903,602 | 40,300,940 |
| Inflation hedge - energy | 24,687,844 | 5,048,661 | 7,578,148 | 4,812,532 | 26,970,889 |
| Inflation hedge - real estate | 25,685,408 | 4,563,056 | 2,347,293 | 195,524 | 28,096,695 |
| | <u>\$125,672,536</u> | <u>\$26,315,975</u> | <u>\$25,206,562</u> | <u>\$14,444,381</u> | <u>\$141,226,330</u> |

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 | | |
| | <u>\$679,363,908</u> | <u>\$370,176,975</u> | <u>\$183,514,397</u> | <u>\$125,672,536</u> |

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

| | <u>Balance 6/30/2010</u> | <u>Capital Additions</u> | <u>Distributions</u> | <u>Income</u> | <u>Balance 6/30/2011</u> |
|-------------------------------|------------------------------|------------------------------|----------------------|---------------------|------------------------------|
| 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 | <u>13,088,535</u> | <u>8,428,454</u> | <u>1,369,484</u> | <u>5,537,903</u> | <u>25,685,408</u> |
| | <u>\$96,497,729</u> | <u>\$26,676,470</u> | <u>\$23,084,072</u> | <u>\$25,582,409</u> | <u>\$125,672,536</u> |

3. PROGRAM AUTHORIZATIONS PAYABLE

At June 30, 2012, program authorizations scheduled for payment at later dates were as follows:

| | |
|--|---------------------|
| July 1, 2012 through June 30, 2013 | \$15,906,742 |
| July 1, 2013 through June 30, 2014 | 3,777,857 |
| Thereafter | <u>198,555</u> |
| Gross program authorizations scheduled for payment at a later date | 19,883,154 |
| Less adjustment to present value | <u>40,423</u> |
| Program authorizations payable | <u>\$19,842,731</u> |

A discount rate of 1.07 % was used to determine the present value of the program authorizations payable at June 30, 2012.

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, 2012 and 2011. Pension expense under this plan was approximately \$1,031,000 and \$1,013,000 for the years ended June 30, 2012 and 2011, 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 \$136,000 and \$148,000 for each of the years ended June 30, 2012 and 2011.

Expected contributions under the postretirement medical plan for the fiscal year ended June 30, 2013 are expected to be approximately \$137,000. Additional required disclosure on the Fund's postretirement medical plan for the years ended June 30, 2012 and 2011 is as follows:

| | 2012 | 2011 |
|--------------------------------------|--------------------|--------------------|
| Benefit obligation at June 30 | \$4,602,212 | \$4,776,443 |
| Fair value of plan assets at June 30 | — | — |
| Status - unfunded | 4,602,212 | 4,776,443 |
| Actuarial loss | — | — |
| Accrued benefit cost recognized | <u>\$4,602,212</u> | <u>\$4,776,443</u> |
| Net periodic expense | \$(38,369) | \$384,861 |
| Employer contribution | \$135,861 | \$148,380 |

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

| | 2012 | 2011 |
|---|------|------|
| Discount rate | 7.4% | 7.7% |
| Health care cost trend rates - Initial | 6.3% | 6.3% |
| Health care cost trend rates - Ultimate | 6.3% | 6.3% |

The discount rate is based on the Fund's 10 year investment return.

At June 30, 2012, benefits expected to be paid in future years are approximately as follows:

| | |
|--------------------------------|--------------|
| Year ended June 30, 2013 | \$ 137,000 |
| Year ended June 30, 2014 | \$ 191,000 |
| Year ended June 30, 2015 | \$ 202,000 |
| Year ended June 30, 2016 | \$ 198,000 |
| Year ended June 30, 2017 | \$ 215,000 |
| Five years ended June 30, 2022 | \$ 1,375,000 |

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, 2012 and 2011, that excise tax rate was 2% and 1%, respectively. The Fund is also subject to Federal and state taxes on unrelated business income. In addition, The Fund records deferred Federal excise taxes, based upon expected excise tax rates, on the unrealized appreciation or depreciation of investments being reported for financial reporting purposes in different periods than for tax purposes.

The Fund is required to make certain minimum distributions in accordance with a formula specified by the Internal Revenue Service. For the year ended June 30, 2012, the Fund was required to distribute approximately \$32 million dollars. As of June 30, 2012 the Fund had to distribute an additional \$1.7 million to meet this requirement. As of the date of this report, the Fund had met this requirement.

In the Statements of Financial Position, the deferred tax liability of \$1,539,655 and \$2,734,441 at June 30, 2012 and 2011, respectively, resulted from expected Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2012 and 2011, the tax provision was as follows:

| | 2012 | 2011 |
|---|---------------------|---------------------|
| Excise taxes - current | \$ 764,175 | \$ 492,785 |
| Excise taxes - deferred | (1,194,786) | 1,395,220 |
| Unrelated business income taxes - current | - | - |
| Total Taxes | <u>\$ (430,611)</u> | <u>\$ 1,888,005</u> |

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, 2012 and 2011, Picker program grants totaled approximately \$1,563,000 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, 2012 and 2011, grants in the amount of \$318,000 and \$224,000 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, 2012 and 2011, the Frances Cooke Macgregor grants totaled approximately \$195,000 and \$390,000, 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, 2009.

9. LINE OF CREDIT

The Fund has a line of credit in the amount of \$20 million. The Fund did not use this facility in 2012 or 2011.

10. 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, 2012 through December 4, 2012 which was the date the financial statements were available to be issued.



FOUNDERS AND BENEFACTORS



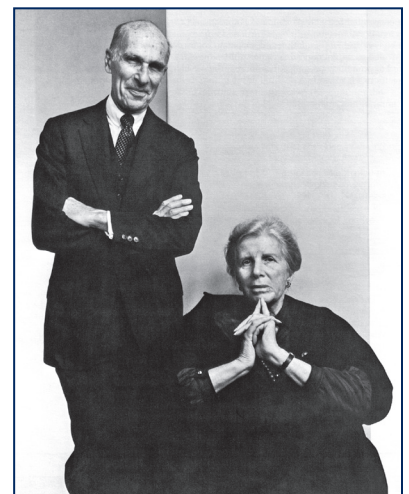
Anna Harkness and Edward Stephen Harkness

The story of The Commonwealth Fund begins with the family of Stephen V. Harkness, an Ohio businessman who began his career as an apprentice harness-maker 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 orga-

nizations 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.





DIRECTORS AND STAFF



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, the 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.

President Karen Davis Steps Down

In November 2011, Commonwealth Fund president Karen Davis informed the Board of her plans to leave the Fund at the end of December 2012, having served as the foundation's chief executive since January 1995. In accepting her decision, Fund chairman James R. Tallon, Jr., said:

Karen Davis is one of the outstanding thinkers and leaders on health care reform. A distinguished health policy researcher, university department chair, and federal health agency executive, she positioned The Commonwealth Fund to make a major contribution to the recent health care reform debate and to the implementation of those reforms. The foundation is extremely fortunate to have had Karen at its helm at a time of great opportunity for improving the performance of our health system.

Reflecting on Davis's achievements as president, Tallon pointed to areas in which the foundation has made a difference during her tenure:

- Contributing independent analysis to inform development of the Affordable Care Act—a landmark law that will be instrumental in providing better access to health care, improved quality, and greater efficiency through strategies to cover the uninsured, reform provider payment, and promote models and tools for patient-centered, coordinated care.
- Developing, identifying, assessing, and spreading health care delivery system innovations, such as the patient-centered medical home, resident-centered nursing home care, interventions to reduce hospital readmissions, enhancement of the health care information technology infrastructure, and patient safety initiatives.
- Creating databases that help generate the will and capacity to improve performance, including those based on international, national, state, and local health system scorecards and surveys, as well as the WhyNotTheBest.org Web site, which features comparative performance data on health care providers.
- Through the Mongan Commonwealth Fund Fellowship Program in Minority Health Policy, based at Harvard University, preparing the next generation of minority physician leaders committed to ensuring access to care for vulnerable populations and to the elimination of disparities in quality of care and health outcomes.
- Promoting the exchange of international innovations and experience through the Harkness Fellowships in Health Care Policy and Practice and the International Health Policy and Innovation program. Featuring annual international surveys and ministerial-level symposia, these activities have brought international performance comparisons to bear on the U.S. health reform debate.

Noting Karen Davis's dedication to ensuring the effective dissemination of information produced by the Fund, Board vice chair Cristine Russell said:

Karen Davis is committed to the importance of applying policy research to real-world problems. She has created an effective modern communications strategy to ensure that Fund-generated information and expertise is accessible to those in a position to effect change in the health care system, from participants in the foundation's annual Bipartisan Congressional Health Policy conferences to an electronic network of almost 40,000 leaders and experts in health policy and practice nationwide.

Under Dr. Davis's leadership, The Commonwealth Fund's endowment and organizational capacities were significantly strengthened. The average fiscal-year market value of the foundation's endowment increased from \$375 million to \$647 million from 1994–95 to 2011–12, while the Fund expended \$542 million to advance its mission of promoting a high performance health system. Over the past 18 years, the Fund created a unique and highly productive model for a policy-oriented foundation, in which grantmaking is enriched by professional staff, and the results of grants are assiduously harvested and communicated for maximum impact in the real world.

