

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary of Planning and Evaluation Office of Health Policy
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

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Proposal – An innovative model for primary care office payment

Dear PTAC Committee Members:

On behalf of many small primary care practices, I am pleased to present an innovative payment model for office based primary care payment that is broadly testable, thoughtful, straightforward, and elegant, and which provides a patient centered approach to primary care outpatient payment. We hope that the PTAC will review our proposal, provide feedback, and recommend it to HHS for approval and implementation nationwide.

Primary care, when done well, improves outcomes and lowers costs. Primary care is currently an illogical career choice however, hence there is a PCP shortage.

Patients have similar troubles- they cannot get access, or they gain access but without continuity or care coordination. To fully realize the value proposition of primary care, changes in payment, practice structure, and tools to support the work are all needed. What the author and colleagues are after is sustainability of primary care -for both patients and providers.

Our proposed model is an opportunity to strengthen primary care for its' providers and its' patients.

The author realizes the potential criticisms of lack of experience in health policy and risk management and payment design. However, many of the elements proposed here have been trialed in varied practices.

As a founder of the nonprofit Ideal Medical Practices, as a level 3 NCQA PCMH, and member of the NCQA 2017 PCMH review committee, occasional author and current chair of the primary care service at the local hospital, the author has received many contributions to this proposal, though she remains as single author .Dozens of small practices across the country are asking you to accept a trial of this innovative initiative

We know this will help achieve the goals of improving health outcomes and lowering costs, by ensuring the sustainability of primary care .

Thank you for your time and consideration of this proposal.

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An innovative model for primary care office payment

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Abstract

The foundations of primary care are access, comprehensive care, continuity of care, and care coordination. When done well, primary care improves outcomes and reduces costs. The primary care delivery system in the US has neither tools nor financial support to achieve its potential. The expectations, work and business models of primary care physicians (PCPs) have expanded and changed, and frustrated the most passionate and persistent practitioners, with devastating consequence to the delivery of high quality care.

This proposal outlines a way forward driven by the work of high functioning practices. This model would fund office-based primary care, with one tool to capture both risk and quality, and is a real-world **capitation model** for outpatient services.

The proposed tool for **risk assessment, measurement and improvement** is a low burden, Internet-based instrument that contributes to the welfare of the individual patient and to overall practice improvement. Available free of charge to practices from HowsYourHealth.org (HYH)¹, it has been extensively validated.

The proposed **quality measurement** tool is based on the same patient reported survey (HYH), and measures both standard metrics and the patient's view of their quality of care. HYH is based on what matters to patients, an approach which improves care and outcomes, and, as well, collects disease centric and cost metrics.

The **capitation fee** would be paid monthly, based on risk assessment of patients. Payment structure would be straightforward, align with actuarial values, and bring primary care into parity with specialists- both a payment goal and a necessity to support primary care. Any primary care physician or independent NP (PCP) could participate, without practice size or geographic restrictions.

This proposal is elegantly innovative and rigorously planned, and is targeted to small independent practices. This proposal meets PTAC's request for an innovative proposal targeting small independents and is a scalable pilot that remains large enough to gather relevant data. **We request a limited scale testing in a pilot big enough to gather data.**

This model

- (1) Can be used in any clinical primary care setting
- (2) Evaluates quality of care
- (3) Evaluates cost
- (4) Reflects the Joint Principles of the Patient-Centered Medical Home (PCMH) and the five key functions of the CPC+
- (5) Attributes patients based primarily on patient choice;

¹ *How's Your Health* <https://www.howsyourhealth.org>

- (6) Carries the expectation that at least 50% of qualifying participants will use certified electronic health record technology (CEHRT).

I. Background and Model Overview

While the author read the AAFP's PTAC proposal ² and wholeheartedly agrees with their assessment of primary care's value, this proposal is quite dissimilar. The author acknowledges using occasional background material excerpted from the AAFP proposal rather than reinventing descriptions.

The AAFP is our major specialty society and highly experienced in reviewing policy matters. yet numerous PCPs privately feel that the AAFP has failed them. Their proposal reflects some of the reasons.

First, the AAFP proposal is complex. Ours is simple. A PCP who signs on to the AAFP proposal cannot know how much they will make. Who takes a job without knowing the salary? Our proposal is transparent.

Second, the AAFP proposal uses MIPS metrics, which are deeply flawed and contain no useful information about social determinants of health. Ours includes and measures SDH. MIPS measures are not only innately flawed as an evaluation of health outcomes, its' reporting requirements let physicians choose their best measures or the ones easy to report- providing uncertain value. We offer simple reporting at no cost, low burden and high value.

This author is well connected to small practices nationally and no one who read the AAFP proposal, no working PCP, could understand it or showed any interest. If put into place we would sign up for it ,yes- because any program that offers even marginal improvement gets a fair trial, but the author has also spoken to people in CPC+ and is met with fatigue, eye rolling and frustration, though certainly some practices do well with it. CPC+ is very complex with imposing requirements.

We offer something better. This proposal has physicians all over the country keeping their fingers crossed for a trial. This proposal is elegantly simple, low cost and offers a chance to unmask issues that truly influence health outcomes, to guide clinical care, and to provide better income for struggling PCPS.

Addressing and managing social determinants of health (SDH) is critical to improving outcomes. Acknowledged widely, but poorly addressed in current initiatives, we propose that evaluating "what matters to patients" vs "what is the matter with them" changes the paradigm from the paternalistic "patients need to take responsibility" and from labels of "noncompliant", to the caregivers being compliant with patients' needs and wishes, for successful health care to occur. We also posit that primary care needs to be paid simply. More codes with more criteria are counterproductive. We need time to build a relationship with, and tend to the needs of, our patients and our practices. Currently too much of our day is spent on administrative trivia. Providing physicians with "breathing room" is crucial. High risk patients need coordination of services and repetitive support. If physicians are paid only when the patient comes in, practices

² <https://aspe.hhs.gov/system/files/pdf/255906/AAFP.pdf>

chase their tails to find money and time, and simply cannot provide care consistent with current guidelines and patient need.

Medicare chronic care management code 99490 began the recognition of pay for non-face-to-face care, but its implementation is problematic. 99490 requires significant documentation and billing work - by calendar month only - for about \$42.00.

Example: If a patient has only diabetes and no second diagnosis, they are not eligible for chronic care under this code.

Example: If a PCP billed for 2 hours of work from Days 1-10 of the month but the patient was admitted on the last day of the month, the PCP could be asked to return the \$32.00 (the Medicare 80% payment for 99490) because CMS views that the patient was in the hospital and therefore not eligible for this payment (author's personal experience).

Medicare's transitional care code, also well intended, requires knowledge of a discharge - which the PCP may not be privy to - and then, in short order, risk stratification of the patient and a follow up office visit. If the patient returns, the office must then hold that bill for 30 days before submission, then wait another 30 days, at least, for payment. Such complexity is disrespectful to working physicians, and wasteful.

These explanations are included to inform the varied members of the PTAC to demonstrate unintended downstream realities of upstream good ideas.

This model proposes:

- Capitation paid monthly. Capitation = risk.*
- Risk assessment by a low burden tool that incorporates social determinants of health (SDH)
- Substantial performance risk*
- Quality benchmarks derived from patient reported outcomes and SDH
- Targeted to any and all primary care practices of any size*
- Payment for all outpatient primary care services (except those that incur a significant supply cost to the office).
- Other integral characteristics of this model include capped panel size, quality accountability and risk adjustment using an inexpensive high value tool (HYH), and a with-hold of 15% annual income until benchmarks are met.

The patient reported outcomes tool (PROM), at HowsYourHealth.com (HYH) provides structure to stratify risk, which both guides care and determines payment, as higher risk may drive costs. Practices request patients to enter information on the HYH site. Survey data is returned for sharing between the individual practitioner and the patient, and practice-wide data is aggregated online.

Information from HYH provides a low burden, validated³ method to collect practice function metrics such as access, continuity and care coordination. HYH risk- adjusts patients for payment,

³ journals.plos.org/plosone/article/comments?id=10.1371/journal.pone.0192475

for targeting resources, and it measures quality benchmarks. Risk stratification derived from use of HYH determines which PMPM payment level should be applied to an attributed patient. We propose two levels of risk and payment –low and medium risk patients, and high risk.

The risk stratification score-provided automatically within HYH- is based on five items: pain, emotional issues, medical complexity (polypharmacy), medication side effects and health care confidence.⁴The social determinants of health, measured here along with polypharmacy, are acknowledged to play a large role in health outcomes, but are not well measured by current initiatives.

Financial structure

We propose a primary care capitated payment for outpatient services of \$60.00 PMPM for low and medium risk patients and \$90.00 PMPM for high risk patients.

This model originates from the work of very low overhead practices, who could provide care for patients for \$ 1.00/day, while more traditional practices in higher cost markets, provided care for \$2.00/day or \$60/mo.

We considered the average number of visits per year that patients were requiring and the payment for them; a 99214 is about 98.00 for Medicare. At 4 visits a year this is just under \$1.00/ day (\$30/mo.)

