# APPENDIX E

# MEDICARE CARE MANAGEMENT PERFORMANCE (MCMP) DEMONSTRATION BENEFICIARY SURVEY

OMB Approval No.: xxxx-xxxx
Expiration Date: xx/xx/xxxx

MATHEMATICA
Policy Research, Inc.

# Medicare Care
# Management Performance (MCMP) Demonstration
# Beneficiary Survey

*Draft*

## ABOUT THIS SURVEY

The questions in this survey are about you, your health, and how you use health care services.

Most of the questions can be answered by simply checking a box. A few ask you to write in your answer.

All of your answers will be treated confidentially to the extent allowable by law. Your responses will not change your Medicare coverage, other health benefits, or any premiums you pay.

If you do not know an answer, please write “DK” next to the question.

If you have questions about this survey or your participation in it, please call Julita Milliner-Waddell, the survey director, at 609-275-2206.

If you have difficulty answering the questions or would prefer to answer by telephone, please call 1-xxx-xxx-xxxx toll free and ask for Melanie Costas.

When you are finished, please return the questionnaire in the enclosed postage-paid envelope.

Thank you for your time and cooperation.

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-XXXX**. 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.

## A. HEALTH STATUS

**A1. In general, would you say your health is excellent, very good, good, fair, or poor?**

**MARK ONE ANSWER ONLY**

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

**A2. The next questions are about chronic health conditions you may have. Please mark "Yes" if a doctor has ever told you that you had any of the conditions listed below.**

| | MARK ONE ANSWER PER ROW | |
|---|---|---|
| | Yes | No |
| a. **Congestive heart failure (CHF)** | 1 ☐ | 0 ☐ |
| b. **Coronary artery disease (CAD)** | 1 ☐ | 0 ☐ |
| c. **Other heart problems such as arteriosclerosis, myocardial infarction, heart attack, angina, or angina pectoris** | 1 ☐ | 0 ☐ |
| d. **Diabetes or Diabetes mellitus** | 1 ☐ | 0 ☐ |
| e. **A stroke** | 1 ☐ | 0 ☐ |
| f. **Partial or complete paralysis** | 1 ☐ | 0 ☐ |
| g. **Alzheimer's disease or dementia** | 1 ☐ | 0 ☐ |
| h. **A mental or psychiatric disorder other than Alzheimer's disease or dementia** | 1 ☐ | 0 ☐ |
| i. **Any kind of cancer, malignancy, or non-benign tumor** | 1 ☐ | 0 ☐ |
| j. **Arthritis, including rheumatoid arthritis** | 1 ☐ | 0 ☐ |
| k. **Osteoporosis** | 1 ☐ | 0 ☐ |
| l. **Kidney disease** | 1 ☐ | 0 ☐ |
| m. **Lung conditions or breathing problems such as emphysema, asthma, or chronic obstructive pulmonary disease (COPD)** | 1 ☐ | 0 ☐ |
| n. **Parkinson's disease** | 1 ☐ | 0 ☐ |
| o. **Other (Please list any other chronic conditions that a doctor has said you have. (A chronic condition is any condition that lasts for 3 months or more and has no known cure.)** | 1 ☐ | 0 ☐ |

**A3. How would you rate your knowledge about your chronic health conditions and the factors that may affect these conditions in the future?**

**MARK ONE ANSWER ONLY**

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

**A4. How would you rate your knowledge about what to do if problems or symptoms associated with your health conditions get worse?**

**MARK ONE ANSWER ONLY**

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

## B. ACCESS TO CARE

**B1. Do you have a doctor whom you see or a place you go regularly to receive medical care?**

1 ☐ Yes
0 ☐ No

**B2. A primary care physician is a doctor who provides regular basic care. A primary care physician can be a family or general practitioner, internist, or any specialist that provides regular basic care.**

