



The Robert Wood Johnson Foundation  
National Strategic Indicators Survey

**RWJF Priority and Program Area Performance  
Indicators Summary Report**

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# The Robert Wood Johnson Foundation National Strategic Indicators Survey

## Executive Summary RWJF Program and Priority Area Performance Indicators Summary Report

### Prepared by

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With funding and ongoing guidance and input by the RWJF, FACCT—The Foundation for Accountability and Harris Interactive, Inc. have collaborated on a national on-line survey to assess the quality of health and health care in the United States. The study has two broad objectives:

- To provide RWJF with a snapshot of health and healthcare today, and
- To establish baseline indicators of health system performance in major topical areas in which the Foundation operates. Specifically, seven online surveys were designed to produce data to construct a baseline picture of performance for nine RWJF program areas:

Tobacco  
Health and Behavior  
Community Health  
Alcohol and Illegal Drugs  
Clinical Care Management for Chronic Conditions  
Supportive Services  
End of Life Care  
Priority Populations  
Insurance Coverage

### Methods

Survey data were collected from seven online samples of target populations: teenagers, general adult population, adults with diabetes, adults with depression, adults with chronic health problems, parents of children with asthma, caregivers of people who have died. Response rates to the on-line invitation ranged from 1% (1,240 of 124,050 teenagers responded to the invitation to complete the survey) to 28% (10,923 of 39,635 of people with depression responded). Inevitably, the unequal distribution of internet access and the relative newness of on-line survey methods will require the Foundation to interpret these findings cautiously. Even after statistical adjustment for demographic and psychosocial factors, survey respondents report slightly better health status than the national population and slightly higher health care utilization. These data provide an excellent profile of the roughly 50% of Americans now using the Internet, and a reasonable estimate of the population as a whole – but there is reason to believe that some estimates provided here are optimistic, perhaps representing a somewhat more health aware, motivated and ‘empowered’ segment of the overall population.

## General Findings

Wherever appropriate, common individual performance indicators and leading indicator composite scores were created across all population groups. This approach permits us to compare how different populations report their experiences with the care system, in terms of access, working with their providers, receiving guidelines-based services, and engaging in healthy behaviors. A few general observations stand out:

1. The **quality** of health care reported here is generally fair to poor – between 40% and 70% of optimal care. For example:
  - 47% of adult **smokers** have been advised to quit by their physician;
  - between 54% and 63% of all patients report being involved “most of the time” in **treatment decisions**;
  - 22% of parents of **children with asthma** report having a written care plan;
  - 68% of caregivers report that the **terminal patient** they cared for had their treatment wishes honored “mostly” or “completely”
2. **Teenagers** and people experiencing **depression** seem to receive guidelines-based care less often than other groups, are less likely to receive counseling about risk behaviors, and generally report less effective relationships with their providers.
3. **Preventive services** are not provided uniformly. People with chronic illness are generally more likely to receive counseling about risk behaviors than other groups, perhaps as a result of their more frequent visits with physicians. Still, frequency of counseling is far below recommended guidelines.
4. **Access to care** is comparable across most populations – at about 75% of optimal – but people without **health insurance** rate their access to medical and dental care about 20% lower than those with insurance.
5. Many people with chronic illness feel **empowered** to seek out good care and advocate for themselves but do not feel that they are effective in managing their own daily health. Those who serve as a “health care agent” – caregivers of patients at the end of life and parents of children with asthma – report highest self-advocacy behaviors of all seven populations sampled.

### Findings related to RWJF Priority Areas

#### **Access to health care services**

Access to health care was generally good and comparable across the populations surveyed. Overall, access to dental care and rehabilitation and counseling services was most difficult. Access to care was uniformly better for older adults. While non-white and Hispanic respondents reported slightly worse access to medical and dental care than whites or non-Hispanics, the greatest disparities were associated with **inadequate insurance coverage**. Across all populations, people without health insurance had 8.5%-24.5% lower access to care scores than those with insurance. (Table 20)

#### **Chronic care management**

Care for chronic illness remains uneven and often inadequate. On most performance indicators rating clinical care—such as compliance with medical guidelines or services to identify and address risk behaviors—patients reported scores from 40% to 70% of optimal care. (Figure 2.8) Quality of care appears to vary with the individual diagnosis. Patients with **depression** report

the lowest scores on most indicators, including receiving care consistent with guidelines, smoking, physical activity, receiving counseling to quit smoking and access to care. Patients with **diabetes** report relatively favorable scores in several areas, including receiving care consistent with guidelines and receiving counseling to reduce risk behaviors. Patients with diabetes also report frequent physician visits (averaging over 9 per year). We observe that patients with more frequent physician visits report higher rates of appropriate care and preventive counseling.

### **Health promotion**

Interventions to reduce smoking and alcohol misuse and increase physical activity are offered to about one-half of those who need them, and they are offered unevenly (Figure 2.11). Teenagers are least likely to be advised to change unhealthy behaviors. People with lower levels of social isolation are more likely to be physically active and participate in a healthy lifestyle (Figure 3.8).

### **Care at the end of life**

Caregivers of people who have died report having received more help in making advance preparations for death and achieving a peaceful death than in minimizing suffering, receiving support as caregivers, having the patient's treatment wishes and spiritual beliefs honored, and being involved in care decisions (Figure 2.10)

Interestingly, those with lower incomes and non-white populations tend to be more likely to report a peaceful death in spite of lower scores on other dimensions of performance. Overall, people are more likely to report a peaceful death regardless of the actual quality of the care received as measured here.

### **Consumer empowerment in chronic disease**

People reported relatively high levels of empowerment and an ability to advocate for themselves—seeking second opinions, asking questions of pharmacists. But empowerment does not necessarily translate into confidence in managing one's own illness. Self-efficacy scores are especially low for people with diabetes (35.3%) and depression (18.3%) in spite of relatively high consumer empowerment scores for those groups (75.7% and 62.6%, respectively).

### Recommendations for Future Work

The RWJF National Strategic Indicators Survey project has yielded valuable information for understanding health care quality in America and informing existing and future Foundation efforts. To ensure that the information collected is most effectively used, FACCT recommends four areas for future work:

- Additional Technical Analysis
- In-depth RWJF Program Area Analyses
- Communication of Findings
- Planning for Future Updates

## Section 1 INTRODUCTION

### 1.1 Purpose

The Robert Wood Johnson Foundation has committed substantial resources to improving health and health care for all Americans. Relatively few resources exist to help the Foundation evaluate its success at achieving these goals. Large-scale national surveys, such as the Behavioral Risk Factor Surveillance System and National Health Interview Survey, are vital sources of information, but they do not delve deeply enough into the specific strategies and concerns of the Foundation. Industry monitoring systems, such as NCQA's Health Plan Employer Data and Information Set (HEDIS), only address a subset of U.S. health care providers and patients and cover only some of the topics of interest to RWJF. Despite widespread interest in measuring and monitoring the performance of the U.S. health care system and assessing its impact on the nation's health, the cost and logistical difficulty of reviewing medical charts or conducting extensive mail or phone surveys have severely limited the ability to evaluate improvement initiatives or properly target resources.

Under the direction of the Foundation and in consultation with Foundation program staff, FACCT and Harris Interactive have conducted a national, on-line survey intended to increase our understanding of health and health care performance in contemporary America. This study has two broad objectives:

- To provide RWJF with a snapshot of health and healthcare today, and
- To establish baseline indicators of health system performance in major topical areas in which the Foundation operates. Specifically, eight online surveys were designed to produce data to construct a baseline picture of performance for nine RWJF's program areas:

- Tobacco
- Health and Behavior
- Community Health
- Alcohol and Illegal Drugs
- Clinical Care Management for Chronic Conditions
- Supportive Services
- End of Life Care
- Priority Populations
- Insurance Coverage

On-line surveys were administered to each of seven populations:

- Teenagers
- General adult population
- Adults with chronic health problems
- Adults self reporting type 2 diabetes
- Adults self reporting depression
- Parents of children with asthma
- People who were caregivers to people who died within the past two years

A physician online survey was also conducted and will be reported elsewhere.

In addition to providing baseline performance information, this project should be understood as an early demonstration of the potential for monitoring health care performance on the Internet, using a sample of on-line users as a proxy for the nation as a whole. Inevitably, the unequal distribution of internet access and the relative newness of on-line survey methods will require the Foundation to interpret these findings cautiously. These data provide an excellent profile of the roughly 50% of Americans now using the Internet, and a reasonable estimate of the population as a whole—but there is reason to believe that, even after weighting is conducted, some estimates provided here are optimistic, representing a somewhat more health aware, motivated and ‘empowered’ segment of the overall population.

## 1.2 Analysis of Survey Results

Both Harris Interactive and FACCT conducted analysis of survey results. FACCT was charged with ensuring that survey items were included in each survey to allow specific performance indicators to be developed and to construct these performance indicators using survey data. More information about FACCT’s role and responsibilities in the RWJF National Strategic Indicators Survey project is provided in Attachment A. This report presents results of analysis conducted by FACCT only.

Across each of the seven sampled populations, 314 performance indicator scores were constructed and are presented in Appendices A-G. Appendices A-G also present these scores by age, gender, race, and income groups and, for measures related to access to care, by insurance status. As can be seen in Appendices A-G, performance indicators are grouped by topical area and type of measure (outcomes, process of care).

The analyses of survey results for the seven population-based samples are presented in two major sections in this report.

In Section Two, we present and discuss a snapshot of the overall performance of the U.S. health system, based on leading indicator composite scores created for five high-level health system domains:

- Access to care
- Staying healthy
- Living with chronic illness
- Adapting to changing health needs at the end of life
- Consumer empowerment

Overall, 148 of the 314 performance indicators were used to construct these RWJF leading indicator composite scores across the seven sampled populations.

In Section Two, we present baseline performance summaries for each of the nine RWJF priority program areas targeted by the survey project. Each baseline picture of performance addresses:

- Level of performance on key individual performance topics
- Populations for which best and worst performance is noted

A more thorough discussion of the methodology used to develop both the leading indicator composite scores and individual performance indicators is presented in Attachment A and Appendices A – G.

### 1.3 Survey Limitations

#### Generalizability of Findings

The internet is a rapidly expanding communications medium, and people from all parts of American society make use of it. Harris Interactive has developed a method for weighting on-line data to permit estimates of attitudes and behavior for the overall U.S. population. These weights are based on both demographic characteristics and variables that predict the propensity for various population groups to appear in an online sample. These weights are based on population statistics and on a parallel telephone survey conducted of a random sample of Americans. Data from two of the seven surveys conducted for the RWJF National Strategic Indicators reflect this robust weighting scheme (teenagers and general adult population). Data from the other five surveys are adjusted for demographic variables only. See Attachment A for a description of weighting methods used by Harris Interactive.

After adjustments, the online population remains somewhat different from the population as a whole. Highlights of the types of differences we observe are listed below.

**Better health status:** The telephone sample found 16% of general adult respondents reporting themselves to be in Fair or Poor health status; only 12% of the weighted, on-line sample reports Fair/Poor health status. The national Behavioral Risk Factor Surveillance survey reports that 68% of Americans experience no bad physical health days in a typical month; the telephone survey found 65% reporting no bad physical health days; the weighted online survey found only 52% reporting no bad physical health days. The variation in bad mental health days was less striking (BRFSS 69% no bad days; telephone 69% no bad days; online 67% no bad days).

**More with regular doctor:** Seventy-seven percent of the telephone respondents reported having a regular doctor; 80% of online respondents report having one. This question is not always asked in the BRFSS; in the 1995 Kansas State BRFSS survey, 77.6% reported having a regular doctor.

**Comparison to managed care:** We observe significant differences between our online respondents and published managed care performance statistics, but can offer no explanation for these differences. The 1998 HEDIS data—submitted by only a subset of HMO and POS plans—reported a national average of 62.5% of smokers having been advised to quit; the rate in our telephone sample was 48% and in the online sample 49%. Among HMO members with diabetes, in 1998 41% received a retinal exam; in our online sample of people with diabetes, 61.4% reported undergoing a retinal exam.

**Consumer empowerment:** The online sample did not report significantly different levels of self-confidence or behavioral style when asked about interactions with the health system. For example, 87% of the telephone sample said they would seek a second opinion on a serious diagnosis, compared with 89% of online users. However,

72% of online users have used the internet to find information about medical conditions, compared with only 29% of the telephone sample.

These discrepancies from benchmark data sets should remind us to interpret these results cautiously, putting greater emphasis on variations between population groups and on deficiencies from expected levels of performance.

### Response Rate

Harris Interactive maintains a database of over 5 million Americans willing to reply to online health surveys. Harris has conducted preliminary surveys of these panelists so that it can field surveys to specific groups—such as people diagnosed with diabetes or who have recently cared for someone facing terminal illness. Attachment A includes an example of the invitation letter used by Harris Interactive to invite individuals in its online sample to complete the surveys.

Characteristics of the sampling frame and completed samples for the seven surveys are summarized in Attachment A to this report. The proportion of those invited to respond to the online surveys that completed the surveys ranged from 1% for teenagers to 27.5% for people with depression. People with diabetes had the next highest rates of response (19%).

It is important to note the low response rate to online surveys compared to mail and telephone surveys does not necessarily mean that the information derived can not be used to derive representative performance indicators as long as weighting adjustments are made to account for differences in characteristics of those sampled versus those responding. It is not clear whether this type of adjustment can be assumed after the adjustments made to help make the on-line sample more representative of the general population are applied.

## Section 2 Overall Health Care System Performance

### 2.1 Snapshot of Overall Performance

As summarized above, we computed leading indicator composite scores for each of five national leading indicators, each of which aligns with one or more priority areas for the RWJF:

- Access to care
- Staying healthy
- Living with chronic illness
- Adapting to changing needs at the end of life
- Consumer empowerment

Each score is computed on a scale from 0 to 100, where 100 is the best possible performance. The leading indicator composite scores are presented for each appropriate sampled population group. Leading indicator composite scores are presented in graphical form here. Actual leading indicator composite scores and, in turn, the performance indicator subcategory scores used in the construction of the leading indicator composite scores are included in Attachment B to this report.

#### Access to Care

Figure 2.1 shows the overall access to care scores. This indicator includes whether people report receiving needed medical and dental care in a timely manner, having a medical (and dental) home, and having access to needed supportive services (see Section 3.6). Note that across all populations, scores are in the mid-70s. Nationally, access to care is “good”, with significant room for improvement.

Note that two populations report more difficulty getting access to care: people with depression and caregivers for terminal patients.

As can be seen in the Priority Populations (see Section 3.8) and Insurance Coverage (see Section 3.9) priority area performance summary presented later in this report, non-white individuals and people without insurance coverage consistently report poorer experience with access to care. The gap in reported access to care between the insured and uninsured is much more pronounced than the gap in access to care between white and non-white individuals (Figures 2.2 and 2.3).

#### Access to Care Scores

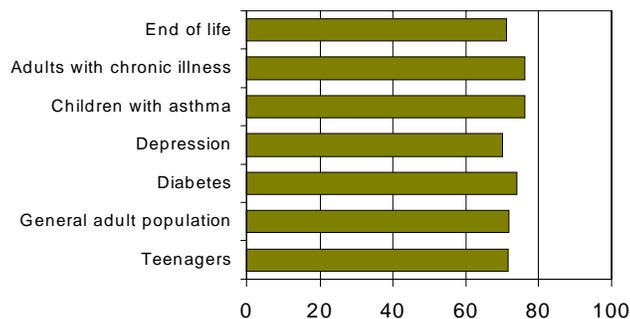


Figure 2.1

When we examine variations in reported access to care for Hispanic and non-Hispanic populations, across the eight core access to care measures differences are either not significant or are less than 10% (range: Hispanic 1.1% higher to 8.3% lower scores compared to non-Hispanic population). The largest differences are observed in reported experience getting timely access to care. See Figure 2.4.

**Coverage & Access Program:**  
*Timely access to medical care - by race*

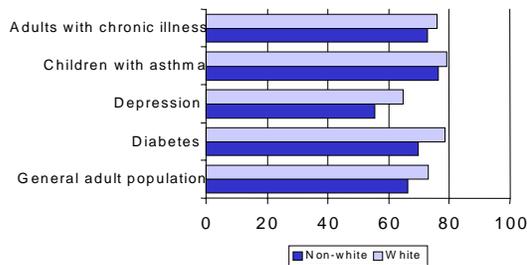


Figure 2.2

**Coverage & Access Program:**  
*Timely access to medical care - by insurance*

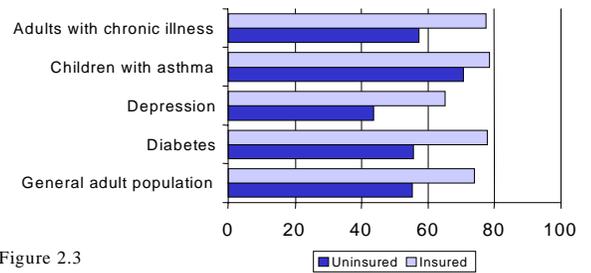


Figure 2.3

Those reporting an Hispanic ethnic affiliation report significantly more problems getting timely care (range across sampled populations: Hispanic 10% to 19% less likely than non-Hispanic population). The largest differences in reported ease of getting timely access to care between the Hispanic and non-Hispanic population are observed for people with diabetes (Hispanic 19% lower score) followed by children with asthma and people with depression (Hispanic 11.5% and 11.3% lower scores, respectively).

Smallest differences are observed in reports of having at least yearly health care visits (range across sampled populations: Hispanic 4.2% more likely to 2.1% less likely than non-Hispanic population). See Figure 2.5.

*Timely access to medical care - by race*

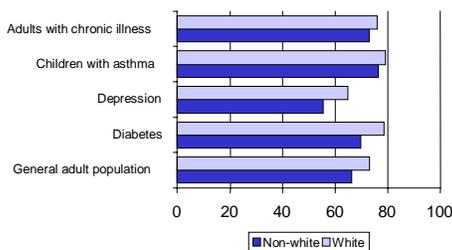


Figure 2.4

*1+ visit to doctor in year - by Hispanic status*

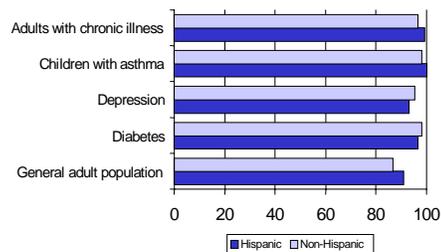


Figure 2.5

We observe that the average reported income for Hispanic individuals is not significantly different than that reported by non-Hispanic individuals. However, Hispanic individuals are much more likely to report not having insurance coverage (27.2% vs. 14.5%). Perhaps this combination of factors explains the observation that those who report an Hispanic ethnic affiliation do get care, but have a harder time doing so.