A native of Oklahoma, Karen Davis earned her bachelor's degree and a doctoral degree in economics from Rice University. After service at the Brookings Institution as a senior fellow, she was appointed, in 1977, deputy assistant secretary for planning and evaluation in the Office of the Secretary of the U.S. Department of Health and Human Services (then known as Health, Education and Welfare). In 1980, she became the first woman to head a U.S. public health service agency when she became the administrator of the Health Resources Administration. From 1981 to 1992, she was a professor at Johns Hopkins University

and, beginning in 1983, chairman of the Department of Health Policy and Management at the School of Hygiene and Public Health. In 1992, she became executive vice president of The Commonwealth Fund, and in 1995 became president.

Throughout her career, Karen Davis has served on numerous health care boards and committees, including the Congressional Budget Office Health Advisory Panel and committees of the Institute of Medicine of the National Academies. She received the Baxter Health Services Research Award in 2000, the AcademyHealth Distinguished Investigator Award and the Picker Award for Excellence in the Advancement of Patient-Centered Care in 2006, and the Institute of Medicine Adam Yarmolinsky Medal in 2007. Dr. Davis has been awarded honorary doctorates from Johns Hopkins University, the University of Maryland–Baltimore, and Newcastle University in the United Kingdom. She is on the board of directors of the Geisinger Health System, a member of the Kaiser Commission on Medicaid and the Uninsured, and an AcademyHealth distinguished fellow. In 2009, she was elected a fellow of the American Academy of Arts and Sciences and, in 2011, an honorary fellow of the Royal College of Physicians in the United Kingdom.

On January 1, 2013, Dr. Davis will return to Johns Hopkins University, serving as the Eugene and Mildred Lipitz Professor in the Department of Health Policy and Management and director of the Roger C. Lipitz Center for Integrated Health Care.

David Blumenthal Chosen as New President

In July 2012, the Board of Directors of The Commonwealth Fund elected David Blumenthal, M.D., to become the foundation's next president, taking office on January 1, 2013, and to serve on the Board. Dr. Blumenthal is one of the nation's preeminent health information technology experts, thought leaders on primary care and professionalism, and foremost health policy scholars. Prior to joining the Fund's Board and staff, he was Samuel O. Thier Professor of Medicine at Harvard Medical School and

Chief Health Information and Innovation Officer at Partners HealthCare System in Boston. He has served since June 2011 as the chairman of the Commonwealth Fund Commission on a High Performance Health System.

Dr. Blumenthal served from 2009 to 2011 as U.S. National Coordinator for Health Information Technology, with the charge to build an interoperable, private, and secure nationwide health information system and to support the widespread, meaningful use of health IT. He succeeded in putting in place one of the largest publicly funded infrastructure investments the nation has ever made in such a short period, in health care or any other field.

Prior to his appointment as the National Coordinator for Health IT, Dr. Blumenthal was a practicing primary care physician, director of the Institute for Health Policy, and professor of medicine and health policy at Massachusetts General Hospital/Partners HealthCare System and Harvard Medical School. He is the author of more than 250 books and scholarly publications, including most recently *Heart of Power: Health and Politics in the Oval Office*. He is a member of the Institute of Medicine and a former board member and national correspondent for the *New England Journal of Medicine*. He has also served on the staff of the U.S. Senate Subcommittee on Health and Scientific Research; is the founding chairman of AcademyHealth, the national organization of health services researchers; and a trustee of the University of Pennsylvania Health System.

Dr. Blumenthal received his undergraduate, medical, and public policy degrees from Harvard University

and completed his residency in internal medicine at Massachusetts General Hospital. With his colleagues from Harvard Medical School, he authored the seminal studies on the adoption and use of health IT in the United States. He has held several leadership positions in medicine, government, and academia, including senior vice president at Boston's Brigham and Women's Hospital and executive director of the Center for Health Policy and Management and lecturer on public policy at the Kennedy School of Government. He served previously on the board of the University of Chicago Health System and is recipient of the Distinguished Investigator Award from AcademyHealth, an Honorary Doctor of Humane Letters from Rush University, and an Honorary Doctor of Science from the State University of New York Downstate.

Glenn Hackbarth Leaves Board

Glenn M. Hackbarth, J.D., stepped down from the Fund's Board in the fall of 2012, having served as a valued member since November 2008. He also provided valuable service to The Commonwealth Fund as a member of its Commission on a High Performance Health System, from its creation in 2005 through mid-2012. In his capacity as chairman of the Medicare Payment Advisory Commission (MedPAC—an independent congressional agency), Mr. Hackbarth is one of the nation's foremost thought leaders on and contributors to payment and delivery system reforms needed to bring about a high performance health system. The Commonwealth Fund is indebted to him for the time and creative service he provided so generously as a Board and Commission member during a crucial period in the drive for health care reform.

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Jennie Smith, *Program Associate, Payment and System Reform*

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² Current as of January 1, 2013.

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Jamie Sellers, *Receptionist*

Annie Shek, *Grants Associate*

Shelford Thompson, *Building Manager*

Matthew Johnson, *Dining Room Manager*

Tony Burke, *Assistant Dining Room Manager*

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

David C. Radley, *Senior Analyst and Project Director, Scorecard Project*

Jacob A. Lipka, *Senior Research Associate, Scorecard Project*

White & Case, *Counsel*

Owen J. Flanagan and Company, *Auditors*

Cover: David Blumenthal, M.D., moderates a session at the June 2012 meeting of The Commonwealth Fund's Commission on a High Performance Health System. Blumenthal, who currently chairs the Commission, was elected to be the new president of the Fund. He succeeds Karen Davis, who served as president for 18 years, in January 2013.

Photo: © Michael Malyszko.

2011–12 GRANTS APPROVED

DELIVERY SYSTEM INNOVATION AND IMPROVEMENT

Board Grants—Health System Quality and Efficiency

Brandeis University

\$79,437

Evaluating the Impact of the Alternative Quality Contract on Medical Groups' Capacity to Provide Accountable Care, Phase 2

In phase 2 of the Commonwealth Fund-supported evaluation of the Alternative Quality Contract (AQC), the accountable care payment model initiated by Blue Cross Blue Shield of Massachusetts in 2009, the research team will continue to assess the development of strategies and mechanisms for controlling medical spending and improving care for the eight original participating physician groups. In addition, the project team will evaluate four additional physician groups that signed the AQC in 2010 and 2011, focusing on their rationales for participating, their strategies, and their progress in developing practice infrastructure. Project findings will inform other health care organizations and policymakers about what it takes to perform well under accountable care payment models in which providers bear significant financial risk for their performance.

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Trustees of Dartmouth College

\$377,693

The Dartmouth Accountable Care Organization Tracking Project, Year 3: Assessing Implementation, Identifying Success Factors, and Supporting Spread

Under previous Commonwealth Fund grants, Dartmouth researchers led by Elliott Fisher, M.D., M.P.H., developed a framework for the timely evaluation of accountable care organizations (ACOs). This project will assess trends in the formation of ACOs. The project team will: 1) develop and field a survey to describe the characteristics of delivery system change associated with ACOs; and 2) conduct interviews and site visits to gain a better understanding of the factors that contribute to the establishment of successful and sustainable ACOs. The overall project will make new and significant contributions to our understanding of how ACO implementation is progressing nationally.

Elliott Fisher, M.D.
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President and Fellows of Harvard College

\$363,260

Assessing the Characteristics and Performance of Accountable Care Organizations and Their Potential for Spread, Phase 1

A major aim of health reform is the promotion of care delivery systems that are accountable for quality and costs. As accountable care organizations (ACOs) take hold and evolve, it will be critical to assess their performance and impact on an ongoing basis. With this project, The Commonwealth Fund will embark on a multiyear effort to track patterns of integration and health care utilization, cost, and quality among these emerging entities. Phase 1 work will focus on identifying structural variations among different types of ACOs, as well as differences in their patient populations, including those related to race, ethnicity, income, and health status. Future phases of work might examine the strategies followed by different types of ACOs to achieve their goals.

Arnold Epstein, M.D.

John H. Foster Professor and Chair

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Institute for Healthcare Improvement

\$750,000

State Action on Avoidable Rehospitalizations (STAAR) Initiative, Phase 4

Recognizing that high numbers of avoidable hospital readmissions are indicative of a poorly functioning health care system, the Board in 2008 approved an investment in the State Action on Avoidable Rehospitalizations (STAAR) initiative to develop and test a model of statewide system collaboration to redesign the care transition process for patients leaving the hospital. To date, 64 hospitals in Massachusetts, Michigan, and Washington have participated in the effort, receiving technical assistance from experts working with

frontline care transition teams. STAAR also supports coalitions of providers, purchasers, and state officials charged with addressing systemic barriers and identifying solutions. In the next phase, a second cohort of 50 hospitals in Massachusetts and Michigan will engage in the collaborative, with Washington having recently disengaged from full STAAR participation. By 2012, three to five hospitals in each state are expected to be ready to serve as national role models for improving transitional care, and one-fifth of hospitals will have lowered 30-day readmissions by 20 percent to 30 percent within a pilot population.