**Do you have a primary care physician? Please include specialists if you see them for regular basic care.**

1 ☐ Yes
0 ☐ No → **GO TO QUESTION B6**

**B3. What is your primary care physician's name?**

__________________________________________

**B4. What is the name of the office or practice where you usually see your primary care physician?**

______________________________________________

**B5. How long have you been going to this primary care physician?**

**MARK ONE ANSWER ONLY**

1 ☐ Less than 1 year
2 ☐ Between 1 and 3 years
3 ☐ Between 3 and 5 years
4 ☐ More than 5 years

**GO TO QUESTION B11**

**B6. Is there one particular clinic, health center, doctor's office, or other place that you usually go to if you are sick or need advice about your health?**

1 ☐ Yes
0 ☐ No → **GO TO QUESTION B11**

**B7. Please indicate the kind of place you usually go to if you are sick or need advice about your health.**

**MARK ONE ANSWER ONLY**

1 ☐ Doctor's office or HMO
2 ☐ Clinic or health center
3 ☐ Hospital outpatient department
4 ☐ Hospital emergency room
5 ☐ Urgent care center
6 ☐ Other type of place *(Please describe)*

______________________________________________ _____

**B8. Is there one particular doctor or health care professional, such as a nurse or physician's assistant, that you usually see at this place?**

1 ☐ Yes
0 ☐ No → **GO TO QUESTION B11**

**B9. What is the name of the doctor or other health care professional that you usually see at this place?**

________________________________________________

**B10. What is the name of the office or facility where you usually see this doctor or health care professional?**

________________________________________________

**B11. The next questions are about health care you may have received during the past 12 months. During the past 12 months, how many times did you visit a physician or clinic?**

**MARK ONE ANSWER ONLY**

- 0 ☐ Never
- 1 ☐ 1 to 2 times
- 2 ☐ 3 to 5 times
- 3 ☐ 6 to 10 times
- 4 ☐ More than 10 times

**B12. During the past 12 months, how many times did you go to an emergency room or urgent care center for medical attention?**

**MARK ONE ANSWER ONLY**

- 0 ☐ Never
- 1 ☐ 1 to 2 times
- 2 ☐ 3 to 5 times
- 3 ☐ 6 to 10 times
- 4 ☐ More than 10 times

## C. HEALTH CARE PROCESSES

**For these next questions please think about the last time you saw your doctor or other health care professional, such as a nurse or physician's assistant.**

**C1. Please mark "Yes" if a doctor or other health care professional did any of the following things during your last visit.**

| | MARK ONE ANSWER PER ROW | |
|---|---|---|
| | Yes | No |
| a. **Measure your blood pressure** | 1 ☐ | 0 ☐ |
| b. **Measure your height** | 1 ☐ | 0 ☐ |
| c. **Measure your weight** | 1 ☐ | 0 ☐ |
| d. **Ask if you have ever had a pneumonia vaccination** | 1 ☐ | 0 ☐ |
| e. **Examine your heart and lungs with a stethoscope** | 1 ☐ | 0 ☐ |
| f. **Examine your feet with a monofilament. This is a tool that looks like a piece of nylon line that is pressed against the skin.** | 1 ☐ | 0 ☐ |
| g. **Work with you to set goals for avoiding illness and staying healthy** | 1 ☐ | 0 ☐ |
| h. **Provide materials such as booklets, pamphlets, articles, or videotapes to help you understand your health or chronic condition or recommended treatments** | 1 ☐ | 0 ☐ |
| i. **Explain what to expect with your health or illness in the future** | 1 ☐ | 0 ☐ |
| j. **Explain what to do if problems or symptoms continued, got worse, or came back** | 1 ☐ | 0 ☐ |

**C2. During the past 12 months, has your doctor or other health care professional, such as a nurse or physician's assistant, advised you to do any of the following things?**

If a question does not apply to you, please mark "No".