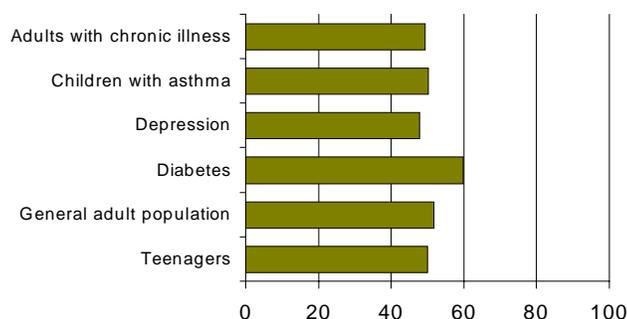
It should be noted that overall, access to care scores are worst and vary the most across populations in the area of access to dental care. Among the various access to care indicators, access to supportive services is also among the lowest scores across the population groups (see Section 3.6). Finally, older adults consistently report better experience with accessing needed care.

## Staying Healthy

Figure 2.6 shows the national leading indicator composite scores for Staying Healthy (end-of-life caregivers are not reported here). This index covers health status, quality of life, healthy lifestyle, risk reduction and health counseling activities. Generally, scores are in the mid-40s to 50's, with very substantial room for improvement. We see that adults with chronic illness do somewhat better in this area. This is perhaps associated with the more immediate negative impact of poor health behaviors for people with diabetes or their substantially more frequent contact with medical providers. People with diabetes, for example, report an average of 9.2 doctor visits in the past year, compared with 4.5 visits for the general adult population.

Figure 2.6

### Staying Healthy Scores



As discussed in the Tobacco (Section 3.2), Health and Behavior (Section 3.3) and Alcohol and Illegal Drugs (Section 3.5) priority area performance summaries, older adults with a chronic condition report significantly better health habits in the areas of smoking, drinking and physical activity and are more likely to be counseled by providers on these topics. We also observe that while individuals with a higher income are less likely to report smoking and more likely to report physical activity, they are also more likely to report at-risk drinking and yet are less likely to report being counseled by providers on use of alcohol. No clear patterns in health behaviors or counseling on health behaviors have emerged according to racial affiliation. However, multi-variate analyses expected to be conducted at a later date may reveal such patterns.

### Staying Healthy Scores: Proportion Excellent/Very Good Health

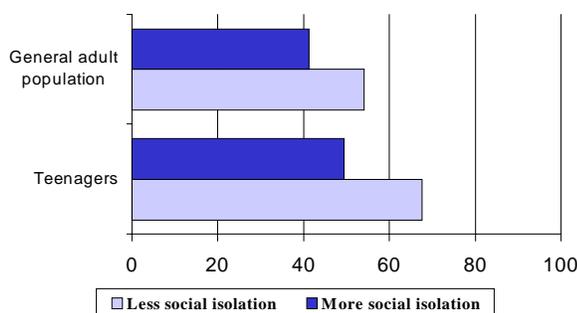


Figure 2.7

## Association between health status, health behaviors and social isolation

Self-reported general health status, health behaviors and social isolation for the general adult and teenage populations are included in the Staying Healthy leading indicator score. As also summarized in the Community Health priority program area (Section 3.4), we observe a strong association between increased social isolation and the propensity to engage in unhealthy lifestyle behaviors and report lower general health status.

As is illustrated in Figure 2.7, both adults and teenagers who are categorized as being more socially isolated are less likely to report having “Very Good or Excellent” health status. Specifically, 12.9% fewer adults and 18.2% fewer teens who are categorized as more socially isolated report “Very Good to Excellent” health status compared to those who are less socially isolated. Similarly, both adults and teenagers who are categorized as being more socially isolated are less likely to report engaging in healthy lifestyle behaviors. Specifically, 5.2% fewer adults and 14% fewer teens who are categorized as more socially isolated report healthy lifestyle behaviors compared to those who are less socially isolated (see Section 3.4).

## Living with Illness

The Living with Illness leading indicator composite score represents performance on health status and quality of life, getting appropriate care, education and teamwork, self-efficacy, and—for asthma—avoiding exacerbations requiring hospitalization or emergency room use. Figure 2.8 illustrates the scores for four populations of people Living with Illness. We see fair to poor performance across the board, with particular deficiencies in care for people with depression and best performance for children with asthma.

Living with Illness Scores

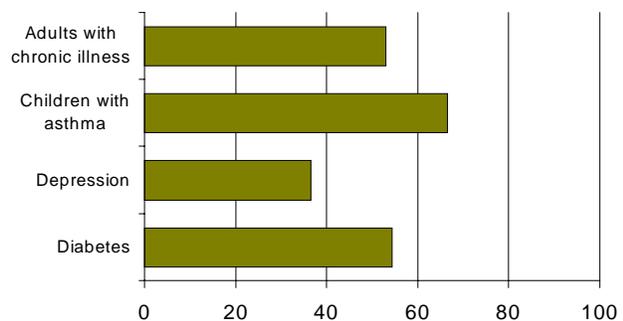


Figure 2.8

As discussed in the Clinical Care Management priority area performance summary (Section 3.1), a general pattern did emerge in the data across the populations of adults with chronic conditions. Older adults and those with higher incomes report higher health status and quality of life—including less social isolation—receipt of appropriate care, sufficient education and teamwork and self-efficacy.

Interestingly, it appears that adult males with diabetes who also have higher incomes are most likely to receive appropriate clinical services such as diabetic eye exams, having skill in testing blood sugar observed, and receiving diabetes specific patient education. While those with higher incomes appear to receive better care than those with lower incomes, no clear patterns according to race or gender have emerged. Again, such patterns may be revealed in the context of multi-variate analyses.

## Consumer Empowerment

Figure 2.9 summarizes the levels of consumer empowerment found among the various online populations. As all these groups are active internet users, this score is comprised only of self-care advocacy items which include the propensity to assess the quality of providers, ask for second opinions and be proactive in looking up information about medicines and health conditions.

### Consumer Empowerment Scores

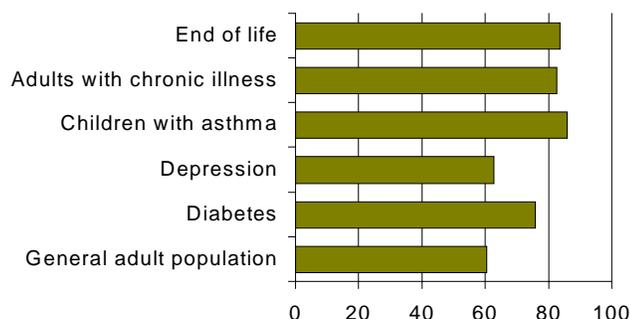


Figure 2.9

Note that compared to the general population, people with diagnoses of chronic illness report much higher levels of self-advocacy than the general population—with the significant exception of people experiencing depression. The relatively high level of consumer empowerment for these groups should not be mistaken as high levels of self-efficacy in caring for their condition. Self-efficacy scores are especially low for people with diabetes (35.3%) and depression (18.3%) in spite of the relatively high consumer empowerment/self advocacy scores presented here (75.7% and 62.6% respectively). People who are caregivers (asthma and end of life) had the highest consumer empowerment scores of all sampled populations (86% and 84% respectively). We have also observed that older adults are more likely to report more self-advocacy behaviors than younger adults.

## Changing Needs

The Changing Needs overall score was 70.8. The elements of the Changing Needs leading indicator composite score are not generally found in the other population groups, but Figure 2.10 shows the relative weight of each component performance score making up the overall Changing Needs leading indicator composite score.

### Changing Needs Components

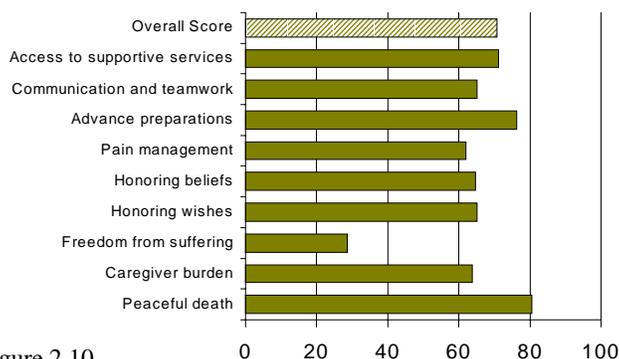


Figure 2.10

Overall, caregivers report relatively better help in advance preparations and achieving a peaceful death than in minimizing suffering, receiving support as caregivers, having the patient's spiritual beliefs and treatment wishes honored and getting information about and being involved in care decisions.

In general, scores are consistently higher for older patients (over 85 years of age) and those with higher incomes, especially in the areas of managing pain, supporting caregivers and honoring treatment wishes.

Interestingly, those with lower incomes and non-white populations tend to be more likely to report a peaceful death in spite of lower scores on other dimensions of performance. Overall, people are more likely to report a peaceful death regardless of the actual quality of the care received as measured here. This may be, in part, due to a tendency for individuals to frame the death experience in positive terms or simply that by the time the time of death came the patient was in fact free from suffering (even if he/she suffered days/weeks prior to the actual death experience).

## 2.2 A Comprehensive View of Quality Care

This section provides a more in-depth snapshot of performance across basic aspects of quality care. As noted earlier, we suggest that complete and effective health care should include at least four dimensions of quality: access, appropriate care, education and teamwork, and positive outcomes. What do these surveys tell us about our strengths and weaknesses in delivering quality care today?

### Access

Overall, all population groups report similar levels of access—at about 75% of optimal performance. Most people—especially those we identified with specific chronic illnesses—have a regular health care provider, and receive at least annual medical and dental care. A significant minority of Americans report that they do not receive the care they need, particularly non-medical services often regarded as instrumental to good outcomes such as rehabilitation, counseling, transportation and home care services (see Section 3.6).

Throughout these analyses, we see people with depression reporting the lowest levels of access to all needed services. We also observe significant differences across a number of dimensions of access to care according to race and insurance status (see Section 3.8 and 3.9)

Risk Reduction Scores

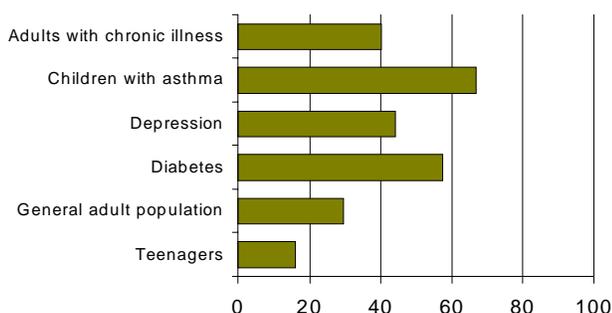


Figure 2.11

### Appropriate care

The quality indicators used here make use of established standards of care wherever possible. These can only be applied where (1) a standard has been established and (2) patients can reliably report whether a particular service was provided. We apply the concept of appropriate

care in all clinical and health areas. The concept of appropriate care is organized into two domains: *reduction of health risks and compliance with medical guidelines*.

For all sampled populations, risk reduction counseling was assessed for smoking, alcohol misuse and physical activity.

Guidelines compliance is defined specific to each population. For people with depression it involves maintenance in treatment programs; for people with diabetes it means regular monitoring for retinopathy and peripheral vascular disease; for children's asthma, it involves provision of a written care plan and education on use of inhalers.

## Guidelines Compliance Scores

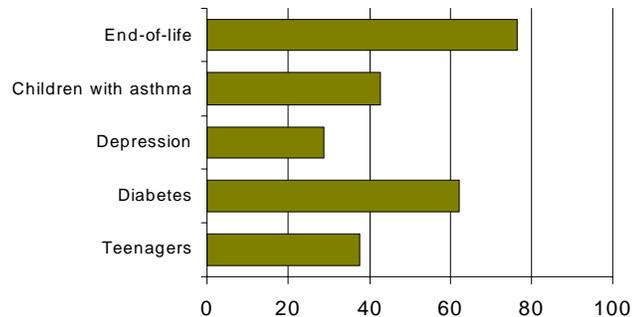


Figure 2.12

Figures 2.11 and 2.12 illustrate the relative performance of the health system in delivering appropriate care to the populations we surveyed.

Performance on efforts to reduce health risks was slightly better than compliance with medical guidelines, but still far below desired levels. People with a diagnosed illness received risk reduction interventions about half of the time, while those in the general adult and teen populations failed to receive recommended services 80% of the time.

In particular, respondents in the end of life sample reported relatively high levels of advance directives—perhaps reflecting the national efforts focused on these services over the past decade. Compliance with guidelines for patients with diabetes was fair, and performance for the other populations we studied was poor.

## Education and Teamwork

All populations—but especially those Americans affected by chronic illness—need to have an effective relationship with their health care providers. They need to understand the information they are given and be successful managing their own health and using health care resources successfully. The person with diabetes needs to monitor his or her own blood sugar; the child with asthma needs to use her own inhaler; the patient taking medications needs to know how and when to use them; the patient making a

## Education and Teamwork Scores

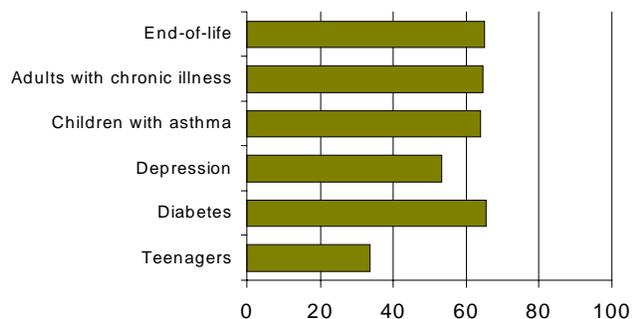


Figure 2.13

difficult treatment decision needs to understand his/her options and have confidence in his/her doctor's opinions. Effective communication, self-management, and a sense of self-confidence about health care decisions are essential to all people with an ongoing health condition.

Figure 2.13 summarizes the ratings each survey population gave to these competencies. Performance is quite uniform, with all scores at about 60% of optimal. The notable exception is care provided to teenagers, where effective communication and partnership remain infrequent.

### **Health outcomes**

Both the public health and health services systems seek to improve the health of Americans. For this survey, health outcomes along two dimensions are addressed: health status and healthy lifestyle. The healthy lifestyle profile asks: does this person avoid engaging in behaviors likely to negatively impact their health—smoking, alcohol misuse and sedentary lifestyle (little or no regular physical activity)? The health status profile asks: can the person function well day-to-day, with minimal activity limitations, adequate social interaction and support and a positive view of his/her own health?

**Healthy Lifestyle Scores**

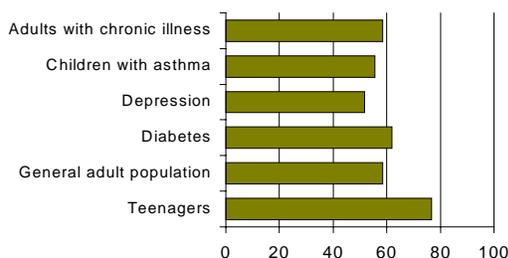


Figure 2.14

**Health Status Scores**

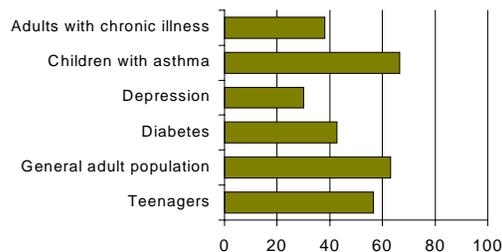


Figure 2.15

Figures 2.14 and 2.15 illustrate the Healthy Lifestyle and Health Status scores for populations sampled in this survey. As can be seen, people with depression have the lowest Healthy Lifestyle and Health Status scores. For the Healthy Lifestyle score, people with diabetes have the highest score among adults with chronic conditions.

Note that Health Status indicators are difficult to use in a broad national survey, since each population faces specific levels of morbidity and disease severity that are difficult to adjust for using generic instruments. The Health Status scores are of interest as a broad-brush illustration of the public's overall perception of its health and, for people with a chronic condition, self-assessed Health Status not yet adjusted for variations in disease severity.

### Section 3

## RWJF Priority Area Baseline Performance Summaries

This section provides a starting point summary for each of nine RWJF priority program areas:

Clinical Care Management for Chronic Conditions  
Tobacco  
Health and Behavior  
Community Health  
Alcohol and Illegal Drugs  
Supportive Services  
End of Life Care  
Insurance Coverage  
Priority Populations

For each area three overarching questions are addressed:

What **performance topics** were addressed in the National Strategic Indicators Survey that relate to the specific program area?

What is the **level of performance** on key indicators for each program area?

What **patterns of variation** appear to exist among different population groups?

There are two places external to the body of this report where more detailed information exists that will be of interest to program area staff:

1. Attachment C contains a **condensed summary of performance scores** for each sampled population. Here, the range of scores observed according to age, gender, race and income is summarized along with the level of statistical significance for variations observed and the population subgroup for which performance is best or worst.
2. Appendices A-G contain:
  - Copy of **survey for each sampled population with frequencies** for each item typed in
  - **Comprehensive set of performance score tables** for each sampled population. For each of the seven tables included, performance indicators are organized into four groups—outcomes of care, processes of care, access to care and consumer empowerment. Tables included are:
    - Table 1: Sample specific performance index
    - Table 2: Aggregate scores for all performance indicators calculated for each sample {NOTE: Survey items associated with each performance indicator are listed in Table 2.}
    - Table 3: Performance scores by age groups
    - Table 4: Performance scores by gender
    - Table 5: Performance scores by race groups
    - Table 6: Performance scores by income groups
    - Table 7: Access to care performance scores by insurance status

The following program area summaries provide a baseline picture of performance. Additional analysis of available data should be conducted to further understand the level and variations in performance, relationships among aspects of care (e.g. involvement in care decisions and getting appropriate care) and characteristics of populations (e.g. locus of control and self-efficacy).

### 3.1 Clinical Care Management

#### Relevant performance topics included

Six performance topics were uniformly assessed for each of the four chronic condition samples (diabetes, depression, pediatric asthma, general chronically ill):

- Involvement in decision making
- Education and teamwork
- Coordination of care
- Getting needed care
- Medical home
- Access to specialized and supportive services

In addition, 12 additional condition specific performance topics were addressed:

#### Diabetes

- Regular retinal eye exam
- Supervised education on how to monitor glucose
- Diabetes-specific education (avoiding complications, glucose monitoring and control, diet, exercise)
- Diabetes-specific self-efficacy in managing diabetes

#### Depression

- Treatment completion/lost to follow up
- Mental health treatment specific satisfaction with staff and treatment program
- Mental health treatment specific satisfaction with outcomes of care
- Depression-specific self-efficacy in managing depression

#### Pediatric Asthma

- Asthma-specific education (use of inhalers, peak flow meters and medicines)
- Written care plan provided to parents
- Avoiding acute exacerbations requiring hospital or emergency room use
- Coordination with school/daycare

### Summary of Findings

Each of the six performance topics common to all four chronic condition samples and performance scores for each of the condition specific performance indicators are summarized in Tables 1 and 2.