Karen Boudreau, M.D.

Senior Vice President

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Joan and Sanford I. Weill Medical College of Cornell University

\$241,201

Exploring How Small Physician Practices Can Achieve Higher-Quality, Lower-Cost Care

As health care costs continue to rise, the search for innovative ways to reduce costs without compromising quality of care continues in earnest. Physician practices clearly have a central role to play in this endeavor, but not enough is known about how the organizational structure, clinical processes, and financial incentives of practices, particularly smaller ones, influence the quality and cost of care they provide. Using data previously collected from a national survey of small and medium-sized physician practices, the project team will assess the incentives practices are exposed to and the extent to which implementation of care management processes, such as those recommended for medical homes, affect quality and cost. The results will inform private sector and federal officials implementing health system reform.

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University of Oregon

\$295,461

How a Health System Uses an Innovative Physician Compensation Model to Drive Improvements in Care Delivery

Decoupling health care providers' income from the volume and intensity of services they deliver is critical to the success of health care reforms intended to tie payment more closely with patient outcomes. This study will examine the provider payment reforms instituted by Fairview Health Services, an integrated health system in Minnesota that is discarding fee-for-service and replacing it with performance-based payment focusing on quality, productivity, patient experience, and cost. Using qualitative and quantitative methods, the investigators will study how physicians respond to the new compensation system and assess the impact over time on clinician behavior, quality of care, and cost containment. The findings will yield valuable insights at a time when payment reform is being implemented nationwide.

Judith Hibbard, Dr.P.H.
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Yale University

\$194,931

Spreading Effective Hospital Strategies for Reducing 30-Day Mortality for Heart Attack, Phase 1

Frances Cooke Macgregor Grant

Building on work conducted under an earlier Commonwealth Fund grant, Yale researchers will evaluate the process of change at hospitals participating in a national quality alliance sponsored by the American College of Cardiology to improve 30-day risk-adjusted mortality rates for hospitalized heart attack patients. The project team will survey hospitals that join the alliance about factors that are likely to be associated with significant improvements in the adoption of recommended best practices and the prevention of heart attack deaths. If this work proceeds satisfactorily, support for a second phase will be requested to repeat the survey after 18 months, link the findings to Medicare data to ascertain which hospital characteristics have the greatest impact on mortality, and conduct interviews with hospital leaders and frontline staff for a richer understanding of the process of organizational change at high-performing hospitals.

Elizabeth Bradley, Ph.D.
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Small Grants—Health System Quality and Efficiency

Brigham and Women's Hospital, Inc.

\$49,518

Effect of Health Information Exchange on the Cost of Medical Tests

Alexander Turchin, M.D.
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Center for Health Policy Development, National Academy for State Health Policy
\$49,101
Developing a Central Resource to Track State Accountable Care Delivery System

Mary Takach
Program Director
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Harvard Pilgrim Health Care
\$35,000
Interpreting Results of Evaluations of Healthcare Interventions: Shedding Light on the Impact of Research Designs on Validity and Consequences for Recommending Adoption and Spread

Stephen Soumerai, Sc.D.
Professor of Population Medicine
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Johns Hopkins University
\$25,000
Exploring Approaches to Developing a Valid Standard Measure of Rehospitalizations, Phase 2

Gerard Anderson, Ph.D.
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National Academy of Sciences
\$40,000
Developing New Approaches to Governance and Financing of Graduate Medical Education for the 21st Century

Jill Eden
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Board Grants—Patient-Centered Coordinated Care

Brigham and Women’s Hospital, Inc.

\$371,661

Evaluating a Comprehensive Primary Care Medical Home Payment Model in Albany, N.Y., Phase 2

Researchers at Brigham and Women’s Hospital will expand an evaluation of the innovative payment initiative currently being tested in five primary care practices in Albany, N.Y., and Boston, Mass. Under this medical home-based reimbursement model, primary care physicians are paid a comprehensive, risk-adjusted, per-patient annual fee, augmented by a bonus tied to performance on quality and efficiency. With early results indicating cost-savings for the Albany practices, the participating payer, Capital District Physician Health Plan, will spread the reimbursement model to a total of 24 sites in 2012. This evaluation will assess changes in quality, utilization, and health care costs in the 24 primary care sites in the Albany region. In addition, the evaluation team will complete the analysis of the five original sites included in phase 1.

David Bates, M.D.

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Group Health Cooperative

\$316,826

Creating a National Medical Home Curriculum: Diffusion of the Safety Net Medical Home Initiative

The Bureau of Primary Health Care, the federal agency that oversees the nation’s community health centers, is building a quality improvement infrastructure modeled largely on The Commonwealth Fund’s Safety Net Medical Home Initiative. The project team leading the Fund initiative, which supports the hiring and training of coaches

to help clinics become medical homes, has an opportunity to build on its experience and spread lessons to the regional organizations representing 1,300 federally qualified health centers nationwide. While the team has developed a set of useful materials to help safety-net clinics make care more accessible, coordinated, and patient-centered, additional work is needed to create a national curriculum for new medical home coaches working with safety-net primary care sites. A national committee of policymakers, primary care experts, and community health center leaders will guide the curriculum development and adoption.

Edward Wagner, M.D.

Director, McColl Institute for Healthcare Innovation

Group Health Research Institute

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Massachusetts General Hospital

\$138,899

Implementing Care Management for Complex Patients in Medical Homes: A Comparison of Models

A number of patient-centered medical home sites across the country have added care managers to their primary care team to help coordinate and manage services for high-cost, complex patients. Research shows that care management programs can improve quality of care and health outcomes for high-risk patients as well as reduce per capita expenditures, by reducing the need for emergency room visits and hospitalizations. This project will analyze and compare primary care-based care management programs, focusing on their staffing, scope of responsibilities, and patient populations. As more medical home sites prepare to add care management components, providers and program managers will need to know the characteristics and features that are closely associated with successful implementation.

Timothy Ferris, M.D.

Associate Professor

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University of Montana

\$155,488

Cost Analysis of a Nurse Care Management Program for High-Risk Medicaid Patients in Montana

In 2010, Montana established a promising nurse care management program that connects high-risk Medicaid patients who are cared for in federally qualified health centers with services that are needed to improve health outcomes and control costs. Care management services are shared with small private physician practices to bolster their capacity to serve as medical homes. With a preliminary analysis of the program indicating cost savings after six months, this project will support an external evaluation over a full year to determine the longer-run impact on health care utilization, quality of care, and costs.

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Qualis Health

\$1,620,000

Transforming Safety-Net Clinics into Patient-Centered Medical Homes, 2012–13

In 2009, 65 safety-net health centers in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania were selected to participate in The Commonwealth Fund's Safety Net Medical Home Initiative, which assists clinics in becoming patient-centered medical homes that achieve benchmark levels of clinical quality, efficiency, and patient experience. In the past year, the clinics established patient-provider panels to improve continuity of care, retrained staff to work as teams, introduced patient care management programs, and implemented emergency department notification systems to improve care coordination. Recent data show improvement in all key domains of medical home transformation. In the year ahead, the project team will continue to: 1) support practice transformation through meetings, webinars, and site visits; 2) help several clinics achieve formal national recognition as medical homes; 3) promote a "learning laboratory" for the clinic teams and state leaders; and 4) engage in payment reform efforts aimed at sustainability and spread. With this grant, the Fund concludes its support for the five-year initiative.

Jonathan Sugarman, M.D.
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Small Grants—Patient-Centered Coordinated Care

Center for Health Policy Development, National Academy for State Health Policy

\$32,013

Transforming Primary Care Through State Initiatives: Adapting the North Carolina Experience

Jill Rosenthal

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University of Chicago

\$49,869

Incorporating Medical Home Measures into National Reporting Systems for Federally Qualified Health Centers

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Joan and Sanford I. Weill Medical College of Cornell University

\$49,931

Transforming the Primary Care Provider Workday

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Board Grants—Vulnerable Populations

Center for Studying Health System Change

\$233,455

Models of Access to Specialty Services for Medicaid Enrollees: Implications for Health Reform

For low-income Americans and other vulnerable populations, accessing specialty care services is at least as great a problem as accessing primary care. The Affordable Care Act does not specifically address access to specialty care, and most previous efforts to facilitate access have focused on physician referral processes and care coordination, bypassing the underlying financial constraints. This project 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 determine which ones are sustainable and to consider policy options for promoting their adoption.

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Trustees of Dartmouth College

\$246,398

How Will Vulnerable Populations Fare in Accountable Care Organizations?

Driven by a mission to deliver well-coordinated, high-performance health care, accountable care organizations (ACOs) hold promise for improving the health and care of vulnerable populations. Existing inequity within the health care system, however, presents the possibility of unintended, adverse consequences for high-risk groups enrolled in ACOs. This project will: 1) assess the possible consequences

of ACO proliferation for vulnerable populations, using data obtained from Medicare ACO simulations; 2) examine the extent to which these organizations are taking hold in disadvantaged communities; and 3) conduct a case study of a safety-net provider organization that is forming an ACO, to gain a better understanding of the unique challenges these providers face.

