Appendix B
Survey Instrument

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

DRAFT

NAME
ADDRESS
CITY, STATE ZIP

Dear NAME:

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency that administers the Medicare program. Our responsibility is to make sure that you get high quality care. One of the ways we can do that is to find out directly from you about how the care you are currently receiving under the Medicare program affects your health.

CMS is conducting a survey of people with Medicare called the **Medicare Health Survey**. Your name was selected at random from a list of people currently enrolled in Medicare. We hope that you will participate in this important survey.

Within the next few days, you will receive a questionnaire asking about the state of your health. We hope that you will take a few minutes to complete the questionnaire and return it in the postage-paid envelope to RTI, the organization assisting us with this survey. If you have any questions about your involvement in this study, please call us toll-free at X-XXX-XXX-XXXX.

Your help is voluntary and your decision to participate or not to participate will have no effect on your Medicare benefits. All information you provide will be held in confidence by CMS and is protected by the Privacy Act. While you do not have to participate in this survey, we hope that you will choose to help us. Learning about the state of your health is very important to us.

If you have any questions about the survey or would like to find out how to complete the survey by phone, please call XX toll-free at X-XXX-XXX-XXXX, Monday through Friday, between 8:15 a.m. and 5:00 p.m. Eastern time.

Thank you in advance for your help with this important survey.

Sincerely,

Walter D Stone

Walter Stone
Privacy Officer

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

NAME
ADDRESS
CITY, STATE ZIP

Dear NAME:

Recently, we sent you a letter asking for your help with a research survey that the Centers for Medicare & Medicaid Services (CMS) is conducting, called the **Medicare Health Survey**. A copy of the survey is enclosed with this letter.

Your name was selected at random from a list of people who are currently enrolled in Medicare. Please take a few moments to complete the questionnaire and return it in the enclosed postage-paid envelope to RTI, the organization helping us with this survey.

All information you give in this survey will be held in confidence and is protected by the Privacy Act. The information you provide will not be shared with anyone other than authorized persons at RTI and CMS. You do not have to participate in this survey. **Your help is voluntary and your decision to participate or not to participate will not affect your Medicare benefits in any way.** However, by completing this survey you are providing us with valuable information about the state of your health.

If you have any questions about the survey or would like to find out how to complete the survey by phone, please call XX toll-free at 1-800-XXX-XXXX, Monday through Friday, between 8:15 a.m. and 5:00 p.m. Eastern time.

Thank you in advance for your participation.

Sincerely,

Walter Stone
CMS Privacy Officer

Dear Medicare Beneficiary,

The Centers for Medicare & Medicaid Services (CMS) is conducting the Medicare Health Survey. We sent you a questionnaire for this survey about a week ago.

If you have completed & returned your survey, thank you very much for your help. If not please take a few minutes to complete and return it today!

If you have any questions or would like to do the survey by telephone, please call toll-free:

1-800-XXX-XXXX

Thank you again for your help.

The Survey Project Team

DRAFT

Medicare Health Improvement Survey

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- . The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Survey Instructions

This survey asks about you and your health. Answer each question thinking about <u>yourself</u>. Please take the time to complete this survey. Your answers are very important to us. If you are unable to complete this survey, a family member or friend can fill out the survey about you. If a family member is NOT available, please ask someone who knows you and your care for help.

Please return the survey with your answers in the enclosed postage-paid envelope.

- Answer the questions by putting an "X" in the box next to the appropriate answer category like this:

  Are you male or female?

  ☐ Male
  ☒ Female

- Be sure to read <u>all</u> the answer choices given before marking a box with an 'X.'

- It is important that you answer EVERY question on this survey. If you are unsure of the answer to a question or that a question applies to you, please answer the question anyway, choosing the BEST possible answer.

All information that would permit identification of any person who completes this survey will be kept strictly confidential. This information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without your permission.

If you have any questions or want to know more about the study, please call [vendor name] at [toll-free number].

About Your Health

These questions ask for your views about your health, about how you feel and how well you are able to do your usual activities.