| | MARK ONE ANSWER PER ROW | |
|---|---|---|
| | Yes | No |
| a. **Increase your physical activity or exercise** | 1 ☐ | 0 ☐ |
| **If "YES", did you increase your physical activity or exercise?** | 1 ☐ | 0 ☐ |
| b. **Quit smoking** | 1 ☐ | 0 ☐ |
| **If "YES", did you quit smoking?** | 1 ☐ | 0 ☐ |
| c. **Cut down on or quit drinking** | 1 ☐ | 0 ☐ |
| **If "YES", did you cut down on or quit drinking?** | 1 ☐ | 0 ☐ |
| d. **Cut down on salt in your diet** | 1 ☐ | 0 ☐ |

| | | |
|---|---|---|
| **If "YES", did you cut down on salt in your diet?** | 1 ☐ | 0 ☐ |
| e. **Eat fewer high fat or high cholesterol foods** | 1 ☐ | 0 ☐ |
| **If "YES", did you eat fewer high fat or high cholesterol foods?** | 1 ☐ | 0 ☐ |

**C3. During the past 5 years, have you had a test for colon cancer such as a stool blood test, sigmoidoscopy, or colonoscopy?**

A stool blood test is done to detect hidden blood in the stool. A sigmoidoscopy is an internal exam of the *lower portion of the colon* using an instrument with a small camera attached to a flexible tube. A colonoscopy is an internal exam of the *entire colon* using an instrument with a small camera attached to a flexible tube. All three tests are used to view the colon for signs of cancer and other health problems.

1 ☐ Yes
0 ☐ No

**C4. During the past two years, did you receive a flu vaccination?**

1 ☐ Yes
0 ☐ No

**Please answer question C5 only if you have been diagnosed with diabetes.**

**C5. During the past 12 months, on average, how often have you examined your feet?**

**MARK ONE ANSWER ONLY**

1 ☐ Daily
2 ☐ 5 or 6 days a week
3 ☐ 3 or 4 days a week
4 ☐ 1 or 2 days a week
5 ☐ Less than once a week
6 ☐ Never

**Please answer question C6 only if you have been diagnosed with congestive heart failure (CHF).**

**C6. During the past 12 months, on average, how often have you weighed yourself?**

**MARK ONE ANSWER ONLY**

1 ☐ Daily
2 ☐ 5 or 6 days a week
3 ☐ 3 or 4 days a week
4 ☐ 1 or 2 days a week
5 ☐ Less than once a week
6 ☐ Never

## D. CARE COORDINATION

**D1. These next questions are about how your doctors share information about your care. During the past 12 months, was there ever a time when you thought your doctors did not talk to each other enough about your care?**

**MARK ONE ANSWER ONLY**

1 ☐ Yes

0 ☐ No

2 ☐ One doctor only

**D2. If you were referred to a specialist during the past 12 months, did the specialist have the information he or she needed from your medical records?**

**MARK ONE ANSWER ONLY**

1 ☐ Yes

0 ☐ No

2 ☐ Not referred to a specialist

**D3. During the past 12 months, has your doctor ever been unaware of results of tests or diagnostic procedures that another doctor had ordered?**

**MARK ONE ANSWER ONLY**

1 ☐ Yes

0 ☐ No

2 ☐ No test results or procedures

## E. SATISFACTION WITH CARE

**E1. Thinking about the past 12 months, please indicate how satisfied you were with the following aspects of the care you received from your doctor or other health care professional, such as a nurse or physician's assistant?**