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Dougherty Management Associates, Inc.

\$76,865

Role and Financing of Enabling Services for Vulnerable Populations

Once the health reform law has been fully implemented, vulnerable populations will have significantly greater access to affordable health insurance. Having coverage, however, does not guarantee access to health care, nor does it ensure that patients will be able to benefit fully from the services available to them. Safety-net providers typically offer a variety of “enabling services”—transportation, interpretation, psychosocial support, and outreach, among others—to overcome personal, social, geographic, financial, and environmental barriers to care. This project 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.

Wendy Holt

Principal

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Health Management Associates, Inc.

\$179,729

Medicaid Managed Care Innovations to Improve Care for Vulnerable Populations

Medicaid managed care organizations (MCOs) have the potential to foster the delivery of quality care to vulnerable populations while also containing cost growth. This project will examine ways in which Medicaid managed care can improve health care delivery to low-income families and disadvantaged minority Americans. Based in part on a previously fielded national survey of Medicaid managed care activities, the research team will explore innovative contracting arrangements between state Medicaid agencies and MCOs that are intended to improve the quality and efficiency of care beneficiaries receive. The team will then prepare case studies of four service and delivery innovations. By gathering and synthesizing information about effective and promising Medicaid managed care practices, this project will inform state and federal policymakers in their efforts to promote high-quality, cost-effective care for their expanding Medicaid populations.

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Institute for Community Health, Inc.

\$148,557

Examining a Safety-Net System's Transformation into an Accountable Care Organization

With its potential to deliver well-coordinated, comprehensive health services, the accountable care organizations (ACO) can improve care for vulnerable populations. In 2008, Cambridge Health Alliance (CHA), a leading safety-net provider, began its transformation to an ACO, turning primary care sites into patient-centered medical homes and testing global payment arrangements. This grant will support an in-

depth case study of CHA's approach to delivery system and payment reform, documenting the organization's progress in becoming an ACO, clarifying the challenges for safety-net systems, and identifying lessons to help these providers deliver efficient, patient-centered population-based care. The grantee will provide in-kind support.

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Small Grants—Vulnerable Populations

The Board of Trustees of the University of Alabama for the University of Alabama at Birmingham

\$16,500

Dissemination of CAHPS Cultural Competency and Health Literacy Surveys

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Center for Health Care Strategies, Inc.

\$49,888

Preparing Medicaid to Implement Accountable Care Organizations: A Learning Collaborative for States, Health Plans, and Providers

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Manatt, Phelps & Phillips, LLP

\$45,000

Medicaid's Role in Payment and Delivery System

\$49,400

Sustainable Funding for Safety-Net Hospitals

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Massachusetts General Hospital

\$19,875

The Healthcare Quality and Equity Action Forum

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**The Mongan Commonwealth Fund Fellowship in
Minority Health Policy**

President and Fellows of Harvard College

\$800,000

*The Mongan Commonwealth Fund Fellowship in Minority Health
Policy: Support for Program Direction and Fellowships, 2012–13*

Since 1996, the Commonwealth Fund/Harvard 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 receive an enriched program that includes 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. In 2012–13, the Fund will support four fellows.

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

Florida Atlantic University

\$260,000

National Dissemination of a Program for Improving Management of Acute Conditions in Nursing Homes

Picker Program Grant

INTERACT, or Interventions to Reduce Acute Care Transfers, is an evidence-based quality improvement program that enables nursing home staff to manage many of the illnesses that commonly affect residents and, thereby, helps reduce the need to transfer them to a hospital. Findings from a Commonwealth Fund–supported study of the program’s effectiveness in 25 nursing homes show a 17 percent reduction in all-cause hospital admissions for residents. Some 200 facilities in Massachusetts and 35 in New York City have received INTERACT training, with several hundred more homes nationally deploying at least some of the component interventions. This project will build on this success by refining the program and helping to spread it to nursing homes throughout the United States.

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President and Fellows of Harvard College

\$145,202

Helping Dually Eligible Beneficiaries with Mental Illness Receive Better Care Coordination

Picker Program Grant

People enrolled in both Medicare and Medicaid have complex, costly health care needs that account for a disproportionate share of spending in both programs. Dually eligible beneficiaries with severe and persistent mental illness incur especially high costs. A team of Harvard researchers will study state-based programs that have lowered costs and improved care for special-needs patients by emphasizing better coordination of patients’ services. As part of this work, the researchers will estimate the expected outcomes, costs, and savings from different combinations of coordination models, payment schemes, organizational structures, and targeting strategies. Policymakers should find the results useful in their efforts to hold organizations accountable for the quality of the care they provide to patients with multiple health conditions.

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LeadingAge, Inc.

\$439,225

Advancing Excellence in America’s Nursing Homes: Accelerating Results Through Coalitions, Year 5

Picker Program Grant

Advancing Excellence in America’s Nursing Homes, supported by The Commonwealth Fund and the Centers for Medicare and Medicaid Services (CMS), continues to demonstrate its effectiveness in stimulating improvements in resident care. Three years of data indicate that, in the aggregate, nursing homes participating in the national quality campaign are more able to reduce use of physical restraints, prevent pressure ulcers, and improve pain management than are facilities not participating. In the coming year, Advancing Excellence will work with CMS and Medicare Quality Improvement Organizations to address revised priorities, including improved care transitions, and to help implement the new federal Nursing Home

Quality Assurance and Performance Improvement Initiative. Staff will also issue a new round of state performance improvement challenge awards, continue to assist the campaign's state learning networks, revise education materials, and test the use of social media to reach a wider group of stakeholders.

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National Senior Citizens Law Center

\$110,000
Ensuring Consumer Engagement in State Planning for Integrated Dual-Eligible Care
Picker Program Grant

The Centers for Medicare and Medicaid Services (CMS) recently awarded \$1 million to each of 15 states for the design of integrated service delivery and payment models for dual eligibles, people with high health care needs who are enrolled in both Medicare and Medicaid. In its directions to these states, CMS emphasized that consumer stakeholders must be included in the planning process and their suggestions openly considered. This project will help consumers climb the steep learning curve to becoming well-informed, helpful participants, since resolving many of the problems facing states in coordinating care for dual eligibles requires considerable knowledge of a technically complicated set of issues. The project team will develop accessible informational resources for consumer groups and, through a state workgroup, act as a platform for sharing ideas and strategies for improving care for this particularly vulnerable population.

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Visiting Nurse Service of New York

\$318,084
Promoting Integrated Care for Dual Eligibles, Phase 1
Picker Program Grant
Health Services Improvement Fund

To control rising health care costs, pressure is building to accelerate the enrollment of people dually eligible for both Medicare and Medicaid into managed care plans. Because of these beneficiaries' complex health care needs, it is especially important that they are served by plans with the capacity to deliver high-quality, coordinated care. This project will seek ways to expand the capacity and scalability of existing well-performing integrated managed care plans that serve dual eligibles. Central to this work is the creation of a consortium of plans working jointly to align plan and provider interests, create mechanisms for producing excellent quality while managing costs, and formulate strategies for expanding enrollment and increasing retention. If phase 1 proceeds well, support for a second phase will be requested to synthesize and disseminate consortium members' strategies and best practices.

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

AcademyHealth

\$23,230

Long-Term Care Interest Group 2012 Policy Seminar

Picker Program Grant

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AcademyHealth

\$13,493

2012 Disability Research Interest Group Meeting & Webinars

Picker Program Grant

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American Health Care Association

\$49,940

Keeping Pace with National Priorities: New Goals for Advancing Excellence

Picker Program Grant

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Dobson DaVanzo & Associates, LLC

\$38,898

Understanding the Potential Impact of Medicare Payment Bundling on Long Term Services and Supports

Picker Program Grant

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President and Fellows of Harvard College

\$26,150

Organizing Coordinated Care for Medicaid: A Case Study

Picker Program Grant

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New York University

\$49,971

Promoting Spread of Patient Centered Models for Transitions Between Acute and Long-Term Care

Picker Program Grant

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Trustees of the University of Pennsylvania

\$50,000

Identifying Best Practices in the Care of Seriously Ill Nursing Home Residents: A Positive Deviance Approach

Picker Program Grant

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University of Pittsburgh

\$38,816

Improving Nursing Home Care in New York City: The Importance of Workforce Relationships and Staff Stability to Achieving Better Quality

Picker Program Grant

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HEALTH REFORM POLICY

Board Grants—Affordable Health Insurance

Brigham and Women’s Hospital, Inc.