1. In general, would you say your health is

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. The following items are about activities you might do during a typical day. Does *your health now limit you* in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. ***Moderate activities*, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf**	☐	☐	☐
b. **Climbing *several* flights of stairs**	☐	☐	☐

3. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities as a *result of your physical health*?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. ***Accomplished less* than you would like**	☐	☐	☐	☐	☐
b. **Were limited in the *kind* of work or other activities**	☐	☐	☐	☐	☐

About Your Health

4. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities *as a result of any emotional problems* (such as feeling depressed or anxious)?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. *Accomplished less* than you would like	☐	☐	☐	☐	☐
b. Didn't do work or other activities as *carefully* as usual	☐	☐	☐	☐	☐

5. During the <u>past 4 weeks</u>, how much did *pain* interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

6. These questions are about how you feel and how things have been with you. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <u>past 4 weeks</u>

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt *calm and peaceful*?	☐	☐	☐	☐	☐	☐
b. Did you have *a lot of energy*?	☐	☐	☐	☐	☐	☐
c. Have you felt *downhearted and blue*?	☐	☐	☐	☐	☐	☐

About Your Health

7. During the <u>past 4 weeks</u>, how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

8. In the <u>past 2 weeks</u> have you been bothered by little interest or pleasure in doing things?

Not at all	Several days	More than half of the days	Nearly every day
☐	☐	☐	☐

9. In the <u>past 2 weeks</u> have you been bothered by feeling down, depressed, or hopeless?

Not at all	Several days	More than half of the days	Nearly every day
☐	☐	☐	☐

About Your Health

10. Because of a health or physical problem, do you have any difficulty doing the following activities? (Please mark one response for each activity.)

	I am not able to do this activity	Yes, I have difficulty	No, I do not have difficulty
a. Bathing	☐	☐	☐
b. Dressing	☐	☐	☐
c. Eating	☐	☐	☐
d. Getting in or out of chairs	☐	☐	☐
e. Walking	☐	☐	☐
f. Using the toilet	☐	☐	☐

11. Do you receive help from another person with any of these activities?

	Yes, I receive help	No, I do not receive help
a. Bathing	☐	☐
b. Dressing	☐	☐
c. Eating	☐	☐
d. Getting in or out of chairs	☐	☐
e. Walking	☐	☐
f. Using the toilet	☐	☐

Your Health Care

A health care team consists of a variety of people who help you take care of your health condition. For some people, this team may include nurses, case managers, or doctors. These individuals make up your health care team. Please think about your health care team when answering the questions below.

12. During the past 6 months, has someone from your health care team helped you set goals to take care of your health problems?

☐ Yes
☐ No

13. During the past 6 months, has someone from your health care team helped you make a plan to take care of your health problems?

☐ Yes
☐ No

These next questions are about services you may have received during the past 6 months. Please consider information you may have received from your health care team, at physicians' offices, during telephone calls from someone from your health care team, or by mail when answering the next questions.

14. How helpful were the one-on-one educational or counselling sessions you may have received to help you care for your health problems?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not receive counseling
☐	☐	☐	☐	☐

15. How helpful were discussions you may have had with your health care team about how and when to take your medicine?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not discuss medicine
☐	☐	☐	☐	☐

Your Health Care

16. How helpful were discussions you may have had with your health care team about how to deal with stress or feeling sad?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not discuss stress/sadness
☐	☐	☐	☐	☐

17. How helpful were discussions you may have had with your health care team about the foods you should be eating?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not discuss food
☐	☐	☐	☐	☐

18. How helpful were discussions you may have had with your health care team about the amount of exercise you should get?

Very helpful	Somewhat helpful	A little helpful	Not helpful	Did not discuss exercise
☐	☐	☐	☐	☐

Taking Care of Your Health

The next questions ask about how sure you are that you can do certain things for your health.

19. How sure are you that …

a. You can take all of your medications when you should?

Very unsure	Somewhat unsure	Neither	Somewhat sure	Very sure
☐	☐	☐	☐	☐

b. You can plan your meals and snacks according to dietary guidelines?

Very unsure	Somewhat unsure	Neither	Somewhat sure	Very sure
☐	☐	☐	☐	☐

c. You can exercise two or three times weekly?

Very unsure	Somewhat unsure	Neither	Somewhat sure	Very sure
☐	☐	☐	☐	☐

The questions below ask about self-care activities.

20. On how many of the past 7 days did you take your medication as prescribed?

0	1	2	3	4	5	6	7
☐	☐	☐	☐	☐	☐	☐	☐

21. On how many of the past 7 days did you participate in at least 30 minutes of continuous physical activity (including walking)?