Among the three condition-specific populations (diabetes, depression and asthma), children with asthma had the highest performance scores for five of the six common indicators, whereas people with depression had the lowest scores for five of the six common indicators. Better performance for pediatric asthma is especially pronounced in the area of condition specific self-efficacy. For pediatric asthma, nearly 85% of parents say that they know what to do to manage their child's asthma whereas only 35.3% and 18.3% of people with diabetes and depression respectively report that they are "very confident" (vs. somewhat or not at all confident) in their ability to self manage their diabetes or depression.

Clinical Care Management Program:  
*Involvement in treatment decisions*

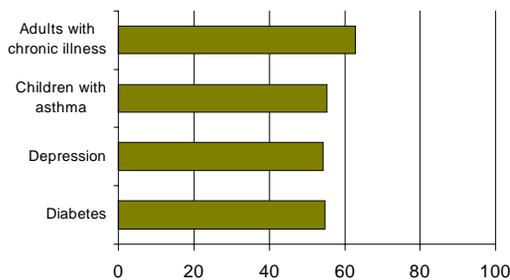


Figure 3.1

Clinical Care Management Program:  
*Guidelines Compliance Scores*

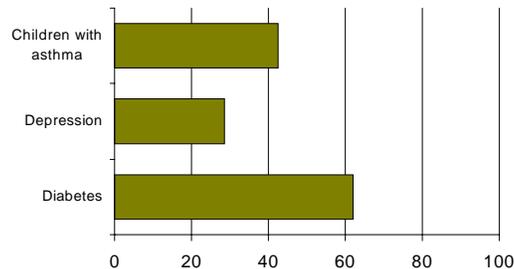


Figure 3.2

While performance does vary across sampled populations and is better in some areas than others, overall there is significant need for improvement in the care of people with chronic conditions in all areas.<sup>1</sup>

As illustrated in Figure 3.1, uniformly low performance is observed for involvement in treatment decisions (54.2%-62.8%), an aspect of health care that has been shown to have an important and unique impact on outcomes of care (Kaplan, 1989, Greenfield and Kaplan, 1985, Liptak, 1996). Similarly low scores (51.5%-61.9%) are observed in the area of coordination of care.

Figure 3.2 provides a condition specific performance summary on provider guidelines compliance. The average provider guidelines compliance score for people with diabetes is 66.5%. Included in this score are regular eye exams, watching patients test own blood glucose and providing diabetes-specific patient education. The average provider guidelines compliance score for people with depression is 28.6%. Included in this score is the only depression process indicator included in this study -- treatment completion. The average provider guidelines compliance score for children with asthma is 42.7% and includes provision of a written care plan and teaching parents and children how to use inhalers. As can be seen, many opportunities are missed to provide basic aspects of good clinical care for each of the three condition specific populations.

When variations in performance scores are examined within and across demographic groups for each of the four chronic condition samples, we observe that older adults, males and those with higher incomes tend to report the best care quality. While no clear patterns emerge according to race, with only a couple of exceptions, white individuals do not have the highest performance scores.

<sup>1</sup> The general chronically ill population was identified using a five-item screening tool assessing current consequences due to a medical, mental or other health problem lasting or expected to last at least 12 months. Over 80% of those qualifying on this tool named a condition that qualifies as chronic using classification norms used by the National Center for Health Statistics. Ongoing work is underway by FACCT to examine the validity of this short screening tool.

See Attachment C for summary tables on variations in scores observed across demographic groups. Additional analyses are needed to further examine the nature and explanation for observed variations.

Table 1: Clinical Care Management: Scores for common performance topics

Performance Topic	Rates by Sample			
	People with Chronic Illness	People with Diabetes	People with Depression	Children with Asthma
<b>Involvement in decision making:</b> Proportion with score of 75 or above on survey scale (equivalent to answering “most of the time” to all items).	62.8%	54.7%	54.2%	55.3%
<b>Education and Teamwork:</b> Proportion with score of 75 or higher on survey scale (equivalent to saying at least “helpful” on all items)	72.4%	70.0%	59.0%	72.0%
<b>Coordination of care:</b> Proportion receiving care from more than one provider who get help coordinating their care	58.7%	61.9%	53.3%	51.5%
<b>Getting Needed Care:</b> Proportion with a score of 66 or higher on scale (equivalent to answering “usually” or “always” to access to care questions).	75.1%	75.4%	62.4%	78%
<b>Medical Home:</b> Proportion reporting that they have a regular doctor	92.9%	95.8%	86.3%	97.1%
<b>Access to Supportive Services:</b> Proportion with at least one serious need for specialized and supportive services who received all needed services	83.4%	52.8%	53.0%	52.9%

Table 2: Condition Specific Clinical Care Management Scores

Diabetes		Depression		Pediatric Asthma	
Indicator	Score	Indicator	Score	Indicator	Score
1. Proportion getting regular eye exam	61.4%	1. Proportion completing treatment for depression/ NOT lost to follow up	28.6%	1. Proportion with a score of 75 or higher on self-efficacy scale	84.9%
2. Proportion watched checking glucose	62.7%	2. Proportion with score of 80 or higher on satisfaction with mental health treatment outcomes	49.0%	2. Proportion of parents who have a copy of a written care plan for their child	22.2%
3. Proportion with score above 66 on diabetes education scale	75.4%	3. Proportion with score of 80 or higher on satisfaction with treatment staff and program	51%	3. Avoiding hospitalization	83.5%
4. Proportion "very confident" in ability to self care for diabetes	35.3%	4. Proportion "very confident" in ability to self manage their depression	18.3%	4. Avoiding emergency use	65.8%
5. Proportion "very confident" in ability to care for general health	58.8%	5. Proportion "very confident" in ability to care for their general health	50.3%	5. Taught use of inhaler	63.1%
				6. Coordination with school	74.0%

## 3.2 Tobacco

### Relevant performance topics

Five performance topics were addressed in the area of tobacco use. Topics addressed are:

- History of smoking
- Intensity of smoking
- Provider counseling about smoking
- Provider counseling to quit smoking
- Smoke-free home

Table 3 summarizes which of these topics is addressed for which sampled population.

Table 3: Tobacco: Summary of performance topics addressed for sampled populations

Performance Topic	Samples For Which Topic Is Addressed					
	Teenagers	General Adult	People with Diabetes	People with Depression	People with a chronic illness	Parents of children with asthma
History of smoking	✓	✓	✓	✓	✓	✓
Intensity of smoking	✓	✓	✓	✓	✓	✓
Provider counseling about smoking	✓	✓	✓	✓	✓	✓
Provider counseling to quit smoking	✓	✓	✓	✓	✓	✓
Smoke-free home						✓

### Summary of Findings

Two of these six performance topics are selected as the focus for this starting point summary:

- Rate of current smoking
- Rate of advice/counseling to quit smoking

As can be seen in Table 4 and Figure 3.3, rates of smoking fall below 20% for teens and people with diabetes, approach 30% for people with a chronic health problem and are around 40% for both parents of children with asthma and people who are depressed.

For most sampled populations, there is a significant need for improvement in counseling smokers to quit. Rates of counseling range from 10% for teenagers to 80.8% for people with diabetes. For the two populations for which smoking rates are highest, approximately two thirds of individuals report being advised to quit smoking by their health care providers (63-67%). See Figure 3.4.

**Tobacco Program:  
Rate of current smoking**

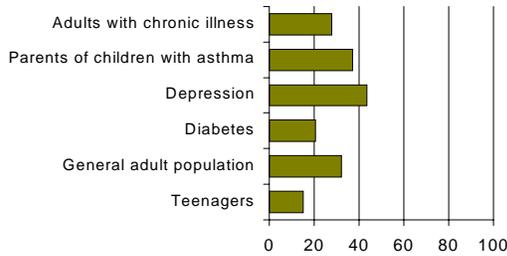


Figure 3.3

**Tobacco Program:  
Rate of counseling to quit**

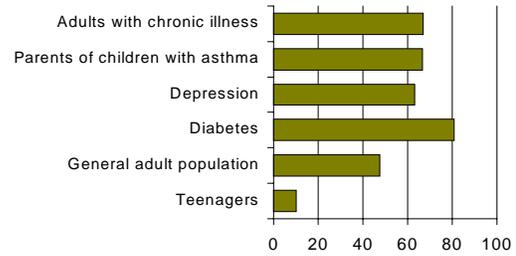


Figure 3.4

Table 4: Selected Tobacco Performance Indicator Scores

Performance Topic	Rates by Sample					
	Teenagers	General Adult	People with Diabetes	People with Depression	People with a chronic illness	Parents of children with asthma
Rate of current smoking	15%	32.2%	20.6%	43.6%	27.9%	37.1%
Rate of counseling to quit smoking	10%	47.4%	80.8%	63.1%	66.9%	66.8%

When variations in rates of current smoking and advice to quit smoking are examined within and across population groups we observe that, in general, older adults and people with health problems are less likely to report currently smoking and, for those who do smoke, more likely to report that they were advised to quit smoking than younger adults and the general population. No clear patterns of variation in rates of smoking or advice to quit smoking were observed according to race or gender.

See Attachment C for summary tables on variations in scores observed across demographic groups. Additional analyses are recommended to further examine the nature and explanation for observed variations.

### 3.3 Health and Behavior

#### Relevant performance topics

Eight performance topics were addressed in the area of physical activity, the primary focus for the Health and Behavior program area. Topics addressed are:

- Physically active (past week)
- Physically active (past 6 months)
- Frequency/intensity of exercise (past week)
- Intentions to engage in physical exercise (next 30 days; next six months)
- Provider counseling to engage in physical activity
- Reasons for lack of physical activity
- Preferred setting for physical activity
- Locations have engaged in physical activity

Table 5 summarizes which of these performance topics is addressed for which sampled populations.

Table 5: Physical Activity: Summary of performance topics addressed for sampled populations

Performance Topic	Samples For Which Topic Is Addressed					
	Teenagers	General Adult	People with Diabetes	People with Depression	People with a chronic illness	Children with asthma
Physically active (past week)		✓	✓	✓	✓	✓
Physically active (past 6 months)		✓	✓	✓	✓	✓
Frequency/intensity of exercise (past week)	✓	✓	✓	✓	✓	✓
Intentions to engage in physical exercise (next 30 days; next six months)		✓	✓	✓	✓	
Provider counseling to engage in physical activity (past 12 months)	✓	✓	✓	✓	✓	✓
Reasons for lack of physical activity		✓	✓	✓	✓	
Preferred setting for physical activity		✓	✓	✓	✓	
Locations have engaged in physical activity		✓	✓	✓	✓	✓

## Summary of Findings

Two of these eight performance topics are selected as the focus for this starting point summary:

- Current physical activity (current - past week)
- Regular physical activity (past six months)
- Counseling on physical activity (past 12 months)

Here, physical activity was defined as set forth by the Centers for Disease Control and Prevention as an activity that is intense enough to increase heart rate and/or breathing levels. To be categorized as regularly physically active, an individual must report that they are physically active for 30 minutes at a time or more and done at least 4 days a week.

As can be seen in Table 6 and Figure 3.5, rates of current physical activity are highest for children with asthma (43.2%) and teenagers (50.9%). Among adults, rates of current physical activity are highest for the general population (23.1%) and people with a chronic condition (17.5%). Lowest rates of physical activity are reported for people with diabetes (15.8%) and people who are depressed (14.6%) despite the known benefits of physical activity for these populations. Overall, rates of physical activity are far below public health targets for all adult populations.

Health & Behavior Program:  
*Physically active past 7 days*

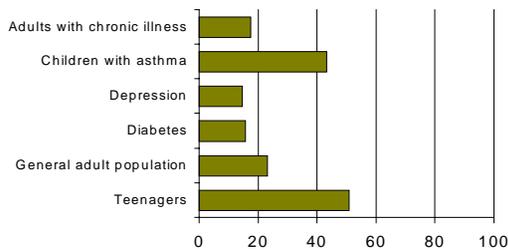


Figure 3.5

Health & Behavior Program:  
*Inactive people advised to exercise*

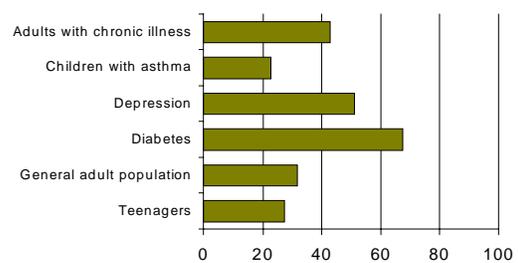


Figure 3.6

Adults with a chronic health problem, diabetes or depression were much more likely than the general adult population or teenage and child populations to report having received provider counseling to engage in physical activity. Even so, rates of counseling are near or under 50% for all sampled populations except for diabetes, which is somewhat higher (67.4%). See Figure 3.6.

Table 6: Selected Physical Activity Performance Scores

Performance Topic	Rates by Sample					
	Teenagers	General Adult	People with Diabetes	People with Depression	People with a chronic illness	Children with asthma
Proportion currently physically active (past week)	50.9%	23.1%	15.8%	14.6%	17.5%	43.2%
Proportion regularly physically active past six months	66.7%	55.6%	38.3%	30.9%	45.5%	81.6%
Proportion of those not physically active counseled by health care provider	27.4%	31.7%	67.4%	51.1%	42.9%	22.8%

When variations in rates of physical activity and counseling to engage in physical activity are examined within and across population groups we observe that, in general, older adults, people with health problems and people reporting higher incomes are more likely to report regular physical activity and counseling to engage in physical activity than younger adults, the general population or lower income individuals. No clear patterns of variation in rates of smoking or advice to quit smoking were observed according to race or gender.

See Attachment C for summary tables on variations in scores observed across demographic groups. Additional analyses are needed to further examine the nature and explanation for observed variations.

### 3.4 Community Health

#### Relevant performance topics included

Seven performance topics are covered in the area of community health. Here only the general teenage and adult populations are examined. Topics addressed are:

- Self-reported health status
- Days bothered by health or emotional problems in past 30 days
- Risk for unhealthy behaviors
- Satisfaction with self and life
- Good physical health days in past 30 days
- Good mental/emotional health days in past 30 days
- Social isolation (adults) or involvement and participation in activities (teens)
- Confidence to care for own health

Table 7 summarizes which of these topics are addressed for the general adult and teen populations.

Table 7: Community Health: Summary of Performance Topics Addressed

Performance Topic	Samples For Which Topic Is Addressed	
	Teenagers	General Adult
Self-reported health status	✓	✓
Days bothered by health or emotional problems in past 30 days	✓	
Risk for unhealthy behaviors	✓	
Satisfaction with self and life	✓	
Good physical health days in past 30 days	✓	✓
Good mental/emotional health days in past 30 days	✓	✓
Social isolation (adults) or involvement and participation in activities (teens)	✓	✓
Confidence to care for own health		✓

#### Summary of Findings

Four of these performance topics are selected as the focus for this starting point summary for the general adult population and three for the teenage population.

## Adults

Proportion reporting Very Good or Excellent health status  
 Proportion with one or fewer poor physical health days in past 30 days  
 Proportion with social isolation score above 70 (equal to 'probably true' or 'true' on all items in scale.)  
 Confidence to care for own health

## Teenagers

Proportion reporting Very Good or Excellent health status  
 Proportion with no days when health or emotional problems bothered in past 30 days  
 Proportion answering 'a lot' or 'somewhat' to all questions about feeling involved in school

As can be seen in Table 8 below, self-reported health status is Very Good or Excellent for nearly two thirds of the teenage population and half of the adult population (61% and 50% respectively). Adults report few poor health days (70% with zero or one poor health days in the past month). However, only 50.5% of teens said that there were no days in the past month when they were not significantly bothered by health or emotional problems. In terms of social isolation or involvement, adults reported higher scores (75.4%) compared to teenagers (55.1%).

Table 8: Selected Community Health Performance Scores

Performance Topic	Rates by Sample	
	Teenagers	General Adult
Proportion reporting Very Good or Excellent health status	61.0%	50.2%
Proportion with one or fewer poor physical health days in past 30 days	NA	70%
Proportion with no days when health or emotional problems bothered in past 30 days	50.5%	NA
Proportion with social isolation score above 70 (equal to 'probably true' or 'true' on all items in scale)	NA	75.4%
Proportion answering 'a lot' or 'somewhat' to all questions about feeling involved in school	55.1%	NA
Confidence to care for own health	NA	56.0%

For adults, when variations in self-reported health status, social isolation and days bothered by health problems are examined across population groups we observe that older adults, males and those reporting higher incomes are consistently more likely to report better health status and fewer days bothered by health problems. In the area of social isolation, older adults, females and those with higher incomes tend to report less social isolation. No clear trends are observed by race group, however there are no indicators where whites report the highest score.

For teenagers, when variations in self reported health status, school involvement and days bothered by health and emotional problems are examined across population groups we observe that older teens and male teenagers tend to report better health status and younger teens report fewer days bothered by health or emotional problems. No significant differences are observed in school involvement according to the gender and age of teenagers.

Association between health status, health behaviors and social isolation

As has been found in other studies (RWJF ADVANCES, Issue 3, 2000), we observe a strong association between increased social isolation and the propensity to engage in unhealthy lifestyle behaviors and report lower general health status.

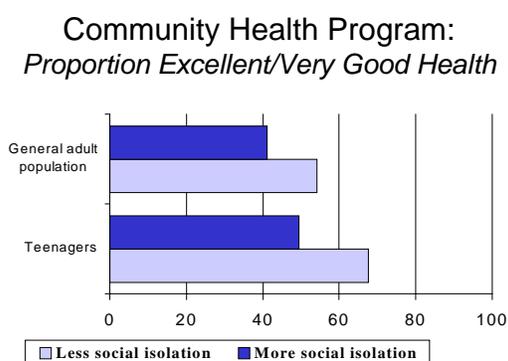


Figure 3.7

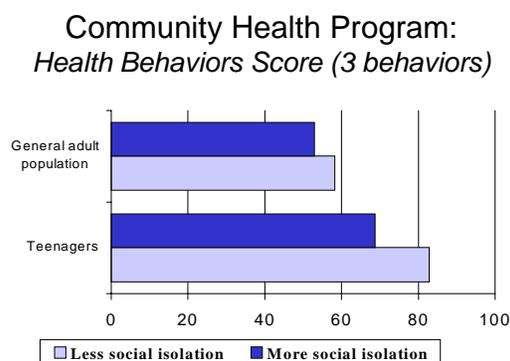


Figure 3.8

In this study, for adults social isolation is assessed using The Interpersonal Support Evaluation List (ISEL) which was developed to assess social support in general populations (1,2) (Cohen, 1983, 1985)<sup>2</sup>. The original ISEL contains 40 items, but a 12-item form was developed by the ISEL creators and used in this study. The 12 items measure three components of social support, labeled “Appraisal”, “Belonging”, and “Tangible”. “Tangible” refers to forms of instrumental support, or help that people receive from others in the form of specific activities (e.g., getting a ride somewhere). “Belonging” refers to having people to do things with (e.g., going to a movie). “Appraisal” refers to personal emotional support (e.g., someone to go to for advice).