\$132,083

The Potential of Value-Based Insurance Design: Evaluating the Effect of Eliminating Prescription Drug Copayments for Heart Attack Patients

Large employers are expressing growing interest in value-based insurance designs that can improve their employees’ health while reducing overall health care costs. A growing body of evidence suggests that reducing cost-sharing for treatments and medications that have been proven effective can strengthen patients’ medication adherence. However, there has been no rigorous longer-term economic evaluation of the impact such coverage policies have on health spending. Based on data from a three-year randomized trial conducted with 5,800 Aetna beneficiaries, this project will evaluate how medication adherence and spending by payers and patients would be affected if copays were eliminated for recommended medicines following a heart attack. The findings will provide guidance to both public and private insurers in designing benefit packages to improve outcomes and lower health costs over time.

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Center for Studying Health System Change

\$156,689

The Affordability of Medical Care: Management of Chronic Conditions and the Potential Effects of Health Reform, Phase 2

During the first phase of this project, the research team has been examining recent national and state trends in the affordability of medical care for Americans. In the proposed second phase, the team’s analysis will focus on changes over time in the financial burden associated with two chronic illnesses: diabetes and asthma. The analysis will examine the level of out-of-pocket spending by patients with optimal treatment and care management, and spending by patients with suboptimal treatment and care management. The findings will inform federal and state policymakers and regulators of the possible need for policy remedies to provide patients with additional protections and assistance to help ensure compliance with recommended treatment regimes.

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The Commonwealth Fund

\$300,000

Analysis and Modeling of Health Care Reform and Implementation

In 2010, the Board of Directors approved a special appropriation that allowed The Commonwealth Fund’s president flexibility in approving grants to take advantage of unique opportunities to inform implementation of the Affordable Care Act, now in its second year. This year’s appropriation for analysis and modeling opportunities will authorize the Fund’s president to continue to underwrite projects that inform policymakers about issues critical to successful implementation of the law’s major provisions. These issues might include: how to address small employers’ needs in the design of the new health insurance exchanges; how to encourage exchange participation by both large and small employers; how to ensure coordination of public and private subsidized coverage; and how to improve the ability of individuals and employers to make informed plan choices. The appropriation will also enable the Fund to respond to federal requests for expert meetings and analysis.

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The George Washington University

\$174,959

Analysis of State Health Insurance Exchange Legislation and Implementation

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President and Directors of Georgetown College for Georgetown University

\$175,000

Implementing the Affordable Care Act: Tracking and Analysis of State Implementation of Insurance Market Reforms Outside of the Exchanges

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National Opinion Research Center

\$146,119

Surveying Small Employers to Inform the Design of State Insurance Exchanges

To ensure that risk pools in the new state-based health insurance exchanges are broad and diverse and that premiums do not rise rapidly, state and federal officials must work to maximize the participation of employers, both those that are offering health insurance now and those that are not—but who may want to do so in a reformed health insurance system. The National Opinion Research Center will survey 600 randomly selected private employers with 50 or fewer workers about their current health insurance experiences and their future preferences regarding coverage through the exchanges. Understanding the perspectives of small employers should aid policymakers as they design the exchanges.

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Princeton Survey Research Associates International

\$399,300

The Commonwealth Fund Biennial Health Insurance Survey, 2012

The Commonwealth Fund Biennial Health Insurance Survey, conducted every two years since 2001, shines a light on trends in U.S. working families' health coverage, including the proportions of people who lack health coverage, have gaps in their coverage, are underinsured, experience cost-related problems getting needed care, and are paying off medical debt over time. By 2012, two years into implementation of the Affordable Care Act, the survey will be able to identify the effects of early reform provisions as well as provide baseline data on insurance coverage for comparison with 2014, when the law's major coverage expansions and insurance market regulations take effect.

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Wake Forest University Health Sciences

\$135,232

Using Medical Loss Ratio Data to Determine Insurers' Administrative Costs and Investments in Quality Improvement

In an attempt to reduce the amount private health insurance plans spend on administration and other items not directly related to patient care, the Affordable Care Act requires commercial carriers to maintain a minimum medical loss ratio (MLR). In 2012, health plans with MLRs below the minimum will be required to rebate their members the difference. To enforce the new rule, carriers must report on standardized forms detailed information about their administrative expenses, their profits, and their efforts to improve quality of care. The project team will analyze this newly collected information, map out compliance with the MLR requirement in each state, and assess the stability and structure of the health insurance marketplace in each state. The findings will yield important insights for regulators and policymakers striving to increase the efficiency of insurance markets.

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Small Grants—Affordable Health Insurance

Trustees of Columbia University in the City of New York

\$43,090

Programming Support for The Commonwealth Fund's Research Programs: Analysis of National Datasets on Health Reform Issues

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Education and Research Fund of the Employee Benefit Research Institute

\$22,500

2012 Support of the Employee Benefit Research Institute Education and Research Annual Consumer Engagement in Health Care Survey

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The George Washington University

\$9,279

Exploring the Opportunities in the ACA's Multi-State Plans

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President and Directors of Georgetown College for Georgetown University

\$49,098

Implementation of the Affordable Care Act: Critical Issues About the Private Health Insurance Market, Entities, Products, and Implications for Successful Health Insurance Reforms and State Exchanges

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University of Kansas Center for Research, Inc.

\$29,503

Evaluation of Pre-Existing Condition Insurance Plans Under the Affordable Care Act

\$39,999

Evaluation of the Pre-Existing Condition Insurance Plans Under the Affordable Care Act: Immediate and Long-Term Implications for Federal Health Policy

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RAND Corporation

\$50,000

The Impact of Health Insurance on Financial Risk

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Board Grants—Payment and System Reform

Actuarial Research Corporation

\$250,000

Modeling the Impact of Health Care Payment, Financing, and System Reforms

This contract will support modeling efforts of the impact of health care delivery and payment system reforms. This work will support the Commission on a High Performance Health System in developing a report with specific policy recommendations that can build on the Affordable Care Act to help control the growth of health spending. The policies being considered include payment and delivery system reforms, changes to consumer incentives, and insurance markets reforms.

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The Commonwealth Fund

\$250,000

Modeling the Impact of Payment, Financing, and System Reform

This special appropriation will provide The Commonwealth Fund's president with flexibility in approving grants and contracts to model the impact of health care delivery and payment system reforms. Potential subjects for analysis include: the modernization of Medicare benefit design; payment models for incentivizing greater efficiency across health care settings; and potential policy recommendations for the Independent Payment Advisory Board. Fund staff will work closely with the selected consultants to produce publications that inform policymakers seeking to promote high-value health care.

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President and Fellows of Harvard College

\$298,667

Evaluating the Clinical and Economic Impact of the Alternative Quality Contract, Phase 2

In place since 2009, the Alternative Quality Contract is Blue Cross Blue Shield of Massachusetts' novel provider payment system, under which medical groups receive a global payment covering all care used by each patient. The annual increase in that payment is set at the anticipated rate of general inflation over a five-year contract period, with additional performance-based payments available to each group. Early results from a Commonwealth Fund-sponsored evaluation indicate that the Alternative Quality Contract has reduced per-enrollee health care spending. This project will further investigate how the payment system is achieving this success and what the longer-run implications are for health care utilization and spending.

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Pacific Business Group on Health

\$346,291

Identifying, Describing, and Tracking Innovative Payment Initiatives

New ways of paying health care providers are being developed and tested throughout the private sector to spur the delivery of higher-value health care. These include enhancements to traditional fee-for-

service, bundled payment, and global payment. Catalyst for Payment Reform, an independent nonprofit organization, is proposing to create an online, publicly accessible compendium of private-sector payment reform initiatives across the nation, as well as an annually updated tracking report, to describe these efforts, monitor progress in creating effective payment strategies, and identify trends. These new resources will inform health care organizations, purchasers, and policymakers about the range of possible approaches to payment reform and highlight the most effective and promising models.

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Small Grants—Payment and System Reform

Brigham and Women's Hospital, Inc.
\$8,791
The Promise and Perils of Shared Savings Programs

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Mathematica Policy Research, Inc.
\$24,975
Variation in the Efficiency of Medicare Advantage Plans Relative to Medicare Fee For Service

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Regents of the University of Michigan
\$29,501
Assessing the Impact of the Medicare Advantage Bid System: Market Structure, Plan Payment and Enrollment

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Board Grants—Policy Development and Convening

Alliance for Health Reform

\$376,547

Commonwealth Fund Bipartisan Congressional Retreat, 2012

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 ongoing attention being paid to health reform in 2011, the retreat will enable participants to take stock of progress made in the first years 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

\$366,156

Health Policy Seminars and Roundtables, Staff Dialogues, and Congressional Staff/Support Agency Retreat, 2011–12

Alliance for Health Reform briefings, roundtables, and staff dialogues are valuable resources for congressional staff, journalists, and members of the broader Washington policy community seeking information and analysis on the latest health policy developments and the implementation of health reform. In the coming year, the Alliance will conduct seven Commonwealth Fund–sponsored briefings or roundtables and four staff dialogues on Capitol Hill, with

sessions focusing on topics pertinent to reform implementation in 2011 and 2012. The annual Congressional Staff Retreat, a partnership with the Catholic Health Association of the United States, provides an opportunity for 50 to 75 senior health staff from both parties to engage in an informal, off-the-record exchange of ideas.

