

# exploring







# exploring

## vision statement

We envision continual improvement in people's health as a result of research being converted to practical benefit.

## mission statement

We will be an imaginative, collaborative and engaged participant in the process that begins with rigorous health research and ends in realized health benefits and by doing so give the vision of Ethel Donaghue its best expression.

## goals

1. Promote knowledge uptake of health research into the realms of healthcare delivery, practice, and policy.
2. Advance the Foundation's mission by collaborating with people and organizations that have the opportunity and responsibility to improve health.
3. Ensure that our grantmaking programs are structured to support rigorous research that more directly leads to a positive impact on health.
4. Identify and support researchers and organizations whose work encompasses the principles of knowledge uptake.
5. Build networks and collaborations to test innovative ideas related to grantmaking and health research.
6. Contribute to efforts, both internal and external to the research enterprise, that optimize the capacity of health research to address the needs of policymakers, practitioners, and consumers.

## values

Steadfast in our commitment  
Principled and practical  
Engaged to the point of effect  
Respectful and reflective





from the trustees



Lynne Garner, PhD  
President and Trustee



Amy R. Lynch, JD  
U.S. Trust, Bank of America, Trustee

Dear Friends,

The Foundation's Annual Report is an opportunity for us to reflect on the activities and accomplishments of the foundation over the past year. It is a welcome exercise where we examine and evaluate the various grant programs and discuss how they will influence what we strive for in 2018.

Toward the end of 2017, we began to question how to redefine The Donaghue Greater Value Portfolio Grant Program so that funded research could more closely align with potential users. After conversations with advisers, health services researchers and practice leaders, we decided to put greater focus on the connection between research and its application to improve health. This means that for 2018 we will be requesting some additional information from our applicants that is unique to this connection. We will also be changing the selection criteria for the review process.

We also began to investigate what more Donaghue could do for our grantees that would assist them in bringing their work to healthcare decision-makers. Our first activity in this direction was a symposium, sponsored through our partnership with the AAMC, to consider how electronic health records can be more useful to research across different healthcare and community settings. Our Linking Evidence and Practice program was also established to bridge between evidence creators and evidence users, but after five years and more than \$150,000 we decided to end the LEAP program.

By the end of 2017, Donaghue's Another Look - Improving Health for Elders in Care Facilities had provided \$3.2 million for stakeholder-engaged research studies. At the end of the 2018 award cycle,

we'll suspend the Another Look program for at least one year. During this time, we will review what we've learned as funders from the past seven years and will focus on ways Donaghue might bring the work of some of these scholars to wider audiences. A grant to the National Governor's Association Center for Best Practices in the summer of 2018 to help fund an expert roundtable on effective long-term care is a first step in this direction.

You'll find two other ideas that we're exploring in our twenty-sixth annual report. At the back is the Donaghue Journal, and in this year's issue we hear from three experts on using an anchor mission strategy to improve hospitals' local economies and the health status of community members. Also, we know you'll notice the data visualizations describing our four Greater Value Portfolio awards and the Another Look program. We've been a big fan of data viz even before our 2011 conference that focused on design thinking. The data visualizations come from a collaboration with HealthDataViz.com and Farrell Marketing & Design, and we are grateful to both of them for their talents and expertise as we developed this new direction for our annual report.

A handwritten signature in cursive script that reads "Lynne Garner".

Lynne Garner, PhD  
President and Trustee

A handwritten signature in cursive script that reads "Amy R. Lynch".

Amy R. Lynch, JD  
U.S. Trust, Bank of America, Trustee

## new awards

### another look

**Laura Hatfield, PhD**  
Harvard Medical School  
"Using Telemedicine to Reduce Hospital Transfers"

**Carolyn Thorpe, PhD**  
University of Pittsburgh  
"De-prescribing of Anti-dementia Medications"

### greater value portfolio

**Amol Navathe, MD, PhD**  
**Mitesh S. Patel, MD**  
The University of Pennsylvania  
"The REDUCE Trial Randomized trial of EHR Defaults and Using Social Comparison Feedback to Effectively Decrease Opioid Prescription Pill Burden"

**Jennifer Raymond, MD, MCR**  
Children's Hospital Los Angeles  
"CoYoT1 to California (CTC) – Telemedicine to Engage Young Adults with Diabetes"

**Karen Sepucha, PhD**  
Massachusetts General Hospital  
"Matching the Right Person to the Right Treatment: Shared decision making for high cost elective procedures"

**Peter Ubel, MD**  
Duke University  
"Examining Best Practices for Factoring Out-Of-Pocket Expenses into Patients' Health Care Decisions"

### R3 - 2nd opportunity award

**Leslie Curry, PhD**  
Yale School of Public Health  
"Translating 'Leadership Saves Lives' for Greater Impact"

**Patricia Folcarelli, RN, PhD**  
Beth Israel Deaconess Medical Center  
"Understanding Preventable Harm"

## continuation awards

### another look

**Kenneth Boockvar, MD, MS**  
The New Jewish Home Research Institute on Aging  
"Adverse Effects of Diuretics in Nursing Home Residents with Dementia"

**Carrie H. Colla, PhD**  
Dartmouth College  
"Transforming Nursing Home Care under the ACO Model"

**David Grabowski, PhD**  
Harvard University  
"Impact of Enhanced Primary Care in Nursing Homes"

**Donovan Maust, MD, MS**  
University of Michigan  
"Unintended Effects of Antipsychotic Reduction in Nursing Homes"

**Helena Temkin-Greener, PhD, MPH**  
University of Rochester  
"Improving the Quality of Mental Health in Nursing Homes"

### greater value portfolio

**Scott Halpern, MD, PhD**  
University of Pennsylvania  
"Behavioral Economics Approaches to Improve Palliative Care for Critically Ill Patients"

**Sophia Jan, MD, MSHP**  
The Feinstein Institute for Medical Research  
"Long Term Care Planning for Adults with Intellectual/Developmental Disabilities"  
Funded in partnership with the Rx Foundation

**Jeffrey T. Kullgren, MD, MPH**  
**Eve A. Kerr, MD, MPH**  
University of Michigan  
"Patient, Provider, and Health System Effects of Provider Commitments to Choosing Wisely"

**Valerie A. Lewis, PhD**  
Geisel School of Medicine at Dartmouth College  
"Demonstrating Methods to Integrate Clinical Care, Public Health, and Social Services with Value-Based Payment Models"

**Dale Ellen Lupu, PhD MPH**  
George Washington University  
"Implementing Shared-Decision Making with Chronic Kidney Disease: Testing its impact on improved quality of life and reduced health care costs"

**Ateev Mehrotra, MD, MPH**  
Harvard University  
"Just Google It: What is the Impact of Health Care Price Information Being More Accessible to Consumers?"