| | MARK ONE ANSWER PER ROW | | | |
|---|---|---|---|---|
| | **Very Satisfied** | **Somewhat Satisfied** | **Somewhat Dissatisfied** | **Very Dissatisfied** |
| **a. The amount of time your doctor or other health care professional spends with you during office visits?**.................................. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **b. The attention that your doctor or other health care professional gives you during office visits (for example, not getting easily distracted by telephone calls or other patient needs)?**.................. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **c. How well your doctor or other health care professional explained what to expect with your health or illness in the future?**........................................................ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **d. The ability to talk to your doctor or other health care professional as soon as you need to, to get medical advice or help?**... | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **e. The ability to get an appointment as soon as you want?**.................................... | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **f. Your doctor's or other health care professional's knowledge about your health problems?**...................................... | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **g. Reminders you may receive from your doctor or other health care professional to make or keep appointments for medical care?**............................................ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **h. Advice you may receive from your doctor or other health care professional about ways to avoid illness or stay healthy?**..... | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **i. Your doctor's or other health care professional's involvement in your overall care?**.............................................. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **j. Your doctor's or other health care professional's communication with other doctors or health care professionals about your medical care?**......................... | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **k. Overall quality of health care and services?**.................................................. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

## F. BACKGROUND INFORMATION

**F1. What is the highest grade or year of school you have completed?**

**MARK ONE ANSWER ONLY**

1 ☐ Did not complete high school or GED
2 ☐ High school: diploma
3 ☐ High school: GED
4 ☐ Some college or some vocational courses after high school
5 ☐ A vocational school diploma
6 ☐ 2-year or 3-year college degree (Associate's Degree)
7 ☐ 4-year college degree (Bachelor's Degree)
8 ☐ Some graduate work but no graduate degree
9 ☐ Graduate or professional degree (e.g., MA, MBA, Ph.D., JD, MD)
10 ☐ Other type of degree (*Please specify*)

______________________________________________ ______

**F2. Is English your primary spoken language?**

1 ☐ Yes → **GO TO QUESTION F4**
0 ☐ No

**F3. What is your primary spoken language?**

______________________________________________

**F4. What is your current marital status?**

**MARK ONE ANSWER ONLY**

1 ☐ Married
2 ☐ Single and living with partner
3 ☐ Separated
4 ☐ Divorced
5 ☐ Widowed
6 ☐ Never married

**F5. Please indicate which of the following best describes your household's composition.**

**MARK ONE ANSWER ONLY**

1 ☐ Live alone –> **GO TO QUESTION F7**

2 ☐ Live with a spouse only –> **GO TO QUESTION F7**

3 ☐ Live with a spouse and other relatives

4 ☐ Live with other relatives

5 ☐ Live with non-relatives

6 ☐ Live in some other living arrangement *(Please describe)*

______________________________________________ ______

**F6. How many people live in your household including yourself?**

|___|___| PEOPLE IN HOUSEHOLD

**F7. Please indicate whether you own your home, rent your home, or live in one of the other housing arrangements listed below.**

**MARK ONE ANSWER ONLY**

1 ☐ Own your home

2 ☐ Rent your home

3 ☐ Live with family or friends and pay part of the rent or mortgage

4 ☐ Live with family or friends and not pay rent or a mortgage

5 ☐ Live in a group shelter

6 ☐ Live in an assisted living facility

7 ☐ Live in some other housing arrangement *(Please describe)*

______________________________________________ ______

**F8. Which of the following best describes your current employment status?**

**MARK ONE ANSWER ONLY**

1 ☐ Working full-time
2 ☐ Working part-time
3 ☐ Not working, but not retired
4 ☐ Retired

**F9. Counting everyone in your household, what was your total household income in 2007? Please include wages, benefits, earnings, and all other sources of income.**

**MARK ONE ANSWER ONLY**

1 ☐ Less than $10,000
2 ☐ $10,000 or more, but less than $20,000
3 ☐ $20,000 or more but less than $30,000
4 ☐ $30,000 or more but less than $40,000
5 ☐ $40,000 or more but less than $50,000
6 ☐ $50,000 or more but less than $75,000
7 ☐ $75,000 or more but less than $100,000
8 ☐ More than $100,000

**Thank you for taking the time to complete this questionnaire. Please mail your completed survey in the pre-paid envelope provided. If you have misplaced your envelope, please mail it to:**

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