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Center for Health Policy Development, National Academy for State Health Policy

\$124,785

ABCD III: Distilling and Disseminating Lessons for Improving Care Coordination for Young Children

The Assuring Better Child Health and Development (ABCD) initiative is currently helping five states develop integrated, community-based systems of care coordination for children enrolled in public insurance programs. This grant will support the National Academy for State Health Policy as it wraps up its technical assistance and project guidance for states, synthesizes lessons for a national audience, and promotes the new care coordination models to state and federal policymakers through webinars, conferences, and briefs. With this grant, The Commonwealth Fund concludes its support for ABCD.

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The Commonwealth Fund

\$149,848

Commonwealth Fund Commission on a High Performance Health System: Meetings

Over the next year, the Commonwealth Fund Commission on a High Performance Health System will continue to promote the principles and goals of a high performance health system, helping to realize the potential of health reform by focusing on promising payment and delivery system reforms, considering options for slowing spending growth by improving value throughout the health system, and supporting policies that ensure access to health care for vulnerable populations. The Commission will continue to issue periodic performance scorecards to identify opportunities for health system improvement and inform such Fund-sponsored activities as the Bipartisan Congressional Health Policy Conference, the 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, sets ongoing priorities, and plans future activities.

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Health Management Associates, Inc.

\$179,491

Case Studies of State Innovations in Payment and Delivery System Reform

This project will inform federal policymakers about current and emerging state innovations in health care delivery and payment and provide guidance to federal officials awarding state grants to test health system reforms. Six case studies conducted by Health Management Associates will also help The Commonwealth Fund identify topics and speakers for its series of briefings and dialogues

conducted with the Alliance for Health Reform and for the Bipartisan Congressional Health Policy Conference and Congressional Staff Retreat. In addition, the case studies will inform other projects within the Federal and State Health Policy program, including work proposed with the National Association of Medicaid Directors and the Progressive States Network to explore Medicaid's role as a lever for payment and delivery system reform.

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New York, NY 10036
ssilowcarroll@healthmanagement.com

National Association of Medicaid Directors

\$137,910

Working with State Medicaid Leaders to Promote Health Care Delivery and Payment Reforms

In 2014, when the Affordable Care Act's expansion of eligibility takes effect, Medicaid enrollment is expected to grow by 16 million, making the federal-state program the largest purchaser of health insurance. As fiscal pressures mount at the federal and state levels, Medicaid will also likely take on a greater role in driving needed reforms to health care delivery and provider reimbursement. To prepare for these changes, communication and collaboration between state officials and policy researchers, and between state and federal policymakers, will be important. Through briefings, webinars, and conference calls, the National Association of Medicaid Directors seeks to inform federal dialogue on Medicaid reforms, enable state Medicaid directors to share ideas and best practices, and provide guidance and support to these officials as they design and implement system and payment reforms. Particular attention will be paid to opportunities for better coordination of services for at-risk populations and for evidence-based quality measurement.

Kathleen Nolan
Director of State Policy & Programs
444 North Capitol Street NW, Suite 309
Washington, DC 20001
kathleen.nolan@namd-us.org

Small Grants—Policy Development and Convening

AcademyHealth

\$19,806

Support for the 2012 Activities of AcademyHealth's State Health Research and Policy Interest Group

Enrique Martinez-Vidal
Vice President
1150 17th Street NW, Suite 600
Washington, DC 20036
enrique.martinez-vidal@academyhealth.org

Brandeis University

\$15,000

19th Annual Princeton Conference: States' Role in Healthcare Reform—Possibilities to Improve Access and Quality

Stuart H. Altman, Ph.D.
Professor and Chair, Council on Health Care Economics and Policy
The Florence Heller Graduate School
Institute for Health Policy—MS035
P.O. Box 549110
Waltham, MA 02453
altman@brandeis.edu

Grantmakers In Health

\$30,000

Support for the Federal–State Implementation Project

Osula Evadne Rushing
Program Director
1100 Connecticut Avenue, NW, Suite 1200
Washington, DC 20036
orushing@gih.org

Progressive States Network

\$50,000

Progressive States Network: Convening of State Legislators

\$35,000

Progressive States Network Legislative Pre-Conference

Ann Pratt
Executive Director
82 Wall Street, Suite 200
New York, NY 10005
apratt@progressivestates.org

HEALTH SYSTEM PERFORMANCE ASSESSMENT AND TRACKING

Board Grants—Health System Performance Assessment and Tracking

The Commonwealth Fund

\$213,575

Authorization to Support Data Acquisition and Report Printing

The national and state health system scorecards developed by The Commonwealth Fund’s research unit at the Institute for Healthcare Improvement reveal persistent deficits in overall health system performance and wide variability across the states. These findings have helped focus attention and policy efforts on areas of underperformance and opportunities for improvement. In the wake of federal health reform, the Fund is poised to strengthen its standing as a go-to source for health system performance tracking. The proposed grant will support the research unit’s second year, during which time the team will produce the first local health system scorecard, a companion report, and a new report on state health system performance. Additional case studies, briefs, and other papers will be produced on topics of national, state, and local policy interest.

Cathy Schoen
Senior Vice President for Policy, Research and Evaluation
One East 75th Street
New York, NY 10021
cs@cmwf.org

Institute for Healthcare Improvement

\$367,722

Support for a Research Unit to Update Health System Scorecards and Analyze Local Variations in Performance, 2011–12

The national and state health system scorecards developed by The Commonwealth Fund’s research unit at the Institute for Healthcare Improvement reveal persistent deficits in overall health system performance and wide variability across the states. These findings have helped focus attention and policy efforts on areas of underperformance and opportunities for improvement. In the wake of federal health reform, the Fund is poised to strengthen its standing as a go-to source for health system performance tracking. The grant will support the research unit’s second year, during which time the team will produce the first local health system scorecard, a companion report, and a new report on state health system performance. Additional case studies, briefs, and other papers will be produced on topics of national, state, and local policy interest.

David Radley, Ph.D.

Senior Analyst and Project Manager, Commonwealth Fund Scorecard Project
20 University Road, 7th Floor
Cambridge, MA 02138
dr@cmwf.org

IPRO, Inc.

\$495,000

Profiling the Performance of Health Care Organizations and Systems on WhyNotTheBest.org, Phase 4

The Commonwealth Fund’s health care quality improvement resource WhyNotTheBest.org has continued to evolve and grow in the past two years. The site now features a wider range of data sources and performance measures; profiles additional types of health care providers (physician practices as well as hospital systems); extends performance data reporting to the county and regional levels; and expands analytic functionality for performance assessment. The WhyNotTheBest.org team has also worked to improve the user interface. This year’s grant will support additional work to identify systems of care and levels of horizontal and vertical integration, as well as to identify locations of Beacon Communities and patient-centered medical homes and assess performance in these localities.

Through these innovations, WhyNotTheBest.org will continue to serve as a source of cutting-edge information on health system performance.

Jaz-Michael King
Senior Director, eServices and Health Care Transparency
1979 Marcus Avenue, Suite 105
Lake Success, NY 11042-1002
jmking@ipro.us

Pear Tree Communications, Inc.

\$219,333

Profiling the Performance of Health Care Organizations and Systems on WhyNotTheBest.org, Phase 4

The Commonwealth Fund's health care quality improvement resource WhyNotTheBest.org has continued to evolve and grow in the past two years. The site now features a wider range of data sources and performance measures; profiles additional types of health care providers (physician practices as well as hospital systems); extends performance data reporting to the county and regional levels; and expands analytic functionality for performance assessment. The WhyNotTheBest.org team has also worked to improve the user interface. This year's grant will support additional work to identify systems of care and levels of horizontal and vertical integration, as well as to identify locations of Beacon Communities and patient-centered medical homes and assess performance in these localities. Through these innovations, WhyNotTheBest.org will continue to serve as a source of cutting-edge information on health system performance.

Martha Hostetter

Partner

3035 Lincoln Boulevard

Cleveland Heights, OH 44118-2033

mh@cmwf.org

INTERNATIONAL HEALTH POLICY AND INNOVATION

Board Grants—International Health Policy and Innovation

The Commonwealth Fund

\$75,000

Commonwealth Fund/Nuffield Trust International Conference on Quality Improvement and Delivery System Reform, 2012

The annual transatlantic forum on quality improvement sponsored by The Commonwealth Fund and the United Kingdom's Nuffield Trust provides a unique opportunity to build relationships among senior policymakers in the U.S. and the U.K., showcase health system innovations, and facilitate the exchange of ideas on what works and what does not. The 13th conference in this series will examine how sweeping health reforms in the two countries aim to transform the delivery of care and achieve cost savings. Key issues to be addressed include: the implications for current hospital clinical and business models; challenges in reconfiguring care processes, services, and referral patterns; the payment models that best support quality, efficiency, and accountability; and the organizational environments that motivate provider engagement and receptivity to change.

