



The Patrick and Catherine
Weldon Donaghue
Medical Research Foundation

2020 Annual Report
Number 29



Vision Statement:

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

Mission Statement:

The Donaghue Foundation supports rigorous health research that leads to realized health benefits and thereby gives the vision of Ethel Donaghue its best expression.

Donaghue strives to adhere to these Guiding Principles:

■ **Practical benefit**

The founder, Ethel Donaghue, directed that the funds support research that provides knowledge of practical benefit to improve health. We interpret this to mean that Donaghue-funded research studies should have the near-term potential to be adopted and implemented by policy-makers, practitioners and the public to improve health.

■ **Engagement**

Optimizing the capacity of research in a way that addresses the needs of policy makers, practitioners and the public requires more than simply providing financial resources. Therefore, we commit to continuous learning and actively working with others both internal and external to the research enterprise whose work connects with ours.

■ **Inclusivity**

To assure that research can meaningfully contribute to the achievement of optimal health for all, Donaghue will identify and welcome people from under-represented groups to engage as advisers and grantees and to incorporate the health concerns of diverse communities into grant portfolios. Donaghue will assess on an ongoing basis elements of grant programs that may unintentionally exacerbate health inequality.

■ **Integrity**

The integrity of grant-awarding programs is an essential responsibility for Donaghue as a research funder. Applicants, grantees, advisers and other colleagues must be assured that the selection, evaluation and oversight are equitable, based on expertise, transparent, accessible, and efficient.

■ **Innovation**

Donaghue will explore new ideas and be willing to test them for the purpose of advancing the Foundation's mission.





Lynne Garner, PhD
President and Trustee



Amy R. Lynch
Bank of America Trustee

Dear Friends,

Each year the Foundation’s annual report provides us with the opportunity to reflect on the Foundation’s activities and wider events. This year, the coronavirus pandemic changed our work routines, our home life, and the way we interacted with our colleagues and friends. It also brought much heartache and loss to so many.

Alongside with this loss, 2020 forced us to work in new ways. We learned to meet with our colleagues, advisers, and friends over WebEx or Zoom, and were welcomed into colleagues’ homes through these online calls. Dining rooms, rec rooms, and bedrooms became makeshift offices as people struggled to find space and bandwidth for everyone to have online access. Parents juggled meeting agendas to fit within their children’s classroom assignments. Pets and little ones became unofficial meeting participants — and they were missed when they skipped a meeting. This unprecedented transition to online was disruptive and challenging, but it also highlighted the resilience and adaptability of our colleagues and grantees and provided the opportunity to get to know each other in a more authentic way.

Although we didn’t make changes to our program that specifically addressed research regarding Covid-19, we funded several projects that centered on the pandemic. Some of these topics include the potential trauma to older adults when they need to be transferred resulting from Covid-19 in their facilities, employers’ effort to train and prepare staff during the pandemic, and the impact on value and access to low-resource populations from the rapid shift to telehealth. We were also pleased to be able to fund research that considered the role of equity in health and health care — an issue that was made undeniably visible in Covid-19 statistics.

We’d like to close with another reflection — that of gratitude. We are thankful for the assistance of all are advisers who make it possible for us to continue our mission. In addition, there are so many individuals who have worked hard during this past year and whose efforts kept us safe and healthy. We are grateful for all the essential workers — the grocery store workers, truck drivers and delivery people, public health officials, vaccine scientists, nurses, doctors, and so many more. *Thank you.*

Lynne Garner, PhD
President and Trustee

Amy R. Lynch
Bank of America Trustee



AWARDS

Another Look
NEW

Katherine Abbott, PhD
“The Impact of Person-Centered Care on Nursing Home Quality”
Miami University, Scripps Gerontology Center
Stakeholder organization: American Health Care Association/National Center for Assisted Living

Chiang-Hua Chang, PhD and Ana Montoya, MD
“Transfer Trauma in Nursing Home Long-Term Care Residents”
University of Michigan, Division of Geriatric & Palliative Medicine
Stakeholder organization: Michigan Department of Health and Human Services

Verena R. Cimarolli, PhD
“The Impact of COVID-19 in Nursing Homes”
Leading Age, LTSS Center @UMass Boston
Stakeholder organization: Wellspring Lutheran Services, WeCare ConnectTM

Francesca Falzarano, PhD
“Communication Among Family and Formal Caregivers”
Joan & Sanford I. Weill Medical College of Cornell University
Stakeholder organization: LeadingAge LTSS Center @UMass Boston

Helena Temkin-Greener, PhD, MPH
“End-of-Life Care in Assisted Living Communities”
University of Rochester
Stakeholder organization: American Health Care Association and National Center for Assisted Living

Kali Thomas, PhD
“Examining Disparities in Outcomes for Duals in Assisted Living”
Brown University
Stakeholder organization: National Association for Regulatory Administration

Jasmine Travers, PhD and Jason Falvers, PhD
“Neighborhood Socioeconomic Disadvantage and Nursing Home Outcomes”
New York University, Rory Meyers College of Nursing
Stakeholder organization: Leading Age

Diana L. White, PhD
“Multiple Views of Quality in Long Term Care”
Portland State University, Institute on Aging
Stakeholder organization: Department of Human Resources, Aging and People with Disabilities Division

CONTINUING

Thomas Gallagher, MD
University of Washington
“Promoting Safety by Adapting CANDOR to Eldercare Setting”
Stakeholder organizations: Collaborative for Accountability and Improvement and Arthur J. Gallagher & Co.