“Can provide care” however, affords physicians an income consistent with current PCPs, not with that of their procedure-based colleagues. Physicians in traditional offices who have an overhead approaching 57%⁵, cannot provide wrap-around care for all patients for \$1.00 or \$2.00/day. We propose a payment of \$3.00/day - \$90 PMPM -to allow practices to call high risk patients for follow up on weight and edema if they have congestive heart failure, monitor peak flows in asthmatics, and proactively ask about side effects before patients discontinue medication, etc.

Approach to confounders

To ensure that capitation does not drive up panel sizes in a bid for income, with potential reduction in care quality, we include panel size caps.

Practices will be accountable for quality and costs by a withhold of a 15% of annual income.to encourage targeting resources towards care If physicians do not meet benchmarks they stand to lose that income

Successful providers in this model will see improved access for patients as well as efficiency and coordination of care. To achieve success, budget review, nontraditional visit use, evaluation of re visit intervals, and care coordinate tools will be required. Practices will incorporate a process to use HYH and appropriately respond to the survey results.

Patients and other providers would see no difference in this model from how they interact with practices currently.

⁴ *Quality of Life Research* 27(1) · April 2017 DOI: 10.1007/s11136-017-1573-x

⁵ <http://medicaleconomics.modernmedicine.com/medical-economics/news/clinical/personal-finance/exclusive-survey-practice-expenses>

We do not support increases in patient copays. Since physicians would submit encounter forms with the level of work that is currently familiar – i.e. 99214 and a diagnosis code, the patients' copays should remain the same.

In summary, this model proposes adequate pay for primary care in a transparent, low burden manner, risk adjusted, per patient per month, paid monthly, for most outpatient primary care services. Other characteristics of the model include capped panel size, quality accountability, and risk adjustment using an inexpensive, high value tool, and a with-hold of 15% annual income until benchmarks are met.

II. Scope of Proposed PFPM (High Priority Criterion)

PTAC seeks ways to broaden the APM portfolio by either addressing an issue in payment policy in a new way, or including entities whose opportunities to participate in APMs have been limited. Both are addressed here.

This proposal can be implemented nationally, and once tested, benefit large numbers of patients. It can be available to any primary care physician or independent nurse practitioner. This proposal is not currently targeted to pediatrics.

The author found widespread interest in participation when she surveyed small independent practices across the country, supporting a trial of at least 5000 Medicare patients. The author suggests the model begin with Medicare. The author can suggest practices specifically that could provide such a test group. The Ideal Medical Practices 501c3 (impcenter.org), a small nonprofit, has dozens of practices working with the tools proposed here. We have over a decade of experience with HYH and some with capitation; many more starting with value based contracts, in small practices of various size, payers, locations and practice focus. The author writes with many behind her.

This proposal can be extended to any willing payer.

Employed physicians and NPs, in large or small practices, are all eligible.

Since the model requires participants to assume significant performance risk, but no insurance risk, it is feasible and attractive to small practices.

A few years ago US Health Care in Pennsylvania showed many of the concepts here to be feasible, though it was structured differently.⁶

Our model is feasible for small practices and is attractive to them.

The AAFP proposal estimated that over 30 million Medicare patients would be impacted if models were implemented nationally, and a substantially higher number for a multi-payer model. This is significant scope.

⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193601/>

III. Quality and Cost (High Priority Criterion)

PTAC seeks input on how a payment model would improve or maintain health care quality while decreasing cost, or both improve quality and lower cost. This model can improve both quality and cost parameters.

Cost

Reimbursement to PCPs would rise significantly from current levels (*higher costs*), but this would be offset by the well-established cost savings of investing in primary care.⁷

Those costs are also paid for by reduced use of specialist services derived from comprehensive care and care coordination functions. **Preventing one lower cost hospital admission or extensive ER evaluation alone, could pay for the care of ten low risk patients for an entire year in this model.**

The anticipated impact on spending is therefore net savings to the payers involved.

Quality

Patient-reported experience of care (PROM) predicts health care outcomes. Our tool HYH is validated with CAHPS⁸. “When collected through well-designed survey instruments that direct patients to report their experiences, rather than their general “feelings”, even a controversial measure such as “satisfaction” appears to be tied both theoretically and empirically to quality.”⁹

The patient-entered HYH metrics that include validated SDH (social determinants of health) are what current quality measurement lacks. This is innovative material with the potential for improved care processes and better outcomes.

Quality

Metrics

The twin engines of the proposal’s innovation are its’ payment design and its metrics. The quality metrics are collected by HowsYourHealth.org (HYH). HYH risk stratifies patients and measures quality and does so with minimal burden to practices This is a major difference from the AAFP proposal.

Risk adjustment determines capitation rate. Capitation is the risk.

The country has been experimenting with payment for performance (P4P) and best practices of quality measurement in primary care. Starfield reminded us that people come with problems not diseases. Back pain is the classic example .Disease focused metrics such as those found in MIPS face the challenges of being both unrelated to patients’ quality of life and of chasing ever-changing guidelines, or inaccuracies due to data inputs in the variety of EMRs Current approaches do not accurately reflect care.

HYH has enabled practices to obtain actionable data both on processes - e.g. does the patient have good access- and on realistic outcomes-e.g. are medicines making them sick? Extracting

⁷ Millwood 2010, and Primary Care Spending 2014

⁸ <https://www.ncbi.nlm.nih.gov/pubmed/23748272>

⁹ *Nejm* 2013 <http://www.nejm.org/doi/full/10.1056/NEJMp1211775#t=article>

actionable and care guiding data from quality and patient experience measures is a key difference from the AAFP and MIPS approach.

HYH is a user friendly, highly sophisticated tool that unmask social determinants of health and gets at cost proxy measures and the more “standard measures” such as diabetic and hypertension control and preventative care. Developed in 1994 and disseminated on the Internet since 1999 without charge to primary care practices, HYH provides a source of information about patients’ function, diagnosis, symptoms, health habits, preventive needs, capacity to self-manage chronic conditions, and their experiences of care. Patients enter all the data.

HYH provides a summary of all patient data (with national benchmarks, so we have established benchmarks to utilize in this project) and a secure registry to target interventions at groups of patients with similar needs (such as diabetes, emotional problems, or low confidence to self-manage health problems). The HYH system is used by hundreds of practices in the United States and Canada, and initiatives to increase uptake are underway in Iowa, Massachusetts, and British Columbia. The system is endorsed by several medical specialty organizations. The author has no financial interest in HYH

How HYH works:

A.Data gathering

Patients are asked to take an online survey, which takes about 15 minutes. On completion, the practice is immediately emailed a report that looks like this: [This is a real patient’s form]

Name: removed by Dr A

Birthdate: “

- Date: **2017-08-21**
- Age: **18-34**
- Gender: **Female**
- BMI: **30.1**

BOTHERSOME PAIN: Not Present

BOTHERSOME EMOTIONS: Not Present

POSSIBLE MEDICATION RISKS: Not Present

HEALTH CONFIDENCE: Not Very Confident

What might improve health confidence? "Less stress and more motivation to take care of myself. A lot of nights lately I have skipped meals to work on projects. A larger income would also help reduce stress and make healthier foods more affordable." Ask: Problem most difficult to manage

ASSETS

FUNCTION	HABITS	KNOWLEDGE	PREVENTION
Social Activities - Slight limitations Social Support - As much as wanted Physical Fitness - Very heavy	Generally avoids accident risks Does not smoke Does not drink excessively Exercises Regularly	Birth control Sexual diseases	Had pap test Education about birth control Education about sexual diseases

NEEDS

FUNCTION (*italics = clinician unaware*): None

SYMPTOMS/BOTHERS: None

CONCERNS OR FAMILY HISTORY: Sexual issues/birth control; AIDS/sexually transmitted diseases; Exercise/nutrition needs; Family history of heart trouble/arteries; Family history of diabetes; Family history of lipid disorder

HABITS: None

PREVENTION: Lacks essential money

IMMUNIZATIONS: "flu". Should have had MMR, DPT, Varicella, and HPV.

RISK CONSIDERATIONS

Chronic Diseases: None

Risk for ED or Hospital Use: Medium

Habit Change Plan for next 2 months: Patient does not wish to make any change in risks to health at this time.

SUGGESTED READING AND EDUCATION

- Risks: What Are My Chances?
- Exercise and Eating Well
- Health Habits and Health Decisions
- Sexual Questions
- Women's Health

Planning With Health Professionals (During Visit)

ALLERGIES:

CURRENT MEDICATIONS:

IF SICK, WHO DECIDES:

ADDITIONAL PLAN FOR HEALTH CHANGES:

___ See Above Only ___ See Below ___ From Problem Solving

- Additional Change:
- Goal:
- Steps:
- Barriers to Steps:
- Ways to Overcome:
- Confidence (0-10):
- Help Needed:

B. Data use to guide care

The report received by the PCP flags preventive care gaps and performs risk stratification at the point of care. In contrast, MIPS reporting is after the fact. For the above patient follow up might include reviewing the chart about family history and calling the patient to clarify concerns and give information.

