APPENDIX B: Statistical Instruments

Survey of Medicare Patients Who Use Oxygen Equipment

The purpose of the study is to learn more about your satisfaction with the equipment, supplies, and service you receive from your oxygen (or other durable medical equipment) supplier. We also hope to better understand your experiences in obtaining and using this equipment.

□ 1	there	e person this survey was mailed to cannot complete the survey is no one else who can do so for him or her, please check her in the blank survey in the enclosed postage-paid envelope.	•
		Please return by	

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-NEW. The time required to complete this information collection is estimated to average 30 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.

Instructions

The questions in this survey ask about your experiences as a person who uses oxygen equipment.

To complete the survey, please answer the questions by checking the box to the left of your answer (as shown below). You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow beside your response with a note that tells you which question to answer next, like this:

- Yes
- I don't know

If there is no arrow next to your response, please proceed to the next question.

Some people might ask someone else (maybe a spouse, child, or friend) to help them complete this survey. If someone is helping you fill out the survey, remember that the questions always refer to <u>you</u> and <u>your</u> experience with oxygen treatment and equipment.

Confidentiality

All information that would let someone identify you or your family will be kept confidential. You may choose to answer this survey or not. If you choose not to, this will not affect the Medicare benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we won't send you reminders.

If you have any questions about the survey, please call Abt Associates, the survey company, at 1-888-XXX-XXXX.

This is a toll-free call.

A. USE OF OXYGEN SYSTEMS

A1. When did you begin using oxygen equipment and tanks at home?	A3a. Why did you stop using oxygen? (Please check all that apply and then go to SECTION G on p. 19.)
 □₁ 2010 □₂ 2009 □₃ 2008 □₄ Before 2008 □₅ I have never used oxygen equipment at home (Skip to SECTION G on page 19) A2. When you first began using oxygen equipment and tanks at home, how long did you expect to use it? 	 □₁ I believed that my breathing got better so I did not need it anymore □₂ My doctor said I did not need it □₃ Oxygen therapy costs too much □₄ I just did not like using it □₅ Equipment was too heavy or cumbersome □₆ Equipment kept breaking down □դ I had a problem getting the supplies from my oxygen supplier □₃ I was embarrassed to use it □₃₀ Other, please specify:
 □₁ Less than 1 month □₂ 1 to 6 months □₃ More than 6 months □₄ Forever □₃⊌ I don't know 	YOUR CURRENT USE OF OXYGEN SYSTEM
A3. Do you use any type of oxygen system now? This includes using oxygen all of the time, with exercise or walking only, at night only, or using it with another medical device such as a ventilator or a CPAP machine? (A CPAP machine blows air through a hose into a face mask or ventilator, to improve breathing while asleep.)	 A4. When did you first get the oxygen equipment you use now? □₁ Less than 6 months ago □₂ 6-12 months ago □₃ More than 12 months ago A5. Did you get your current oxygen system while you were in a nursing home or hospital? □₁ Yes □₂ No
\square_1 Yes (\rightarrow Skip to A4) \square_2 No, I no longer use Oxygen	

A6. Does someone regularly help you use your oxygen equipment (for example, a relative, friend, or home health aide)?	A8.	If a respiratory therapist was the professional who explained your oxygen equipment, where was the information provided?
□₁ Yes □₂ No A respiratory therapist is a specially trained professional who helps you improve your breathing.	\square_1 \square_2 \square_3 \square_{98}	(Please check all that apply.) Information was provided in my home Information was provided while I was in the hospital A respiratory therapist did not provide me with information I don't know
A7. Did a respiratory therapist or another medical person like a doctor or a nurse ever explain the following to you (Please check all that apply): □ Oxygen equipment options and which might be best for you □ Why you need to use oxygen equipment □ How much oxygen you need □ When to use your oxygen equipment □ None of these things were explained by a respiratory therapist, doctor, or nurse	□ ₁ □ ₂ □ ₃ □ ₉₈	How often does a medical person like a nurse or a respiratory therapist come to your home and clip an oxygen measurement device to your fingertip, to measure your oxygen? At least once each month A few times each year No one ever comes to my home to do a fingertip oxygen measurement I don't know