Greater Value Portfolio
NEW

Hannah Cohen-Cline, PhD
Providence Health & Services
“Does a Rising Tide Lift All Boats? Assessing the Direct and Indirect Effects of APMs in Primary Care”
Partner organization: Care Oregon

Megan Cole, PhD, MPH and June-Ho Kim, MD, MPH
Boston University School of Public Health
“Value and Equity of Telehealth for Low-Income Patients with Chronic Conditions at Federally Qualified Health Centers”
Partner organization: Community Care Cooperative

Sunitha Kaiser, MD
University of California, San Francisco
“The PIRCH Study: Pathways for Improving Respiratory Illness Care for Hospitalized Children”
Partner organization: Value in Inpatient Pediatrics

Fasika Woreta, MD
Johns Hopkins University School of Medicine
“Real-time Prescription Benefit Tools in the Electronic Health Record: Working towards greater value for prescribers and patients”
Partner organizations: Froedtert and Medical College of Wisconsin, Yale New Haven Health System, and Johns Hopkins Health System



AWARDS

CONTINUING

Laura Garabedian, PhD
Harvard Pilgrim Health Care
“Impact of an Innovative Joint Venture on Health Care Value”
Partner organization: Benevera Health

Sophia Jan, MD
Feinstein Institute for Medical Research
“Long Term Care and Future Planning for Adults with Intellectual or Developmental Disabilities”

Amol Navathe, MD, PhD and Mitesh S. Patel, MD, MBA
University of Pennsylvania
“The REDUCE Trial: Randomized trial of EHR Defaults and Using social Comparison feedback to Effectively decrease opioid prescription pill burden”

Malini Nijagal, MD, MPH and Courtney Lyles, PhD
University of California San Francisco Medical School
“The Use of Telemedicine to Achieve Higher Value Pregnancy Care for Low-income, Urban Women”
Partner organization: San Francisco Health Network

Jennifer Raymond, MD, MCR
Children Hospital of Los Angeles
“CoYoT1 to California (CTC) – Telemedicine to Engage Young Adults with Diabetes”

Scott Regenbogen, MD
The Regents of the University of Michigan
“Hospital Strategies for Success in Episode Based Hospitals”
Partner organization: Michigan Value Collaborative

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

Mary Tinetti, MD
Yale University
“Reducing Unwanted Care and Improving Outcomes”
Partner organization: Cleveland Clinic Center for Geriatric Medicine

Peter Ubel, MD
Duke University
“Examining Best Practices for Factoring Out-of-Pocket Expenses into Patients’ Health Care Decisions”

Kai Yeung, PhD
Kaiser Foundation Health Plan of Washington
“Value-based Formulary Essentials: Testing and Expanding on Value in Prescription Drug Benefit Design”
Partner organization: Premera Blue Cross

Opportunity Portfolio
NEW

Connecticut Health Advancement & Research Trust
Lunchtime Conversations
Exploring Issues Related to Covid-19 Crisis

The Hastings Center
Surprising Billing and the Erosion of Trust

Health Research Alliance
Support for 2020 Members Meeting

Institute for Clinical & Economic Review
Patient Engagement Program

Yale School of Public Health
Report of Climate Change & Health in Connecticut

CONTINUING

Association of American Medical Colleges
Assessment of Partnerships in the Greater Value Portfolio program

The Hastings Center
Expanded Ethics Scholarship and Engagement with Targeted Publics

Another Look: Research to Improve Health for Older Adults in Long Term Care Facilities

Provides funding for research that has the near term potential to improve quality for older adults living in long term care facilities. Researchers must use already existing datasets for the research being conducted and must include stakeholders from clinical, programmatic or policy arenas on their project team to help inform the research.

In 2020, Donaghue awarded over \$1.2 million for eight research studies from the Another Look: Research to Improve Health for Older Adults in Long Term Care Facilities program.



The Impact of Person-Centered Care on Nursing Home Quality

Katherine Abbott, PhD
Miami University, Scripps Gerontology Center

Stakeholder organization: American Health Care Association/National Center for Assisted Living

The Preferences for Everyday Living Inventory (PELI) is a tool that providers can use to learn about an individual's preferences and integrate that information into their personalized care plans. In 2015, the Ohio Department of Medicaid mandated that all Medicaid certified nursing homes use the PELI to enhance person-centered care. This mandate provides the opportunity to answer three key questions: Is use of the PELI a predictor of resident and family satisfaction; a predictor of clinical (e.g., pressure ulcers, falls) and care process outcomes (e.g., physical restraints, antipsychotic medication use); and is it a predictor of quality ratings (e.g., overall star rating, health inspection rating, staffing rating, quality rating, number of complaints).