**David Meltzer, MD, PhD**  
University of Chicago  
"Longitudinal Effects of the Comprehensive Care Physician Program"

### funding partnerships

**Alexander Ommaya, DSc**  
Association of American Medical Colleges  
"Advancing Implementation Science in Community/Academic Partnered Research"

## history and purpose



**Ethel Donaghue**

The search for knowledge by Donaghue-funded scientists has been made possible by the vision of Ethel F. Donaghue, who died in 1989 without immediate family to inherit her wealth. Her father died in 1910 of heart disease when Ethel was only fourteen, and her mother succumbed to cancer in 1933. Spurred on by living through several family health problems and outliving her entire immediate family by over three decades, Miss Donaghue developed an abiding interest in health care and research. Her commitment to advancing health culminated in a trust devoting the bulk of her estate to The Patrick and Catherine Weldon Donaghue Medical Research Foundation, which honors the memory of her parents.

The testamentary intent of Ethel Donaghue is the immutable mandate for the Donaghue Foundation trustees. Miss Donaghue said in her will that her trustees should seek out useful health knowledge through research, and she gave them permission to undertake unusual and non-standard activities in furtherance of her purpose. Therefore, a frequent question in trustee discussions of policy and program design is "If she had the facts that we do today, what would Miss Donaghue do?"



The Patrick and Catherine Weldon Donaghue Medical Research Foundation is a charitable trust created pursuant to the will of Ethel F. Donaghue, late of West Hartford, Connecticut. The Foundation, which began operations in 1991, is governed by Bank of America, N.A. and Lynne Garner, PhD, Trustees. The Foundation is exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, is a private foundation within the meaning of Code Section 509(a), and is subject to the jurisdiction of the Probate Court for the District of West Hartford.



## program descriptions

**Another Look** – Better Health for Elders in Care Facilities provides funding for research programs that can improve the quality of care for the elderly population in nursing homes or other care facilities. Researchers must use data that already exists for their studies. In addition, grantees must work with a stakeholder from the care delivery or policy arena with whom they will either consult or collaborate to develop a research product that may readily be used to improve care.



**Greater Value Portfolio** supports research projects for three, four or five years that demonstrate or test new approaches to increasing the benefits of healthcare delivery to more people at an equivalent or reduced rate.



**R3 – Making Research Relevant & Ready** is designed to promote the knowledge gained from Donaghue-funded research so that it will improve health. This grant program recognizes that expertise from disciplines outside those traditionally eligible for research funding is needed for scaling, dissemination, and the sustainability of evidence-based program and practices. Donaghue grantees past and present are eligible for the R3 program and are welcome to contact the Donaghue office if they are interested in receiving an R3 award.



Through its **Linking Evidence and Practice** program, the Donaghue Foundation allocated funds to support initiatives by other organization whose work is aligned with the Donaghue mission. Through LEAP, Donaghue offered sponsorship support for events and programs that connect research evidence with leaders in healthcare policy and health systems, practitioners, patients and the public. The foundation ended the LEAP program in 2017 to provide opportunities more directly related to its research grantees.

**Funding Partnerships** – Donaghue works with other funders to leverage its resources on a variety of topics.



# greater value portfolio



The Donaghue Foundation believes value in health care is achieved with uniformly high quality outcomes and favorable patient experience for the money spent.

In alignment with this belief, **the Greater Value Portfolio** supports research that can be expected to develop actionable solutions to one or more of the symptoms of low value healthcare such as:

- High and rising healthcare costs
- Unacceptable variation in quality
- Unwarranted variation in prices
- A lack of transparency in both price and outcomes



**Amol Navathe, MD, PhD**  
**Mitesh S. Patel, MD**  
The University of Pennsylvania

Project Cost - \$593,108  
*The REDUCE Trial-Randomized Trial of EHR Defaults and Using Social Comparison Feedback to Effectively Decrease Opioid Prescription Pill Burden*



**Karen Sepucha, PhD**  
Massachusetts General Hospital

Project Cost - \$599,997  
*Matching the Right Person to the Right Treatment: Shared decision making for high cost elective procedures*



**Peter Ubel, MD**  
Duke University

Project Cost - \$599,862  
*Examining Best Practices for Factoring Out-Of-Pocket Expenses into Patients' Health Care Decisions*



**Jennifer Raymond, MD, MCR**  
Children's Hospital  
Los Angeles

Project Cost - \$590,701  
*CoYoT1 to California (CTC) – Telemedicine to Engage Young Adults with Diabetes*



# Greater Value Portfolio Research Spotlight

## OPIOID ABUSE AND PHYSICIAN PRACTICE PATTERNS

Co-Principal Investigators: Amol Navathe, MD, PhD, and Mitesh S. Patel, MD, MBA, University of Pennsylvania



### Contribution to Improve Value

This project examines an approach to changing prescribing practice for a medication with potential harm.

### About This Project

A three-year grant totaling **\$593,108** was awarded to Amol Navathe, MD, PhD and Mitesh S. Patel, MD, MBA of the University of Pennsylvania to conduct a pragmatic, randomized, controlled trial that will evaluate the effect of two behavioral economic approaches on changing physician opioid prescribing.