A40	When wee the last time year	Λ11	a.lf you have different oxygen
A10.	When was the <u>last time</u> you discussed your need for oxygen with a doctor or another medical person like a nurse or a respiratory therapist?	AII	equipment, why did you make a change? (Please check all that apply.)
$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_3 \\ \square_4 \\ \square_{98} \end{array} $	Within the last 6 months Between 6 months and 1 year ago Between 1 and 3 years ago More than 3 years ago I don't know	\Box_1 \Box_2 \Box_3	Equipment needed to be replaced because it did not work My condition/breathing changed I found new equipment that was better for me My supplier became ineligible to provide my equipment under Medicare
A11.	Are you still using the same oxygen equipment as when you first started using oxygen at home?	\square_5 \square_6	My supplier told me Medicare no longer covered equipment Doctor prescribed a different type of
\square_1	Yes (→Skip to A12)		equipment
□ ₂ □ ₉₈	No I don't know (→Skip to A12)	□ ₇ □ ₉₉	My supplier did not tell me why they changed my equipment Other, please specify:
		\square_1 \square_2	. Do you believe that you now have the oxygen equipment that is right for you? Yes No I don't know

□ ₁ □ ₂ □ ₉₈	equipment difficult or uncomfortable? Yes No (→Skip to A14) I don't know (→Skip to A14)		equipment make you feel better? Yes No I don't know
A13a	a.What is it about your current oxygen equipment that makes it difficult or uncomfortable to use? (Please check all that apply.)		Are you using less oxygen than your doctor, nurse or respiratory therapist recommended?
\square_1	Equipment makes it difficult to		Yes, I use it for fewer hours per day than my doctor recommended
\square_2	move freely around my home Equipment makes it difficult to go outside of my home for a short	\square_2	Yes, I use it for fewer days each week than my doctor recommended
\square_3	walk Equipment makes it difficult to go to the doctor when I need to	\square_3 \square_4	Yes, I use a lower flow rate than my doctor recommended No (→Skip to SECTION B)
\square_4	Equipment makes it difficult to go to church, visit friends, shop, or leave the house for more than a short time	□ ₉₈	I don't know (→ Skip to SECTION B)
\square_5	Equipment is too heavy or cumbersome (hard to lift, doesn't fit easily into the car)		
\square_6	Equipment doesn't supply enough oxygen		
□ ₇ □ ₈	I'm afraid I will run out of oxygen Equipment breaks down a lot or is undependable		
 9	Equipment is too complicated for me to use		
□ ₁₀	I am embarrassed to use the equipment outside my home		
1 99	Other, please specify:		

- A15a.Please tell us why you are using less oxygen than your doctor or other medical person recommended. (Please check all that apply.)
- □₁ I believe that my breathing got better so I don't need oxygen as much
- \Box_2 Oxygen therapy costs too much
- \square_3 I just don't like using it
- \square_4 I am embarrassed to use it
- □₅ Equipment is too heavy or cumbersome
- □₆ Equipment keeps breaking down
- □₇ Equipment is too complicated for me to use
- □₈ I have a problem getting the supplies from my oxygen supplier
- \square_{96} Other, please specify:

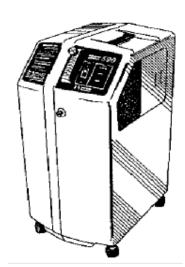
B. STATIONARY OXYGEN

Stationary oxygen systems are heavy pieces of equipment that you cannot move easily.

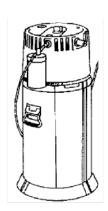
These include non-portable oxygen concentrators, liquid oxygen vessels, and large compressed gas oxygen cylinders.

- B1. Do you use any type of stationary oxygen system <u>now</u>?
- □₁ Yes
- \square_2 No (\rightarrow Skip to SECTION C)

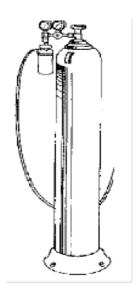
- B2. What type of <u>stationary</u> oxygen system(s) do you usually use at home? (Please check all that apply.)
- □₁ Oxygen concentrator machine (unit that plugs into the wall and produces oxygen) [pictured below at left]
- □₂ Liquid oxygen vessel (large tank that is usually placed in the home and not moved) [pictured below at center]
- □₃ Large compressed oxygen cylinder (resembles a welding tank) [pictured below at right]
- Oxygen concentrator system that allows you to fill small cylinders [not pictured]
- □₉₈ I don't know