Transfer Trauma in Nursing Home Long-Term Care Residents

Chiang-Hua Chang, PhD
and Ana Montoya, MD

University of Michigan, Division of Geriatric & Palliative Medicine

Stakeholder organization: Michigan Department of Health and Human Services

The COVID-19 pandemic has increased the urgency of addressing transfer trauma, the negative impact of transferring nursing home residents between different

facilities, as the creation of regional hubs may have increased transfers between facilities. Therefore, the research question for this study is whether there are adverse consequences of facility transfers that can be measured and monitored prospectively to prevent transfer trauma in the future. To answer this question, this study will use the Minimum Data Set data linked to Medicare data to identify transfers and to assess negative outcomes among nursing home long-term residents and to determine the impact of COVID-19 on these outcomes.



The Impact of COVID-19 in Nursing Homes

Verena R. Cimarolli, PhD
Leading Age, LTSS Center @UMass Boston

Stakeholder Organization: Wellspring Lutheran Services, WeCare ConnectTM

Nursing homes are currently facing an unprecedented crisis due to the rapid spread of COVID-19. Not only are nursing home residents and patients at risk for infection and death, but Certified Nursing Assistants (CNAs) who are on the frontlines providing hands-on care are also at risk for infection and death. The overall purpose of this 18-month cross-sectional study is to investigate the impact of COVID-19 on CNAs and nursing home residents and patients when taking into account employers' efforts to train and prepare CNAs for their work during COVID-19.



Communication Among Family and Formal Caregivers

Francesca Falzarano, PhD
Joan & Sanford I. Weill Medical College of Cornell University

Stakeholder organization: LeadingAge LTSS Center @UMass Boston

Considerable research has shown that better family-staff communication is associated with better resident quality of life and quality of care. However, it is unclear how this relationship generalizes to residents and family caregivers in assisted living facilities. Thus, this study will analyze data from a subsample of both nursing homes and assisted living facilities and their family caregivers to examine family caregivers' perceptions of aspects of communication (e.g., frequency, availability, helpfulness) with formal care providers and their influence on resident outcomes (e.g., health and psychosocial functioning).



End-of-Life Care in Assisted Living Communities

Helena Temkin-Greener, PhD, MPH
University of Rochester

Stakeholder organization: American

Health Care Association and National Center for Assisted Living

While assisted living residents wish to age in place, many experience frequent transitions across care settings at the end of life. To date, there have been no national-level studies of variations in end-of-life burdensome transitions in assisted living, and of their relationship with assisted living and state-level factors. This study will focus on the following research questions: 1) How frequent are burdensome EOL care transitions among assisted living residents and how do they vary across communities, counties and states? 2) What assisted living-level factors are associated with these transitions? 3) Is there an association between state assisted living regulations and EOL care transitions? 4) Is there an association between assisted living-level factors and state-level regulatory stringency and COVID-19 case prevalence and deaths among assisted living residents in selected states?



Examining Disparities in Outcomes for Duals in Assisted Living

Kali Thomas, PhD
Brown University

Stakeholder organization: National

Association for Regulatory Administration

Assisted living, a popular long-term care option for older adults needing personal care assistance, is increasingly serving a vulnerable population of low-income older adults dually-enrolled in Medicare and Medicaid. However, little is known about the needs of this population, the quality of care they are receiving, and how this varies across states and assisted living providers. This project will examine how state policies and provider behavior drive disparities in the health outcomes of dually eligible assisted living residents.



Neighborhood Socioeconomic Disadvantage and Nursing Home Outcomes

Jasmine Travers, PhD and Jason Falvers, PhD

New York University, Rory Meyers College of Nursing

Stakeholder organization: Leading Age

There is growing evidence that neighborhood-level factors, such as poverty, public transportation infrastructure, and housing quality, may influence both the quality and quantity of healthcare delivered to older adults. These factors are especially relevant for nursing home residents, for whom even small declines in health status could result in hospitalization or death. Our preliminary work suggests that nursing homes are disproportionately located in socioeconomically disadvantaged neighborhoods and may have worse infrastructure and more difficulty attracting and retaining staff. These relationships may contribute to health inequities. The goal of our study is to evaluate nursing home resident outcomes across degrees of neighborhood socioeconomic disadvantage.



Multiple Views of Quality in Long Term Care

Diana L. White, PhD

Portland State University, Institute on Aging

Stakeholder organization: Department of Human

Resources, Aging and People with Disabilities Division

Scholars increasingly view quality of life and quality of care as concepts that are mutually related, multidimensional, perspective-dependent, and context-dependent. A holistic approach to measuring quality is important because incongruent views by different actors have negative implications for service delivery and receipt. The project will use qualitative and quantitative secondary data to develop and test a measure of person-centered care from the perspective of residents. In addition to resident interviews, data were collected from administrators, direct care staff, nurses, and others. Additionally, administrative and regulatory data about participating organizations were collected.