Unlike typical disease management quality data from payers- which can be useless due to small sample size- HYH measures office quality metrics (access, efficiency, coordination) which are germane to *every* patient in the practice (and not just patients with disease X) so the quality metrics thus generated quickly approach statistical significance.

In addition, practices can customize their survey and add specific questions. [See Appendix B.]

C. Data use for practice improvement

Practices log into the HowsYourHealth server to retrieve practice -wide aggregated data .The data can be parsed by discrete time periods, patient age, disease state, or socioeconomic factors, and can be used to determine populations at risk for ER and hospital utilization. [Please see Appendix A for an annotated example of a HYH data set along with the explanation of benchmarks and risk adjustment.]

HYH identifies potential care interventions for patients. The system collects generic patient-reported outcomes, including measures on pain, mobility, mental health, age and sex specific preventive health needs, and self-management capacity for common risks and conditions. It assesses patients' general function, concerns, symptoms, health habits, chronic condition management, and communication with clinicians, and quality of healthcare services. It also produces a portable health record for the patient and automatically enters data into a registry for the clinician (on the basis of the patient's diagnoses, functional limitations, confidence with self-management, and several biomedical measures).

Patients control their HYH information and its security, and its' use does not require a personal identifier or password.

A controlled trial involving 45 PCPs and 1651 patients aged ≥ 70 years found that using HowsYourHealth significantly improved patient ratings of overall care quality and their understanding of important risks¹⁰. Patients also reported that it helped with daily activities, emotional issues, and social support.

Practices typically build HYH into the routine “annual check-up.”

A significant body of literature supporting practices use of HYH to improve care exists.¹¹:

MIPS metrics such as colorectal screening, breast cancer screenings, coordination with specialists, having knowledge of and knowing what to do about blood sugar or blood pressure, are included in HYH. Thus, the proposal meets the quality measurement standard for an AAPM.

D. Data use for risk assessment

Patients are grouped into low and medium risk or high risk by HYH. High risk is determined by five items: pain, emotional issue, polypharmacy, adverse medication effects, and low confidence in managing health problems HYH refers to these as the What Matters Index (WMI). See Appendix B for how HYH extracts this from the data. The WMI has been shown in one study of 19,000 patients in three diverse test populations, to be strongly associated with the use of hospital and emergency services.¹² Since relatively few patients use costly care, both the WMI and a prototypic risk-designation model in the study had comparably low-positive predictive values. The WMI can be used to place patients into groups associated with levels of costly services. People with certain responses are more or less likely to end up in the ED or with inpatient hospitalizations, which are reasonable resource use markers even if they do not cover all resource use utilization. The principles of risk adjustment are to put people into medical resource utilization “buckets” to enable comparison. Hence, “Dr. Antonucci is performing as expected as her patients have the expected rate of medical resource utilization” is reasonable. One might argue this is crude, but in fact it follows the evidence.

HYH captures the risk variables, and the level of risk informs both care and payment level.

E. Data and validity

Practices’ use of data from multiple sources is encouraged. Although small sample sizes affect validity from payer supplied data, because HYH compares variables that are generalizable to all patients, a sample size of 30- 60 surveys/yr is statistically reliable. Model regulations would require practices to obtain surveys from a significant percentage of patients/yr .We know from work in the Ideal Medical Practices project that physician engagement with transformation was

¹⁰ journals.plos.org/plosone/article/comments?id=10.1371/journal.pone.0192475

¹¹ <https://www.howsyourhealth.org/static/html/whereWhy.html>

¹² journals.plos.org/plosone/article/comments?id=10.1371/journal.pone.0192475

proportional to the number surveys are completed. 100% of patients will not be a realistic goal and is not necessary.¹³

Practices typically receive information from various sources. Using HYH compares them to national benchmarks. Planned care assesses every patient for guideline-recommended needs like tobacco assessment /bmi/colorectal screen etc. We propose that practices also routinely ask all patients to take HYH.

Concerns have been raised about validity of patient reported measures. Chart audits over the years by Dr. Wasson have shown accuracy in this regard¹⁴.

Example: Patient's HYH survey reports lack of lipid measurement, but investigation finds adequate measurement but without communication to patient in meaningful way which creates a care opportunity.

Example: Access to care is an important metric. NCQA requires proof of extended or nontraditional hours with screen shots of consecutive days of pre- day and post-day scheduling.

We believe that only patients can assess access, and we measure that. When people can call someone knows who they are, and who knows that the pharmacy is a 30-minute drive and closes at 1 PM on Saturday, health related behavior improves. Patients do not want necessarily to go to the ER (a common cost metric). They want to know what to do and what to expect.

IV. Payment Methodology (High Priority Criterion)

Payment details have been outlined above- with forgiveness for repetition we describe it fully here.

Low overhead practices communicating with the author report providing good care of patients for \$30.00 PMPM. Most practices have little experience with low overhead. With typical staffing ratios and office space they need \$60 to \$90.month, depending on care needs. This forms the basis of our proposal.

Low risk patients may see us 1-2 times/year with additional paperwork, and phone calls.

Currently at Medicare rates those services generate \$200.00/yr. (2 99214s or perhaps a wellness visit at 139.00 plus perhaps a 99213 or 99213 68-98.00 → \$249.00 maximum

These numbers vastly underpay PCPS.

Complex patients at higher risk levels need more visits and many more phone calls to nurses, family, pharmacies, and paperwork as prior auths, review of tests etc. Four visits a year at Medicare rates is just under 400.00/yr. That number does not include non-face to face time, estimated at 1-2 hrs. /mo. but with great variability. When using those estimates we still arrive at payment levels far below those of procedural colleagues .Thus our proposal is based on real world experience, current payment, and an appropriate level of support for non-face to face work.

¹³ <https://www.ncbi.nlm.nih.gov/pubmed/23748272>

¹⁴ "

As stated, FFS payments undervalue primary care services. Payment via administrative schemes to assess risk such as HCC codes has proven to be complex and scorned. Physicians view this as gaming the system when our ACOs tell us to find the code that makes the patient the sickest. Our proposal is clear, simple, and the risk tool derives from the work of physicians and patient need. We reject HCC. We reject disease centric metrics .It is not unimportant to measure AICs of course, but current attempts force physicians into being big data collectors; and without straightforward relationship to patients' well-being ,needs to be set aside. Our proposal is innovative but not casual It is elegant and low cost, but not homegrown.

This proposal offers a modified, capitated fee schedule.

Successful examples of capitation do exist, in the author's use of the proposed model for 10 yrs. and its use in Iora Health for example. Also in US Health Care in the late 1990s as previously referenced.

Appropriate capitation represents the best opportunity to eliminate the impediments of FFS by allowing immediate investment in the primary care infrastructure, reducing the administrative burden, and rewarding physicians for providing care in a variety of ways.

The proposed payment model is based on patient risk /per patient /unit volume of time. This proposal suggests risk assignment both to manage care -which reduces costs when done well- AND risk assignment to pay PCPs.

Risk management guides care, and risk management also informs payment in this project.

Risk assignment can forecast cost only at population levels, so pooled data in a large project is necessary to trial our proposal properly.

Adequate risk adjustment is essential to protect against cherry picking patients, inappropriate underutilization of services, and undue risk on practices. Using HYH, patients can be risk stratified into low / medium, and high risk categories. Risk adjustment is not likely to forecast costly service use for individuals. However, the WMI (what matters Index from HYH) is based on measures that will immediately guide care for every patient, and good care reduces costs.

Quality and cost-effective care relative to benchmarks will be regularly assessed. Practices which meet or exceed benchmarks would retain full capitation and maintain their standing in the project. Failure to meet benchmarks would involve loss of the withhold (15% of capitated rate) and possible removal from the project. Rules for participation should include an appeal for those that come close to achieving the benchmark or have extenuating circumstances.

A prospective, capitated, risk adjusted, monthly payment differs from Track 2 CPC+ where practices are paid via a complex formula with a reduced FFS payment after services, and with many requirements. In our model, practices would be paid based on the complexity of the patient and would be paid on a **real world capitation based on costs determined from years of real practices work, and with an elegant simplicity.**

Financial Risk

The proposed model includes performance risk for participating practices.

Pay for performance / risk, for large networks may someday be part of the fabric of American health care but it is not appropriate currently to lay financial risk before physicians, especially small practices. We agree with the AAFP in opposing putting practices at financial risk for utilization of services outside their control (total cost of care). Such risk is properly borne by health plans and payers. Primary care physicians assume various types of risk now- for misdiagnoses and litigation, for financial risk when narrow networks by payers exclude them, and when some carriers pay for services others will not, and when similar work carries dissimilar payment. The goal is to eliminate the staggering work necessary to remember all of this and use time for patients' benefit.

Accountability is acknowledged and accepted. High medical costs in this country occasion requests for financial accountability. We offer accountability in this model.

Previous studies show patients prefer small practices and they appear to offer high quality at lower costs ¹⁵However, small practices struggle.