# 91 x 365

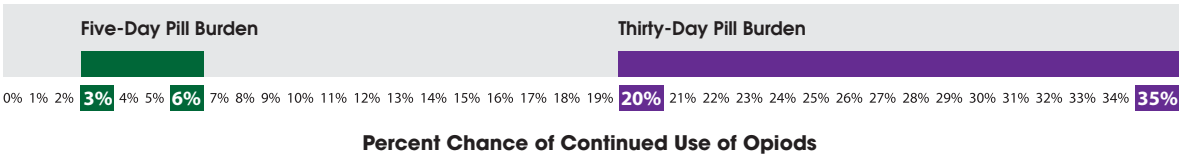
At present, drug overdose is the leading cause of injury-related death in the United States, with **91 Americans dying from opioid-related overdoses each day.**



### The Problem

Physician behavior and prescription patterns have played a particularly important role in the genesis and acceleration of the opioid epidemic in the United States. Over the last two decades, the number of opioid prescriptions has quadrupled, and drug overdose deaths due to prescription opioids have more than tripled.

Of particular interest is the pill burden, that is, the number of days a prescription covers. The higher the pill burden in an individual opioid prescription, the more likely it is that a patient will continue to use opioids at one and three years. For example, a 5-day prescription leads to a 3 - 6% chance of continued use, while a 30-day prescription leads to a 20 - 35% chance of continued use. **Physicians who are higher-intensity opioid prescribers are more likely to have patients who use opioids for longer durations.**



### Project Approach

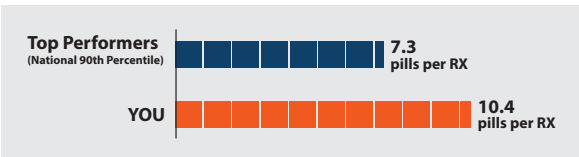
The trial will be conducted at 58 sites throughout Sutter Health System, focusing on new opioid prescriptions for higher volume, lower acuity conditions (e.g., acute joint sprains or back spasms) in emergency or urgent care settings.

#### • Status Quo Bias

The researchers will evaluate the impact of setting default opioid prescription options in the electronic health record. This evaluation addresses *status quo bias* — the tendency to follow the path of least resistance, in particular selecting the default option in an EHR.

#### • Relative Social Ranking

The researchers will evaluate the impact of providing social comparison feedback on opioid prescribing behaviors to physicians. This approach leverages the *relative social ranking* principle — the tendency for individuals to change behavior based on social norms and status.



#### • Evaluation of Approach

The researchers will evaluate the individual and combined effect of these approaches and their impact on reducing acute pain.

**You Prescribe MORE Pills Per Prescription Than Top Performers**

#### • Translating Research to Practice

The researchers propose to scale successful interventions across the entire network of the participating health care system and to broadly disseminate findings in an effort to transform prescribing patterns for opioids nationwide.



# Greater Value Portfolio Research Spotlight

## MATCHING THE RIGHT PERSON TO THE RIGHT TREATMENT: SHARED DECISION MAKING FOR HIGH COST ELECTIVE SURGERIES

Principal Investigator: Karen Sepucha, PhD, Massachusetts General Hospital



### Contribution to Improve Value

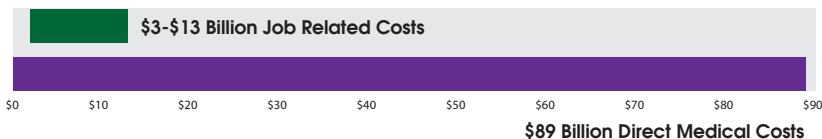
The study will explore using routine measurement of shared decision making to motivate administrators and practitioners to engage patients and improve the quality of surgical decisions.

### About This Project

A three-year grant totaling **\$599,997** was awarded to Karen Sepucha, PhD, of Massachusetts General Hospital to conduct research about the impact of shared decision making on four, high cost, elective orthopaedic procedures. The key objective of this project is to study if patient decision aids and measures of patient reported outcome measures will help providers to assess whether the right person is matched with the right treatment and, subsequently, move toward higher-value patient-centered care.

### The Problem

Osteoarthritis and low back pain are the two leading causes of disability in the U.S. These musculoskeletal problems present a considerable economic burden and result in \$89 billion in direct medical costs and estimated job-related costs ranging from \$3-\$13 billion for osteoarthritis alone.



Surgery is a common treatment for these conditions, and more than 1,000,000 hip and knee replacements were performed in 2010 in the U.S. For elective surgical procedures, such as total joint replacement and spine surgery, these procedures should only be done when patients meet clinical criteria and have a clear, well-informed preference for it. A mismatch between the treatment received and patients' preferences has been called a "preference misdiagnosis." Studies suggest up to 20-30% of elective surgical patients may have a preference misdiagnosis, and this may indicate a serious medical error — namely, operating on a patient who did not want the procedure (akin to operating on the wrong side). These errors are evidence of low value care and may result in increased costs, reduced safety, and worse health outcomes.

In 2010 there were more than 1 million hip and knee replacements procedures. Of those, it is estimated that as many as 300 thousand may have a patient preference misdiagnosis.



### Project Approach

This project is primarily focused on measurement — implementing new measures to assess the extent to which patients are involved, informed, and have a clear preference for surgery and on patients' satisfaction and functionality after surgery.

### Assess Quality of Shared Decision Making

The project team will conduct a survey across four hospitals to examine the quality of elective surgical decisions for hip and knee osteoarthritis, lumbar herniated disc, and spinal stenosis, including whether the patient received decision aids.

### Identify and Disseminate Best Practices

Patients, clinicians and administrators will be engaged to examine the data and to identify high performers with best practices. They will then work with advisers to encourage the adoption of best practices across the network.

### Re-assess Shared Decision Making Quality

Use of patient decision aids and shared decision making will be assessed with a new sample of patients undergoing the same procedures to examine whether the project resulted in measurable improvements in value.

### Translating Research Into Practice

The researchers have selected National Quality Forum endorsed measures for use in this project because they are publicly available and will qualify for many performance-based payment initiatives. The team also plans to develop case studies for clinicians to learn how shared decision making can help improve patient outcomes. Finally, presentations and papers will be delivered at high-visibility conferences to disseminate the results of this study.