Robin Osborn
Vice President & Director, IHP
One East 75th Street
New York, NY 10021
ro@cmwf.org

The Commonwealth Fund

\$1,472,320

Harkness Fellowships in Health Care Policy and Practice, 2013–14

Support for a 16th class of Harkness Fellows in Health Care Policy and Practice will allow The Commonwealth Fund to continue developing

promising policy researchers and practitioners from Australia, Canada, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom. To build on the partnership model that has enabled the European expansion of the Harkness Fellowships, the Fund will seek sponsorship to extend the program to France in 2012. With a critical mass of 170 Harkness Fellows, the Fund will continue to leverage the fellowships, drawing on alumni's on-the-ground expertise to highlight international policy and delivery system innovations through commissioned research and Fund publications.

Robin Osborn
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New York, NY 10021
ro@cmwf.org

The Commonwealth Fund

\$365,000

International Symposium on Health Care Policy, Fall 2012

The Fund's 15th annual International Symposium on Health Care Policy will focus on the policy levers and strategies that support outstanding health system performance on behalf of patients with chronic illness. Participants will compare countries' unique national policy frameworks, health care delivery models, and payment strategies to gain a better understanding of how the best outcomes at the lowest costs are achieved, with a particular focus on high-priority health conditions, such as heart disease, diabetes, and cancer. Specifically, the symposium will address: investing in prevention; ensuring access to effective treatments and technologies; and using payment mechanisms and chronic care models to support care coordination and reduce hospital readmissions. In bringing together leading policymakers and researchers from 11 countries, the symposium will distill relevant lessons for U.S. health reform implementation. The Fund and the Alliance for Health Reform will also cosponsor a briefing on Capitol Hill showcasing international innovations relevant to the United States.

Robin Osborn
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New York, NY 10021
ro@cmwf.org

Harris Interactive, Inc.

\$470,609

International Health Policy Survey, 2012

The Commonwealth Fund's 2012 International Health Policy Survey will assess health care system performance from the perspective of primary care physicians. To be conducted in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States, the survey will explore primary care physician practices' capacity to serve as medical homes and coordinate care; their participation in integrated care systems and deployment of care teams for chronically ill patients; their use of electronic health records with information exchange capabilities; payment arrangements; and satisfaction with primary care practice. The analysis of survey results will compare physician experiences and practice arrangements to those reported in 2009 and 2006. Findings will be presented at the Fund's 2012 International Symposium and submitted to *Health Affairs*.

Roz Pierson, Ph.D.

Vice President, Public Affairs and Policy
8320 Colesville Road #112
Silver Spring, MD 20910
rpierson@harrisinteractive.com

London School of Economics and Political Science

\$189,750

International Data Tracking Project: Comparison of Health Care Costs in the U.S. with Those in Selected Countries

Comparisons of health system spending between the United States and other industrialized countries reveal the U.S. to be an extreme outlier, far outspending any other country. This project will generate baseline health system cost data, to be updated on a biennial basis, comparing U.S. spending with spending in selected countries within the Organization for Economic Cooperation and Development (OECD) on hospital costs for 25 procedures, hospital administrative costs, a market basket of the top 50 pharmaceuticals, a set of high-volume/high-cost medical devices, and physician specialty incomes. These data will be integrated with pilot data from the OECD comparing the costs of more than 25 hospital procedures. Findings will be presented at The Commonwealth Fund's 2012 International Symposium on Health Care Policy and summarized in a paper for *Health Affairs*.

Sarah Thomson, Ph.D.

Research Fellow in Health Policy and Deputy Director of LSE Health
Houghton Street
London WC2A 2AE
United Kingdom
s.thomson@lse.ac.uk

London School of Economics and Political Science

\$199,540

International Lessons for the Financial Sustainability of Health Systems

As the Affordable Care Act is implemented, debate continues over the best way to curtail the steady climb in health care costs. This grant, the fifth 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 will focus on cost-containment strategies in high-income countries, efforts to protect access to high-quality care during the recent fiscal shocks, and the role of primary care infrastructure as a driver of system performance. Results will be disseminated through the Fund's 2012 international symposium, through a Commonwealth Fund/Alliance for Health Reform briefing, and, potentially, through *Health Affairs*.

Sarah Thomson, Ph.D.
Research Fellow in Health Policy and Deputy Director of LSE Health
Houghton Street
London WC2A 2AE
United Kingdom
s.thomson@lse.ac.uk

Urban Institute

\$82,916
Enhancing the International Program's Communications and Publications Capacity, Year 4

To strengthen the impact of The Commonwealth Fund's international program and spark creative health policy thinking in the United States, this grant will support an external contractor working with Fund staff to produce a series of issue briefs highlighting innovations in health policy and practice from abroad that might be transferable to the United States. These publications will provide a vehicle for communicating fresh ideas tried in other countries to U.S. policymakers, journalists, and researchers. The contractor will serve as the series' coeditor, helping to identify salient topics and working with international authors to present information in an accessible format.

Bradford H. Gray, Ph.D.
Associate
2100 M Street, NW
Washington, DC 20037
bgray@urban.org

Small Grants—International Health Policy and Innovation

The Commonwealth Fund

\$3,620
International Session at AcademyHealth Annual Research Meeting: "Insurance Exchange Implementation: What Can We Learn Abroad?"

Robin Osborn
Vice President & Director, IHP
One East 75th Street
New York, NY 10021
ro@cmwf.org

Geisinger Clinic

\$25,000
Comparative Survey in Structured Diabetes Care

Thomas Graf, M.D.
Chairman of Community Practice Network, Geisinger Health System
100 North Academy Avenue
Danville, PA 17822
trgraf@geisinger.edu

Harris Interactive, Inc.

\$45,000
The Commonwealth Fund 2012 International Health Policy Survey: Co-Funding for Germany, the Netherlands, and Sweden

Roz Pierson, Ph.D.
Vice President, Public Affairs and Policy
8320 Colesville Road #112
Silver Spring, MD 20910
rpierson@harrisinteractive.com

Johns Hopkins University

\$24,800

Top 10 Health Innovations for the U.S. to Consider

Gerard Anderson, Ph.D.

Professor and Director

Center for Hospital Finance and Management

Bloomberg School of Public Health

624 North Broadway, Room 302 Hampton House

Baltimore, MD 21205

ganderso@jhsph.edu

London School of Economics and Political Science

\$50,000

Analysis of Medical Imaging Policies, Prices and Utilization in High-Income Countries

Sarah Thomson, Ph.D.

Research Fellow in Health Policy and Deputy Director of LSE Health

Houghton Street

London WC2A 2AE

United Kingdom

s.thomson@lse.ac.uk

Scientific Institute for Quality of Healthcare

\$5,500

Dutch Harkness Fellowships Marketing Event at IQ Healthcare Annual Conference

\$28,736

Expansion of 2012 Commonwealth Fund International Health Policy Survey to Include the Netherlands

Gert Westert, Ph.D.

Professor and Director

Raboud University Nijmegen Medical Centre

P.O. Box 9101 114

Nijmegen, 6500 HB

The Netherlands

g.westert@iq.umcn.nl

Trustees of Tufts College

\$48,246

International Lessons on Impact of Comparative Effectiveness Research: Patient Access to New Cancer Drugs in U.S. and Europe

Joshua Cohen, Ph.D.

Senior Research Fellow

75 Kneeland Street, Suite 1100

Boston, MA 02111

joshua.cohen@tufts.edu

OTHER CONTINUING PROGRAMS

Board Grants—Communications

The Commonwealth Fund

\$200,000

Educating Key Audiences About How the U.S. Health System Is Reforming

A critical challenge leading up to full implementation of the Affordable Care Act is to increase understanding of the law among segments of the population most likely to experience its benefits. At the same time, many aspects of health care delivery are undergoing significant transformation, both in anticipation of reform implementation and independent of it. This special communications authorization will support a range of activities over the coming year to provide traditional and nontraditional Commonwealth Fund audiences with comprehensible information about the many ways in which U.S. health care is changing. Anticipated products include a cluster of journal articles covering topics like payment reform and evidence-based medicine, a new publication series explaining key insurance market and delivery system reforms, and educational partnerships with media outlets and state and regional media associations.

Barry Scholl

Senior Vice President for Communications and Publishing

One East 75th Street

New York, NY 10021

bas@cmwf.org

The Commonwealth Fund

\$100,000

Online Resources for Educating Key Audiences About Policy and Delivery System Reforms

Interactive online features have proven to be highly popular enhancements to The Commonwealth Fund's Web site. The international and health system data centers, for example, contain a variety of maps and comparison tools, while the health reform resource center offers an implementation timeline and the ability to perform custom searches for the reform law's provisions. Recently, the development of infographics—graphic visual representations of information, data, or knowledge—have proven equally valuable to Fund audiences, including major media outlets. This special authorization will support the development and dissemination of a greater number of these features over the coming year, a critical period for health reform.

Barry Scholl

Senior Vice President for Communications and Publishing

One East 75th Street

New York, NY 10021

bas@cmwf.org

The Commonwealth Fund

\$1,051,939

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 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. After one year, the authorization has proven to be highly successful. The renewal proposed here will support the continuation and enhancement of the Fund's communications activities and partnerships in four main areas in fiscal year 2011–12: publications development and dissemination, Web design and content development, media services, and licensing.