Payment details

In a 1000 patient small practice (some PCPs carry panels of over 2000, although various sources suggest 1400 as optimal), **about 15% of patients may be in the high risk category** [J. Wasson personal communication].

Our proposal would pay this practice \$784,000/yr. (a 2000 patient panel \$1,560,000); with a maximal overhead of 57 %, the doc would net \$337,120 (\$670,800 for the larger panel Frankly larger panels run overhead as higher as 67% or more.)

The Medscape physician compensation report for 2017 ¹⁶ puts family medicine salaries at \$ 209,000 and ortho at \$489,000.

Monies to support this model will come from reducing the admissions and excess testing and treatment. **One prevented admit pays for ten low risk patients for one year.** There is plenty of money in the system- reallocation is needed; this model's sustainability comes from the well documented reward to society of good primary care.

The savings are long term. The payment to PCPs must start now if we are to salvage the moribund primary care network.

Coding/Claims

We recognize that, to the extent that doctors are capitated, payers would not see diagnoses and procedures. Practices in this model will submit claims with ICD 10 and a CPT, but the CPT will have no connection to payment. There will be no denials / adjustments / correction of modifiers. This model is currently in effect with the author's arrangement with a payer. This took a short time to set up and was not an undue burden for either party.

¹⁶ <https://www.medscape.com/slideshow/compensation-2017-overview-6008547> family medicine 209,000

Fix copays work better than cost sharing. A few services will require practices to purchase expensive supplies up front. These should not be capitated. Examples are IUD insertion for the cost of the device, and vaccines, which require costly bulk purchasing. All other services, including suturing, bandages, nebulized meds, injections of meds unless over a cost threshold, and CLIA waived tests would be capitated. Model rules would specify cost thresholds. For those services still paid on a fee-for-service basis, payers would determine payment as they do now.

V. Value over Volume

The PTAC seeks input on how the proposal can provide incentives to practitioners to deliver high-quality health care.

Performance-based payments, with established quality benchmarks with a withhold, induce accountability for quality and cost. This model encourages PCPs to deliver high-value health care. To preserve quality and prevent accepting large scale funding without accountability panel sizes would be capped at 1500 patients per physician; a practice with significant staffing developing skill in the model, could perhaps care for more in the future, this could be encouraged given the primary care shortage.

Limiting panels is unlikely to induce any further primary care shortage. Small practices will have the resources to expand, all practices will have the resources to serve further patients by providing e-visits and telehealth, and, as well, favorable payment and innovation induces others to enter the field.

VI. Flexibility

Our model supports physician engagement in practice redesign and works with any willing provider, and is fully adaptable to accommodate all clinical settings and patient subgroups. This model should be especially attractive to small and rural practices - an area of intense need.

Infrastructure Changes.

Operational shifts will be required by the participating practices, while administrative and reporting burdens will be reduced. The model requires clinicians to shift to a primarily capitated operation, and incorporate HYH into practice flow. There will be minimal focus on claims and coding for payment, and more on panel management, which will benefit patients. Since the model relies on performance measurement via automatically gathered patient input, there will be less reporting burden as compared to the payer-centric model with the inconsistent measures that currently encumber practices. This frees physician to do what they do best.

How model participants prepare and build the infrastructure to implement the proposed model will vary. As a group, Ideal Medical Practices, the project from which this model originated, and a current non-profit (impcenter.org) plus Dr. Wasson of HYH, have extensive experience in connecting primary care practices with the resources that they need to transform from a

traditional care delivery and practice management model to the model that is inherent in this proposal.

In layman's terms, practices will need to remake their budgets and revise work flow. In comparison to the requirements practices have had to take on for survival of practice advisory councils, logging of phone call response times, and documents required to get glucometers and supplies, the author has seen practices not only do this work but engage in it enthusiastically.

VII. Ability to be evaluated

The model (as opposed to the practices) should be evaluated annually based on changes in the quality, patient experience, and utilization using the data of HYH. Details can be fleshed out, but while they would include overall improvement annually, the goal is to meet or exceed benchmarks. HYH details national medians and top thirds. Payer cost data will assist in looking at utilization. The author, and small practices in the country do not have access to Medicare and other payer claims data. This will need engineering into the fabric of the proposal through payers. However HYH provides cost proxy data because it measures ER use, specialist use and hospital use. Long term (to be defined) evaluation of costs should stabilize or go down. Practices that improve may see immediate drop in ER costs but long-term savings may be judged by sustainability and stewardship, not further cost reduction, at some point.

The model relies on attribution of identified patients to the practices. The attribution method is primarily through patient choice and if needed, through the AAFP's model noted as in the appended document. A key goal of the movement to value-based care is to control the total cost of care of patients. Measurement should consider if, and how, it impacts total cost of care - and whether the model can help control those costs across the care continuum. Primary care has the power to influence total cost of care but cannot be responsible for all of it.

Evidence suggests that the longer payment reform programs to support primary care have been in place, the more evident cost savings and improved outcomes are. Adequate time for measurement of the project as a whole will take several years. In the long term, advanced primary care practices with well-developed care coordination and management capabilities should be able to demonstrate impact on total cost of care.

VIII. Integration and Care Coordination

PTAC seeks to encourage greater integration and care coordination among practitioners and across settings relevant to delivering care. Care coordination is a key function for patients and has traditionally been poorly addressed in the medical literature.

HYH establishes whether patients are seeing multiple doctors and if they know who's in charge, and gets at care coordination issues in other ways:

Example: HYH tells clinicians that a patient has not had a mammogram when perhaps we

thought they were “seeing women’s care”.

Example: HYH tells us if a patient is getting good help from treatment- why, we sent them to the pain clinic didn’t we?

Care coordination is facilitated in this proposal by providing both information to the clinician and the financial support to do the work. There will be learning curves for practices to become more engaged in this work. We note that there is no national benchmark or tool for “care coordination”. Our model provides the support and tools to move forward. HYH gives actionable information, in contrast to MIPS or to the NCQA approach, which is to make a practice count numbers of specialist notes and have consultants attest to communicating, the current low value, and high check box approach. Counting referral rates has been suggested but there are no benchmarks to evaluate that. As stated, when physicians have breathing room, they can design processes that work for their patients. Some practices text patients to remind. Some have high needs patients on regular call back lists, some have a program to call after any consultant visit to assess and coordinate.

Care coordination takes time but is not otherwise expensive. Starfield tells us that there is a structure and a behavior to care coordination [presentation to small group, no reference] as practices must not only provide and seek information, they must have a way to act on it. The information from HYH plus payment that allows time to use it, supports care coordination. Systems need to be in place as per the examples above, whether the practice has a secure electronic portal or call back index cards. Good ideas should be flexible in their utilization. Care coordination takes caring staff and time. Current panel size is often driven by finances, with tracking systems and follow-up falling by the wayside. Paid adequately, primary care practices can do their job well. Your attention is called to Milstein’s report on example practices.¹⁷

IX. Patient Choice

PTAC seeks to encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individuals.

By supporting primary care with a tool that provides useful information in a timely fashion, and by enabling doctors with the time to address these concerns, PCPs improve the health of the population. Since patients will choose their PCP, this model fully preserves patient choice of health care providers. If available nationally, the model would greatly expand, both demographically and geographically, the diversity of participating patients beyond the limitations of the CPC and CPC+. The only limitation would be any imposed by payers. When payers do not engage, patients must follow their wallet, often to practices that do not suit them or provide poorer quality care. Therefore, we encourage this as a national project engaging all payers and any willing provider.

⁷ content.healthaffairs.org/content/28/5/1317.abstract

X. Patient Safety

PTAC seeks to maintain or improve standards of patient safety. There is nothing safer than good primary care and nothing more unsafe than uncoordinated rushed care. The performance measures will drive necessary care and are not harmed by efforts to achieve practice benchmarks.

Practices that stint on care will not meet benchmarks and will lose income. The model supports patient safety also by making patient choice the primary attribution methodology. Practices have an incentive to treat patients appropriately. HYH specifically addresses certain safety parameters:

Example: Are your meds making you sick?

Example: Are there concerns about violence in the home?

These are captured by HYH and delivered to the PCP for intervention.

XI. Health Information Technology

PTAC seeks to encourage use of health information technology to inform care.

At least 50% of qualifying participants are expected to use CEHRT.

Additionally, HYH embraces user friendly technology to collect information, and aggregates it across a practice, along with providing national benchmarks. In other words, without direct interoperability, HYH collects and benchmarks from all users. In addition, as alluded to above, the structure of a trial run presumably by Medicare with involvement possibly of other payers, one hopes would provide information about national resource utilization.

Current HIT is designed first to support documentation and billing and only secondarily to support delivery of care. In this model the focus on documentation for billing is diminished, while focus on improved quality, reduced cost, and improved patient experience is rewarded. As practices use the IT of HYH to drive care and to drive practice improvement the author believes this meets the criteria for using IT to improve care. Access to a common resource is not the same as interoperability, but interoperability is not the practices 'responsibility to support. This was a national error in not putting us all on one EMR, and must await policy and funding at a national level.