We assessed the internal consistency of the ISEL scales using the weighted data from the general adult sample. The internal consistencies score for Appraisal, Belonging, and Tangible were .81, .75, and .68 respectively, which is quite good, especially for 4-item scales. The internal consistency score for the full 12 items was also high, .88, and the

<sup>2</sup> Cohen, S., & Hoberman, H. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology*, 13, 99-125; Cohen, S., Mermelstein, R., Kamarck, T., & Hoberman, H. (1985). Measuring the functional components of social support. In I. G. Sarason & B. R. Sarason (Eds.), *Social support: theory, research, and application*. The Hague, Holland: Martinus Nijhoff.

intercorrelations on the three scales were .58, .60. and .64. Therefore, we report the scores for the three components of social support as well as for the overall score on the scale. For teenagers, social isolation is measured by the degree of involvement in school and extracurricular activities.

As is illustrated in Tables 9 and 10 and Figures 3.7, both adults and teenagers who are categorized as being more socially isolated, are less likely to report having “Very Good or Excellent” health status. Specifically, 12.9% fewer adults and 18.2% fewer teens who are categorized as more socially isolated report “Very Good to Excellent” health status compared to those who are less socially isolated. Similarly, both adults and teenagers who are categorized as being more socially isolated, are less likely to report engaging in healthy lifestyle behaviors. Specifically, 5.2% fewer adults and 14% fewer teens who are categorized as more socially isolated, report healthy lifestyle behaviors compared to those who are less socially isolated. See Tables 9 and 10 and Figure 3.8.

See Attachment C for summary tables on variations in scores observed across demographic groups. Additional analyses are needed to further examine the nature and explanation for observed variations.

Table 9: Reported Health Behaviors and Health Status for Those with More versus Less Social Isolation (individuals qualify as having less social isolation if they answer at least “probably true” to each survey item within a scale)

	<b>Social Isolation: Appraisal Scale</b>		<b>Social Isolation: Belonging Scale</b>		<b>Social Isolation: Tangible Scale</b>		<b>Overall Social Isolation Scale</b>	
	More Social Isolation	Less Social Isolation	More Social Isolation	Less Social Isolation	More Social Isolation	Less Social Isolation	More Social Isolation	Less Social Isolation
Proportion Non Smokers	64.1%	69.0% *	65.3%	68.8%	59.3%	69.9% *	62.6%	70.0% *
Proportion who are not at-risk drinkers	75.8%	80.4% *	81.9%	78.2% *	75.9%	80.1% *	77.7%	79.9%
Proportion who currently exercise (past week)	21.5%	23.6%	17.6%	25.2% *	21.8%	23.4%	19.3%	24.7% *
Average proportion of all 3 healthy behaviors	53.1%	57.8% *	54.7%	57.4% *	52.4%	57.7% *	53.0%	58.2% *
Proportion reporting health status as very good or excellent	37.1%	54.7% *	42.0%	53.4% *	40.2%	52.7% *	41.2%	54.1% *

\*= Observed difference in health behavior and health status scores between those who met and did not meet the social isolation score threshold is significant at least the  $p = .05$  level.

Table 10: Reported Health Behavior and Health Status for Teens According to Level of Involvement in Activities Within and Outside of School.

	School Involvement		Involvement in Extracurricular Activities	
	Somewhat or A lot Involved	Involved a little or not at all	Involved at least one or two days a week	Involved less than one or two days a week
Proportion Non Smokers	91.7%	76.5% *	88.6%	78.0% *
Proportion No Binge Drinking	94.2%	84.0% *	93.4%	82.7% *
Proportion No Illegal Drug Use	91.6%	81.6% *	90.9%	80.3% *
Proportion Physically Active (past week)	55.9%	44.9% *	59.0%	36.1% *
Average proportion of all four healthy behaviors	83.2%	71.3% *	82.8%	68.8% *
Proportion reporting very good or excellent health status	69.3%	51.3% *	67.6%	49.4% *

\*= Observed difference is significant at least the  $p = .05$  level.

### 3.5 Alcohol and Illegal Drug Use

#### Relevant performance topics included

Seven performance topics are addressed in the area of alcohol and illegal drug use. Topics addressed are:

- Frequency and intensity of alcohol use
- Binge drinking
- Provider advises to quit drinking
- Need for and access to alcohol treatment
- Use of illegal drugs (self and friends)
- Provider counseling regarding illegal drugs

Table 11 summarizes which performance topics are addressed for which sampled populations.

Table 11: Alcohol and Drugs: Summary of Performance Topics Addressed

Performance Topic	Rates by Sample				
	Teenagers	General Adult	People with Diabetes	People with Depression	People with a chronic illness
Frequency and intensity of alcohol use	✓	✓	✓	✓	✓
Binge drinking	✓	✓	✓	✓	✓
Provider advises to quit drinking		✓	✓	✓	✓
Provider talks about healthy use of alcohol	✓				
Need for and access to alcohol treatment		✓	✓	✓	✓
Use of illegal drugs (self and friends)	✓				
Provider counseling on illegal drugs	✓				

#### Summary of Findings

Each of these seven performance topics are selected as the focus of this summary:

- Proportion at-risk drinkers
- Proportion reporting binge drinking one or more times in a month
- Rate of counseling on alcohol (for at-risk drinkers only on adult populations)
- Proportion needing alcohol treatment that got it as soon as wanted
- Proportion using illegal drugs
- Rate of counseling to stop illegal drugs

As can be seen in Table 12 and Figure 3.9, across sampled populations 8%-21% of individuals reported a frequency and intensity of drinking that is indicative of alcohol misuse or abuse. At-

risk drinking was defined using guidelines set forth by developers of the AUDIT screening tool.<sup>3</sup> Lowest rates of alcohol misuse are reported for people with diabetes (8%) and those with a chronic condition (13.6%) and are highest for the general population (21.1%).

Among adults who were identified as having at-risk drinking, few were counseled by providers to quit drinking. While this may not be an appropriate standard (quitting vs. counseling), it is

**Alcohol & Drug Program:  
Proportion of at-risk drinkers**

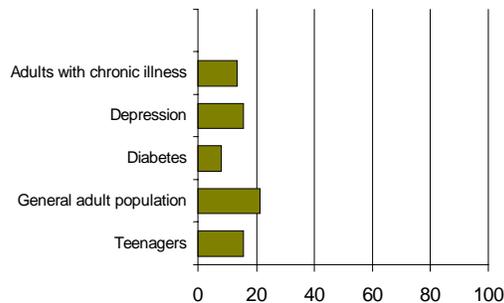


Figure 3.9

**Alcohol & Drug Program:  
Proportion of at-risk drinkers counseled**

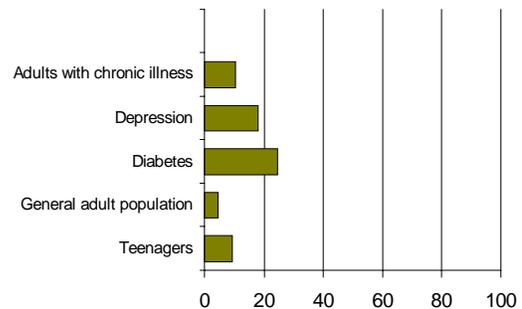


Figure 3.10

appropriate for people with diabetes and depression to be counseled to quit drinking alcohol. Indeed, counseling to quit was highest for people with diabetes (24.4%) and depression (17.9%). However, in both cases, over 75% of at-risk drinkers with diabetes or depression were not counseled to quit drinking. See Figure 3.10.

With respect to teenagers, 15.7% reported binge drinking one time per month or more. Binge drinking was defined as five or more drinks of alcohol on any one occasion. Rates of counseling on alcohol (not quitting) were strikingly low for teenagers (9.3%) as has been found in other studies (Bethell, Klein and Peck, 2000). Similar results were found for illegal drug use. Nearly 13% of teens reported illegal drug use and fewer than 10% of these teens indicated that providers talked with them about stopping using illegal drugs.

For adults, when variations in use of alcohol and counseling to quit at-risk drinking are evaluated, we observe that older adults are consistently more likely to report healthier use of alcohol. There is a tendency for those with lower incomes to also report a healthier use of alcohol as well as higher rates of counseling to quit drinking when at-risk drinking does occur. For several sampled populations, non-white populations were less likely to report unhealthy use of alcohol compared to whites.

For teenagers, when variations in use and counseling on drugs and alcohol are examined across population groups, we observe that younger teens are both less likely to report binge drinking (8% for under 13 vs. 20% for over 16) and illegal drug use (6% for under 14 vs. 18% for over 16) and they are more likely to report counseling on alcohol (14% for under 14 vs. 7% for over 16) and illegal drugs among teens who report using illegal drugs (36% for under 14 and 4.6% for over 16).

<sup>3</sup> Three of ten AUDIT items were included in the survey and scored using age and gender specific guidelines provided by John Higgins-Biddle, PhD.

See Attachment C for summary tables on variations in scores observed across demographic groups. Additional analyses are needed to further examine the nature and explanation for observed variations.

Table 12: Selected Performance Scores on Alcohol and Illegal Drugs

Performance Topic	Rates by Sample				
	Teenagers	General Adult	People with Diabetes	People with Depression	People with a chronic illness
Proportion at-risk drinkers	NA	21.1%	8%	15.7%	13.6%
Proportion reporting binge drinking one or more times in a month	15.7%	19.1%	10.2%	16.9%	12.8%
Rate of counseling on alcohol (for at-risk drinkers only on adult populations)	9.3%	4.5%	24.4%	17.9%	10.4%
Proportion needing alcohol treatment who got it as soon as wanted	NA	N too small	N too small	50.3%	N too small
Proportion using illegal drugs	12.8%	NA	NA	NA	NA
Rate of counseling to stop illegal drugs	9.7%	NA	NA	NA	NA

### 3.6 Supportive Services

#### Relevant performance topics included

Ten performance topics are addressed in the area of supportive services:

- Need for and receipt of special medical equipment
- Need for and receipt of care from a medical provider
- Need for and receipt of home health/personal care
- Need for and receipt of special transportation services
- Need for and receipt of meals delivered at home
- Need for and receipt of rehabilitative therapy
- Need for and receipt of mental/emotional counseling
- Need for and receipt of adult day care
- Need for and receipt of care at a nursing home
- Type of counseling received
- Longest amount of time waited to receive supportive services
- Main reason did not receive needed supportive services

Table 13 summarizes which of these performance topics are addressed for which sampled populations.

Table 13: Supportive Services: Summary of Performance Topics Addressed

Performance Topic	Samples For Which Topic Is Addressed				
	People with Diabetes	People with Depression	People with a chronic illness	Children with Asthma	End of Life Caregivers
Need for and receipt of special medical equipment	✓	✓	✓	✓	✓
Need for and receipt of care from a medical specialist	✓	✓	✓	✓	✓
Need for and receipt of home health/personal care	✓	✓	✓	✓	✓
Need for and receipt of special transportation services	✓	✓	✓	✓	✓
Need for and receipt of meals delivered at home	✓	✓	✓	✓	✓
Need for and receipt of rehabilitative therapy	✓	✓	✓	✓	✓
Need for and receipt of mental/emotional counseling	✓	✓	✓	✓	✓
Need for and receipt of adult day care	✓	✓	✓		
Need for and receipt of care at a nursing home	✓	✓	✓		✓
Type of counseling received	✓	✓	✓	✓	
Longest amount of time waited to receive supportive services	✓	✓	✓	✓	✓
Main reason did not receive needed supportive services	✓	✓	✓	✓	✓

## Summary of Findings

Two of the 12 indicators are selected as the focus of this summary:

**Receipt of Services:** Proportion of individuals with one or more serious need for supportive services who received those services (serious need includes all those who reported that they needed the service and did not indicate that the reason they did not get the service was because they did not need it very badly)

**Waiting for Services:** Proportion of individuals who received supportive services who received those services within one month

In addition, the services for which individuals reported the most difficulty receiving are summarized.

Table 14 and Figures 3.11 and 3.12 summarize findings for the “receipt of services” and “waiting for services” indicators. As can be seen, for adults with chronic conditions, only a little more than one half report that they received supportive services that were seriously needed (52.8%-55.6%). Performance is somewhat higher for children with asthma (78%) and people at the end of life (59.1%). For all four of the chronic condition samples, among the eight types of services asked about, individuals reported the most difficulty in receiving needed services in four areas:

Rehabilitation Services  
Counseling Services  
Transportation Services  
Home Health Services

Most difficult of all was receiving needed rehabilitation and counseling services. For the end of life population the services most commonly reported as needed but not received were home care, nursing home care and rehabilitation and transportation services.

Supportive Services Program:  
*Proportion getting needs met*

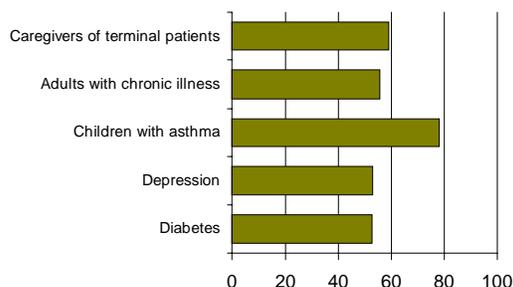


Figure 3.11

Supportive Services Program:  
*Proportion getting services in 1 month*

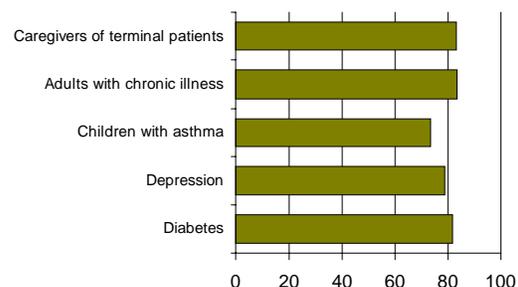


Figure 3.12

While barriers to access to supportive services appear to be significant for all populations, waiting time for receiving services received is less problematic. Nearly 80% of all those who reported receiving needed services also reported receiving them within one month (ranged from 73.5%- 83.2%).

Table 14: Selected Performance Scores on Supportive Services

Performance Topic	Rates by Sample				
	People with Diabetes	People with Depression	People with a chronic illness	Children with Asthma	End of Life Caregivers
Proportion of those with at least one serious need who received needed services	52.8%	53.0%	55.6%	78.0%	59.1%
Proportion of those who received needed supportive services within one month	81.6%	78.9%	83.4%	73.5%	83.2%
Top three services most difficult to receive for each sample (proportion not receiving services said they needed)	Rehabilitation, Counseling, Home Health	Rehabilitation, Counseling, Transportation	Rehabilitation, Counseling, Transportation	Rehabilitation, Counseling, Transportation	Home Care Nursing Home Care Rehabilitation/ Transportation

When need for and receipt of supportive services is examined within and across population groups we observe that older adults, males, those with higher incomes and non-whites tend to report the fewest problems getting needed services and getting them quickly. The one exception is the end of life population, where caregivers of white females who died report the fewest problems.

See Attachment C for summary tables on variations in scores observed across demographic groups. Additional analyses are needed to further examine the nature and explanation for observed variations.

## 3.7 End of Life

### Relevant performance topics included

Thirteen performance topics are addressed for patients at the end of life and their caregivers:

#### Outcomes of Care

- Peaceful death
- Caregiver burden during end of life episode
- Pain and emotional distress of patient during the final illness
- Treatment wishes honored
- Correct level of intervention for pain and suffering (not too much or too little done)
- Possession of living will and/or power of attorney
- Spiritual beliefs honored

#### Process and Access to Care

- Coordination of Care
- Access to supportive services
- Involvement in and comfort with treatment/care decisions
- Written care plan
- Caregiver communication and support during final illness
- Good communication about process to manage pain

### Summary of Findings

Results for eleven of the thirteen topics selected as the focus for this summary are summarized in Table 15 and Figure 3.13. Performance on Access to Supportive Services and Waiting Time for Supportive Services for the end of life population is also reviewed in the Supportive Services Program Area Summary (Section 3.6).

As already summarized in Section 2.1 of this report, overall, caregivers report relatively better help in advance preparations and achieving a peaceful death than in minimizing suffering, receiving support as caregivers, having the patient's spiritual beliefs and treatment wishes honored and getting information about and being involved in care decisions.

In general, scores are consistently higher for older patients (over 85 years of age) and those with higher incomes, especially in the areas of managing pain, supporting caregivers and honoring treatment wishes. Interestingly, those with lower incomes and non-white populations tend to be more likely to report a peaceful death in spite of lower scores on other dimensions of performance.

## End of Life Program: *Services at the end of life*

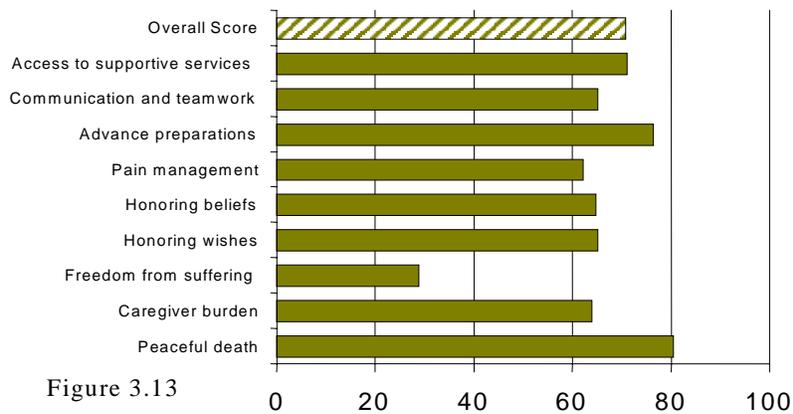


Figure 3.13

Table 15: Performance Scores on End of Life Care

Performance topics	Performance Score
<b>Involvement in and comfort with treatment/care decisions:</b> Proportion answering “yes” to 4 of 5 survey items.	68.3%
<b>Caregiver communication and support:</b> Proportion answering “yes” to 3 of 4 survey items.	51.5%
<b>Communication about managing pain:</b> Average proportion of “yes” answers on survey item about communicating about pain mgt.	62.0%
<b>Management of pain:</b> Proportion with satisfaction with the level of intervention to manage pain (not too much or too little was done to manage pain)	62.0%
<b>Advance Preparations:</b> Proportion with a living will or power of attorney	70.3%
<b>Honoring treatment wishes:</b> Proportion answering “mostly” or “completely” to survey items.	68.2%
<b>Honoring spiritual beliefs:</b> Proportion reporting no barriers to having spiritual beliefs honored	64.7%
<b>Freedom from Suffering:</b> Level of physical and emotional distress of patient during the final illness was no greater than “somewhat difficult” vs. “very or extremely difficult”	28.7%
<b>Caregiver burden:</b> Proportion with a score of 50 or above on survey scale (equivalent to answering at least “moderately, but tolerable” to each of four items).	63.8%
<b>Peaceful death:</b> Proportion with “yes” response to question about whether patient had a peaceful death	80.5%
<b>Written care plan:</b> Proportion indicating that they and the provider(s) developed/have a written care plan on how to care for the patient at the end of life	82.4%

See Attachment C for summary tables on variations in scores observed across demographic groups. Additional analyses are needed to further examine the nature and explanation for observed variations.