The PIRCH Study: Pathways for Improving Respiratory Illness Care for Hospitalized Children

Sunitha Kaiser, MD

University of California, San Francisco

Partner Organization: Value in Inpatient Pediatrics

Contribution to Improved Value

Reduce routine treatments, tests, and screenings for patients for whom the potential harms, including financial harm, outweigh potential benefits

About This Project

Pathways are visual, step-by-step diagrams that are integrated into clinical workflows and are based on clinical guidelines. They have been shown to be easier to use than guidelines to improve care. Although most hospitals implement pathways for one medical condition at a time, a method for simultaneously implementing multiple pathways for multiple pediatric conditions has been successfully tested at an academic hospital. This intervention improved guideline adherence and decreased length of stay and costs. This project will test this new pathway in community hospitals, which care for more than 70% of children nationally.

The Problem

Asthma, pneumonia, and bronchiolitis are the top causes of childhood hospitalization in the U.S., leading to more than 350,000 hospitalizations and approximately \$2 billion in costs annually. Evidence-based clinical guidelines can be difficult to incorporate into practice, adding to poor adherence and poorer outcomes for children hospitalized with these respiratory illnesses. Poor adherence to guidelines also increases the administration of unnecessary treatments and tests and increases the risks of prolonged recovery time and stays, transfers to intensive care, and readmissions.

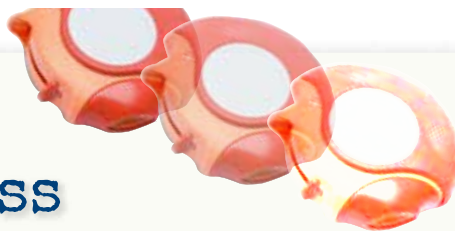
Project Approach

Pathways, usually accessed by paper or electronically, are visual, step-by-step diagrams that are integrated into clinical workflows and facilitate quick, easy guidance on evidence-based practices. The multi-condition pathway that is part of this study was developed and tested at a free-standing children's hospital that is part of a medical school. However, most hospital care for children is done in community hospitals. Thus, this study will test the pathway in 32 diverse community hospitals across the U.S. The test will determine the effectiveness of the multi-condition pathway and, as the secondary goal, will identify barriers and facilitators to implementation experienced by the community hospitals as they implemented and used the new pathway.

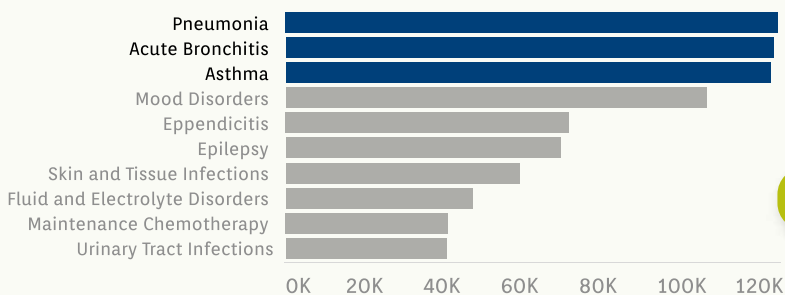
Translating Research to Practice

This study will provide evidence on an intervention that can leverage implementation resources by tackling multiple pathways and rapidly improving value of care for hospitalized children. Value in Inpatient Pediatrics, a quality improvement network of more than 450 hospitals, is the partner organization and will assist in the study and with disseminating, and potentially scaling the intervention broadly.

Improving Respiratory Illness Care for Children



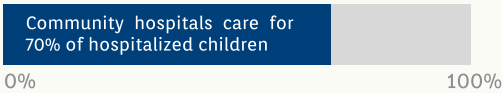
Asthma, pneumonia, and bronchiolitis are the top three causes of childhood hospitalization in the US, leading to more than 350,000 hospitalizations and over \$2 billion in cost annually.



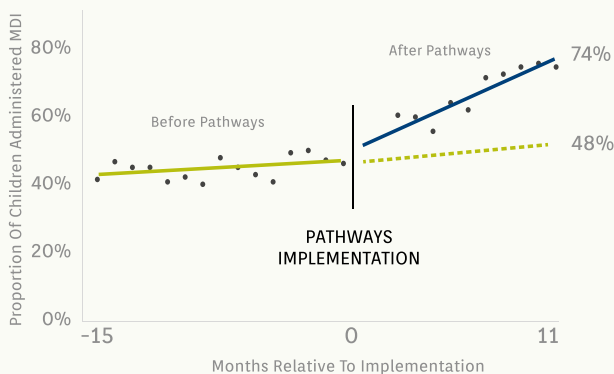
Hospital Stay Counts for Children Ages 0-17, 2012

Pathways Tools Improve Clinical Guideline Adherence

Pathways are step-by-step diagrams that are integrated into clinical workflows and provide quick guidance on evidence-based practices. This project will test pathways in community hospitals.



Guideline Adoption After Pediatric Asthma Pathways Implementation Shows Significant Increase



Pathways improved the use of Metered-Dose Inhalers (MDIs) during hospitalizations compared to the projected rate without Pathways.