# Greater Value Portfolio Research Spotlight

## EXAMINING BEST PRACTICES FOR FACTORING OUT-OF-POCKET EXPENSES INTO PATIENTS' HEALTH CARE DECISIONS

Peter Ubel, MD, Duke University



### Contribution to Improve Value

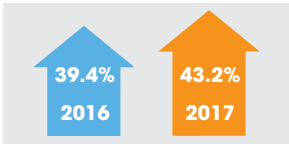
This study examines approaches to encourage physicians and their patients who have a serious illness to engage in difficult conversations about preferences and trade-offs related to the cost of care.

### About This Project

A three-year grant totaling **\$599,862** was awarded to Peter Ubel, MD, at the Fuqua School of Business, Duke University to examine best practices for difficult cost conversations between physicians and patients. The focus of the study will be on patients with a serious illness who are experiencing financial distress from healthcare costs.

### The Problem

In recent years, an increasing number of Americans have enrolled in health insurance plans that carry high out-of-pocket expenses (e.g. copays and deductibles). According to U.S. national data, the percentage of adults under the age of 65 who were in high-deductible plans rose from 39.4 percent in 2016 to 43.2 percent in 2017.



In theory, such costs are supposed to incentivize patients to scrutinize the cost and quality of their healthcare alternatives. Unfortunately, patients often do not learn about their out-of-pocket expenses in time to inform their healthcare choices. One result of this situation is that in 2015 1 in 5 Americans reported being unable to pay medical bills on time.



**1 in 5 Americans** reported being unable to pay medical bills on time.

Additional adverse outcomes, such as poor medical adherence, poor quality of care and poor life outcomes, also often occur. And although experts recommend and most patients want to discuss this information, a retrospective analysis of dialogue from 1,755 outpatient visits in community-based practices nationwide from 2010 to 2014 found that only 30% of visits included costs conversations. Of those visits that included a conversation about the cost of treatment, only 45% discussed cost saving strategies.



Time constraints and a lack of viable cost-saving solutions are the two factors most frequently cited by physicians as barriers to having these conversations.

### Project Approach

The goal of this research project is to work with 40 physicians who are explicitly attempting to hold productive cost conversations with their seriously ill patients (patients diagnosed with advanced cancer, multiple sclerosis, rheumatoid arthritis, or major depression). By observing and analyzing their experiences, the researchers plan to identify and examine best practices for how to discuss out-of-pocket expenses with patients during clinical interactions in ways that inform their healthcare choices.

### Audio Recordings

Audio recordings of three clinical interactions will be made for each of the 40 participating physicians with subsequent patient and physician interviews to explore their perceptions of how they factored out-of-pocket decisions into their medical decision-making. The researchers will provide physicians with a primer of potential ways to discuss out-of-pocket costs with patients. Physician coaching sessions to review the three recorded clinical encounters will follow this. Then three additional audio recordings will be made of clinical interactions during which cost and clinical decisions will be made. Surveys and interviews will again be conducted with the participating physicians and patients.

### Evaluation of Approach

The project team will develop descriptive analyses that will include both quantitative (such as who initiated the cost conversation and how many alternative treatments were discussed) and qualitative elements (such as descriptive observations about behaviors). Additional analysis will be performed to understand any discrepancies between the patient and the physician's report of their communication, and researchers will look for instances of particularly effective or ineffective cost conversations as determined by both physicians and patients.

### Translating Research Into Practice

The project team will disseminate the results of this project through presentations at conferences and articles in leading publications as well as develop a discussion guide to help clinicians discuss out-of-pocket expenses with patients so that they may make more informed medical decisions.



# Greater Value Portfolio Research Spotlight

## COYOT1 TO CALIFORNIA – TELEMEDICINE TO ENGAGE YOUNG ADULTS WITH DIABETES

Principal Investigator: Jennifer Raymond, MD, MCR Children’s Hospital Los Angeles



### Contribution to Improve Value

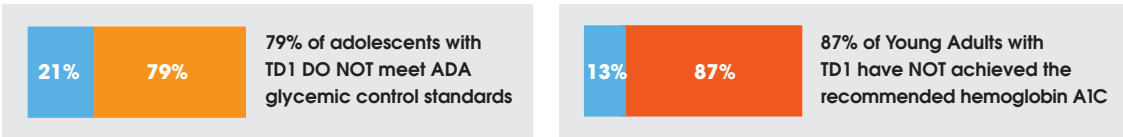
This project studies whether a promising, inexpensive yet currently underused clinical intervention shown to improve outcomes can be effectively expanded to a population with high barriers to care.

### About This Project

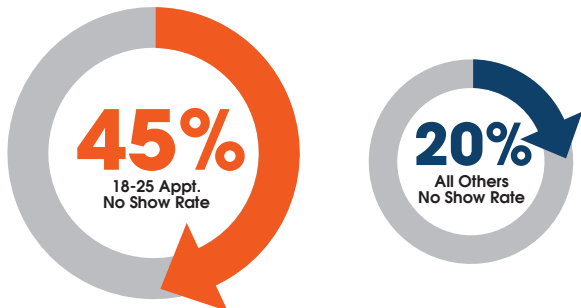
A three-year grant totaling **\$590,699** was awarded to Jennifer Raymond, MD, at the Children’s Hospital Los Angeles (CHLA) to conduct a study aimed at increasing access to care, improving follow-up frequency, and strengthening patient satisfaction in high-risk young adults with Type 1 Diabetes (T1D). The goal of this project is to adapt the successful Colorado Young Adults with T1D (CoYoT1) clinic model, which combines telemedicine and shared medical appointments, to better care for this population and improve their health outcomes.

### The Problem

More than 13,000 children are diagnosed with T1D each year but only 21% of adolescents with T1D meet the American Diabetes Association (ADA) glycemic control standards. Additionally, according to T1D Exchange, only 13% of young adults achieve the recommended hemoglobin A1c value.