## Section 3.8 Priority Populations and Access to Care

### Relevant performance topics included

Ten survey topics on access to care are addressed for different racial and income groups (race and income information collected for adult populations only). Topics addressed are:

- Type of health insurance coverage
- Having a regular doctor or other health provider
- Type and location of regular provider
- Number of provider visits in last 12 months
- Having a regular dentist
- Number of visits to dentist in last 12 months
- How often got timely medical care when needed it, got help or advice by phone and got appointments in a timely manner.
- How often got timely medical and dental care when needed it, got help or advice by phone and got appointments in a timely manner.
- Access to supportive services
- Waiting time to receive supportive services

Table 16 summarizes which of these topics are addressed for which sampled populations.

Table 16: Insurance Coverage and Access: Summary of Performance Topics Addressed

	Samples For Which Topic Is Addressed				
	General Adult	People with Diabetes	People with Depression	People with a chronic illness	Children with Asthma
Type of health insurance coverage	✓	✓	✓	✓	✓
Having a regular doctor or other health provider	✓	✓	✓	✓	✓
Type and location of regular provider	✓	✓	✓	✓	✓
Number of provider visits in last 12 months	✓	✓	✓	✓	✓
Having a regular dentist	✓	✓	✓	✓	✓
Number of visits to dentist in last 12 months	✓	✓	✓	✓	✓
How often got timely medical care when needed it, got help or advice by phone and got appointments in a timely manner	✓	✓	✓	✓	✓
How often got timely dental care when needed it, got help or advice by phone and got appointments in a timely manner	✓	✓	✓	✓	✓
Access to supportive services	✓	✓	✓	✓	✓
Waiting time to receive supportive services	✓	✓	✓	✓	✓

## Summary of Findings

Table 17 summarizes performance scores for eight of the ten access to care topics for white vs. non-white populations:

- Proportion having a regular doctor or other health provider
- Proportion with at least one health care visit in the past 12 months
- Proportion having a regular dentist
- Proportion with at least one dental visit in the past 12 months
- How often got timely medical care when needed it, got help or advice by phone and got appointments in a timely manner.
- How often got timely medical and dental care when needed it, got help or advice by phone and got appointments in a timely manner.
- Proportion receiving needed supportive services
- Proportion having to wait one month or less to receive supportive services

As can be seen in Table 17, there are statistically significant differences between white and non-white populations in reported access to care in each of these eight areas. In all cases, scores for whites are higher than for non-whites. The average difference in scores across the

### Coverage & Access Program:

*Timely access to medical care - by race*

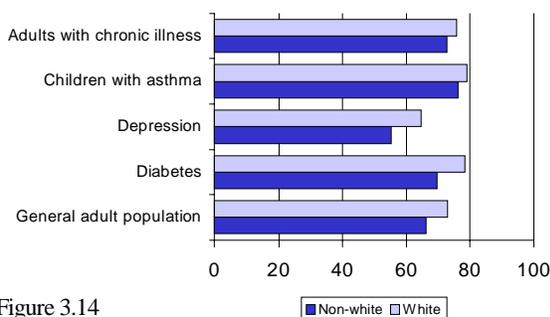


Figure 3.14

### Coverage & Access Program:

*Timely access to dental care - by race*

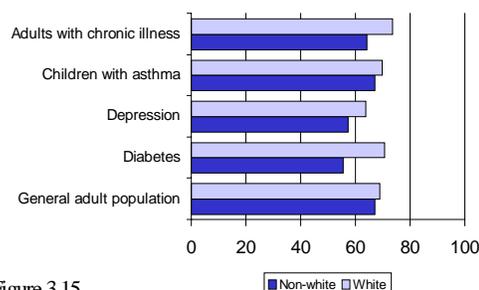


Figure 3.15

eight indicators according to race range from 1.4% to 8.15% across sampled populations.

Among the eight indicators, the biggest average differences in scores between whites and non-whites across sampled populations are “timely to dental care” (13.3%), “access to supportive services” (10%) and “waiting for supportive services” (9.7%).

The smallest differences in access by race were observed for children with asthma and most pronounced for people with depression. Across the eight access indicators listed in Table 17, average racial difference in scores for children with asthma was 3.7%. The average racial difference for people with depression was 6.9%.

As will be seen in the next program area summary (insurance status and access to care), the impact of race on access to care is much less than that of insurance status. As noted earlier, the average differences in performance scores between whites and non-whites across the eight indicators and sampled populations is 1.4%-8.15% whereas the average differences are 8.5%-24.5% for insurance status.

Table 17: Variation in Access to Care Indicators: White vs. Non-White (all indicators are proportions/rates)

Performance Value	Adult Core		Diabetes		Depression		Pediatric Asthma		Adult Chronic	
	White	Non-White	White	Non-White	White	Non-White	White	Non-White	White	Non-White
Average Score Across Indicators	71.5	68.4	73.9	68	70.4	65	79.2	75.6	77.2	73.3
Regular doctor	81.16	76.39	96.49	94.26	87.69	81.23	97.95	95.57	93.69	89.87
At least one visit to doctor	86.97*	83.96	98.21	96.81	95.61	92.01	98.19*	98.73	96.63*	97.29
Regular dentist	58.14*	56.06	56.35	50.93	57.61	49.42	76.73	73.48	67.54	62.23
At least one visit to dentist	60.78*	60.83	58.74	56.41	60.03*	60.63	80.08*	78.48	68.34*	70.08
Reported timely access to medical care	72.99	66.22	78.37	69.70	64.61	55.16	78.98	76.24	75.74	72.64
Reported timely access to dental care	68.98*	67.19	70.74	55.62	63.68	57.27	69.87	67.12	73.50	64.28
Receiving all supportive services seriously needed	N/A	N/A	50.47	40.22	53.90	50.11	54.76	49.08	55.62*	55.41
Receiving supportive services within one month	N/A	N/A	82.12*	80.41	80.36	74.11	76.74	66.50	86.45	75.03
Receiving treatment for alcohol abuse quickly	N/A	N/A	Sample too small		54.14*	34.73	N/A	N/A	Sample too small	

\* = difference between white and non-white samples is not statistically significant

When we examine variations in reported access to care for Hispanic and non-Hispanic populations, across the eight core access to care measures differences are either not significant or are less than 10% (range: Hispanic 1.1% higher to 8.3% lower scores compared to non-Hispanic population). Among the eight core access to care indicators, the largest differences are observed in reported experience getting timely access to care. See Figure 3.16.

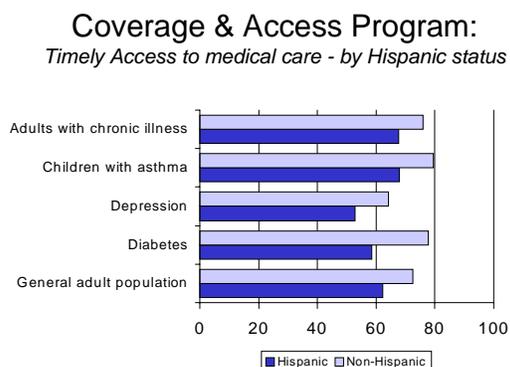


Figure 3.16

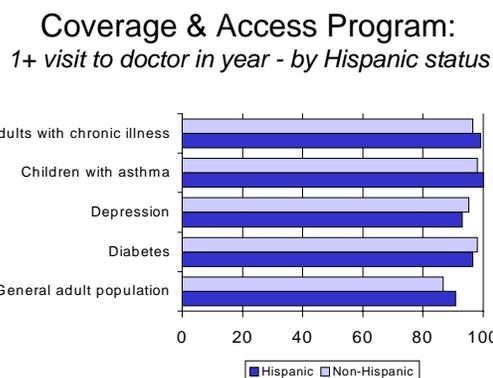


Figure 3.17

Those reporting an Hispanic ethnic affiliation report significantly more problems getting timely care (range across sampled populations: Hispanic 10% less likely to 19% less likely than non-Hispanic population). The largest differences in reported ease of getting timely access to care between the Hispanic and non-Hispanic population is observed for people with diabetes (Hispanic 19% lower score) followed by children with asthma and people with depression (Hispanic 11.5% and 11.3% lower scores, respectively).

Smallest differences are observed in reports of having at least a yearly health care visits (range across sampled populations: Hispanic 4.2% more likely to 2.1% less likely than non-Hispanic population). See Figure 3.17.

As can be seen in Table 18, across each of the eight core access to care indicators, the largest difference between the Hispanic and non-Hispanic population is observed for the general chronically ill population (average 8.3% lower access scores) followed by people with depression and children with asthma (average 4.8% and 4.9% lower access scores respectively) and diabetes (average 1.8% lower access scores).

We observe that the average reported income for Hispanic individuals is not significantly different than that reported by non-Hispanic individuals. However, in the general adult population, Hispanic individuals are much more likely to report not having insurance coverage (27.2% vs. 14.5%). Perhaps this combination of factors explains the observation that those who report an Hispanic ethnic affiliation do get care, but have a harder time doing so.

Multi-variate analysis is required before conclusions can be made about the unique impact of race and ethnicity on access to care and to further examine the nature and explanation for observed variations. See Attachment C for additional information on variations in scores observed across demographic groups.

Table 18: Variation in Access to Care Measures: Hispanic versus non-Hispanic (all measures are proportions/rates)

Performance indicator	Adult Core		Diabetes		Depression		Pediatric Asthma		Adult Chronic	
	Hispanic	Not Hispanic	Hispanic	Not Hispanic	Hispanic	Not Hispanic	Hispanic	Not Hispanic	Hispanic	Not Hispanic
Regular doctor	80.8%	79.2%	90.9%	96.3% *	80.8%	86.9% *	94.0%	97.8% *	88.4%	93.1% *
At least one visit to doctor	90.8%	86.6%	96.4%	98.0% *	93.0%	95.1% *	100.0%	98.1% *	99.2%	96.5% *
Regular dentist	58.6%	56.2%	53.4%	54.8%	53.0%	56.7%	69.3%	76.5% *	59.0%	66.6% *
At least one visit to dentist	62.5%	59.8%	67.6%	57.2% *	59.7%	60.1%	68.5%	81.0% *	69.9%	68.4%
Reported timely access to medical care	62.3%	72.4% *	58.6%	77.7% *	52.9%	64.2% *	68.0%	79.5% *	67.7%	75.9% *
Reported timely access to dental care	75.3%	66.7% *	62.5%	66.6%	60.1%	63.0%	57.3%	70.6% *	63.9%	71.8% *
Receiving all supportive services seriously needed	NA	NA	54.6%	46.4% *	51.4%	53.5%	51.2%	53.1%	33.3%	57.0% *
Receiving supportive services within one month	NA	NA	70.8%	83.3% *	80.4%	79.5%	70.2%	75.2%	66.3%	84.6% *
Receiving treatment for alcohol abuse quickly	NA	NA	NA	NA	37.9%	53.9%	NA	NA	NA	NA
Average Differences Between Hispanic and Non-Hispanic Across Measures	Hispanic 1.1% higher on average across eight measures		Hispanic 1.8% lower on average across eight measures		Hispanic 4.8% lower on average across nine measures		Hispanic 4.9% lower on average across eight measures		Hispanic 8.3% lower on average across eight measures	

\* = difference between Hispanic and non- Hispanic samples **IS** statistically significant (p<.05). Hispanic includes any race (white, black etc.) reporting an Hispanic ethnic affiliation.

### 3.9 Insurance Status and Access to Care

#### Relevant performance topics included

Ten survey topics on access to care are addressed for those who report having any type of health insurance and those who do not report having any type of health insurance. Access to care topics addressed are:

- Type of health insurance coverage
- Having a regular doctor or other health provider
- Type and location of regular provider
- Number of provider visits in last 12 months
- Having a regular dentist
- Number of visits to dentist in last 12 months
- How often got timely medical care when needed it, got help or advice by phone and got appointments in a timely manner.
- How often got timely medical and dental care when needed it, got help or advice by phone and got appointments in a timely manner.
- Access to supportive services
- Waiting time to receive supportive services

Table 19 summarizes which of these topics are addressed for which sampled populations.

Table 19: Insurance Coverage and Access: Summary of Performance Topics Addressed

Performance Topic	Samples For Which Topic Is Addressed				
	General Adult	People with Diabetes	People with Depression	People with a chronic illness	Children with Asthma
Type of health insurance coverage	✓	✓	✓	✓	✓
Having a regular doctor or other health provider	✓	✓	✓	✓	✓
Type and location of regular provider	✓	✓	✓	✓	✓
Number of provider visits in last 12 months	✓	✓	✓	✓	✓
Having a regular dentist	✓	✓	✓	✓	✓
Number of visits to dentist in last 12 months	✓	✓	✓	✓	✓
Reported experiencing accessing medical care in a timely manner	✓	✓	✓	✓	✓
Reported experience in accessing dental care in a timely manner	✓	✓	✓	✓	✓
Access to supportive services	✓	✓	✓	✓	✓
Waiting time to receive supportive services	✓	✓	✓	✓	✓

Across all sampled populations, approximately 17% of individuals reported not having health insurance with younger populations, those with lower incomes, males and non-whites more likely to report not having any type of health insurance. See Attachment C for a table summarizing reported insurance status by sampled population and demographic groups.

## Summary of Findings

Table 20 summarizes performance scores for eight of the ten access to care topics for insured vs. uninsured populations:

- Proportion having a regular doctor or other health provider
- Proportion with at least one health care visit in the past 12 months
- Proportion having a regular dentist
- Proportion with at least one dental visit in the past 12 months
- How often got timely medical care when needed it, got help or advice by phone and got appointments in a timely manner.
- How often got timely medical and dental care when needed it, got help or advice by phone and got appointments in a timely manner.
- Proportion receiving needed supportive services
- Proportion having to wait one month or less to receive supportive services

As can be seen in Table 20, there are statistically significant and often strikingly large differences between insured and uninsured populations in reported access to care in each of these eight areas. In all cases, scores for those reporting insurance are higher than for those not reporting insurance coverage. The average difference in scores across the eight indicators according to insurance status range from 8.5% to 24.5% across sampled populations.

**Coverage & Access Program:**  
*Have regular doctor? - by insurance*

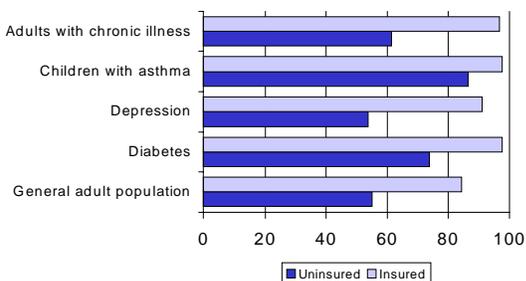


Figure 3.18

**Coverage & Access Program:**  
*Timely access to medical care - by insurance*

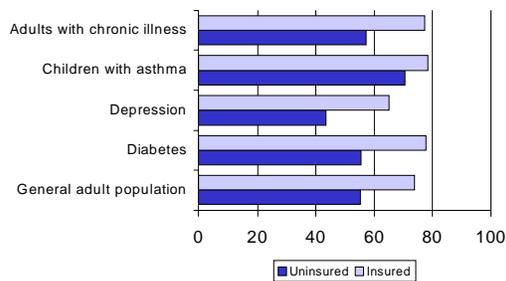


Figure 3.19

Among the eight core access to care indicators, the biggest average differences in scores between insured and uninsured people are for “having a regular doctor” (26%), “timely access

to dental care” (23%) and “reporting timely access to medical care” (18.4%). Figure 3.18 illustrates observed differences in the “regular doctor” indicator across

**Coverage & Access Program:**  
*Have regular dentist? - by insurance*

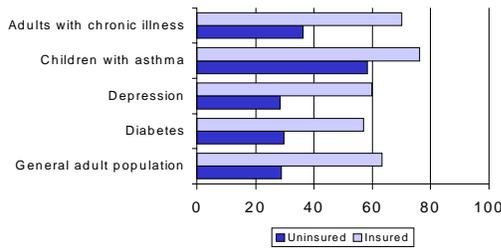


Figure 3.20

**Coverage & Access Program:**  
*Timely access to dental care - by insurance*

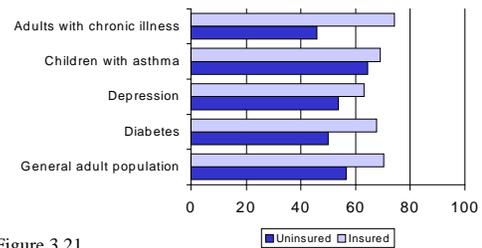


Figure 3.21

**Coverage & Access Program:**  
*1+ visit to doctor in year - by insurance*

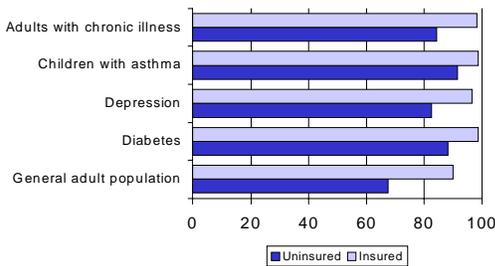


Figure 3.22

**Coverage & Access Program:**  
*1+ visit to dentist in year - by insurance*

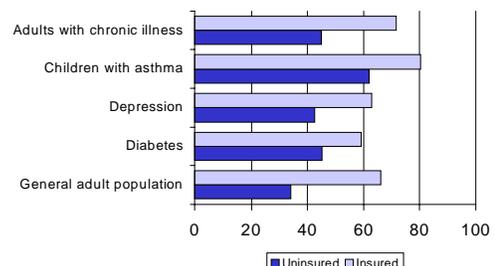


Figure 3.23

Sampled populations and the Figure 3.19 illustrate differences observed in the “timely access to medical care” indicator across sampled populations. Figures 3.20-3.23 illustrate differences in other access to care scores by insurance status.

As depicted in Figures 3.18-3.23, the smallest differences in access to care scores are observed for children with asthma and most pronounced for people with depression. Across the eight access indicators listed in Table 20, average difference in scores by insurance status for children with asthma was 11.95%. The average difference in scores by insurance status for people with depression was 20.5%.

As noted in the previous program area summary (Priority Populations, Section 3.8), the impact of insurance status on access to care appears to be much greater than that of race. The average differences in performance scores between insured and uninsured across the eight indicators and sampled populations is 8.5%-24.5% whereas the average differences are 1.4%-8.15% for racial group (white vs. non-white).

Multi-variegate analysis is required before conclusions can be made about the unique impact of reported insurance status on access to care and to further examine the nature and explanation for observed variations. See Attachment C for additional information on variations in scores observed across demographic groups.