While existing HIT, or even paper charts and simple internet access can drive success in this model, the need to become fluent in IT is acknowledged as we move towards interoperability.

Final remarks

The author and her colleagues recognize that working details are outside of the scope of the proposal. But we do not want any more complexity We do not need more codes for more things The current system cannot be tweaked We are prepared to help put this model into practice. Primary care is in dire need of concrete support. The nation's population is in dire need of accessible quality care. We stand ready to do the work with proper support.

For a Medical Home Model to be an AAPM, it must include provisions that potentially:

- Withhold payment for services to the APM entity and/or the APM entity's eligible clinicians;
- Reduce payment rates to the APM entity and/or the APM entity's eligible clinicians;
- Require the APM entity to owe payment(s) to CMS; or
- Lose the right to all or part of an otherwise guaranteed payment or payments.

This model qualifies.

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A Troubled Asset Relief Program for the Patient-Centered Medical Home
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Attribution Methodology (per AAFP)

Patient attribution is critical to payment, quality and cost performance measurement and cost. We support the method used by the AAFP **IF patient choice is not appropriate**. (actually listed as step 1). The AAFP recommends a patient-based, prospective, four step Process that includes a 24-month look-back period for attribution

The Four-Step Attribution Process

1. Patient Selection of Primary Care Physician and Team

This is the acknowledgement that patient selection is the best choice in attribution and should be prioritized as such.

2. Primary Care Visit Events: Wellness Visits

If a patient is not attributed by self-selection of a primary care physician, payers should use well visits, including Welcome to Medicare, preventative codes and Annual Wellness Visits provided by the patient's primary care physician or the practice team, as the next step in the attribution process.

3. Primary Care Visit Events: All Other E/ M Visits

If a patient is not attributed by choice or a wellness visit, the next incremental step is to include all other evaluation and management (E/ M) visits to a primary care physician. The payer should attribute the patient to the primary care physician who provides the plurality of E/ M visits.

4. Primary Care Prescription and Order Events

If the patient is not attributed by choice, a wellness visit or any other E/ M services, payers should consider claims related to medication prescriptions, durable medical equipment prescriptions, and lab and other referral orders made by primary care physicians. Payers should require a minimum of three such events before attributing a patient on this basis.

Please see table on the next page.

In Event of a Tie 24 months use plurality of 3 events /most recent event

APC-APM for Delivering Patient-Ce... x

Pages

Advanced Primary Care | page 4

Step In Process	Event Type	Eligible Procedure or Event	Look-back Period	Assignment Criteria	Minimum Threshold for Assignment	In Event of a Tie
Step 1	Patient Selection of Primary Care Physician	NA	NA	NA	NA	NA
Step 2	Primary Care Visits: Wellness Visits	Well Visit E/M and Select G Codes Only	24 months	Plurality	1 visit	Most recent visit
Step 3	Primary Care Visits: All Other E/M Visits	Any E/M Codes	24 months	Plurality	1 visit	Most recent visit
Step 4	Primary Care Prescriptions and Order Events	Any Rx code, claims related to medication prescriptions, durable medical equipment, and lab and referral orders	24 months	Plurality	3 events	Most recent event

Review and Reconciliation of Attributed Patients

No patient attribution methodology is perfect. The four-step methodology recommended above may still produce errors in assignment. Physicians should have the option to engage in a reconciliation process in which they can review, add, and remove patients from the formal list the payer supplies to them. Like

MedPAC also stated, "The Commission has also become concerned that the fee schedule is an ill-suited payment mechanism for primary care."⁹ Accordingly, MedPAC has recommended Congress establish a per beneficiary payment for primary care.

MedPAC further noted, "The (ESI) fee schedule is oriented

Review and Reconciliation of Attributed Patients

No patient attribution methodology is perfect. The four-step methodology recommended above may still produce errors in assignment. Physicians should have the option to engage in a reconciliation process in which they can review, add, and remove patients from the formal list the payer supplies to them. Like the attribution process, review and reconciliation should occur quarterly and include enough time to adequately review the list.

Risk stratification and risk adjustment should occur annually. This process enables a physician's performance to be adjusted appropriately for factors outside of their control.

Baseline and Benchmarking

The baseline for performance should be a set time period prior to the performance year. A baseline is needed to assess improvement, so the incentive to improve is not improvement, and undermines investments by physicians to improve the effectiveness of care delivery. Payers should hold the benchmarks steady for at least two years (if not longer) instead of reassessing after each performance year.

APPENDIX A Whole practice report x 2 yrs

Anonymous Summary Report

Done with Summary Reports

Practice Quality

Selected IMP110 Since 2016-01-01 00:00:00.00 through 2018-04-01 00:00:00.00

	All Records	Income Problems
Attributes of Care	68	9
Single Measure for Patient Centered Medical Care	67.16	66.67
Medical Home	91.07	80.00
Very Good Communication for Chronic Disease	87.10	Too Few
Aware of Functional Limits	77.78	57.14
	All Records	Income Problems
Desirable Outcomes	68	9
Patient Confidence	66.18	33.33
Practice Benchmark	76.00	61.54
Wellness Activities	67.65	72.22
No Hospital or ED use for chronic disease	100.00	Too Few
Meds not making ill	88.89	Too Few
	All Records	Income Problems
Measures Often Requested by Regulators	68	9
Efficiency of Care (Does not waste time)	95.52	88.89
Any Sick Day in 3 Months	16.18	33.33
Any Stay in Hospital in One Year	7.35	11.11
Continuity (Personal Doctor or Nurse)	98.53	88.89
Any Current Specialist Care	31.34	33.33
One Clinician in Charge	100.00	Too Few
Medical Care Perfect (Nothing needs improvement)	70.59	66.67
Very Easy Access	79.41	66.67

Quality Summary Table

The first half of this Quality Summary Table is based on categories that illustrate important patient-perceived attributes of care, and desirable outcomes that arise from excellence in these attributes. (The rationale for choosing these particular categories is described in Wasson JH, Benjamin R, Johnson D, Moore LG, and Mackenzie T., "Patients Use the Internet to Enter the Medical Home", J.Amb.Care.Mgmt. 2011; 34:38-46.)

The derivation of the categories from their corresponding HowsYourHealth question(s) are shown as a single attribute, or if a composite measure, as the sum of their individual measures below. The individual measures which comprise each question are tagged with a letter (and number if needed) so that they can be identified in the full data set that follows.

- Single Measure for Patient Centered Care: "I receive exactly the care I want and need..."(A)
- Medical Home: Composite measure of access, continuity, efficiency and coordination [Access - "How easy is it to get medical care when you need it"(B1), Continuity - "Do you have one person you think of as your personal doctor or nurse?(B2)", Efficiency - "When you visit your doctor's office, how often is it well organized, efficient, and does not waste your time?"(B3), Coordination - "If you are seeing a specialist physician and your primary physician, do you have one doctor you feel is in charge of your medical care?"(B4)
- Communication: Information quality for chronic disease - "You checked that you have high blood pressure, heart disease, diabetes or breathing problems. How would you rate the information given to you about this(these) problems by a doctor or nurse?"(C)
- Aware of Functional Limits: Composite of provider awareness for any of 6 bothersome functional categories (E1-5)
- Patient Confidence: Activation, self-management and problem solving measure - "How confident are you that you can control and manage most of your health problems?" (D)
- Practice Benchmarks: Composite of preventive screening rates and disease metrics – [mammogram screening (F1), lipid screening (F2), colon cancer screening (F3), blood pressure levels (F4), lipid levels in heart disease and diabetes (F5), blood sugar levels in diabetes (F6)]
- Wellness Activities: Composite of healthy habits – [not smoking (G1), eating well (G2), regular exercise (G3)]
- No Hospital or ED Use for Chronic Disease: Utilization Measure (H)
- Medications Not Causing Illness: "Do you think that any of your pills are making you sick"(I)

Interpreting the Numbers

100 is best. As a measure of equity of care, the Quality Summary lists all patients and those who have financial problems. The difference should be less than 10 absolute points.

In all Tables, "too few" indicates 6 or fewer measures in a cell. Measures are very stable when there are 60 or more; reasonably stable for 20 or more; and crude estimates when < 20.

For the period 2014-2017 the median and cutoff for the top third of over 100 typical clinical settings (in which about half of the patients have a chronic disease or bothersome functional limit) are shown below:

Exactly the Care...: median 40; upper third over 50.
 Medical Home: median 70; upper third 80.
 Excellent Information for Chronic Disease(s): median 70; upper third 80.
 Aware of Functional Limits: median 50; upper third 65.
 Patient Confident with Self-Management: median 55; upper third 60.
 Preventive and Clinical Benchmarks: median 75; upper third 80.
 Patient Habits Generally Healthy: median 70; upper third 75.
 No ED or Hospital Use in Year: median 90; upper third 92.
 Patient Convinced Medications for Chronic Disease(s) Not Causing Illness: median 80; upper third 85.