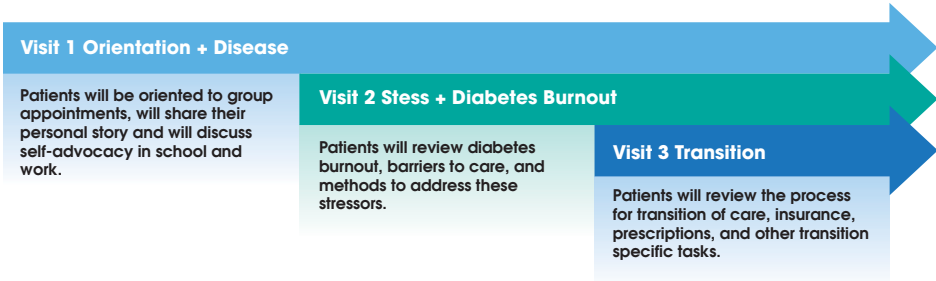


Recent research has found that young adults who have had two or more provider visits in a year have fewer visits to the emergency department. At CHLA, however, patients between 18 and 25 years old and with diabetes have a 45% no show rate, compared to 20% in other clinic patients. An alternative model is needed to improve engagement in clinical care among young adults with T1D. This model must address barriers to attending appointments, such as transportation, and missed time from work and school.



### Project Approach

The primary objective of this study is to adapt an empirically-supported, cost-effective, efficient, yet underutilized intervention to a low SES, ethnically diverse, urban population who frequently encounters barriers to successful diabetes management. The researchers will recruit patients age 18-25 from those already receiving care at CHLA for T1D. Data on social determinants of health and barriers to successful diabetes care will be analyzed. The Colorado Young Adults with Type 1 Diabetes - CoYoT1 - clinical care delivery model will be modified based upon these barriers to successful diabetes care in the CHLA population. One component of this adaptation will be group telemedicine, where the following proposed topics, among others, will be discussed.



### Evaluation of Approach

The researchers will evaluate feasibility and acceptability by patients and providers; glycemic control, and cost-benefit of the refined clinical care model in a pilot, randomized controlled trial.

### Translating Research Into Practice

The dissemination of data and project results will be critical to informing the design of similar interventions and programs for other patients and age groups with diabetes.



## another look



**Laura Hatfield, PhD**  
Harvard School of  
Medicine

\$125,672  
*Using Telemedicine  
to Reduce Hospital  
Transfers*

Does providing access to physicians via video reduce unnecessary emergency room visits for residents of independent living communities? A natural experiment will compare the rate of ED transfers and hospital admissions in the intervention community before and after the introduction of telemedicine over the same period in two other communities.



**Carolyn Thorpe, PhD, MPH**  
University of Pittsburgh  
School of Pharmacy

\$124,892  
*De-prescribing of  
Anti-dementia  
Medications*

Information from Medicare claims and resident assessments will be used to follow a national cohort of fee-for-service beneficiaries with advanced dementia residing in nursing homes. Whether de-prescribing of AchEIs is associated with increased risks, including increases in behavioral symptoms and other negative events, as well as effects on polypharmacy and reduction of potentially inappropriate medications will be examined.

### Another Look Grant Award Summary By Topic 2013 - 2017

**Models of Care Delivery and Payment:  
Effects on quality/outcomes/cost**

**\$1,216,193**

**Medication Effects and Consequences:  
Dementia and Delirium**

**\$801,297**

**Assessing and Improving Quality for Elders with  
Behavioral Mental Health challenges  
(including Dementia)**

**\$548,700**

**Improving Care and Decisions at the  
End of Life**

**\$357,361**

**Approaches to achieve Person-Centered Care:  
Engage Elders, Family and Staff**

**\$353,955**



## making research relevant & ready

R3

**Leslie Curry, PhD**  
Yale School of  
Public Health

\$55,000  
*Translating "Leadership  
Saves Lives" for  
Greater Impact*

This R3 award will continue a long-term collaboration with the American College of Cardiology to leverage, provide additional resources and disseminate Leadership Saves Lives tools to hospitals seeking to improve outcomes for patients with acute myocardial infarction.



**Patricia Focarelli, RN, PhD**  
Beth Israel Deaconess  
Medical Center

\$55,000  
*Understanding Preventable  
Harm*

Working with a leading expert in industry safety and risk education, BIDMC will study new approaches to their current processes for detecting, analyzing and mitigating physical and emotional harm in order to achieve greater results. Elements of the project include identifying key barriers to deploying novel methods for mitigating harm and visiting an organization outside of health care in an ultra-safe industry to learn how their methods are implemented.

## linking evidence and practice



### Prevention Partners

\$5,000

*Healthy Together NC Prevention Academy*

A convening of employers, state and county government officials, community colleges, schools, and others to learn about and share best practices for obesity and tobacco prevention in the workplace.

### Optimus Health Care

\$4,000

*Linking Evidence and Practice: Report to the  
Community: Managing Your Health*

Presentations at community meetings, patient focus groups, local health departments, community health groups and pharmacies to inform the healthcare community and the public about successful efforts to decrease the potential risk of hypertension and heart-related disease among African-American males.

### Research!America

\$10,000

*Investment Report – 12th Edition*

This report provides an analysis of U.S. spending on biomedical research and development and changes in spending over time. This edition includes a section focusing on health services research

highlighting who does this research and why it is so important to our health system. The report provides an important resource for policymakers and stakeholders when analyzing budget and policy options.

### Yale Department of Psychiatry

\$5,000

*Neuroscience 2017: Paths to Recovery*

This annual symposium aimed at mental health professionals, consumers, and families throughout the State of Connecticut highlights recent advances in neuroscience that may lead to improvements in the diagnosis, treatment and prevention of mental illness.

### Yale School of Management

\$500

*2017 Yale Health Care Conference, "Improving  
Health and Healthcare: Bridging Society and  
Industry Interests."*

This annual student run conference is a joint effort between the Yale School of Management and the Health Professional Schools at Yale University that brings together professionals, scholars, and students to engage in an instructive conversation concerning current healthcare issues.