Table 20: Variation in Access to Care Indicators: Insured vs. Uninsured (indicators are all proportions/rates)

Performance Value	Adult Core		Diabetes		Depression		Pediatric Asthma		Adult Chronic	
	Insured	Not Insured	Insured	Not Insured	Insured	Not Insured	Insured	Not Insured	Insured	Not Insured
Average Score Across Indicators	74.6	49.5	73.6	54.7	70.7	47.6	78.4	66.6	78.7	56.8
Regular doctor	84.3	55.1	97.7	73.8	91.1	53.7	97.6	86.4	96.8	61.3
At least one visit to doctor	89.9	67.5	98.6	88.2	96.6	82.5	98.7	91.5	98.3	84.2
Regular dentist	63.3	28.9	56.9	29.6	59.9	28.4	76.3	58.2	70.1	36.2
At least one visit to dentist	66.1	34	59.1	45.3	62.8	42.6	80.3	62.1	71.6	45
Reported timely access to medical care	73.9	55.2	77.7	55.5	65.1	43.4	78.3	70.5	77.2	57.2
Reported timely access to dental care	70.4	56.5	67.7	50.1	63.2	53.8	69.1	64.4	74.2	45.9
Receiving all supportive services seriously needed	NA	NA	49.6	19.6	56.9	30.3	53.3	38.4	57.8	42.8
Receiving supportive services within one month	NA	NA	81.8	75.7	79.2	76.1*	73.8	61.5	83.6	81.7*
Receiving treatment for alcohol abuse quickly	NA	NA	Sample too small		61.8	17.3	NA	NA	Sample too small	

\* = difference between insured and not insured samples is **not** statistically significant

## **Section 4**

### **Recommendations for Future Work**

The RWJF National Strategic Indicators Survey project has yielded valuable information for understanding health care quality in America and informing existing and future Foundation efforts. To ensure that the information collected is most effectively used, FACCT recommends four areas for future work:

- Additional Technical Analysis
- In-depth RWJF Program Area Analyses
- Communication of Findings
- Planning for Future Updates

#### **4.1 Additional technical analysis**

While analyses conducted so far support the validity of the findings presented in this report, several new analyses are required to:

- Further assess the representativeness and, hence, generalizability, of the on-line samples
- identify benchmark comparisons for findings
- evaluate the psychometric properties of the many survey scales included and
- evaluate the nature and explanation for observed variations in performance scores both within and across sampled population groups.

In addition, if the Foundation is interested in creating cross-sample leading indicator scores or in using the leading indicator scores or other performance indicators for purposes of comparing performance within or among populations or health care system groupings, additional work is needed to ensure that sound risk adjustment and index development methods are employed for doing so.

We recommend that, as a first step, further technical analysis of the RWJF National Strategic Indicators Survey data be done to address these issues.

#### **4.2 In-depth program area analysis**

While the baseline performance summaries set forth in this report inform RWJF priority area program staff, numerous observations and opportunities for useful analysis are not fully discussed. We recommend that additional program area specific analyses and reports be pursued.

#### **4.3 Communication of findings**

With this project, RWJF has compiled an important national information resource. We believe that a number of audiences would benefit from access to the survey results, though we

recognize that the complexity of the data structure and its limited generalizability will require publication and distribution of results in a controlled way.

We encourage RWJF to explore several formats and channels for further distribution of these results. Generally, we believe that the Foundation should create both print and web products, and make them available to affected interest groups. We would recommend that the following products be created:

a. Print reports

- Chartbook & executive summary for general distribution
- Audience-specific reports (brief)
- Depression
- Diabetes
- Pediatric asthma
- Teenage health
- End of life
- Tobacco
- Alcohol

b. Web distribution

Establish a web site area with .html, .pdf and downloadable formats of the print reports, including the surveys themselves. RWJF should also consider offering the surveys in an on-line self-administered form for consumers to use directly.

In addition, the Foundation should consider a media or public event to share results of the surveys.

#### **4.4 Planning for future updates**

These surveys were undertaken in order to establish baseline indicators of national health and health care system performance. The work performed to date provides the basis of a long-term indicator tracking process, but it should be regarded critically and humbly. Given the newness of the methods and some of the indicators as well as the relatively rapid execution of this project, we recommend that key program staff in consultation with selected external stakeholders be engaged to identify any important gaps in this survey, new areas of interest, critical areas of continuity, and opportunities for methodological improvement.

It will be important to retain indicators, which provide a year 2000 baseline indicator of national performance, while improving and adding indicators where the need exists. We also recommend that additional data analyses be conducted to respond to the findings of the review and identify desirable changes in the method or indicators. We suggest the development of a revised project protocol reflecting both the qualitative and quantitative reviews. Such a protocol, approved by internal staff, could form the basis of a request-for-proposals for future survey or analysis vendors.

## List of Documents

### Attachment A:

- A1. Robert Wood Johnson Foundation National Strategic Indicators Survey Timeline and Work Conducted by FACCT
- A2. RWJF National Strategic Indicators Survey Summary of Survey Design and Sampling
- A3. Weighting Plan for Strategic Initiatives Tracking
- A4. Sample E-mail Invitation

## Attachment A1

### Robert Wood Johnson Foundation National Strategic Indicators Survey Overview of Timeline and Work Conducted by FACCT

FACCT's role has been to assist in project design, oversee the development of survey content needed to construct performance measures for each topical area and conduct data analysis to produce these measures.

FACCT was responsible for constructing performance measures for seven samples: teenagers, general adult population, people with diabetes, people with depression, people with chronic health problems, parents of children with asthma, and caregivers of people who have died.

FACCT's work can be organized into several areas and time periods as summarized in Table 2 below.

Table 2: Summary of FACCT's work and timeline

Area	Timeline	Products and Comments
Project conceptualization and design	January-February, 2000	Proposal for sampling and survey content needed to construct performance measures for nine RWJF program areas and seven population samples.
Survey design and editing	February-April, 2000	Final surveys incorporated FACCT recommended items and many additions and edits by Harris and RWJF. See <b>Appendices A-G</b> for copy of final surveys fielded and aggregate findings for each survey item.
Support finalization of surveys, data collection and data base construction by Harris Interactive	April-June, 2000 (modifications and delivery of data by Harris was ongoing up to August, 2000)	See <b>Attachment A</b> for summary of final sampling frame for each sample and a summary of weighting procedures used by Harris Interactive to help make the samples representative of the general population.
Specification of performance measures to be calculated	April-June, 2000	See <b>Appendices A-G</b> for description of performance measures calculated for each data set FACCT analyzed.
Construction of performance measures and indices	June-August, 2000	Performance indices for each sample as well as according to RWJF priority areas were created. See <b>Appendices A-G</b> for results of calculated performance measures for each of seven samples: teens, general population, chronically ill, people with depression, people with diabetes, children with asthma, caregivers of people who have died.
Prepare final report	August, 2000	

## Attachment A2 Summary of Survey Design and Sampling

### Identifying performance topics and survey items for purposes of indicator construction

FACCT's role in identifying performance topics and related survey items and scales was based on FACCT's overall approach to defining and measuring health care quality using patient and consumer based performance measures.

Over the past four years, FACCT has developed a series of health care performance measures based on patient or consumer self-report. Each performance measure is based on published practice guidelines, consensus statements, or peer-reviewed literature and has been extensively reviewed by professional societies and recognized experts as well as by consumers to ensure the relevance of indicators to the public.

FACCT's approach to performance measurement reflected in the RWJF National Strategic Indicators Survey has been guided by two broad assumptions:

1. An effective U.S. **health system** should address five broad aspects of our lifetime health care experience:
  - a) Access to care
  - b) Staying healthy
  - c) Getting better when acute health problems arise
  - d) Living as well as possible with ongoing chronic health problems
  - e) Adapting to changing needs such as at the end of life
2. Effective, high quality **health care** should address four dimensions:
  - a) Achieving positive health *outcomes*
  - b) Delivering *appropriate* (i.e., evidence-based) care
  - c) Effecting a positive patient-provider *partnership*
  - d) Enabling patient self-management and *self-efficacy*

Each of these concepts is complex and multi-dimensional, and may be played out differently for different health problems. FACCT's approach in the RWJF National Strategic Indicators Survey project has been to construct four leading indicator composite scores for each sampled population. These leading indicator composite scores correspond to several RWJF priority funding areas:

1. **Access to Care:** Consumer reported experience with getting needed care and supportive services experience with their health care providers.
2. **Staying Healthy:** Health care to help people stay healthy
3. **Living With Illness:** Health care for people living with an ongoing health problem or chronic illness
4. **Consumer Empowerment:** Information seeking and self-advocacy behaviors and attitudes of consumers and patients.

In addition, for the end of life sample, we have constructed a **Changing Needs** leading indicator composite score.

Each index is made up of many individual measures, each of which is specific to a particular health problem or service. Altogether, 148 individual performance indicators are incorporated into the leading indicator composite scores across the seven survey samples. See Appendix A-G for a delineation of indicators included for each sample.

Table 1 below summarizes the performance measurement topics consistently incorporated in the construction of the leading indicator composite scores for sampled populations. As can be seen, both process and outcome measures are included and cover topics ranging from self confidence to care for one's health (self-efficacy) and health behaviors to receiving clinically indicated services and access to supportive services.

By collecting numerous, scientifically valid quality measures in the areas of performance summarized in Table 1, we can construct a variety of leading indicator scores to inform priority concerns of the Foundation. Table 2 illustrates how the measurement concepts outlined in Table 1 are incorporated into the construction of each of the five leading indicator indices.

As can be seen in Table 1, performance topics are included that address the specific concerns of RWJF priority areas, such as smoking, access to care and clinical care for people with chronic conditions. Separate analysis of these performance measures is conducted to construct the RWJF priority program area specific pictures of performance included in Section 3 of this report.

Table 1: Performance measure topics addressed across each of the seven online samples (note: additional concepts addressed for end of life care are not fully summarized here)

Outcome Measures	Process Measures	Access to Care Measures	Consumer Empowerment Measures
<p>1. Health Status and Quality of Life</p> <ul style="list-style-type: none"> <li>✓ Reported health status</li> <li>✓ Days lost due to health</li> <li>✓ Social isolation status</li> </ul> <p>2. Healthy Life Style</p> <ul style="list-style-type: none"> <li>✓ Smoking</li> <li>✓ Risky drinking</li> <li>✓ Physical Activity</li> </ul> <p>3. Self -Efficacy</p> <ul style="list-style-type: none"> <li>✓ Confidence to care for own health</li> </ul>	<p>4. Getting Appropriate Care</p> <ul style="list-style-type: none"> <li>✓ Clinical tests, procedures and medications</li> </ul> <p>5. Risk Reduction Counseling</p> <ul style="list-style-type: none"> <li>✓ Advice to quit smoking, engage in physical activity and stop risky drinking</li> </ul> <p>6. Education and Teamwork</p> <ul style="list-style-type: none"> <li>✓ General self care education and support</li> <li>✓ Condition specific patient education</li> <li>✓ Coordination of care</li> <li>✓ Shared decision making/involvement</li> </ul>	<p>7. Getting Needed Care</p> <ul style="list-style-type: none"> <li>✓ Rating ease of access to medical and dental care</li> </ul> <p>8. Medical Home</p> <ul style="list-style-type: none"> <li>✓ Regular care provider</li> <li>✓ Minimum of one visit per year</li> </ul> <p>9. Access to Supportive Services</p> <ul style="list-style-type: none"> <li>✓ Getting needed services</li> <li>✓ Getting services in a timely manner</li> </ul>	<p>10. Self-Advocacy</p> <ul style="list-style-type: none"> <li>✓ Likelihood of actively seeking information and asking questions about health, health care and quality of medical professionals</li> </ul>

Table 2: Description of RWJF Priority Area Leading Indicator Scores

Leading Indicator Index	Samples Included	Performance Measure Topics Included
<p><b>Living With Illness</b> Health care for people living with an ongoing health problem.</p>	<p>A Living With Illness index is created for each of the four samples of people with chronic health problems.</p>	<p>The health status and quality of life, self - efficacy, getting appropriate care, education and teamwork and avoiding serious exacerbation's (asthma only) performance scores are included.</p>
<p><b>Staying Healthy</b> Health care to help people stay healthy</p>	<p>A Staying Healthy index is created for the general adult and teen samples combined and for each of the four chronic sample</p>	<p>The health status and quality of life, healthy lifestyle and risk reduction counseling performance scores are included.</p>
<p><b>Access to Care</b> Consumer reported experience with getting access to care and supportive services and having regular providers and visits</p>	<p>An Access to Care index is created for the general adult and teen samples, for each of the four chronic samples and for people at the end of life.</p>	<p>The getting needed care, medical home and access to supportive services performance scores are included.</p>
<p><b>Changing Needs</b> Health care for people experiencing severe disability or terminal illness and their caregivers</p>	<p>Data from the survey of caregivers of people who have died is included in this summary score.</p>	<p>The caregiver burden, peaceful death, freedom from suffering, pain management, advance preparations and honoring spiritual beliefs and treatment wishes performance scores are included.</p>
<p><b>Consumer Empowerment</b> Information seeking and self-advocacy behaviors and attitudes of consumers and patients.</p>	<p>A Consumer Empowerment index is created for the general adult population and for each of the four samples of people with chronic health problems.</p>	<p>The self-advocacy performance scores are included. NOTE: Scope of survey items is limited for this category.</p>

### Sampling Frame and Characteristics of Respondents

Harris Interactive maintains a database of over 5 million Americans willing to reply to on-line health surveys. Harris has conducted preliminary surveys of these panelists so that it can field surveys to specific groups – such as people diagnosed with diabetes or who have recently

cared for someone facing terminal illness. Attachment A summarizes the methods used by Harris Interactive to invite individuals in its online sample to complete the surveys as well as an overview of the weighting methodology used to help adjust the online data to be more representative of the population.

Characteristics of the sampling frame and completed samples for the seven surveys are summarized in Table 3 below.

Table 3: Summary of Sampled Populations—weighted values in parenthesis

Sampled Population	Characteristics of Sampling Frame						
	Starting Sample Size	% Female	% Non-White	<18 age	18-49 age	50-64 age	65+ age
<b>Teenagers</b>							
Starting Sample	124,050	50.0%	1.6% [91.6% refused]	(13-17) 53.2%	(18-24) 46.7%	0.0%	0.0%
Completed Sample	1240 (1240)	71.5% (48.6%)	18.2% (22.2%)	(13-17) 100.0% (100.0%)	0.0% (0.0%)	0.0% (0.0%)	0.0% (0.0%)
<b>General adult population</b>							
Starting Sample	31,314	42.5%	3.2% [74.5% refused]	0.0%	67.5%	27.4%	4.9%
Completed Sample	2433 (2433)	53.6% (52.0%)	9.1% (21.8%)	0.0% (0.0%)	54.2% (64.3%)	36.5% (19.5%)	9.4% (16.2%)
<b>Adults with a chronic conditions</b>							
Starting Sample	160,062	52.0%	Not available	0.0%	64.2%	30.4%	5.3%
Completed Sample	9,688 (8,447)	63.6% (57.7%)	8.1% (17.0%)	0.0% (0.0%)	42.3% (48.3%)	48.1% (26.8%)	9.6% (24.8%)
<b>Pediatric Asthma</b>							
Starting Sample	199,999	40.8%	3.0% [82.2% refused]	0.0%	96.3%	3.7%	0.0%
General Pop. (adults)	30,986	63.2%	10.7% [33.2% refused]	0.3%	86.5%	9.0%	4.1%
Completed Sample* (children)	5990 (5990)	72.7% (70.5%)	12.0% (29.0%)	90.2% (92.8%)	9.7% (7.1%)	0.2% (0.1%)	0.0% (0.0%)
<b>Adults reporting diabetes</b>							
Starting Sample	48,706	53.9%	10.3% [36.6% refused]	0.1%	59.2%	29.0%	11.7%
Completed Sample	9,304 (9,304)	45.9% (40.3%)	12.4% (29.1%)	0.6% (1.7%)	32.2% (35.1%)	49.9% (32.2%)	17.3% (30.9%)
<b>Adults reporting depression</b>							
Starting Sample:	39,635	68.2%	7.1% [27.6% refused]	0.1%	70.2%	23.8%	5.7%
Completed Sample	10,923 (10,923)	73.4% (66.2%)	7.5% (19.0%)	0.0% (0.0%)	67.9% (70.9%)	29.5% (22.1%)	2.6% (7.1%)
<b>Caregivers of people who have died</b>							
Starting Sample	749,587	49.5%	2.4% [81.5% refused]	0.0%	66.5%	26.6%	6.9%
Completed Sample	8819 (8819)	71.2% (58.9%)	7.7% (17.4%)	0.0% (0.0%)	37.1% (55.0%)	53.1% (19.4%)	9.8% (25.7%)

\*Completed sample results not separated for general and chronic populations.

## Attachment A3

### MEMORANDUM

**Date:** June 2, 2000  
**To:** John Fiorillo, Christina Bethell  
**From:** Katherine Binns, Paul McGhee  
**Cc:** Bob Leitman, Humphrey Taylor, Marc Rogers  
**Re:** Weighting Plan for Strategic Initiatives Tracing

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This memo outlines the weighting plan that is used for each of the survey sample groups, for the Strategic Initiatives, excluding the practicing physicians.

#### The Survey Sample Groups

The table below provides a summary of the samples and basic specifications for each of the survey sample groups.

Population	Completes	Survey Method
General public	2,000	Telephone
General public	2,000	Online
Adults w/ non-categorical chronic conditions	10,000	Online
Adults with Type II diabetes	10,000	Online
Adults diagnosed with depression	10,000	Online
Parents of children with asthma	10,000	Online
Family members of end-of-life patients	8,000	Online
Women who are/recently were pregnant	1,000	Online
Teens	1,000	Online

#### General Public by Telephone

This sample will be weighted to match the demographic characteristics of the U.S. adult population, using Current Population Survey data from March 1999 as the basis for the targets. The variables to be used are age, sex, race, Hispanic origin, education, household size and insurance status. A weight factor to reduce the number of respondents in households with more than one telephone line will also be applied, to correct for the higher probability of such households falling into the sample.

#### General Public by Internet

This sample will also be weighted to match the demographic characteristics of the U.S. adult population, again using March 1999 CPS data. The variables to be used are age, sex, race, Hispanic origin, education, household size and insurance status. After a first

stage demographic weight is applied, a score representing the propensity of an individual respondent to be online is calculated. This propensity score is derived using a composite of several demographic and non-demographic questions. The final weight is calculated for each respondent using the first stage demographic targets and the propensity score as variables.

### **Adults with Non-Categorical Conditions**

All respondents in this sample group will be included in the weighting, not only the 10,000 respondents with one or more chronic condition. The total sample will be weighted in the same manner as the general public by Internet (demographic weighting, followed by demographic plus propensity weighting).

Each of the next five sample groups will be weighted to the corresponding population within the telephone sample and within the general public Internet sample. The two samples are combined in order to maximize the number of respondents from which each demographic profile is created. The non-categorical chronic condition sample is not used for this purpose because of differences in wording and respondent bases for the relevant questions.

### **Adults with Type II Diabetes**

This sample will be weighted to the demographic characteristics of type II diabetic respondents, weighted, within the combined general public Internet and telephone samples.

### **Adults Diagnosed with Depression**

This sample will be weighted to the demographic characteristics of the respondents diagnosed with depression, weighted, within the combined general public Internet and telephone samples.

### **Parents of Children with Asthma**

This sample will be weighted to the demographic characteristics of respondents who are parents of children with asthma, weighted, within the combined general public Internet and telephone samples.