0	1	2	3	4	5	6	7
☐	☐	☐	☐	☐	☐	☐	☐

22. On average, over the past month, how many DAYS PER WEEK have you followed your healthy eating plan?

0	1	2	3	4	5	6	7
☐	☐	☐	☐	☐	☐	☐	☐

Your Health Care Experience

A health care team consists of a variety of people who help you take care of your health condition. For some people, this team may include nurses, case managers, or doctors. These individuals make up your health care team. Please think about your health care team when answering the questions below.

23. Please think about all the health care providers you have talked with either by phone or in-person over the past 6 months, including any doctors, nurses, or other providers such as pharmacists who you talked to about your health problems.

Overall, how would you rate your experience with these health care providers in helping you cope with your condition?

Excellent	Very good	Good	Fair	Poor
⬇	⬇	⬇	⬇	⬇
☐	☐	☐	☐	☐

24. In the past 6 months, how often did your health care team …

a. Explain things in a way that was easy to understand?

Never	Almost never	Sometimes	Usually	Almost always	Always
⬇	⬇	⬇	⬇	⬇	⬇
☐	☐	☐	☐	☐	☐

b. Listen carefully to you?

Never	Almost never	Sometimes	Usually	Almost always	Always
⬇	⬇	⬇	⬇	⬇	⬇
☐	☐	☐	☐	☐	☐

c. Spend enough time with you?

Never	Almost never	Sometimes	Usually	Almost always	Always
⬇	⬇	⬇	⬇	⬇	⬇
☐	☐	☐	☐	☐	☐

25. In the past 12 months, did your health care team talk with you about the pros and cons of each choice for your treatment or health care?

Definitely yes	Somewhat yes	Somewhat no	Definitely no
☐	☐	☐	☐

26. In the past 12 months, how often did your healthcare team give you easy to understand instructions about what to do to take care of these health problems or concerns?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

27. In the past 12 months, how often did your healthcare team seem informed and up-to-date about your health?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

28. In the past 12 months, when you called someone on your healthcare team with a medical question during regular office hours, how often did you get an answer to your question that same day?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

Your Health Care Experience

29. In the <u>past 12 months</u>, when you called someone on your healthcare team after regular office hours, how often did you get an answer to your question?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

30. In the <u>past 12 months</u>, how often did your health care team show respect for what you had to say?

Never	Almost never	Sometimes	Usually	Almost always	Always
☐	☐	☐	☐	☐	☐

31. How much of a problem are each of these for you?

a. Lack of information about my medical conditions

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

b. Lack of information about my treatment options

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

c. Lack of information about why my medications have been prescribed to me

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

d. Problems getting my medications refilled on time

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

e. Uncertainty about when or how to take my medications

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

f. Side effects from my medications

Very big problem	Big problem	Moderate problem	Small problem	Not a problem at all
☐	☐	☐	☐	☐

About You

These next questions ask for information about you.

32. Are you of Hispanic or Latino origin or descent?

Yes, Hispanic or Latino	No, not Hispanic or Latino
☐	☐

33. What is your race? Please mark one or more.

White	Black or African American	Asian	Native Hawaiian or other Pacific Islander	American Indian or Alaska Native
☐	☐	☐	☐	☐

34. What is the highest grade or level of school that you have completed?

8th grade or less	Some high school, but did not graduate	High school graduate or GED	Some college or 2-year degree	4-year college graduate	More than 4-year college degree
☐	☐	☐	☐	☐	☐

35. What is your current living arrangement? Right now, are you living … (check all that apply)

Alone.. ☐

With spouse or partner.. ☐

With others who are related to you... ☐

With others who are not related to you.. ☐

36. Some people who have Medicare also have <u>other insurance</u> to help pay for some of the costs of their health care. Do you have any other insurance that pays at least some of the cost of your health care?

- ☐ Yes
- ☐ No

37. Do you have insurance that helps to pay for at least some of the cost of your prescription drugs (check all that apply)?

- ☐ Yes, Medicare Part D
- ☐ Yes, Other insurance
- ☐ No

38. Please mark the box below for <u>each type</u> of health insurance that you have (check all that apply).

Medigap.. ☐

Employer, Union, or Retiree Health Coverage....................................... ☐

Veteran's Retiree Benefits, also known as VA Benefits.......................... ☐

Military Retiree Benefits, also known as Tricare.................................... ☐

Medicaid, also known as state medical assistance................................ ☐

Other.. ☐

I don't have health insurance other than Medicare................................ ☐

39. Who completed this survey form?

Person to whom this survey was addressed... ☐

Family member or relative of person to whom the survey was addressed.. ☐

Friend of person to whom the survey was addressed............................ ☐

Other.. ☐