Does a Rising Tide Lift All Boats? Assessing the Direct and Indirect Effects of APMs in Primary Care

Hannah Cohen-Cline, PhD

Providence Health & Services

Partner Organization: Care Oregon

Contribution to Improved Value

Test models of care, coverage or system change that seek to improve value by addressing one or more of the symptoms of low value

About This Project

This study will evaluate a primary care payment model (PCPM) that has been implemented across approximately 130 primary care clinics in Oregon and is designed to improve quality and reduce cost.

The Problem

The United States continues to struggle with high and rising health care costs and unacceptable variations in quality of care across demographic groups and geographic areas, as well as between different providers and plans. One way that purchasers have attempted to address these issues is through the use of value-based payments (VBPs) that incentivize cost-effective and high quality health care. Yet evidence for the impact of VBPs on quality and cost outcomes in primary care is mixed, and existing VBP models and the research studies examining them vary widely in terms of context and design.

Project Approach

This study will evaluate a primary care VBP model in Oregon that has been implemented at scale across approximately 130 clinics in different geographic regions of the state seeking answers to the following questions:

- How has the PCPM affected health care cost and quality at participating clinics?
- To what extent has the PCPM had spillover impacts on cost and quality of care for clinic patients with other sources of coverage?
- How do clinics' experiences with the PCPM, including their level of performance or earnings, influence their interest in and readiness for more advanced VBPs?

Translating Research to Practice

Findings from the study will be used by the partnering organization's value-based payments Steering Committee and external clinical advisory groups to optimize primary care payment model design in future iterations and inform their future value-based payments strategy more broadly.

Improving Quality in Primary Care



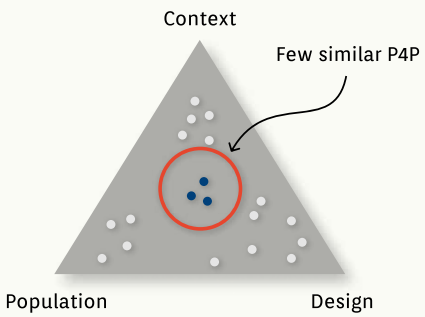
Impact of Value-Based Payment Models is Mixed

Quality Measures	VBP State / Control		
	PA / FL	MN / WI	AL / GA
HBA1C for Diabetes			
LDL for Diabetes			
Beta Blockers for CHF			
Preferred Asthma Treatment	✓		
Cervical Cancer Screening			
Chlamydia Screening			
Utilization			
Inpatient Admissions		✓	✓
Ambulatory Visits	✓		✓
Emergency Services			
ACS ER Visits			
PQI Admissions			
PQI Diabetes Visits			

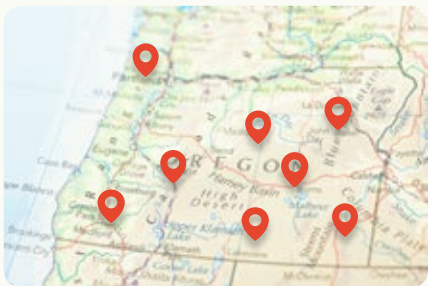
Statistically significant difference

Value-Based Payment (VBP) model research has been mixed. One study found very limited statistically significant findings in VBP intervention states compared to control states.

Wide Variety in Pay-for-Performance Program Design



Evaluating a Primary Care Payment Model in Oregon



Very few P4P programs are implemented with the same context, design, and population. The result is limited research on their efficacy.

This study will evaluate a primary care VBP model in 130 clinics in different geographic regions of Oregon.

Real-time Prescription Benefit Tools in the Electronic Health Record: Working towards greater value for prescribers and patients

Fasika Woreta, MD

Johns Hopkins University School of Medicine

Partner Organizations: Froedtert and Medical College of Wisconsin, Yale New Haven Health System, and Johns Hopkins Health System

Contribution to Improved Value

Promote conversations between patients and their clinicians and care teams about preferences and trade-offs related to alternative treatment options and/or out-of-pocket cost burden to patients and families

About This Project

Real-time prescription benefit (RTPB) tools, recently mandated for use by Medicare, have the potential to promote conversations regarding price between patients and providers, minimize out-of-pocket costs for patients, lower prescription drug costs, and improve medication adherence and health outcomes. However, their impact is not yet known.

The Problem

Prescription drug spending in the U.S. is greater than any other country in the world. This burden increasingly directly impacts patients given the growth of high deductible health plans, which have higher patient out-of-pocket requirements than traditional insurance plans. High costs may lead to patients being unable to afford necessary medications, leading to poorer health outcomes.

Project Approach

Given that RTPB tools have only recently been integrated into electronic health records, their impact on patients and prescribers has not been evaluated. Thus, the overall objective of this study is to assess the utilization and the impact of RTPB tools in three large health systems through the following aims:

- To describe the utilization of RTPB tools by patient, prescriber, setting, and medication class and explore factors associated with alternative prescribing. We will test this framework using an observational cohort, using data from electronic health records and outpatient pharmacy databases
- To assess the impact of RTPB tools on patients and prescribers. We will use an interrupted time-series analysis to measure the impact of these four outcomes before and after adoption of these tools
- To identify barriers and facilitators to adoption of RTPB tools by providers. We will use a mix of qualitative methods to investigate the facilitators and barriers for using RTPB tools by prescribers.