Certifiers and Regulators Turn Toward Patient Report

As certifiers and regulators for the Patient-Centered Medical Home have increasingly become aware of the extreme inefficiency and lack of face validity of process-of-care documentation, they are gradually accepting the summary measure from HowsYourHealth.org to overcome these deficiencies. (HowsYourHealth.org meets NCQA criteria as an "approved" health risk assessment). As an example, for NCQA documentation of medical care access, continuity and coordination the HowsYourHealth.org patient-reported measures may obviate the need for excessive documentation of their processes. A crosswalk between HYH measures that may substitute for NCQA requirements is [posted here](#).

Continuity: median 85; upper third 90.
 In Charge (Coordination if 2 or more clinicians): median 90; upper third 95.
 Very Easy Access: median 50; upper third 60.

A few additional measures included above are also often requested by certifiers and regulators. (In fact, the comprehensive list of your patients' responses below will meet almost any reasonable request.

An additional example illustrates this point. Recently, some clinical sites that are being asked to measure and report social determinants of health according to a scheme proposed by the Institute of Medicine (IOM). To attain IOM suggested standards a practice using HowsYourHealth.org will be able to report measures for stress or emotional problems, health habits and behaviors, exposure to community violence and domestic abuse, physical activity limits, social connections and isolation, and financial status.

Using This Information to Improve Service

In the Action and Planning Form intended for clinical staff, risk for hospitalization and emergency use is reported. The risk is based on the sum of five measures contained in the "What Matters Index"(WMI) : lack of confidence with self-management, significant emotional problems or pain, polypharmacy and medications may be causing illness. The WMI identifies risk as well as archetypical, computer generated risk models. (Wasson JH , Soloway L, Moore LG, Labrec P, and Ho L. Development of a Care Guidance Index Based On What Matters to Patients. *Qual Life Res.* 2017 Apr 11. doi: 10.1007/s11136-017-1573-x). The WMI is also immediately treatable, easy interpretable measure that can be used by practices to compare their sickest or less sick patient reports to other practices. This option for adjustment is included for the summary and registry. However, except for practices only serving poor and very sick patients (e.g. Medicaid settings) or very healthy (e.g. college students) such adjustment is generally not necessary.

The best strategy is to use the Quality Summary to identify domains that are relatively more deficient to set improvement objectives. Once a deficiency is targeted the date selector can be used to document change using a "before-after" analysis. A recent example is described by Lynn Ho, MD, Jean Antonucci, MD. (Using Patient-Entered Data to Supercharge Self-Management. *Ann Fam Med* 2017;15:382. <https://doi.org/10.1370/afm.2068>). In support of their experience, the Center for Medicare and Medicaid Service recently endorsed HowsYourHealth.org as a useful tool for improving self-management.

Often underused but better in many ways that trying to have a representative patient advisory council is to use the open-ended option to ask HowsYourHealth.org respondents to make suggestions about ways to fix a problem you might have identified or suggest problems you have not identified.

Finally, your HowsYourHealth.org registry allows you to automatically select patients by many social determinants of health, WMI measures and common diagnoses. Practices use these lists of patients for special email contacts, focus groups, etc.

Summary for Individual Survey Items

Selected IMP110 Since 2016-01-01 00:00:00.00 through 2018-04-01 00:00:00.00

	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Respondent Characteristics	68	53	15	13	40	1	14	27	2	8	11	9	13	9
Younger Women	19.12	24.53	0.00	100.00	0.00	Too Few	0.00	14.81	Too Few	12.50	0.00	22.22	15.38	22.22
Older Women	58.82	75.47	0.00	0.00	100.00	Too Few	0.00	40.74	Too Few	25.00	72.73	66.67	53.85	66.67
Younger Men	1.47	0.00	6.67	0.00	0.00	Too Few	0.00	0.00	Too Few	0.00	0.00	0.00	0.00	0.00
Older Men	20.59	0.00	93.33	0.00	0.00	Too Few	100.00	44.44	Too Few	62.50	27.27	11.11	30.77	11.11
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Respondent Diagnoses	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% with Hypertension	39.71	28.30	80.00	30.77	27.50	Too Few	85.71	100.00	Too Few	100.00	36.36	55.56	61.54	33.33
% with Hardening of Arteries	2.94	3.77	0.00	7.69	2.50	Too Few	0.00	7.41	Too Few	12.50	0.00	11.11	7.69	11.11

% with Diabetes	11.76	5.66	33.33	7.69	5.00	Too Few	35.71	29.63	Too Few	100.00	18.18	22.22	30.77	11.11
% with Arthritis	16.18	15.09	20.00	0.00	20.00	Too Few	21.43	14.81	Too Few	25.00	100.00	0.00	61.54	11.11
% with Respiratory Disease	13.24	15.09	6.67	15.38	15.00	Too Few	7.14	18.52	Too Few	25.00	0.00	100.00	7.69	22.22
% with Obesity > 15%	19.12	16.98	26.67	15.38	17.50	Too Few	28.57	29.63	Too Few	50.00	72.73	11.11	100.00	22.22
% Income Problems	13.24	15.09	6.67	15.38	15.00	Too Few	7.14	11.11	Too Few	12.50	9.09	22.22	15.38	100.00
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Bothered (often or always) in the Past Month by:	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Limit Daily Activities	2.94	3.77	0.00	0.00	5.00	Too Few	0.00	0.00	Too Few	0.00	9.09	0.00	7.69	11.11
% Limit by Feelings	4.41	3.77	6.67	7.69	2.50	Too Few	7.14	3.70	Too Few	12.50	9.09	0.00	15.38	11.11
% Limit Social Activities	2.94	3.77	0.00	7.69	2.50	Too Few	0.00	3.70	Too Few	12.50	9.09	11.11	15.38	22.22
% Limit by Pain	10.29	9.43	13.33	7.69	10.00	Too Few	14.29	18.52	Too Few	25.00	36.36	22.22	30.77	33.33
% Limited Social Support	4.41	3.77	6.67	0.00	5.00	Too Few	7.14	3.70	Too Few	0.00	0.00	22.22	0.00	11.11
% Limited Physical Function	4.41	1.89	13.33	0.00	2.50	Too Few	14.29	7.41	Too Few	0.00	0.00	11.11	7.69	0.00
% Headaches	8.82	11.32	0.00	23.08	7.50	Too Few	0.00	7.41	Too Few	12.50	9.09	11.11	15.38	33.33
% Abdominal Pain	7.35	7.55	6.67	7.69	7.50	Too Few	7.14	11.11	Too Few	12.50	18.18	11.11	23.08	22.22
% Dizzy/Fatigue	2.94	3.77	0.00	0.00	5.00	Too Few	0.00	3.70	Too Few	0.00	9.09	0.00	7.69	22.22
% Chest Pain	0.00	0.00	0.00	0.00	0.00	Too Few	0.00	0.00	Too Few	0.00	0.00	0.00	0.00	0.00
% Menstrual or Menopausal	4.41	5.66	0.00	15.38	2.50	Too Few	0.00	7.41	Too Few	12.50	0.00	11.11	7.69	22.22
% Eating or Weight	17.65	15.09	26.67	0.00	20.00	Too Few	28.57	25.93	Too Few	37.50	54.55	0.00	61.54	44.44
% Skin	4.41	3.77	6.67	7.69	2.50	Too Few	7.14	3.70	Too Few	12.50	0.00	0.00	0.00	0.00
% Urination	1.47	1.89	0.00	0.00	2.50	Too Few	0.00	3.70	Too Few	0.00	0.00	11.11	0.00	0.00
% Sexual	1.47	0.00	6.67	0.00	0.00	Too Few	7.14	3.70	Too Few	12.50	9.09	0.00	7.69	0.00
% Respiratory	2.94	1.89	6.67	0.00	2.50	Too Few	7.14	3.70	Too Few	0.00	0.00	22.22	0.00	11.11
% Joint Pain	19.12	16.98	26.67	0.00	22.50	Too Few	28.57	29.63	Too Few	25.00	63.64	11.11	53.85	33.33
% Backaches	8.82	7.55	13.33	7.69	7.50	Too Few	14.29	14.81	Too Few	25.00	18.18	22.22	23.08	44.44
% Sleeping	14.71	15.09	13.33	15.38	15.00	Too Few	14.29	14.81	Too Few	25.00	27.27	22.22	30.77	55.56
% Foot Trouble	13.24	13.21	13.33	0.00	17.50	Too Few	14.29	14.81	Too Few	12.50	36.36	0.00	23.08	33.33
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Concerned About	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Violence or Abuse	0.00	0.00	0.00	0.00	0.00	Too Few	0.00	0.00	Too Few	0.00	0.00	0.00	0.00	0.00
% Sexual Issues or Birth Control	1.47	1.89	0.00	7.69	0.00	Too Few	0.00	0.00	Too Few	0.00	0.00	0.00	0.00	11.11
AIDS or STDS	1.47	1.89	0.00	7.69	0.00	Too Few	0.00	0.00	Too Few	0.00	0.00	0.00	0.00	11.11
Better Health Care	16.18	18.87	6.67	0.00	25.00	Too Few	0.00	3.70	Too Few	0.00	27.27	11.11	23.08	33.33
Substance Abuse	4.41	3.77	6.67	15.38	0.00	Too Few	7.14	7.41	Too Few	12.50	0.00	11.11	15.38	11.11
Exercise, Nutrition	20.59	20.75	20.00	30.77	17.50	Too Few	21.43	18.52	Too Few	25.00	27.27	11.11	46.15	33.33

