

MOVE!

Weight Management Program for Veterans

Survey of Patient Experiences

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Thank you for agreeing to complete this survey about your experience with the MOVE! Weight Management Program for Veterans. We are interested in learning about your honest experiences with the treatment you received, whatever they may be. There are no right or wrong answers.

We realize that you may have received MOVE! Weight Management care at more than one VA location. However, it is important that you answer the questions in this survey based on your experience overall.

Most of the questions on this survey are about your experience during treatment, your physical activity or diet choices. You are free to skip any questions you do not want to answer, but we hope you will answer them all because we believe they are all important. Your answers will help us make MOVE! more effective and helpful for those in the future.

If you have not received MOVE! Weight Management treatment at a VA medical center or clinic and believe that you may have received this survey in error, please check this box and return the survey in the enclosed envelope.

Instructions:

For each question on the survey check the box or circle the number that best describes your experience. There are some questions, however, where you can check multiple boxes to tell us about your experience.

For items with a box, mark your selection(s) like this:




For items that ask you to circle a number, mark your selection like this:

0	①	2	3	4	5
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The first section of this survey asks about your current physical activity, eating habits, health, and neighborhood environment.

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation. The following questions ask about the amount and intensity of physical activity you usually do.

Examples of physical activity intensity levels:

<p>Light activities</p> <ul style="list-style-type: none"> • your heart beats slightly faster than normal • you can talk and sing 	 <p>Walking Leisurely Stretching Vacuuming or Light Yard Work</p>
<p>Moderate activities</p> <ul style="list-style-type: none"> • your heart beats faster than normal • you can talk but not sing 	 <p>Fast Walking Aerobics Class Strength Training Swimming Gently</p>
<p>Vigorous activities</p> <ul style="list-style-type: none"> • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths 	 <p>Stair Machine Jogging or Running Tennis, Racquetball, Pickleball or Badminton</p>

1. How physically active are you? (Check one box for each statement)

	Does this accurately describe you?	
	Yes	No
a) I rarely or never do physical activities.	<input type="checkbox"/>	<input type="checkbox"/>
b) I do some light or moderate physical activities, but not every week.	<input type="checkbox"/>	<input type="checkbox"/>
c) I do some light physical activity every week.	<input type="checkbox"/>	<input type="checkbox"/>
d) I do moderate physical activities every week, but less than 30 minutes a day or 5 days per week.	<input type="checkbox"/>	<input type="checkbox"/>
e) I do vigorous physical activities every week, but less than 20 minutes a day or 3 days a week.	<input type="checkbox"/>	<input type="checkbox"/>
f) I do 30 minutes or more a day of moderate physical activities, 5 or more days a week.	<input type="checkbox"/>	<input type="checkbox"/>
g) I do 20 minutes or more a day of vigorous physical activities, 3 or more days a week.	<input type="checkbox"/>	<input type="checkbox"/>
h) I do activities to increase muscle strength , such as lifting weights or calisthenics, once a week or more.	<input type="checkbox"/>	<input type="checkbox"/>
i) I do activities to improve flexibility , such as stretching or yoga, once a week or more.	<input type="checkbox"/>	<input type="checkbox"/>

2. Circle the number of times in one week you typically ...

	Number of Times in One Week								
	0	1	2	3	4	5	6	7	>7
a) Eat restaurant or fast food (for example, Chili's, McDonalds, Burger King, etc).									
b) Eat breakfast in the morning.									
c) Skip meals									

3. Circle the number of times in one day you typically eat or drink...

	Number of Times in One Day								
	0	1	2	3	4	5	6	7	>7
a) Juice drinks (for example, orange juice, apple juice, Sunny Delight, Hi-C, Juicy Juice).									
b) Cans or bottles of non-diet soda pop (for example, Coke, Pepsi, Sprite).									
c) Vegetables (for example, broccoli, spinach, greens, salad, etc).									
d) Fruit (for example, an apple, an orange, a hand full of grapes, etc).									

4. How often do you..... (Check one box for each statement)

	Less than 1 time per month	About 1-2 times/month	About 1-2 times/week	Daily
a) Weigh yourself on a scale?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Keep track of what you eat and drink in a journal or log?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Keep track of your physical activity in a journal or log?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Tell us about your surroundings. (Check one box for each statement)

	Not at all	Slightly	Quite	Extremely
a) Rate your neighborhood as a pleasant place to be physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) How safe from crime do you feel while you are walking in your neighborhood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Strongly disagree	Disagree	Agree	Strongly agree
c) There are many destinations within walking distance from my home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) There are sidewalks on most streets in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) A large selection of affordable fruits and vegetables is available in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) A large selection of affordable low-calorie products is available in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. For me, lack of access to adequate food shopping is: (Check one box)

- A very serious problem
- A somewhat serious problem
- A minor problem
- Not really a problem

7. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

	Days	Don't know
8. Now, thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health NOT good?	_____ days	<input type="checkbox"/>
9. Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?	_____ days	<input type="checkbox"/>
10. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	_____ days	<input type="checkbox"/>

The second section of this survey asks about your experiences with weight management (MOVE!) treatment.