Translating Research to Practice

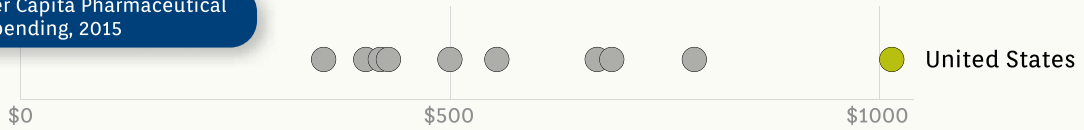
The research team will be sharing results at relevant local, regional, and national meetings and publishing in peer-reviewed journals, and findings will be presented every six months to institutional and departmental quality improvement teams at each site. Given the CMS mandate, institutional and departmental leadership at each institution have a vested interest in information regarding the utilization and impact of RTPB tools.



Real-Time Prescription Benefit Tools

The United States' high prescription spending far out-paces other high-income countries. High-deductible health plans and high costs may result in patients being unable to afford necessary medications.

Per Capita Pharmaceutical Spending, 2015



Patients with high prescription costs are more likely to not refill or abandon their medications at the pharmacy than prescriptions with no co-pay.

Discussing medication costs can support adherence; however, physicians often do not have access to a patient's deductible and copayment information at the time of prescribing.

Likelihood of Not Filling or Abandoning Prescription Compared to Prescriptions with No Co-pay

\$40-\$50 Co-pay



3.4x

\$50+ Co-pay



4.7x

Real-Time Prescription Benefit (RTPB)

Electronic real-time prescription benefit (RTPB) tools in EHRs assess patient eligibility in real-time and return out-of-pocket cost and any appropriate alternatives before a prescription is sent to the pharmacy, which can improve medication adherence and health outcomes for patients.



Value and Equity of Telehealth for Low-Income Patients with Chronic Conditions at Federally Qualified Health Centers

Megan Cole, PhD, MPH and June-Ho Kim, MD, MPH

Boston University School of Public Health

Partner Organization: Community Care Cooperative (C3)

Contribution to Improved Value

Test models of care, coverage or system change that seek to improve value and to reduce racial and ethnic disparities through the provision of higher value healthcare

About This Project

The COVID-19 pandemic has transformed the primary care landscape with rapid shifts to telehealth. Given this fast pace of growth, its impact on outcomes and spending is not yet well known.

The Problem

For low-income patients with chronic conditions who have high utilization and associated costs, often requiring frequent in-person visits, telehealth may have wide-ranging impacts on the value and equity of care. It may potentially lower costs and improve access to primary and specialty care for patients who previously faced difficulties in attending in-person visits, thus mitigating disparities in access and resulting quality of care. However, telehealth could also exacerbate disparities in quality, particularly for low-income patients with inadequate access to technology or internet, or for whom English is not their primary language.

Until recently, very few practices across the US used telehealth to treat chronic diseases outside of mental health. As such, the evidence base on chronic disease telehealth is limited, and there is no known evidence about heterogeneity in the value of chronic disease telehealth for Federally Qualified Health Clinics or similar vulnerable populations.

Project Approach

The research aims are threefold. First, the effects of the availability of telehealth on utilization of high-value chronic disease management services, quality outcomes, and spending among FQHC patients with select chronic conditions (chronic lung disease, diabetes, mental health disorders) will be evaluated. Second, heterogeneity in effects across racial/ethnic and linguistic subpopulations will be assessed. Third, best practices for optimizing value and equity of chronic disease management telehealth in low-income populations will be identified.

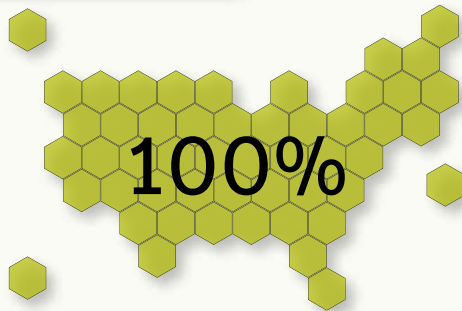
Translating Research to Practice

Community Care Cooperative, the largest risk-bearing Accountable Care Organization of Federally Qualified Health Centers in the country, will integrate evidence from this study into its network of 19 FQHCs in Massachusetts and across the Massachusetts FQHC Telehealth Consortium, a group of 35 FQHCs that provides a platform to scale our research findings into practice and policy.

Increasing Equity in Telehealth Care



Telehealth Coverage



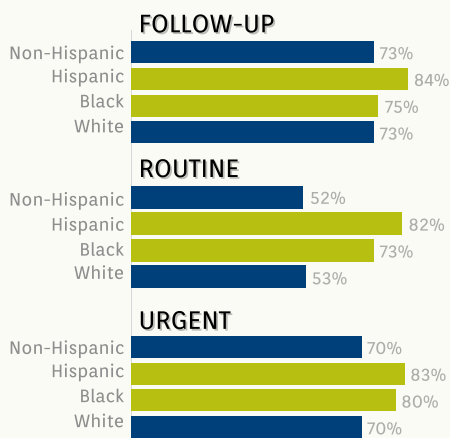
All 50 states and the District of Columbia have some form of Medicaid telehealth reimbursement, predominantly live video. However, what services are reimbursed and how telehealth is reimbursed varies by state.