Needs														
Preventing Injuries	7.35	5.66	13.33	0.00	7.50	Too Few	14.29	3.70	Too Few	0.00	9.09	11.11	7.69	11.11
Preventing Cancer or Heart Disease	13.24	13.21	13.33	7.69	15.00	Too Few	14.29	3.70	Too Few	0.00	9.09	0.00	7.69	22.22
EENT Care	14.71	13.21	20.00	15.38	12.50	Too Few	21.43	11.11	Too Few	12.50	9.09	22.22	15.38	11.11
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Habits	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Current Smoker (Gi)	13.24	16.98	0.00	23.08	15.00	Too Few	0.00	11.11	Too Few	25.00	18.18	11.11	15.38	11.11
% Smoker Ready to Quit	10.29	13.21	0.00	23.08	10.00	Too Few	0.00	7.41	Too Few	25.00	9.09	11.11	15.38	11.11
% Good Nutrition	82.35	81.13	86.67	61.54	87.50	Too Few	85.71	77.78	Too Few	62.50	100.00	77.78	76.92	66.67
% Using Seatbelt	98.53	98.11	100.00	92.31	100.00	Too Few	100.00	100.00	Too Few	100.00	100.00	100.00	100.00	100.00
% ETOH 10 or more/week	10.29	11.32	6.67	15.38	10.00	Too Few	7.14	3.70	Too Few	0.00	0.00	0.00	7.69	22.22
% Told to Reduce ETOH	13.24	11.32	20.00	7.69	12.50	Too Few	21.43	18.52	Too Few	0.00	0.00	11.11	7.69	11.11
% Regular Exercise (Giii)	48.53	49.06	46.67	38.46	52.50	Too Few	50.00	51.85	Too Few	37.50	45.45	55.56	30.77	55.56
% Confident to change a habit	24.39	26.47	14.29	20.00	29.17	Too Few	Too Few	20.00	Too Few	Too Few	0.00	Too Few	9.09	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Knowledgeable About (age <50)	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Good Education about BCP	23.08	23.08	Too Few	23.08	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Good Education about STD	23.08	23.08	Too Few	23.08	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Good Education about Lipid Test Mammogram	69.23	69.23	Too Few	69.23	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Male Education about BCP/STD	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Knowledgeable About (age 50+)	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Good Education about HRT	0.00	0.00	Too Few	Too Few	0.00	Too Few	Too Few	0.00	Too Few	Too Few	0.00	Too Few	0.00	Too Few
% Good Education about PSA	71.43	Too Few	71.43	Too Few	Too Few	Too Few	71.43	66.67	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Prevention (age <50)	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Male Lipid Test (Fii)	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems

Prevention (age 50+)	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Mammogram (Fi)	82.50	82.50	Too Few	Too Few	82.50	Too Few	Too Few	100.00	Too Few	Too Few	75.00	Too Few	71.43	Too Few
% Women Lipid Test (Fii)	55.00	55.00	Too Few	Too Few	55.00	Too Few	Too Few	72.73	Too Few	Too Few	62.50	Too Few	71.43	Too Few
% Women Bowel Cancer Test (Fiii)	77.50	77.50	Too Few	Too Few	77.50	Too Few	Too Few	90.91	Too Few	Too Few	87.50	Too Few	85.71	Too Few
% Women 65+ Bone Scan	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Male Lipid Test (Fii)	85.71	Too Few	85.71	Too Few	Too Few	Too Few	85.71	83.33	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Male Bowel Cancer Test (Fiii)	78.57	Too Few	78.57	Too Few	Too Few	Too Few	78.57	75.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Prevention Any Age	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Pap Test	49.06	49.06	Too Few	84.62	37.50	Too Few	Too Few	46.67	Too Few	Too Few	0.00	25.00	33.33	62.50
% Clinical Breast Exam	0.00	0.00	Too Few	0.00	0.00	Too Few	Too Few	0.00	Too Few	Too Few	0.00	0.00	0.00	0.00
% Breast Self Exam	0.00	0.00	Too Few	0.00	0.00	Too Few	Too Few	0.00	Too Few	Too Few	0.00	0.00	0.00	0.00
% Women at Risk for Domestic Abuse	0.00	0.00	Too Few	0.00	0.00	Too Few	Too Few	0.00	Too Few	Too Few	0.00	0.00	0.00	0.00
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Family History	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Family History of ASCVD	42.65	41.51	46.67	69.23	32.50	Too Few	50.00	51.85	Too Few	50.00	36.36	33.33	38.46	55.56
% Family History of Diabetes	27.94	30.19	20.00	30.77	30.00	Too Few	21.43	25.93	Too Few	25.00	36.36	33.33	30.77	33.33
% Family History of Cancer	36.76	39.62	26.67	46.15	37.50	Too Few	21.43	40.74	Too Few	12.50	45.45	33.33	46.15	44.44
% Family History of High Lipids	41.18	45.28	26.67	69.23	37.50	Too Few	28.57	44.44	Too Few	50.00	27.27	55.56	30.77	66.67
% Family History of Another Disease	14.71	15.09	13.33	15.38	15.00	Too Few	14.29	7.41	Too Few	25.00	36.36	22.22	30.77	11.11
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Limited by Daily Activities	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Clinician Awareness (Ei)	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Very Good Explanation	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Help from Treatment	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Limited by Feelings	68	53	15	13	40	1	14	27	2	8	11	9	13	9

% Clinician Awareness (Eii)	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Very Good Explanation	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Help from Treatment	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Limited by Social Activities	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Clinician Awareness (Eiii)	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Very Good Explanation	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Help from Treatment	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Limited by Pain	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Clinician Awareness (Eiv)	100.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Very Good Explanation	71.43	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Help from Treatment	57.14	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Limited by Social Support	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Clinician Awareness (Ev)	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Very Good Explanation	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Help from Treatment	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Limited by Physical Function	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Clinician Awareness (Evi)	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Very Good Explanation	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Help from Treatment	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If any Chronic Disease	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Very Good Explanation for Chronic Disease	87.10	78.95	100.00	Too Few	78.57	Too Few	100.00	92.59	Too Few	100.00	Too Few	77.78	100.00	Too Few
% Good Help for Living with Chronic	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few

Disease														
% Possibly Sick from Medications	11.11	13.33	8.33	Too Few	15.38	Too Few	8.33	8.33	Too Few	12.50	Too Few	12.50	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Hypertension	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Good Explanation if Dose Missed	81.48	73.33	91.67	Too Few	81.82	Too Few	91.67	81.48	Too Few	87.50	Too Few	Too Few	87.50	Too Few
% Good Explanation about Weight and Salt	85.19	80.00	91.67	Too Few	81.82	Too Few	91.67	85.19	Too Few	87.50	Too Few	Too Few	100.00	Too Few
% Good Explanation for Medication Side Effects	81.48	73.33	91.67	Too Few	81.82	Too Few	91.67	81.48	Too Few	87.50	Too Few	Too Few	87.50	Too Few
% Sometimes or Often Checking Blood Pressure	74.07	60.00	91.67	Too Few	63.64	Too Few	91.67	74.07	Too Few	75.00	Too Few	Too Few	75.00	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Diabetes	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Blood Sugar Always or Often 80-150 (4.5-8.3 international units)	62.50	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	62.50	Too Few	62.50	Too Few	Too Few	Too Few	Too Few
% Good Explanation for Eye Exam	75.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	75.00	Too Few	75.00	Too Few	Too Few	Too Few	Too Few
% Good Explanation for Foot Care	75.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	75.00	Too Few	75.00	Too Few	Too Few	Too Few	Too Few
% Good Explanation for Adjustment of Calling for help	75.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	75.00	Too Few	75.00	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Hardening of the Arteries	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Having a Heart Attack History	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% of those taking ASA and Beta Blocker	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Having a Stroke History	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% of those taking ASA or Warfarin	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Using Nitroglycerin	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% of those mostly satisfied with Angina Control	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Having a History of	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few