### **Family Members of End-of-life Patients**

This sample will be weighted to the demographic characteristics of respondents who have cared for a terminally ill family member in the past year, weighted, within the combined general public internet and telephone samples.

### **Women Who are or Have Recently Been Pregnant**

This sample will be weighted to the demographic characteristics of respondents who are or have recently been pregnant, weighted, within the combined general public Internet and telephone samples.

### **Teens by Internet**

This sample will be weighted to match the demographic characteristics of the U.S. population age 13 through 17, using Current Population Survey data from March 1999 as the basis for the targets. The variables to be used are age, sex, race and Hispanic origin.

## Attachment A4

### Sample E-mail Invitation

Subject: A Chance to Talk about Your Health

\*\*\*\*\*

The Harris Poll Online and a major health care foundation are conducting a survey of Americans about their experiences managing their health and getting medical care when they need it. Help us to understand this important part of life by sharing your views with us in the latest Harris Poll Online!

To thank you for participating in this survey, we are offering you a chance to win \$499! We will be randomly drawing ten \$499 prize winners from among those who participate (U.S. residents only).

To participate, please proceed to:  
<http://survey.harrispollonline.com/J12096.htm?id=59083366>

Please enter the password below when prompted at the beginning of the survey.

Password: 5299

To view the official sweepstakes rules, please go to:  
<http://www.pollg.com/g/rules/j12096rules.htm>

AOL USERS: We encourage you to minimize the AOL window and to use a browser such as Netscape or Internet Explorer (non-AOL version) when participating in Harris Poll Online surveys. These browsers connect DIRECTLY to our surveys, thereby producing a faster connection and a better overall experience. If you would prefer to use the AOL browser, however, then please use the following link:

<a href="http://survey.harrispollonline.com/J12096.htm?id=59083366">Stategic Initiatives Tracking</a>

Thank you for your participation.

\*\*\*\*\*

You have received this invitation from the Harris Poll Online because your e-mail address was selected at random from the Harris Poll Online's registry of members. Please click here to find out how you became a member of the Harris Poll Online:  
<http://vr.harrispollonline.com/register/names.htm>

If you wish to be excluded from Harris Poll Online mailings, please go to  
<http://vr.harrispollonline.com/unsubscribe.asp?XRK1=j12096&where=Invite>

If you have any other comments or questions, please e-mail Susan Richards or John Milton at the Survey Help Desk ([surveyhelp@hpol.harrisinteractive.com](mailto:surveyhelp@hpol.harrisinteractive.com)).  
(12096B)

## Attachment B:

### Robert Wood Johnson Foundation National Strategic Indicator Survey Detailed Tables for Leading Indicator Scores

#### Living with Illness Scores

	People with diabetes	People with depression	Children with asthma	People with a chronic condition
Overall Score	54.3	36.6	66.5	52.94
Health Status and Quality of Life	42.8	30.2	66.4	38.2
Self-efficacy	47.1	34.3	84.9	56
Getting Appropriate Care	62	28.6	42.65	NA
Education and Teamwork	65.4	53.3	63.9	64.6
Avoiding Serious Exacerbations	NA	NA	74.65	NA

#### Staying Healthy Scores

	Teenagers	General Adult Population	People with diabetes	People with depression	Children with Asthma	People with a chronic condition
Overall Score	50	50.9	59.8	47.9	50.2	49.4
Health Status and Quality of Life	56.5	63.2	NA	NA	NA	NA
Healthy Lifestyle	76.8	56.6	62	51.8	55.5	58.6
Risk Reduction Counseling	16.4	27.8	57.5	44	44.8	40.1
Self-efficacy	NA	56	NA	NA	NA	NA

## Access to Care Scores

	Teenager s	General Adults	People with diabetes	People with depression	Children with Asthma	People with a chronic condition	People at the end of life
Overall Score	71.6	72.7	73.7	67.6	76.1	76.3	71.1
Getting Needed Care	NA	69.8	71.1	62.3	73.4	73.4	NA
Medical Home	71.6	75.6	82.8	80.4	91.7	86.1	NA
Access to Supportive Services	NA	NA	67.2	60.1	63.2	69.5	71.1

## Changing Needs Scores

	People at the end of life and their caregivers
Overall Score	64.1
Peaceful Death	80.5
Caregiver Burden	63.8
Freedom from Suffering	28.7
Honoring Treatment Wishes	65.1
Honoring Spiritual Beliefs	64.7
Pain Management	62
Advance Preparations	76.3
Communication and teamwork	65
Access to supportive services	71.1
Consumer empowerment	83.6

## Consumer Empowerment Scores

	General Adult Population	People with diabetes	People with depression	Children with Asthma	People with a chronic condition	Caregivers of people at the end of life
Information Seeking Online (not included in summary score)	74.7	100	100	86.2	81	100
Self Care Advocacy	60.5	75.7	62.6	85.9	80.5	83.6

# List of Documents

## Attachment C:

- C1. Teen High Level Summary of Performance and Variation across Demographic Groups
- C2. Adult Core High Level Summary of Performance and Variation Across Demographic Groups
- C3. Diabetes High Level Summary of Performance and Variation across Demographic Groups
- C4. Depression High Level Summary of Performance and Variation across Demographic Groups
- C5. End of Life High Level Summary of Performance and Variation across Demographic Groups
- C6. Chronic High Level Summary of Performance and Variation across Demographic Groups
- C7. Pediatric Asthma High Level Summary of Performance and Variation Across Demographic Groups
- C8. Insurance Coverage by Demographic Information

## Attachment C1:

### The Robert Wood Johnson Foundation National Strategic Indicators Survey Teen High Level Summary of Performance and Variation Across Demographic Groups

Aggregate Score	Performance Measure	Age Groups	Gender
85%	PV11_500: Non-Smokers	p=.0001 (53.6-75) younger teens highest	p=.03 (59.5-64.5) males highest
10.1%	PM13_505: Talk About Helping Current Smokers Quit	p=.06 (4.5-14.3) not significant	p=.01 (3.7-15.1) females highest
66.7%	PM20tnb_600: Regular Physical Activity (past 6 months)	p=.0001 (60.7-74.2) younger teens highest	p=.01 (63-70) males highest
50.9%	Current Physical Activity (past week)		
27.4%	PM25_905: Provider Talked with Teen about Exercise	p=.88 (26.8-28.6) not significant	p=.08 (25-30) not significant
61.0%	PM1_200: Self reported health status	p=.0001 (58-65) teens age 14-16 highest	p=.001 (54-63) males highest
50.5%	PM4q215: Days Not Bothered by Health or Emotional Problem	p=.001 (48-60) younger teens highest	p=.001 (42-58.6) males highest
55.1%	PM9q400: School Involvement	p=.22 (52-57) not significant	p=.22 (53-56.7) not significant
84.3%	PM15_516: Drinkers who have never had an episode of binge drinking	p=** (80-92) no days younger teens highest	p=** (83-86) males highest
9.3%	PM16_517: Provider Talked With Teen About Drinking	p=.01 (7-14) younger teens highest	p=.68 (8.9-9.6) not significant
87.2%	PM18_525: Teen Does Not Use Illegal Drugs	p=.0001 (82-94) younger teens highest	p=.34 (86-88) not significant
9.7%	PM19_535: Provider Talked to Teens about Illegal Drugs	p=** (4-36) younger teens highest	p=.09 (2.9-11.6) not significant

## Attachment C2:

### The Robert Wood Johnson Foundation National Strategic Indicators Survey Adult Core High Level Summary of Performance and Variation Across Demographic Groups

Aggregate Scores	Performance Measure	Age	Sex	Race	Income
67.8%	PM11_602: Non-Smokers	p=.0001 (61-83.7) 65+older highest	p=.0006 (64.7-71) Males highest	p=.002 (47-82) Asians highest	p=.0001 (60.8-77.2) 75K+ highest
47.4%	PM12_606: Advising Smokers to Quit	p=.09 (42.3-59) not significant	p=.10 (44-50) not significant	p=* (10-94) Hispanics highest	p=.0001 (33-64) 50-75K highest
55.6%	PM16_708: Regular Physical Activity (past 6 months)	p=.0001 (51-65) adults age 56-65 highest	p=.07 (54-58) not significant	p=.008 (44.4-69.7) Hispanics highest	p=.0003 (48-59.7) 75K+ highest
23.1%	Current Physical Activity (past week)				
31.7%	PM17_710: Advising Physical Activity	p=.0001 (23.2-51.6) adults age 56-65 highest	p=.67 (31.1-32.4) not significant	p=* (23.4-39) Hispanics highest	p=.009 (25.4-38.8) 50-75K highest
50.2%	PM1_200: Self reported health status.	p=.0001 (48-51) no trend	p=.004 (53-57) Males highest	p=* (43-74) Asians highest	p=.0001 (40-61.2) 50-75K highest
70.0%	<b>PM2_250a: Good physical health days.</b> Proportion with 1 or fewer bad days in the past 30 days.	p=.10 (54-61.4) not significant	p=.0001 (51.7-63.1) Males highest	p=.0003 (43-70) Asians highest	p=.0001 (45-74) 75K+ highest
75.4% A: 74.3% B: 72.0% T: 80.0%	PM8_500a: Social Isolation: Appraisal (A) PM9_500a: Social Isolation: Belonging (B) PM10_500b: Social Isolation: Tangible (T)	p=.0001-.03 A: (71.6-80) Adults 65+ highest B: (67-80) Adults 65+ highest T: (75-90) Adults 65+ highest	p=.07-.0005 Females highest A: (71-77) Females highest B: (71-72.6) p=.49 not significant T: (78-81) p=.07 not significant	A: (68-79.6) Hispanics highest p=.002 B: (57-93) Others highest p=.0001 T: (61.6-86.8) Asians highest p=.0001	A: (65-78) p=.0001 25-50K highest B: (61-81.5) p=.0001 75K+ highest T: (73.6-85) p=.0005 75K+ highest
56.0%	PM22_912: Self-Care Confidence	p=.0001 (46.5-73.4) Adults 65+ highest	p=.0007 (52.4-59.2) Females highest	p=.0001 (35-94) Native Americans highest	p=.11 (54.8-62.6) not significant
78.9%	PM13_AUDIT: Healthy Use of Alcohol	p=.0001 72.6-87.8 Adults 65+ highest	p=.0001 (68.8-88.2) Females highest	p=.0004 (66.6-89) African Americans highest	p=.0006 (67-80.8) 25K or less highest
80.9%	No binge drinking				
4.5%	PM14_613: Advising At-Risk Drinkers To Quit Drinking	p=* (3.8-8.2) Adults 56-65 highest	p=.48 (4.1-5.6) not significant	p=* (4.1-19.6) African Americans highest	p=* (1.4-6.0) 25-50K highest

### Attachment C3:

## The Robert Wood Johnson Foundation National Strategic Indicators Survey Diabetes High Level Summary of Performance and Variation Across Demographic Groups

Performance Measure and Aggregate Score	Age	Sex	Race	Income
PM11_602: Non-Smokers 79.4%	p=.0001 older less likely to smoke (71.3-91.7) Adults 65+ highest	p=.0001 (74-83) Males highest	p=.0001 (68-89) Asians highest	p=.0001 (76.7-85.7) 75K+ highest
PM12_606: Advising Smokers to Quit 80.8%	p=.0005 (77-88) Adults 65+ highest	p=.53 (80.2-81.4) not significant	p=* (40.7-89.6) Native Americans highest	p=.0001 (75.8-84.9) 25K or less highest
PM16_708: Regular Physical Activity (past 6 months) 38.3%	p=.0001 (35-45) Adults 65+ highest	p=.0001 (32.4-42.3) Males highest	p=.04 (23.4-38.9) Whites highest	p=.0001 (34.6-48.4) 75K+ highest
Current Physical Activity (past week) 15.8%				
PM17_710: Advising Physical Activity 67.4%	p=.0001 (52-80) Adults 35 or younger highest	p=.0009 (64.8-70.7) Females highest	p=.0001 (45.8-91.2) Asians highest	p=.002 (63-73.4) 75K+ highest
PM1_200: Self reported health status. 19.9%	p=.0001 No pattern	p=.0001 (14-24) Males highest	p=.0001 (9.6-26.6) Asians highest	p=.0001 (12-31.3) 75K+ highest
PM2_250a: Good physical health days. Proportion with 1 or fewer bad days in the past 30 days. 35.0%	p=.02 Older adults highest	p=.0001 (27.6-40) Males highest	p=.0001 (2.0-41.1) African Americans highest	p=.0001 (24.7-48) 75K+ highest
PM4D_1108: Diabetes Specific Self-efficacy 78.0%	p=.0001 (70.7-80.8) Adults 65+ highest	p=.0001 (74.1-80.5) Males highest	p=.006 (66.3-85.2) Native Americans highest	p=.0001 (74.4-82.2) 75K + highest
PM13_AUDIT: Healthy Use of Alcohol 90.2%	p=.0001 (89-93) Adults 65+ highest	p=.53 (87.4-95.9) not significant	p=.0001 (70.4-94.6) Asians highest	p=.06 (90.2-92.2) not significant
No binge drinking 89.8%				
PM14_613: Advising At-Risk Drinkers To Quit Drinking 24.4%	p=.0001 (7.8-35.3) Adults 36-55 highest	p=.006 (15.4-26.4) Males highest	(1.7-50.1) Hispanics highest	p=.003 (12.7-30.5) 25-50K highest
PM2CC_1008: Involvement In Decision-Making 54.7%	p=.58 (54.2-56.6) not significant	p=.006 (53.5-56.5) Females highest	p=.0001 (30.3-60.9) Asians highest	p=.0004 (51.8-58.7) 50-75K highest
PM1D_1100: Blood sugar checking 62.7%	p=.0001 (59.4-65.4) No pattern	p=.0001 (60.2-64.4) Males highest	p=.0001 (52.4-74.5) Hispanics highest	p=.0002 (60.2-66) 75K+ highest

## The Robert Wood Johnson Foundation National Strategic Indicators Survey Diabetes High Level Summary of Performance and Variation Across Demographic Groups

Performance Measure	Age	Sex	Race	Income
PM3CC_1010: Education And Teamwork 70.0%	p=.0001 (66.5-74.2) Adults 65+ highest	p=.01 (68.4-70.9) Males highest	p=.0001 (53.6-80.7) African Americans highest	p=.0001 (66.7-73.5) 50-75K highest
PM1CC_1006: Coordination Of Care 61.9%	p=.06 (60-64.6) not significant	p=.04 (60.2-63.1) Males highest	p=.01 (45.3-71.4) Others highest	p=.71 (60.3-63.3) not significant
PM18b_: Access to Health Care 75.9%	p=.0001 (64.5-83.5) Adults 65+ highest	p=.19 (74.9-76.6) not significant	p=.0001 (55-86.45) Asians highest	p=.0001 (67.7-82.7) 50-75K highest
PM4_300: Regular Doctor 95.8%	p=.0001 (85.5-99) Adults 65+ highest	p=.05 (95.4-96.2) Males highest	p=** (83.6-96.9) Others highest	p=.0001 (92.8-98) 50K+ highest
PMCC_1024 : Access To Supportive Care Services 52.8%	p=.0001 (37.1-58.6) Adults 65+ highest	p=.003 (44.4-49.4) Males highest	p=.0001 (21.9-84.8) Hispanics highest	p=.0001 (39.1-59) 75K+ highest
PM2D_1102: Eye Exam 61.4%	p=.0001 (43-73) Adults 65+ highest	p=.001 (58-63.7) Males highest	p=.0001 (35.8-64.1) African Americans highest	p=.0001 (56.9-70.3) 75K+ highest
PM3D_1106: Diabetes Specific Patient Education 75.4%	p=.0001 (68.4-79.7) Adults 65+ highest	p=.0001 (72.5-77.3) Males highest	p=.001 (61.1-76.2) Whites highest	p=.0002 (72.5-77.5) 50-75K highest
PM13CC_1028 : Waiting Time 81.6%	p=.0001 (76.7-84.9) No pattern	p=.29 (80.9-82.6) not significant	p=.0001 (60.2-89.6) African Americans highest	p=.0001 (76-88.6) 75K+ highest
Social Isolation: 70.5% PM8_500a: Social Isolation: Appraisal (A) 66.8% PM9_500b: Social Isolation: Belonging (B) 70.0% PM10_500a: Social Isolation: Tangible (T) 74.8%	p=.0001 All older highest	p=.52-.0001 Males highest	p=.0001-0007 A: (64-77.3) African Americans highest B: (66.2-72.9) Hispanics highest C: (67.3-77.8) African Americans highest	p=.0001 A: (67.8-75) 50-75K highest B: (64.1-77.1) 75K+ highest C: (72.6-81.2) 50-75K highest

## Attachment C4:

### The Robert Wood Johnson Foundation National Strategic Indicators Survey Depression High Level Summary of Performance and Variation Across Demographic Groups

Performance Measure and Aggregate Scoring	Age (older better)	Sex	Race	Income
PM11_602: Non-Smokers 56.4%	p=.0001 (53.2-78.4) Adults 65+ highest	p=.31 (56-57.2) not significant	p=.0001 (48.8-72.8) Hispanics highest	p=.0001 (52.3-64.6) 75K+ highest
PM12_606: Advising Smokers to Quit 63.1%	p=.0001 (57.7-74.1) Adults 65+ highest	p=.31 (62.1-63.6) not significant	p=.0001 (59.4-87.9) Hispanics highest	p=.0001 (62.1-66.1) 50K+ highest
PM16_708: Regular Physical Activity (past 6 months) 30.9%	p=.0001 (28.2-53.7) Adults 65+ highest	p=.0001 (28.7-35) Males highest	p=.03 (29.9-71.3) Asians highest	p=.0001 (29.3-34.9) 75K+ highest
Current Physical Activity (past week) 14.6%				
PM17_710: Advising Physical Activity 51.1%	p=.001 (48.7-64.7) Adults 65+ highest	p=.35 (50-51.6) no significance	p=.0001 (26.4-62.2) Native Americans highest	p=.0001 (44.4-56.1) 50K+ highest
PM1_200: Self reported health status 29.6%	p=.0001 (27.6-33.8) Adults 18-35 highest	p=.0001 (27.8-29.2) Males highest	p=.0001 (18.7-43.3) Asians highest	p=.0001 (23.7-49.6) 75K+ highest
PM8_500a: Social Isolation: Appraisal (A): 53.5% PM9_500a: Social Isolation: Belonging (B): 43.5% PM10_500a: Social Isolation: Tangible (T): 55.6%	p=.0001 (41-68) Older adults highest	A: (50.9-54.9) Males highest B: (40.3-45.2) p=.0001 Females highest T: p=.86 not significant	A: p=.0001 (21.8-54.6) Whites highest B: p=.10 (37.8-48.4) not significant T: p=.0001 (39.9-57.9) Whites highest	A: p=.0001 (47.4-65.7) 75K+ highest B: p=.0001 (34.7-58.6) 75K+ highest T: p=.0001 (47-73) 75K+ highest
PM13_AUDIT: Healthy Use of Alcohol 84.3%	p=.0001 (78.1-94.2) Adults 65+ highest	p=.0001 (88.2-76.6) Females highest	(68.9-84.8) African Americans highest	p=.0001 (77.3-85.3) 25-50 highest
No binge drinking 83.1%				
PM14_613: Advising At-Risk Drinkers To Quit Drinking 17.9%	p=.09 (12.3-20) not significant	p=.0001 (13.3-22.4) Males highest	p=.02 (7.1-19) Whites highest	p=.0001 (12.4-23.8) 25K and less highest
PM2CC_1008: Involvement In Decision-Making 54.2%	p=.0001 (47.8-61.5) Adults 65+ highest	p=.01 (52.5-55.1) Females highest	p=.02 (39.6-59.8) Others highest	p=.0001 (51.3-60) 50K+ highest
PM3CC_1010: Education And Teamwork 59.0%	p=.0001 (51.9-71.8) Adults 65+ highest	p=.76 (58.2-58.9) not significant	p=.0001 (41-64.6) Blacks highest	p=.0001 (56.3-65) 75K+ highest
PM1CC_1006: Coordination Of Care 53.3%	p=.0001 (41.4-74.5) Adults 65+ highest	p=.33 (72.3-72.6) not significant	p=.02 (30.6-61.3) Hispanics highest	p=.03 (41.4-55.1) 75K+ highest
PM18B_ Access to Health Care 62.4%	p=.0001 (54.8-77.9) Adults 55+ highest	p=.03 (61.4-64.5) Males highest	p=.0001 (45.5-66.9) Asians highest	p=.0001 (56.5-69) 75K+ highest