**11. When I received weight management (MOVE!) treatment, I was:
 (Check one box for each statement)**

	Almost never	Generally not	Sometimes	Most of the time	Almost always
a) Satisfied that my weight management care was well organized.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Helped to set specific goals to change my eating habits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Helped to set specific goals to increase my physical activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Asked for my ideas to make a weight management treatment plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Helped to make a weight management treatment plan that I could do in my daily life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Provided with easy to understand instructions to help manage my weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Treated with respect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Satisfied with the changes I made in my weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**12. I used the following as part of my weight management (MOVE!) treatment plan:
 (Check one box for each statement)**

	Never	Rarely	Sometimes	Often	Almost always
a) A pedometer to track my steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) MOVE! Patient Handouts (Information Sheets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) MOVE! Internet Web Site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. When I received weight management (MOVE!) treatment.....(Check one box for each statement)

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Not applicable
a) Staff helped me keep track of the progress I made towards my personal goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Staff listened and responded to my cultural experiences, interests, and concerns.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) The clinic waiting areas, exam rooms, and group treatment rooms had comfortable furniture that I could sit or lie on.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Weight management treatment was provided in clinic areas that were sufficiently private.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Weight management treatment was provided at times and days that were convenient for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Weight management treatment was provided at a location that was convenient for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Friends or family assisted me in shopping for healthy foods.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Friends or family helped me prepare healthy meals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Friends or family helped me be physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Friends or family encouraged me to eat healthy or stay physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Are you currently participating in weight management (MOVE!) treatment? (Check one box)

- Yes → **skip to question 16**
- No, I have already achieved my weight loss goals or have completed the treatment program at my facility --> **skip to question 16**
- No, I am no longer participating in weight management (MOVE!) treatment.

15. Please indicate the main reason why you are no longer participating in weight management treatment. While there may be more than one reason, we are interested in the MAIN reason why you are no longer participating. (Check one box)

- I was not getting the kind of help or support that I needed.
- I did not feel comfortable participating.
- Treatment was not offered at a convenient time for me.
- Treatment was not offered at a convenient location for me.
- Transportation to get to treatment was limited or too expensive
- I have too much pain.
- I have too many other health problems.
- I have too many other responsibilities (for example work or family obligations).
- I lost my interest or motivation to participate.
- Other.

16. Did you have any expenses related to weight management treatment in the VA that you paid for yourself? (Check one box)

- Yes
- No
- I don't know

17. In the last two years, did you use a weight management treatment program outside of the VA? (Examples include Weight Watchers, Jenny Craig, Nutrisystem, TOPS, private medical provider or a community-based program). (Check one box)

- Yes
- No → *skip to question 19*
- I don't know → *skip to question 19*

18. If you answered "Yes" to the above question, please indicate the MAIN reason you used a weight management treatment program outside of the VA. (Check one box)

- More convenient than the treatment available at the VA.
- Better support for my specific needs than treatment available at the VA.
- Better weight loss results than what I was achieving with treatment available at the VA .
- I was able to do these programs with someone else (like a friend or family member), which I can't do at the VA.
- I tried an outside VA program before participating in VA weight management treatment.
- Other.

19. How likely are you to use the following for weight management (MOVE!) treatment? (Check one box for each statement)

	Very Unlikely	Somewhat Unlikely	Somewhat Likely	Very Likely	I don't know
a) Group clinic-based care with other patients receiving similar treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Individual clinic-based care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c). Telephone-based care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Internet-based care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Care delivered through home messaging devices that are connected to your home telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Care delivered through messages sent to your cell phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Lastly, please tell us about yourself so that we can better understand your experiences and preferences.

20. What is the highest level of education you have completed? (Check one box)

- Less than high school graduate.....
- High school graduate.....
- Some college, vocational or technical school.....
- College graduate of 4 year school.....
- Post college.....

21. What is your ethnicity? (Check one box)

- Not Hispanic or Latino
- Hispanic or Latino

22. What is your race? (Check one or more boxes to indicate what you consider yourself to be.)

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

23. What is your marital status? (Check one box)

- Married
- Living as married (living with fiancé, boyfriend or girlfriend but not married)
- Separated or Divorced
- Widowed
- Single, never married, and not living as married

24. Do you have internet access at home? (Check one box)

- No
- Yes → **Check the type of internet access you have at home** (Check one box)
 - High speed (cable modem, DSL, T-1 line, satellite)
 - Dial-up
 - Unknown

25. Do you have internet access at work? (Check one box)

- No
- Yes
- Not applicable

26. Please choose the box that best describes how much you agree with each of the following statements. (Check one box for each statement)

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Not applicable
a) I regularly use computers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I am comfortable using computers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I am comfortable using a cellular/mobile phone for text messaging.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>