CHF														
% of those Good Explanation about Weight and Salt	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% of those Good Explanation for Self Medication Adjustment	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
If Respiratory Disease	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Good Explanation for Adjusting Medications	55.56	50.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	55.56	Too Few	Too Few
% Good Explanation for Using Inhaler	55.56	50.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	55.56	Too Few	Too Few
% Using Inhaled Steroid	55.56	50.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	55.56	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Care Quality Summary	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% Taking 3 or more medications	25.00	20.75	40.00	15.38	22.50	Too Few	42.86	51.85	Too Few	87.50	27.27	33.33	38.46	22.22
% unable to participate fully indaily work- 2 weeks	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% With Sick Days in 3 Months	16.18	18.87	6.67	30.77	15.00	Too Few	7.14	14.81	Too Few	25.00	27.27	22.22	23.08	33.33
% Hospitalized or ED for Chronic Disease (H)	0.00	0.00	0.00	Too Few	0.00	Too Few	0.00	0.00	Too Few	0.00	Too Few	0.00	0.00	Too Few
% Hospitalized for Any Reason in Past Year (H)	7.35	3.77	20.00	7.69	2.50	Too Few	21.43	11.11	Too Few	12.50	9.09	0.00	15.38	11.11
% Necessary of One Hosp/ED	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Necessary of Multi Hosp/ED	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Having a PCP (Bii)	98.53	98.11	100.00	100.00	97.50	Too Few	100.00	100.00	Too Few	100.00	100.00	88.89	100.00	88.89
% Having 2 or more Drs	30.88	32.08	26.67	30.77	32.50	Too Few	28.57	37.04	Too Few	37.50	27.27	44.44	46.15	33.33
% One in charge (Biv)	90.48	94.12	Too Few	Too Few	92.31	Too Few	Too Few	90.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Having Specialist Perfect Care	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
% Having Overall Perfect Care	70.59	67.92	80.00	69.23	67.50	Too Few	78.57	74.07	Too Few	87.50	72.73	66.67	76.92	66.67
% Having Very Easy Access (Bi)	79.41	75.47	93.33	84.62	72.50	Too Few	92.86	88.89	Too Few	87.50	63.64	88.89	61.54	66.67

% Having Confidence in self-management (D)	66.18	67.92	60.00	76.92	65.00	Too Few	57.14	66.67	Too Few	62.50	45.45	77.78	38.46	33.33
% Seldom Wasted Time (Biii)	95.52	94.23	100.00	100.00	92.50	Too Few	100.00	100.00	Too Few	100.00	100.00	87.50	100.00	88.89
% Get Exact Care Needed (A)	67.16	63.46	80.00	76.92	58.97	Too Few	78.57	74.07	Too Few	87.50	54.55	66.67	61.54	66.67
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Additional Indicators	68	53	15	13	40	1	14	27	2	8	11	9	13	9
% BMI > 30	37.31	30.77	60.00	25.00	32.50	Too Few	64.29	62.96	Too Few	87.50	63.64	33.33	92.31	44.44
% personal harm in past year	0.00	0.00	0.00	0.00	0.00	Too Few	0.00	0.00	Too Few	0.00	0.00	0.00	0.00	0.00
% Blood pressure > 150 systolic (Fiv)	18.52	13.33	25.00	Too Few	9.09	Too Few	25.00	18.52	Too Few	25.00	Too Few	Too Few	25.00	Too Few
% Cholesterol > 200 (5.2 international units) (Fv)	0.00	0.00	0.00	Too Few	0.00	Too Few	0.00	0.00	Too Few	0.00	Too Few	Too Few	0.00	Too Few
% Blood sugar > 140 (7.8 international units) (Fvi)	0.00	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	0.00	Too Few	0.00	Too Few	Too Few	Too Few	Too Few
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Self Designated Questions	68	53	15	13	40	1	14	27	2	8	11	9	13	9
Self designated #1 %yes	32.84	34.62	26.67	33.33	35.00	Too Few	28.57	40.74	Too Few	37.50	27.27	44.44	53.85	33.33
Self designated #2 %yes	92.00	95.00	80.00	100.00	93.55	Too Few	77.78	89.47	Too Few	85.71	85.71	87.50	81.82	Too Few
Self designated #3 %yes	27.69	27.45	28.57	23.08	28.95	Too Few	23.08	20.00	Too Few	25.00	30.00	25.00	25.00	37.50
Self designated #4 % picked 1	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
Self designated #4 % picked 2	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
Self designated #4 % picked 3	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
Self designated #5 % picked 1	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
Self designated #5 % picked 2	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
Self designated #5 % picked 3	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
Self designated #5 % picked 4	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few
Self designated #5 % picked 5	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few	Too Few

Done with Summary Reports

APPENDIX B Open ended question/customized here"Is there anything else you want to add about DrAntonucci's care?"

Dr. Antonucci really does not need	By having my drivers licence renewed so I may attend family funcnyons and aa meetings and meetings for my €
All is well!	Free doughnuts and coffee
I connected with Dr. Antonucci be	I am satisfied
Her office and care are fine. Com	I am very pleased with the care I receive from Dr. Antonucci. I feel fortunate to have her as my primary care pl
Compared to his last doctor that	I am very satisfied with my treatment and care.
At this point in time I cannot think	I appreciate the time and al the explanations and he caring attitudde
Dr. Antonucci is right on top of thi	i believe i'm very well cared for
Have patience with me, on occasi	I cannot think of anything at the moment..she shows concern if I am having problems with anything and I do r
I have just had one appointment a	I cannot think of anything. She does very well.
I think she does a fine job! No sug	I have no complaints.
Employ scare tactics to jar me into	I like her care...
I can't think of any changes that w	I like the way Dr. Antonucci practices medicine.
I am very grateful to have her for	I LIKE THINGS AS THEY ARE.
I can't think of anything	I'm happy with Dr. Antonucci 95% of the time. She researches information online, has a good sense of humor,
How can you "better" something t	I'm very satisfied with the care she gives & our communication is very good..
I find Dr A. to be a fine physician a	If she could check blood like the hospital it would be more convienant
I am very satisfied with the level o	ilt and she are just fine. I would like to give her a pretty picture to hang in her office.
DR ANTONONUCCI'S OFFICE AND	It can't be better. She is a very experienced, knowlegeable, and caring doctor.
All great	It could not be better
cant think of anything	just keep calling when i need her
Her office is fine. Dr. Antonucci t	mostly my breathing problems
I have no complaints--I think the p	NO CHANGE, SHE IS THE BEST!
Dr. Antonucci is a great doctor. The	No suggestions
At the present time all is well with	nothing
defoliate the Bushes	nothing
Dr. A is the best!	Nothing
Everything is fabulous! Dr. Antonu	nothing
excellent care and responsiveness	nothing
I am very pleased with the care I r	Nothing

I have no concerns at this time. Dr.	NOTHING ... she is a wonderful doctor ... who takes time to listen to my needs ... and is very clear and specific
I appreciate how quickly she can g	Nothing ... she's just about perfect. A very efficient\r\nand caring physician.
I have only seen Dr. Antonucci on	Nothing at all.
Dr. Antonucci is a very caring and	nothing I can see after 5 years. She should noy be practicing medicine i feel
Dr. Antonucci does a great job att	Nothing I can think of ... she has been great to me and my husband ... and that is why I have changed physicia
I am so pleased with the access an	Nothing I can think of. She is an EXCEPTIONAL doctor who cares very deeply about her patients. She LISTENS
Dr. Antonucci is always prompt abo	nothing she is perfect
I am all set	Nothing that I can think of. Always efficient and pleasant experience.
Dr. A is great! She shouldn't chang	Nothing, she does an excellent job.
I can't think of anything. She does	Nothing!!
I am very satisfied .	Nothing. She does a fine job, always on time and thorough in her questions and exams.
Absolutely nothing - she's a great	Nothing. Am very pleased with the care(and concern!!!)
all set	office arrangement--no automatic doors
I can't think of anything right now	She does just fine.
coat and hat hooks in waiting area	SHE IS VERY THOROUGH .AND TAKES THE TIME\r\nTO TALK NOT ONLY ABOUT MY HEALTH,BUT HAS AN ITERE
I am very satisfied with my care ar	She needs to listen better.
All is well!	She's fine the way she is.
I think her approach to health care	this suvey sucks
I am thrilled with Dr. Antanucci(?)	Too much time spent explaining requirements imposed upon doctors. My last visit this took twenty minutes.
getting the insurance straightened	very happy with my care.
I think she does a fabulous job!	VERY PLEASED. SHE IS THE BEST!
Fortunately for me, I'm usually pr	very satisfied, she is very carring
I am satisfied at this time.	We seem to work well together, she is easy to get an appt. with and always takes the time to hear you out and
Absolutely nothing; she is the best doctor I have ever had.	
Actually, I haven't seen Dr. Antonucci yet and answered many of these questions based on my interaction with my prior PCP	
All doctors are required to be able to refer patients to specialist when the problem is greater than stitching a cut or offering antibiotics. Dr. Anto	
Always been made to feel important and cared for	
continue help me lower my blood pressure	
Does a great job and is a caring person. Glad I made the decision to move from a home health center enviroment	

as to what the problem is and how to treat it.

ns when she came back into our area. She is a very caring physician.

to me and is very forthcoming with reasons and explanations. She doesn't waste my time... she schedules any tests, etc. and refills prescr

ST IN ME AS A PERSON. AND THAT IS WHAT I LIKE.

I don't blame the doctor.

d offers suggestions.

nucci's only weakness is her inability to point to a doctor who can help Nancy with her back situation. Dr. A has tried, but there has been n