## advisory committees

### policy advisory committee

**Carrie Brady, JD**

Principal  
CBrady Consulting & Possibilities Farm

**Carol Buckheit, MS**

Director of Communications  
Connecticut Community Foundation

**Heather Crockett-Miller, DDS, MPH**

Director of Dental Service  
Equitas Health

**Jean Larson, MBA**

Education and Community Outreach  
Manager, Yale University Human  
Investigation Committee (retired)

**Katie Martin, PhD**

Vice President and Chief Strategy Officer  
Foodshare

**Marie Massaro**

Principal  
Massaro Consulting

**Patrick McKenna, AIA**

Project Manager  
Community Solutions Northeast Hartford  
Partnership

**Russell Munson, MD**

Connecticut Medical Director  
Harvard Pilgrim Health Care

**Michelle Spoto**

Student  
University of Connecticut Schools of  
Dentistry and Medicine

**Thomas Van Hoof, MD, EdD**

Associate Professor  
University Connecticut Schools of Nursing  
and Medicine

**Erin M. White, MS**

Student  
Frank H. Netter MD School of Medicine at  
Quinnipiac University

**Lawrence Young, MPH**

Community Engagement and Research  
Coordinator  
Curtis D. Robinson Center for Health  
Equity, Saint Francis Hospital

### another look

**Haim Y. Bar, PhD**

Assistant Professor, Department of  
Statistics  
University of Connecticut

**Lisa Barry, PhD, MPH**

Assistant Professor, Psychiatry  
University of Connecticut Center on Aging

**Randi Berkowitz, MD**

Medical Director for Accountable  
Communities  
MassHealth

**Eilon Caspi, PhD**

Gerontologist & Dementia Behavior  
Specialist  
Dementia Behavior Consulting, LLC

**Leslie Curry, PhD, MPH**

Senior Research Scientist in Public Health  
(Health Policy)  
Co-Director, Robert Wood Johnson  
Clinical Scholars Program  
Yale University School of Public Health

**David M. Dosa, MD, MPH**

Associate Professor of Medicine and  
Health Services, Policy and Practice  
Brown University

**Mary Jane Koren, MD, MPH**

John A. Hartford Foundation  
The Commonwealth Fund, retired

**Stephen Lepowsky, DDS**

Associate Professor  
University of Connecticut School of Dental  
Medicine

**Julie T. Robison, PhD**

Associate Professor of Medicine  
University of Connecticut Center on Aging

**Jennifer Tjia, MD**

Associate Professor  
University of Massachusetts Medical  
School

**Stephen Walsh, ScD**

Associate Professor, School of Nursing  
University of Connecticut

**Emily Wilson, MS**

Geospatial Educator  
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### greater value portfolio

**Anne-Marie Audet, MD**

Vice President Quality Institute  
United Hospital Fund

**Haim Y. Bar, PhD**

Assistant Professor, Department of  
Statistics  
University of Connecticut

**Ann Bonham, PhD**

Former Chief Scientific Officer  
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**Diana Buist, PhD**

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**Emil Coman, PhD**

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**Jessica Greene, PhD**

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**Jack Hoadley, PhD**

Professor, Health Policy Institute  
Georgetown University

**Peter Hussey, PhD**

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RAND

**Stephen Walsh, ScD**

Associate Professor, School of Nursing  
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### R3 - making research relevant & ready

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Mentor-In-Residence, Yale Center for  
Innovative Thinking  
Venture Partner, LaunchCapital

**Marie Massaro**

Principal  
Massaro Consulting

**Veronica Nieva, PhD**

Vice President  
Westat

**Laurel Pickering, MPH**

Chief Revenue Officer  
WellDoc, Inc.

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Senior Vice President, Physician  
Relations  
OptumCare

**Eleanor L. Tandler**

Executive in Residence  
Connecticut Innovations

**Julio Urbina, PhD, MPH**

Vice President  
Samuels Foundation



financials

Investment in marketable securities	\$66,604,909
Cash and cash equivalent	\$ 185,701
Other assets	\$ 9,594
Total assets and fund balance	\$66,800,204
Income	\$ 1,327,030
Expenditures	
Program	
Grants	
Another Look - Better Health for Elders in Care Facilities	\$ 525,512
Funding Partnerships	\$ 231,180
Greater Value Portfolio	\$ 2,216,207
R3 - Making Research Relevant & Ready	\$ 110,000
Linking Evidence and Practice	\$ 24,500
Subtotal	\$ 3,107,399
Program support and Foundation-administered projects	\$ 206,874
Management and General	\$ 609,248
Investment Management	\$ 263,673
Total Expenditures	\$ 4,187,195

Note: In addition to these expenditures, an estimated amount of up to \$2,270,201 has been earmarked for future spending in support of ongoing grants.

The figures listed above are unaudited. Fair market values are approximate.

funds awarded by grant program for grant cycle

Another Look	
New (2)	\$ 152,678
Continuing (5)	\$ 372,834

Funding Partnerships	
New (0)	
Continuing (1)	\$ 231,180

Greater Value Portfolio	
New (5)	\$1,051,904
Continuing (7)	\$1,164,303

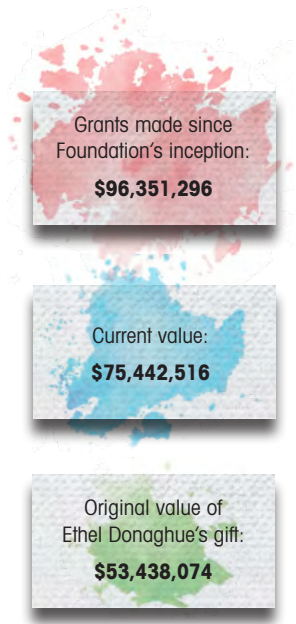
R3 – Making Research Relevant & Ready	
New (2)	\$ 110,000
Continuing (0)	

linking evidence and practice

New (5)	\$ 24,500
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research grants

Institution	New	Continuation	Total
Association of American Medical Colleges		1	1
Beth Israel Deaconess Medical Center	1		1
Children’s Hospital of Los Angeles	1		1
Duke University	1		1
Feinstein Institute for Medical Research		1	1
Dartmouth University		2	2
George Washington University		1	1
Harvard University	2	2	4
Massachusetts General Hospital	1		1
Fund for the Aged, Inc.		1	1
University of Chicago		1	1
University of Michigan		2	2
University of Pennsylvania	1	1	2
University of Pittsburgh	1		1
University of Rochester		1	1
Yale University School of Medicine	1		1
	9	13	22



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Building Community Wealth:  
Healthcare's Role in Addressing Economic Determinants

*David Zuckerman*

Hospitals on West Side of Chicago Collectively  
Work on Anchor Mission Strategy

*Tricia Johnson, PhD*

Housing as a Health Improvement Strategy?