Community Health Centers Rapid Telehealth Adoption

Community Health Center Patients Who Would Continue to use Telehealth Services

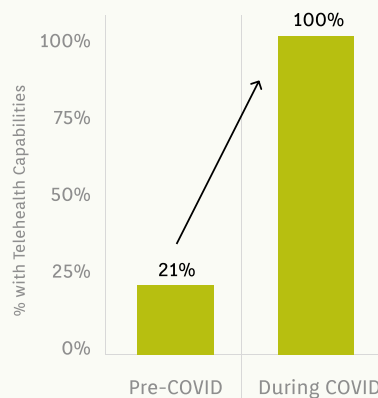
Black and Hispanic patients were significantly more likely to indicate interest in future telehealth appointments.

Percent that Would Use Telehealth Post-COVID
April - May 2020



Massachusetts Community Health Centers quickly increased telehealth services in response to the COVID pandemic. By April 2020, 100% of Massachusetts CHCs had telehealth capabilities compared to only 21% before the pandemic.

MA CHCs with Telehealth Capabilities
Pre and During COVID



From time to time Donaghue chooses to advance the Foundation’s mission through grant opportunities that are outside its standard funding programs. These can be a variety of projects such as research, engaging the public or stakeholders in research, or activities related to enhancing evidence transfer.

Connecticut Health Advancement & Research Trust
Lunchtime Conversations Exploring Issues Highlighted by the COVID-19 Crisis

Funding was provided to Connecticut Health Advancement & Research Trust for hosting a series of lunchtime conversations exploring some of the difficult issues highlighted by the COVID-19 crisis, including profits above people in treatment and vaccine development, racism & COVID-19, and how social distancing and fear of contagion challenge health care voters.

Institute for Clinical and Economic Review
Patient Engagement Program

This work addresses areas identified by patients as key to effective engagement and central to ICER’s mission of increasing patient access to high quality healthcare with fair prices and encouraging innovation. The core activities include developing a patient leaders working group, an ICER Resource Center for Patient Organizations, and testing a process to determine fair honoraria for patient group participation in ICER deliberations.

The Hastings Center
Surprise Billing and The Erosion of Trust in American Health Care: Professionalism can help us

Surprise billing arises at the intersection of professionalism, trust, and health care access, and it is a problem that disproportionately affects people of color. The Hastings Center and University of Connecticut Health Disparities Institute, in conjunction with the American Board of Internal Medicine Foundation, seek effective means to galvanize professional societies, major employers, and organizations responsible for health care quality to collaboratively advance the trustworthiness of health care in the United States through a suite of self-regulatory steps capable of eliminating this vexing problem.

Yale School of Public Health
Climate Change and Health in Connecticut: 2020

Health issues related to climate change vary according to locality. Climate-related health issues affecting Connecticut include adverse health effects of coastal storms, climate-sensitive infectious diseases (e.g., Lyme disease, West Nile fever), heat waves, waterborne infections and shellfish contamination from combined sewer overflows after flooding, toxic algal blooms, aeroallergens, and ground-level ozone formation associated with extreme heat.

Funding was provided to assist in the printing of the first report of Climate Change and Health in Connecticut. The report tracks 19 indicators on climate change and health specifically in Connecticut, which will be of value to policymakers and advocates in Connecticut and also will provide a model for similar reports by other states.

ADVISORY COMMITTEES

POLICY ADVISORY COMMITTEE

Chair
Jean Larson, MBA
Compliance Manager
APNH: A Place to Nourish Your Health

Carol Buckheit, MS
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Just Giving Communications

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Director of Dental Services
Equitas Health

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Community Services Administrator
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Foodshare Institute for Hunger
Research & Solutions

Patrick McKenna, AIA
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Community Solutions Northeast
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CarePartners of Connecticut

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Principal
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Michelle Spoto
Student
University of Connecticut Schools of
Dentistry and Medicine

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Global Living Consulting

Lawrence Young, MPH
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Charter Oak Health Center

GREATER VALUE PORTFOLIO

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Duke University

Ruta Brazauskas, PhD
Assistant Professor
Medical College of Wisconsin

Diana Buist, PhD, MPH
Director of Research and Strategic
Partnerships
Kaiser Permanente Washington
Health Research Institute

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Massachusetts General Hospital

Courtney Gidengil, MD, MPH
Assistant Professor
Harvard School of Medicine

Sarah Greene, MA
Strategic advisor on health care
research and strategy

Michael Gusmano, PhD
Research Scholar
The Hastings Center

Laura Hatfield, PhD
Associate Professor
Harvard Medical School

Jack Hoadley, PhD
Professor, Health Policy Institute
Georgetown University

Tricia Johnson, PhD
Associate Chairperson
Rush University

Donald Klepser, PhD, MBA
Associate Professor and Associate
Dean for Academic Affairs
College of Pharmacy, University of
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Associate Professor
University of Pennsylvania