**The Robert Wood Johnson Foundation National Strategic Indicators Survey Depression  
High Level Summary of Performance and Variation Across Demographic Groups**

<b>Performance Measure and Aggregate Scoring</b>	<b>Age (older better)</b>	<b>Sex</b>	<b>Race</b>	<b>Income</b>
PM4_300: Regular Doctor 86.3%	p=.0001 (74.2-95.6) Adults 56-65 highest	p=.0002 (84.6-87.1) Females highest	p=.0001 (49-76.9) Hispanics highest	p=.0001 (79.5-93.9) 50K+ highest
PMCC_1024: Access To Supportive Care Services 53.0%	p=.0001 (51-62.1) Adults 65+ highest	p=.004 (51.7-55) Males highest	p=.002 (47.8-89.2) Hispanics highest	p=.0001 (46.9-67.9) 75K+ highest
PM1DP_04: Lost to continuing treatment 28.6%	p=.0001 (16.9-50.6) Adults 55+ highest	p=.82 (28.6-28.9) not significant	p=.0001 (13.8-50.1) Native Americans highest	p=.0001 (19.5-49) 75K+ highest
PM2DP_1206 : Satisfaction with treatment staff and program 51.0% PM3DP_1206: Satisfaction with treatment outcomes 49.0%	p=.0001 both SP: (42.6-61.4) Adults 65+ highest O: (41.5-65.3) Older better	p=.02-.84 Males highest SP: p=.02 (49.9-53.3) O: p=.84 (49.1-48.8) not significant	SP: p=.05 (26.4-61.6) Others highest O: p=.03 (30.7-57.9) Hispanics highest	SP: p=.0001 (46-58) 75K+ highest O: p=.0001 (41.8-60.2) 75K+ highest
PM4DP_18: Depression Self-Care Confidence 18.3%	p=.0001 (13.4-38.1) Adults 65+ highest	p=.08 (17.8-19.2) not significant	p=.002 (5.6-18.8) Whites highest	p=.0001 (15.3-23.4) 75K+ highest
PM15_618: Received alcohol treatment quickly 50.3%	p=** (39.8-63.2) Adults 18-35 highest	p=.03 (.43-60.3) Males highest		p=.04 (39.9-66.2) 75K+ highest
PM13CC_1028: Waiting Time 78.9%	p=** (77-84) Adults 65+ highest	p=.24 (78-79.4) not significant	p=.0001 (61.2-84.8) Native Americans highest	p=.0001 (74-86.4) 75K+ highest
PM2_250a: Good physical health days Proportion with 1 or fewer bad days in the past 30 days. 27.0%	p=.0001 (25.7-32.7) Adults 65+ highest	p=.0001 (25.4-29.9) Males highest	p=.0001 (15.3-38.4) Asians highest	p=.0001 (19.8-47.1) 75K+ highest

## Attachment C5:

### The Robert Wood Johnson Foundation National Strategic Indicators Survey End of Life High Level Summary of Performance and Variation Across Demographic Groups

Performance Measure and Aggregate Scoring	Age	Sex	Race	Income
PM1EOL_1700: Involvement In Decision-Making: Care recipient/caregiver 68.3%	p=.0001 (63.8-74.4) Adults 86+ highest	p=.09 (67.8-68.9) not significant	p=.0001 (60.6-75.2) Hispanics highest	p=.0001 (63-71.6) 50-75K highest
PM10EOL_1840: Caregiver Communication and Support 51.5%	p=.0005 (48.9-52.6) Adults 65-85 highest	p=.03 (50.8-52.4) Males highest	p=* (42.9-53.8) African Americans highest	p=.0001 (47.8-56.4) 50-75K highest
PM3EOL:_1718 Communication About Pain Management 62%	p=.0001 (53.5-68.9) Adults 86+ highest	p=.04 (60.7-63) Females highest	p=.0001 (57.4-74.9) Others highest	p=.0001 (57.1-69.7) 50-75K highest
PM4EOL: Correct level of intervention 62%	p=.0001 (50.3-68.9) Adults 86+ highest	p=.04 (60.7-63) Females highest	p=.0001 (25.2-64.3) Whites highest	p=.05 (60.3-65) 75K+ highest
PM8EOL_1830, 1832, 1834: Honoring Spiritual Beliefs: Care Recipient/Caregiver 64.7%	p=.0001 (56.2-68) Adults 86+ highest	p=.96 (66.1-62.8) not significant	p=.0001 (39.3-69.7) African Americans highest	p=.0001 (55-68) 50-75K highest
PM7EOL_1816: Power of Attorney or Living Will: Care Recipient 70.3%	p=.0001 (54.3-79.8) Adults 86+ highest	p=.75 not significant	p=.0001 (48-73.3) Whites highest	p=.0001 (64.8-75.7) 50-75K highest
PM6EOL_1816: Honoring Treatment Wishes: Care Recipient/Caregiver 68.2%	p=.0001 (51.3-73.4) 86K+ highest	p=.005 (66.5-69.6) Females highest	p=.0001 (33.3-71.9) Whites highest	p=.0001 (59.6-74.4) 50-75K highest
PM11EOL_1900: Caregiver Burden 63.8%	p=.0001 (50.2-73.9) Adults 86+ highest	p=.0001 (61.4-65.6) Females highest	p=.0001 (51.5-64.9) Native Americans highest	p=.0001 (57.9-72.9) 75K+ highest
PM9EOL_1836: Peaceful Death: Care Recipient 80.5%	p=.0001 (69.1-86.8) Adults 86+ highest	p=.05 (79.3-81.4) Males highest	p=.0001 (43.1-94.1) African Americans highest	p=.0001 (66.6-82) 25K or less highest
PM2EOL_P: Freedom from Suffering: Care Recipient 28.7%	p=.0001 (18.4-39) Adults 86+ highest	p=.004 (28.6-28.9) Males highest	p=.0001 (21.5-44.3) Hispanics highest	p=.008 (24.7-29.2) 25K or less highest
PMCC_1024: Access to Supportive Care Services: Care Recipient 59.1%	p=.0001 (74.5-82.3) Adults 86+ highest	p=.0001 (54.8-62.3) Females highest	p=.0001 (26.8-62.7) Whites highest	p=.02 (52.8-63.3) 50-75K highest
PM13CC_1028 ACCESS: Waiting Time: Care Recipient 83.2%	p=.0001 (74.5-82.3) Adults 65+ highest	p=.25 (82.6-83.6) not significant	p=.0001 (75.2-84.5) Whites highest	p=.07 (81.1-84.3) not significant

## Attachment C6:

### The Robert Wood Johnson Foundation National Strategic Indicators Survey Chronic High Level Summary of Performance and Variation Across Demographic Groups

Performance Measure and Aggregate Scoring	Age	Sex	Race	Income
PM11_602: Non-Smokers 72.1%	p=.0001 (65-83.8) Adults 65+ highest	p=.0001 (68.5-77) Males highest	p=.0001 (46.1-71.8) Whites highest	p=.0001 (67.1-79.7) 75K+ highest
PM12_606: Advising Smokers to Quit 66.9%	p=.003 (60.2-69.9) Adults 65+ highest	p=.83 (66.6-67) not significant	p=.003 (44.4-68.2) Whites highest	p=.21 (64.4-69.6) not significant
PM16_708: Regular Physical Activity (past 6 months) 45.5%	p=.0001 (39.4-58.1) Adults 65+ highest	p=.0001 (42-50.4) Males highest	p=.02 (37.8-56.7) Asians highest	p=.07 (43.8-48.8) not significant
Current Physical Activity (past week) 17.5%				
PM17_710: Advising Physical Activity 42.9%	p=.0001 (37.5-46) no pattern	p=.97 (42.9-43) not significant	p=.0001 (23.6-53.6) African Americans highest	p=.0001 (36.9-50.3) 75K+ highest
PM1_200: Self reported health status. 38.2%	p=.0001 (33.4-46.1) Adults 65+ highest	p=.0001 (36.2-40.2) Males highest	p=.0001 (31.8-45.5) Asians highest	p=.0001 (30-51.2) 75K+ highest
PM22_912: Self-Care Confidence 64.7%	p=.0001 (54.7-74.9) Adults 65+ highest	p=.0001 (62.1-66.6) Males highest	p=.008 (48.9-65.9) African Americans highest	p=.0001 (61.8-67.8) 55K+ highest
PM13_AUDIT: Healthy Use of Alcohol 86.3%	p=.0001 (78.4-90.4) Adults 65+ highest	p=.0001 (41.2-79.6) Females highest	p=.0001 (72.3-96.5) Asians highest	p=.07 (83.1-86.4) not significant
No binge drinking 87.2%				
PM14_613: Advising At-Risk Drinkers To Quit Drinking 10.4%	p=.68 (8.7-11.8) not significant	p=.0001 (5.1-13.7) Males highest	**	p=.0001 (6.5-17.9) 75K+ highest
PM2CC_1008: Involvement In Decision-Making 62.8%	p=.0001 (57.8-68.2) Adults 55+ highest	p=.59 (62.5-63.1) not significant	p=.07 (50.9-62.9) not significant	p=.03 (61.1-65) 25-50K highest
PM3CC_1010: Education And Teamwork 72.4%	p=.0001 (63.9-83.6) Adults 65+ highest	p=.08 (71.6-73.4) not significant	p=.0001 (55.6-78.9) Asians highest	p=.02 (69.4-73.8) 25-50K highest
Coordination of care 58.7%	p=.0001 (49.7-66.5) Adults 65+ highest	p=.54 (58.3-59.3) not significant	p=.0001 (27.2-63.6) Asians highest	p=.0001 (49.8-63.4) 25-50K highest
PM18_P Access to Health Care 75.1%	p=.0001 (60.7-88.7) Adults 65+ highest	p=.12 (74.5-76) not significant	p=.0001 (57.2-81.9) Whites highest	p=.001 (72-77.9) 50-75K highest

### Attachment C7:

## The Robert Wood Johnson Foundation National Strategic Indicators Survey Pediatric Asthma High Level Summary of Performance and Variation Across Demographic Groups

Performance Measure and Aggregate Scoring	Age	Sex	Race	Income
PM4_300: Regular Doctor 92.9%	p=.0001 (81-98.9) Adults 65+ highest	p=.01 (92.1-93.5) Females highest	p=.0001 (76.2-93.8) African Americans highest	p=.0001 (86.1-96.4) 50-75K highest
PMCC_1024: Access To Supportive Care Services 55.6%	p=.0004 (51.7-61.7) Adults 56-65 highest	p=.03 (53.8-57.8) Males highest	p=.0001 (40.4-70) African Americans highest	p=.06 (53.4-59.9) not significant
PM13CC_1028: Waiting Time 83.4%	p=.0001 (73.7-89.5) adults 65+ highest	p=.04 (81.5-85) Females highest	p=.04 (66.3-85.6) Whites highest	p=.38 (81.7-87.4) 75K+ highest
PM11_602: Non-Smokers: Parent 62.9%	p=.02 (59.4-65.1) no pattern	NA	NA	p=.008 (66.4-78.9) 75K+ highest
PM12_606: Advising Smokers to Quit: Parent 66.8%	p=.007 (78-67.5)	NA	NA	NA p=.008
PM16_708: Regular Physical Activity: Child (past 6 months) 81.6%	p=.0001 (74.9-91.4) 3+ highest	p=.0001 (75.3-86) Males highest	p=.001 (75-88.9) Native American	p=.316 not significant
Current Physical Activity (past week) 43.2%				
PM17_710: Advising Physical Activity: Child 22.8%	p=.0001 (7.3-28.3) 7-12 highest	p=.08 (20.7-25.3) not significant	**	p=.73 not significant
PM17_710: Advising Physical Activity: Child >75 score 55.3%	p=.0001 (52.9-60.8) 7-12 highest	p=.01 (53.8-57.4) Males highest	p=.0001	p=.0001 (51-60.7) no pattern
PM10AST_1404: Copy of written plan: Parent/Child 22.2%	p=.0001 (16-28.2%) 13+ highest	p=.62 not significant	p=.0001 (12.1-29.5) Asians highest	p=.01 (20.1-25.7) 75K+ highest
PM3CC_1010: Education And Teamwork: Parent/Child 72%	p=.0001 (67.5-75.4) 7-12 highest	p=.16 (71.4-73) not significant	p=.0001 (75.4-85.3) African Americans highest	p=.003 (70-75.8) 25K or less highest
PM2AST_1314: Hospitalization: Child 83.5%	p=.0001 (67.1-86.7) 13+ highest	p=.15 (83-84.4) not significant	p=.0001 (70.9-85.5) Whites highest	p=.0001 (74.8-89.2) 75K+ highest
PM3AST_1318: Emergency room: Child 65.8%	p=.0001 (28.6-54) 13+ highest	p=.12 (65-66.9) not significant	p=.0001 (47.3-69.7) Whites, Asians, Hispanics highest	p=.0001 (59.2-73.1) 75K+ highest
PM1CC_1006: Coordination Of Care: Parent/Child 51.5%	p=.005 (46.7-62.6) 0-3 highest	p=.33 not significant	p=.12 (32.2-62.2) not significant	p=.046 (44.7-55.9) 25K or less highest

**The Robert Wood Johnson Foundation National Strategic Indicators Survey Pediatric  
Asthma High Level Summary of Performance and Variation Across Demographic Groups**

<b>Performance Measure and Aggregate Scoring</b>	<b>Age</b>	<b>Sex</b>	<b>Race</b>	<b>Income</b>
PM18b_ACCESS: Access to Health Care: Child >66 score 78.0%	p=.0003 (75.2-80.9) 7 or younger highest	p=.94 not significant	(69.5-88) African Americans highest	p=.0001 (74.8-82.5) 50K+ highest
PM4_300: Regular Doctor: Child 97.1%	p=.0001 (95.7-99.8) 0-3 highest	p=.0001 (96.3-98.4) Males highest	p=.0001 (91.7-98.1) African Americans highest	p=.0001 (96.2-99) 75K highest
PMCC_1024: Access to Supportive Care Services: Child 52.9%	p=.004 (49.8-63.3) 4-7 highest	p=.01 (49.5-55.3) Females highest	p=.02 (26.1-74.5) Native Americans highest	p=.55 (50.7-55.8) not significant
PM13CC_1028: Waiting Time: Child 73.5%	p=.0001 (68.6-88.5) 0-3 highest	p=.56 not significant	p=.0001 (23.7-100) Asians highest	p=.0001 (63.7-77.9) 75K+ highest
PM12AST_1410: Coordination/school: Parent/Child 74.0%	p=.0001 (51.5-96.2) 0-3 highest	p=.001 (68.8-77.4) Males highest	p=.0001 (52.6-100/95.8) Asians, Whites, Native Americans highest	p=.003 (67.1-80.6) 25K or less highest
PM 8AST_1400: Peak flow meter instruction: Parent/Child 66.9%	p=.0001 (18.4-76.1) 13+ highest	p=.83 not significant	p=.002 (53.3-76) Others highest	p=.01 (64.8-72.7) 75K+ highest
PM11AST_1406: Inhaler use observed: Child 63.1%	p=.0001 (41.4-68.5) 13+ highest	p=.44 (62.5-63.6)	p=.0001 (51.9-77.5) Others highest	p=.01 (61.3-68.4) 75K+ highest
PM14AST_605-660: Non-smoking households 60.3%	p=.0001 (53.7-60.6) No pattern	p=.56 not significant	p=.0001 (53.1-81.8) Whites highest	p=.0001 (56-77.4) 75K+ highest

## Attachment C8: Insurance Coverage by Demographic Information

Q316. Now, a question about different kinds of health plan or health insurance, including those provided by the government. Are you covered by any of the following types of insurance?

Base: All respondents

	<b>Cross Section</b>		<b>Adult Core</b>		<b>Chronically Ill</b>		<b>Diabetes</b>		<b>Depression</b>	
	% Insured	% Not Insured	% Insured	% Not Insured	% Insured	% Not Insured	% Insured	% Not Insured	% Insured	% Not Insured
<b><u>Race/Ethnicity</u></b>										
Black	79	21	84	16	90	10	92	8	89	11
White	84	16	85	15	88	12	91	9	85	15
Hispanic	65	35	73	27	84	16	87	13	83	17
<b><u>Sex</u></b>										
Male	82	18	84	16	89	11	93	7	86	14
Female	84	16	83	17	87	13	90	10	86	14
<b><u>Income</u></b>										
<\$15K	66	34	71	29	63	37	83	17	73	27
\$15K-\$25K	74	26	78	22	83	17	85	15	83	17
\$25K-\$35K	81	19	73	27	88	12	92	8	87	13
\$35K-\$50K	91	9	93	7	92	8	94	6	93	7
\$50K-\$75K	97	3	92	8	96	4	98	2	96	4
\$75K+	95	5	91	9	95	5	97	3	96	4
<b><u>Age</u></b>										
18-29	66	34	76	24	80	20	78	22	76	24
30-39	81	19	81	19	85	15	81	19	85	15
40-49	90	10	83	17	86	14	91	9	87	13
50-64	76	14	85	15	88	12	92	8	91	9
65+	98	2	96	4	96	4	98	2	99	1
<b><u>Region</u></b>										
East	87	13	88	12	88	12	93	7	0	0
Midwest	81	19	89	11	91	9	90	10	0	0
South	86	14	79	21	88	12	91	9	0	0
West	81	19	82	18	86	14	92	8	0	0