*Lauren A Taylor, MDiv, MPH*

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## A periodic collection of perspectives on issues important for medical research

This issue of the *Donaghue Journal* is devoted to anchor missions - the concept that an institution has the obligation to improve the community in which it is anchored. Typical anchor institutions are healthcare systems and universities (the “meds” and “eds”). Healthcare systems have a particular opportunity and urgency to use their business operations and investments to improve the economic vitality of their patients’ communities. Because poorer communities have a higher incidence of chronic diseases, tending to the social determinants of health is an effective way to reduce that health burden.

Three experts on anchor missions and their contribution to improving population health have agreed to share their ideas with the *Donaghue Journal*.

- **David Zuckerman** is Director of Healthcare Engagement at The Democracy Collaborative. He is the author of *Hospitals Building a Healthier Community: Embracing the Anchor Mission* and co-author, along with Katie Parker, of the *Hospitals Aligned for Healthy Communities* toolkit series. He directs the Healthcare Anchor Network, a national collaboration of more than 35 health systems.
- **Tricia Johnson** is Professor and Associate Chairperson of Education and Research in the Department of Health Systems Management, Rush University. Johnson is an economist who studies the underlying drivers of costs and quality in the healthcare system. She works with senior managers at Rush University Medical Center and other hospitals in the Chicago West Side to implement their anchor mission.
- **Lauren A. Taylor** is a doctoral candidate in health policy and management at Harvard Business School and a graduate of the Harvard Divinity School. With Elizabeth Bradley, PhD, she wrote *The American Health Care Paradox: Why Spending More is Getting Us Less*.



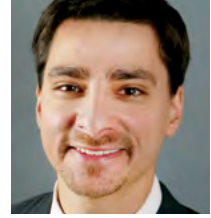
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# Building Community Wealth: Healthcare's Role in Addressing Economic Determinants

**David Zuckerman**

*Director, Healthcare Engagement  
The Democracy Collaborative*



As the systemic nature of economic inequities and their impact on health and well-being have become more widely acknowledged in the U.S., the need for a new way to address these growing disparities has become more urgent. At the Democracy Collaborative, we are focused on articulating a new approach to economic development called Community Wealth Building.

Key to the success of Community Wealth Building is engaging and leveraging the ongoing business activities of “anchor institutions,” such as hospitals and universities. These institutions have become the leading economic engines in many of America’s communities, and their mission, customer base, and place-based investments inextricably link them to the long-term vitality of the place they reside — they both anchor the local economy and are anchored in the communities they serve.<sup>i</sup>

In order to be truly sustainable over the long term and systemic in their impact, the Democracy Collaborative believes that anchor institutions must adopt a deep commitment to their communities at an institutional level. We call this approach the “Anchor Mission.” It goes beyond traditional notions of corporate social responsibility to rethink

the very foundation of the institution’s role and how it can *very intentionally* align, leverage, and deploy its economic and social assets in the community.

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*...The Democracy Collaborative believes that anchor institutions must adopt a deep commitment to their communities at an institutional level.*

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In the last few years, an increasing number of leading health systems have embraced an anchor mission. Rush University Medical Center on Chicago’s West Side is one powerful example — they have elevated this approach as a strategic priority and brought other local anchors into this work.<sup>ii</sup> Other healthcare institutions, like Kaiser Permanente, RWJBarnabas Health in New Jersey, and ProMedica in Toledo, Ohio have made similar commitments.<sup>iii</sup> On a national scale, this movement has driven the creation of the Healthcare Anchor Network, a growing health system-led collaboration of more than 30 health systems focused on improving health and well-being by building more inclusive and sustainable local economies. The Democracy Collaborative serves as the Network’s backbone, helping these institutions advance

an anchor mission internally, in partnership with their communities, and as leaders for the healthcare sector as a whole.<sup>iv</sup>

The challenges before us are systemic in nature. Our solutions must be equally bold if we are to meaningfully address the racial and economic disparities that limit us from achieving outcomes in health and well-being that are within reach. Anything less is an abdication of our individual and institutional moral responsibility, not to mention collectively economically short-sighted. We must change the conversation, develop new relationships, and establish new priorities. This can be achieved with a fundamental reorienting of the role anchor institutions play in our communities through their commitment to the Anchor Mission.

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<sup>i</sup>David Zuckerman and Katie Parker, *Hospitals Aligned for Healthy Communities*, Washington, DC: The Democracy Collaborative, 2017, [hospitaltoolkits.org](http://hospitaltoolkits.org), accessed November 2017.

<sup>ii</sup>Rush University Medical Center, *Anchor Mission Playbook*, Washington, DC: The Democracy Collaborative, August 2017, <https://www.rush.edu/sites/default/files/anchor-mission-playbook.pdf>, accessed November 2017.

<sup>iii</sup>Ted Howard and Tyler Norris, *Can Hospitals Heal America’s Communities?: “All in for Mission” is the Emerging Model for Impact*, Takoma Park, MD: The Democracy Collaborative, December 2015, <https://democracycollaborative.org/content/can-hospitals-heal-americas-communities-0>, accessed November 2017.

<sup>iv</sup>Healthcare Anchor Network, 2017, [healthcareanchor.network](http://healthcareanchor.network), accessed November 2017.

**Tricia Johnson, PhD**

Professor and Economist  
Department of Health  
Systems Management  
Rush University  
Chicago, IL

# Hospitals on West Side of Chicago Collectively Work on Anchor Mission Strategy

Hospitals and health systems have invested in community health benefits for many years, long before the Affordable Care Act began requiring hospitals to complete a community health needs assessment and improvement plans. Hospitals invest in many ways, such as providing charity care, providing community health programs, supporting community initiatives, research and education. However, in most communities these programs, while well-intentioned, have not dramatically moved the dial on global health measures, such as life expectancy, wellbeing or quality of life.