John Pakutka, MBA
Managing Director
The Crescent Group

Sarah Robertson, MS
PhD Candidate
Brown University

Victor Villagra, MD
President
Health & Technology Vector, Inc

ANOTHER LOOK: BETTER HEALTH FOR OLDER ADULTS IN CARE FACILITIES

Chair
Julie T. Robison, PhD
Professor of Medicine
University of Connecticut Center on
Aging

Lisa Barry, PhD, MPH
Assistant Professor, Psychiatry
University of Connecticut Center on
Aging

Eilon Caspi, PhD
Research Associate
University of Minnesota

Emil Coman, PhD
Research Associate
University of Connecticut

Leslie Curry, PhD, MPH
Professor
Yale School of Public Health

David M. Dosa, MD, MPH
Associate Professor
Brown University

Keith Goldfeld, PhD
Associate Professor
NYU Grossman School of
Medicine

Jennifer Gaudet Hefele, PhD
Assistant Professor
University of Massachusetts,
Boston

David Hunter, MBA
President & CEO
Mary Wade Center

Roe Gutman, PhD
Associate Professor
Brown University

Mag Morelli
President
LeadingAge Connecticut

Nora O'Brien Suric, PhD
President
The Health Foundation for
Western and Central New York

Jennifer Tjia, MD
Associate Professor
University of Massachusetts
Medical School

Julio Urbina, PhD
President & Director, Healthy
Aging Program
Fan Fox & Leslie L. Samuels
Foundation

In addition to these advisers, there are many individuals who assist the Donaghue Foundation with its review of letters of intent and with grant opportunities that are outside of its standard program. We are very grateful for the generous contribution of their time and expertise.

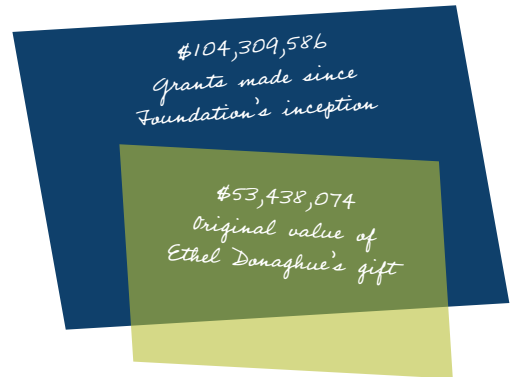
Investment in marketable securities as of December 31, 2020	\$ 86,252,226
Cash and cash equivalent	\$ 6,164
Other assets	\$ 10,102
Total assets and fund balance	\$86,268,492
Income	\$ 1,221,855
Expenditures	
Program	
Grants	
Another Look - Better Health for Elders in Care Facilities	\$ 613,877
Opportunity Awards	\$ 350,250
Greater Value Portfolio	\$ 1,793,296
Subtotal	\$ 2,757,423
Program support and Foundation-administered projects	\$ 88,702
Management and General	\$ 854,100
Investment Management	\$ 213,765
Total Expenditures	\$ 3,913,989

Note: In addition to these expenditures, an estimated amount of up to \$1,714,685 has been committed for future spending in support of ongoing grants.

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

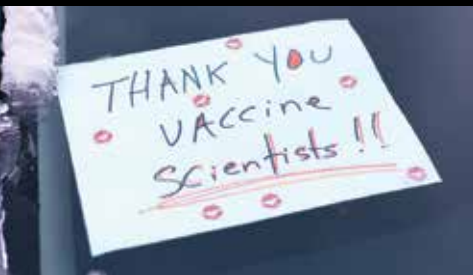
FUNDS AWARDED BY GRANT PROGRAM
(Some awards received payment after December 31, 2020. Dollar amounts show 2020 distributions)

Another Look	
New (8)	\$527,202
Continuing (1)	\$86,675
Opportunities	
New (5)	\$120,250
Continuing (2)	\$230,000
Greater Value Portfolio	
New (4)	\$1,793,296
Continuing (10)	\$2,757,423



RESEARCH GRANTS

Institution	New	Continuation	Total
Association of American Medical Colleges		1	1
Boston University School of Public Health	1		1
Brown University	1		1
Children's Hospital of Los Angeles		1	1
Connecticut Health Advancement & Research Trust	1		1
Duke University		1	1
The Feinstein Institute for Medical Research		1	1
Harvard Pilgrim Health Care		1	1
The Hastings Center	1	1	2
Health Research Alliance	1		1
Institute for Clinical and Economic Review	1		1
Johns Hopkins University	1		1
Kaiser Foundation		1	1
LeadingAge	1		1
Massachusetts General Hospital		1	1
Miami University	1		1
New York University	1		1
Portland State University	1		1
Providence Health and Services	1		1
University of California	1	1	2
University of Michigan	1	1	2
University of Pennsylvania		1	1
University of Rochester	1		1
University of Washington		1	1
Weill Medical College	1		1
Yale University	1	1	2
Total	17	13	30





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