Barry Scholl
Senior Vice President for Communications and Publishing
One East 75th Street
New York, NY 10021
bas@cmwf.org

Nebraska Press Association Foundation

\$36,550
Pilot Model for Creating a State Rural Health News Service

Allen Beermann
Acting Executive Director
845 S Street
Lincoln, NE 68508
abeermann@nebpress.com

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 foundation'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.

Susan Dentzer
Editor-in-Chief, *Health Affairs*; Vice President, Project HOPE
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814
sdentzer@projecthope.org

Small Grants—Communications

Center for Excellence in Health Care Journalism

\$40,000
Support for the Association of Health Care Journalists' Annual Conference, Rural and Regional Health Journalism Workshops, and Aging and Long-Term Care Online Learning Center

Len Bruzzese
Executive Director
10 Neff Hall
Columbia, MO 65211
bruzzesel@missouri.edu

National Business Coalition on Health

\$49,506
"Purchasing High Performance" Newsletter

Andrew Webber
President and Chief Executive Officer
1015 18th Street NW, Suite 730
Washington, DC 20036
awebber@nbch.org

Society of American Business Editors and Writers, Inc.

\$30,000
The Business of Health Care: A Symposium
\$15,000
The Society of American Business Editors and Writers' 2011 Annual Conference and Web-Based Trainings for Journalists

Warren Watson
Executive Director
Cronkite School
555 North Central Avenue, Suite 416
Phoenix, AZ 85004-1248
watson.sabew@asu.edu

OTHER CONTINUING

Organizations Working with Foundations

AcademyHealth

\$165,590

Partnering with Academy Health to Promote a High Performing Health System, 2011–12

\$145,590

Rent and Services, 2012–13

\$18,000

General Support, 2012

Lisa Simpson

President and Chief Executive Officer

1150 17th Street NW, Suite 600

Washington, DC 20036

lisa.simpson@academyhealth.org

The Center for Effective Philanthropy

\$10,000

General Support

Phil Buchanan

Executive Director

675 Massachusetts Avenue, 7th Floor

Cambridge, MA 02139

philb@effectivephilanthropy.org

The Communications Network

\$3,500

General Support

Bruce S. Trachtenberg

Executive Director

1755 Park Street, Suite 260

Naperville, IL 60563

bruce@comnetwork.org

Foundation Center

\$25,000

General Support

Bradford Smith

President

79 Fifth Avenue

New York, NY 10003-3076

bks@fdncenter.org

Grantmakers in Aging, Inc.

\$6,500

General Support

John Feather, Ph.D.

Chief Executive Officer

2001 Jefferson Davis Highway, Suite 504

Arlington, VA 22202

jfeather@giaging.org

Grantmakers In Health

\$15,000

General Support

Lauren LeRoy, Ph.D.

President and Chief Executive Officer

1100 Connecticut Avenue, NW, Suite 1200

Washington, DC 20036

lleroy@gih.org

Grants Managers Network, Inc.

\$2,500

General Support

Michelle Greanias

Executive Director

1666 K Street, NW, Suite 440

Washington, DC 20006

mgreanias@gmnetwork.org

International Society for Quality in Health Care, Inc.

\$1,300

General Support

Roisin Boland

Chief Executive Officer

2 Parnell Square East

Dublin 00001

Ireland

rboland@isqua.org

Nonprofit Coordinating Committee of New York

\$35,000

General Support

Michael Clark

President

1350 Broadway, Suite 1801

New York, NY 10018-7802

mclark@npccny.org

Philanthropy New York

\$18,100

General Support

Ronna Brown

President

1350 Broadway, Suite 1801

New York, NY 10003-3076

rbrown@philanthropynewyork.org

Rockefeller Archive Center and Internet Archive

\$85,000 and \$5,000

Transfer and Maintenance of The Commonwealth Fund's Archives, Year 16

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. This grant will also fund Internet Archive for one year of archiving services for the Fund's main Web site and its provider-focused quality improvement site, WhyNotTheBest.org.

Lee Hiltzik, Ph.D.

Assistant Director and Head of Donor Relations and Collection Development

15 Dayton Avenue

Sleepy Hollow, NY 10591-1598

lhiltzik@rockarch.org

Rick Prelinger

Board President

300 Funston Avenue

San Francisco, CA 94118

rick@archive.org

Friends of the Woodlawn Cemetery, Inc.

\$400,000

Restoration of the Harkness Family Mausoleum at Woodlawn Cemetery

On June 30, 2011, Woodlawn Cemetery in Bronx, New York was designated a National Historic Landmark, based on the 150-year-old institution's status as one of the nation's finest examples of a 19th-century garden cemetery. The Edward S. and Mary S. Harkness Mausoleum at Woodlawn, designed by world-class architect James Gamble Rogers and constructed in 1926, is one of the cemetery's most distinguished structures, but after 85 years requires a major restoration. The work will assist Woodlawn's efforts to promote needed restoration of its historic structures and promote the

Cemetery's use as a major New York City public space. This work advances the Fund's long-standing interest in improving the quality of life in New York City through support of strong maintenance and preservation of public spaces.

Susan Olsen
Director of Historical Services
Webster Avenue & East 233rd Street
Bronx, NY 10470
solsen@thewoodlawncemetery.org

Small Grants—Special Opportunities

The Commonwealth Fund

\$32,950

Performance Assessment and Grants Monitoring: Contracts to Support The Commonwealth Fund Performance Scorecard and Grants Monitoring Activities

Andrea Landes
Vice President, Grants Management
One East 75th Street
New York, NY 10021
acl@cmwf.org

Greater New York Hospital Association

\$1,200

23rd Annual Symposium on Health Care Services in New York: Research and Practice

Tim Johnson
Executive Director
555 West 57th Street, 15th Floor
New York, NY 10019
tjohnson@gnyha.org

National Medical Fellowships

\$15,000

National Medical Fellowships Annual Gala, 2012

Esther Dyer, D.L.S..
President and CEO
347 Fifth Avenue, Suite 510
New York, NY 10016-5007
erdyer@nmfonline.org

New York Academy of Medicine

\$25,000

The Margaret E. Mahoney Fellowship Program

\$2,000

New York Academy of Medicine's 17th Annual Gala

Jo Ivey Boufford, M.D.

President

1216 Fifth Avenue

New York, NY 10029-5293

jboufford@nyam.org

New York eHealth Collaborative

\$2,500

2011 NYeC Gala Sponsorship

David Whitlinger

Executive Director

40 Worth Street, 5th Floor

New York, NY 10013-2988

dwhitlinger@nyehealth.org

Primary Care Development Corporation

\$6,000

Primary Care Development Corporation 2012 Annual Spring Gala

Ronda Kotelchuck

Executive Director

22 Cortlandt Street, 12th Floor

New York, NY 10007

rkotelchuck@pcdcny.org

United Hospital Fund of New York

\$10,000

2011 United Hospital Fund Gala

\$25,000

2012 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, 2012

| | Major Program Grants | Small Grants Fund Grants | Total Authorizations |
|---|----------------------|--------------------------|----------------------|
| Program Grants Approved | | | |
| Delivery System Innovation and Improvement | \$7,861,922 | \$801,593 | \$8,663,515 |
| Health System Quality and Efficiency (see note 1) | \$2,301,983 | \$198,619 | \$2,500,602 |
| Patient-Centered Coordinated Care | \$2,602,874 | \$131,813 | \$2,734,687 |
| Vulnerable Populations | \$884,554 | \$180,663 | \$1,065,217 |
| Mongan Commonwealth Fund Fellowship in Minority Health Policy | \$800,000 | \$0 | \$800,000 |
| Picker/Commonwealth Long-Term Care Quality Improvement Program (see notes 2 and 3) | \$1,272,511 | \$290,498 | \$1,563,009 |
| Health Reform Policy | \$3,499,118 | \$456,542 | \$3,955,660 |
| Affordable Health Insurance | \$1,269,423 | \$243,469 | \$1,512,892 |
| Payment and System Reform | \$894,958 | \$63,267 | \$958,225 |
| Policy Development and Convening | \$1,334,737 | \$149,806 | \$1,484,543 |
| Health System Performance Assessment and Tracking | \$1,295,630 | \$45,000 | \$1,340,630 |
| International Program in Health Policy and Innovation | \$2,855,135 | \$235,902 | \$3,091,037 |
| Communications | \$1,551,939 | \$134,506 | \$1,686,445 |
| Organizations Working with Foundations and Institutional Support | \$936,080 | \$119,650 | \$1,055,730 |
| Total Program Grants Approved | \$17,999,824 | \$1,793,193 | \$19,793,017 |
| Grants Matching Gifts by Directors and Staff | | | \$458,312 |
| Program Authorizations Cancelled or Refunded and Royalties Received | | | (\$343,755) |
| Total Program Authorizations | | | \$19,907,574 |

NOTES:

(1) Frances Cooke Macgregor Award of \$194,931 in 2011–12.

(2) Picker Program Grants totaled \$1,563,009 in 2011–12.

(3) Health Services Improvement Award of \$318,084 in 2011–12.