Tax-exempt hospitals spent approximately 8.1% of operating expenses on community health benefits in 2014, slightly more than was spent prior to ACA implementation in 2010.<sup>1</sup> The ACA has encouraged hospitals to more systematically evaluate the outcomes of these community programs. These organizations are recognizing that programs solely targeting access to and quality of health care are insufficient and that more intentional investments are needed. A holistic approach that addresses health care, education, employment and economic development, and neighborhood needs is needed.

The West Side of Chicago is home to approximately 480,000 individuals, a similar population as Miami, the 40th largest city

in the United States. West Side residents in some neighborhoods have a life expectancy of 69 years, comparable to life expectancy in India, ranked as 164th in the world.

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*West Side residents in some neighborhoods have a life expectancy of 69 years, comparable to life expectancy in India, ranked as 164th in the world.*

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Hospitals in Chicago's West Side have come together to develop and implement a collective "anchor mission strategy" that leverages business practices to improve health and economic vitality in the communities in which they reside. Hospital and health system leaders have committed to working together with the long-term aim of increasing life expectancy and reducing hardship, knowing this will require a decade or more of investments to realize improvements in health and economic vitality. Stakeholders from across the hospitals, representing human resources, supply chain, investments, community engagement and other areas, have been working together for more than a year to develop and implement key initiatives and a set of common metrics to measure success.

These hospitals are working together, as well as on their own specific anchor mission initiatives,

in several areas. The first is to hire locally and create career pathways for professional growth. Hospitals are partnering with community-based organizations to prepare individuals for entry-level positions and developing pathways for employment into high-demand, higher-earning jobs. The second area is local procurement, leveraging hospital's purchasing power on the West Side to buy locally, thereby stimulating local hiring by community vendors and broader economic development. Hospitals are also working together to make community "impact investments," such as community housing developments, that can have a long-lasting stimulus on economic development via job and community wealth creation.

An anchor mission strategy cannot depend on individuals to drive specific initiatives forward. Hospitals must hardwire the strategy into their overarching goals and link it to their mission, vision and values. Success depends on integrating hiring, procurement and investment goals into ongoing, day-to-day business practices. In this way, the commitment to improving health and economic vitality in our own local communities will be ingrained into the fabric of the organization itself.

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<sup>1</sup>Young GL, Flaherty S Zepeda ED, Rauscher Singh S, Rosen Cramer G. Community benefit spending by tax-exempt hospitals changed little after ACA. Health Affairs. 2018; 37(1):121-4.

# Housing as a Health Improvement Strategy?

**Lauren A Taylor, MDiv, MPH**

Doctoral Candidate,  
Harvard Business School



The evidence base for housing's influence on health is among the strongest of all of the social determinants of health. The hundreds of available studies on the topic can be conceptualized as supporting four pathways by which housing improves health or reduces health care utilization, described in greater detail in a recent Health Affairs brief.

- The first pathway is related to housing availability and stability and includes a series of papers demonstrating the health gains and, in a limited number of cases, cost savings associated with providing chronically homeless individuals and families with housing.
- The second pathway is related to the quality and safety of housing, a link commonly evidenced by a series of studies in which investments in the air quality of rental units (e.g. air purifiers, mold remediation, pest eradication) has been linked to significant health gains and cost reductions among asthmatic children.
- The third pathway is related to the health impacts of having (or not having) affordable housing, best seen in a handful of studies that demonstrate difficult choices individuals and families make to forego medical care and healthy behaviors in favor of securing a roof over head.

The hundreds of available studies on the topic can be conceptualized as supporting four pathways by which housing improves health.

- The final pathway relates to neighborhood characteristics on health, exemplified most famously by Raj Chetty and others' work on the federally-funded Moving to Opportunity program but also supported by several excellent studies of the impact of neighborhood violence and blighted spaces on health outcomes.

This evidence base has motivated some health systems to take notable action. In Orlando, Florida, Adventist Health System committed community benefit dollars to CFCH's Homeless Impact Fund, which among other things, provided housing and services for 100 chronically homeless families and individuals.<sup>i</sup> In Portland, Oregon six health systems and plans made a joint investment of \$21.5 million dollars to build new affordable housing in downtown Portland, complete with a medical clinic.<sup>ii</sup> In Boston, Massachusetts, Boston Medical Center announced a \$6.5 million dollar investment in affordable housing, including a combination of no-interest loans to local businesses, a fund by which the hospital will make grants to local housing-focused

organizations, and \$1 million to create a housing stabilization program for homeless individuals with complex medical problems.<sup>iii</sup>

Given how under-supplied low-income housing currently is in many of the nation's major metro areas, health care institutions' assistance in creating new avenues to stable housing is welcomed. That being said, policymakers should be careful about judging the value of housing solely in health care terms. While housing a homeless individual may reduce emergency department utilization, doing so may also create financial returns to the education system, the criminal justice system, and perhaps one day the tax base of a community. Given how expert health services researchers have become in measuring the benefits of improved housing on health, it can be tempting to take their calculations as the final word. Doing so would be a mistake. Many forms of housing investments have been evaluated as not producing positive financial returns to health care but these investments may well be worth making in pursuit of other social gains.

<sup>i</sup>Fazili, Sameera. Can Community Development Improve Health? Emerging Opportunities for Collaboration between the Health and Community Development Sectors. Federal Reserve Bank of Atlanta, Community and Economic Development Department. Discussion Paper 2017-3, December 2017.

<sup>ii</sup>Flaccus, Gillian. 6 Portland Health Providers to Give \$21.5 million for homeless housing. AP. September 23, 2016.

<sup>iii</sup>Boston Medical Center to Invest \$6.5 Million in Affordable Housing to Improve Community Health and Patient Outcomes, Reduce Medical Costs. Boston Medical Center Press Release. December 7, 2017.