Oxygen Concentrator Machine



Liquid Oxygen Vessel



Large Compressed Gas Oxygen Cylinder

B3.	What type of oxygen delivery device do you breathe from to get your oxygen? (Please check all that apply.)	B5. On the days that you do use stationary oxygen, for how many hours do you use it (out of 24 hours in a day)?
\square_1 \square_2	Nasal cannula (nose prongs/tubes) Transtracheal catheter (very thin tube that goes directly in your throat)	hours per day
\square_3	Reservoir cannula: small oxygen storage chamber positioned below nose or on your chest	Sometimes people have serious problems with their <u>stationary</u> systems
\square_4	Oxygen mask	and are forced to stop using oxygen or to
\square_5	Connection to your tracheostomy	use another source of oxygen, such as a portable tank or emergency back-up
	tube	tank.
\square_6	Connection to my CPAP machine,	tair.
	bi-level device, or ventilator	B6. <u>Have you had</u> any serious
□ 98	I don't know	problems that made you stop using your stationary oxygen
B4.	In general, how often do you use	system?
	your <u>stationary</u> oxygen system?	\square_1 Yes \square_2 No (\rightarrow Skip to SECTION C)
\square_1	Less than one day a week	\square_{98} I don't know (\rightarrow Skip to SECTION C
\square_2	1-2 days per week	
\square_3	3-4 days per week	
\square_4	5-6 days per week	
\square_5	Every day	

B6a.	Can you describe the kind of problem(s) that you had? (Please check all that apply.)
\square_1 \square_2 \square_3	Power outage in my home Equipment failed or did not work Unit ran out of liquid oxygen or compressed oxygen
□ ₉₆	Other, please specify:
	How many times did you have these kinds of problems in the past year?
\square_2	One time 2 or 3 times 4 or more times Don't recall the exact number of times

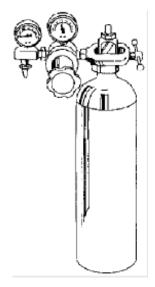
C. PORTABLE OXYGEN

Portable oxygen systems let you keep using oxygen when you are away from the stationary system. They may be light enough to carry on a strap over your shoulder or to pull on a wheeled cart.

Your portable oxygen system may be a small gaseous oxygen tank, a small liquid oxygen cylinder, or a small portable oxygen concentrator.

C1. Do you use any type of <u>portable</u> oxygen system <u>now</u>?

- □₁ Yes
- \square_2 No (\rightarrow Skip to SECTION D)
- □₉₈ I don't know



Mid-Sized Compressed Oxygen Tank

C2. What type of <u>portable</u> oxygen system(s) do you use? (Please check all that apply.)

- □₁ Mid-sized compressed oxygen tank (E-cylinder, resembles a diving tank and can roll on a cart) [pictured below at left]
- □₂ Very small and light compressed oxygen tank that concentrates room oxygen (can carry on your shoulder) [pictured below at right]
- □₃ Mid-sized or standard portable liquid oxygen unit [pictured below in center]
- □₄ Very small liquid portable unit (can carry on your shoulder or belt and that must be refilled) [not pictured]
- □₅ Small portable oxygen concentrator that concentrates room oxygen [not pictured]
- □₆ Small portable concentrator that concentrates room oxygen and also serves as a stationary source [not pictured]
- □₉₈ I don't know
- □₉₆ Other portable oxygen system:



Standard Portable Liquid Unit



Small Compressed Oxygen Tank

C3. In general, how often do you use your portable oxygen system?□₁ Less than one day a week	oxygen system is not meeting your needs. (Please check all that apply.) □₁I believe that my breathing got better so I don't need oxygen as much □₂Oxygen therapy costs too much □₃I just don't like using it □₄I am embarrassed to use it			
 □₂ 1-2 days per week □₃ 3-4 days per week □₄ 5-6 days per week □₅ Every day 				
C4. On the days that you use portable oxygen, for how many hours do you use it (out of 24 hours in a day)? hours per day C5. Is your portable oxygen system meeting your needs?	□ ₅ Equipment is too heavy or cumbersome □ ₆ Equipment keeps breaking down □ ₇ Equipment is too complicated for me to use □ ₈ I have a problem getting the supplies from my oxygen supplier □ ₉ I'm using a different oxygen system □ ₁₀ I'm afraid I will run out of oxygen □ ₉₆ Other, please specify:			
 □₁ Yes (→Skip to C6) □₂ No □98 I don't know (→Skip to C6) 	C6. In general, how often do you get deliveries/refills from your oxygen supplier for your portable oxygen system? This may include oxygen tank deliveries, liquid oxygen refills, etc. □₁4 times a month □₂2-3 times a month □₃Once a month □₃Once every year □₅Less than once per year □₅l don't get refills of any type □₃8 I don't know			

An intermittent flow device gives you oxygen only when you breathe in. Examples of these oxygen-conserving devices are pulse-dosing oxygen regulators and small liquid portable units or portable concentrators that use a pulse-dosing oxygen regulator.

C7.	Do you use any type of intermittent
	flow device with your portable
	system <u>now</u> ?

- □₁ Yes
- \square_2 No (\rightarrow Skip to SECTION D)
- \square_{98} I don't know (\rightarrow Skip to SECTION D)

C7a.When you first received your oxygen equipment that was equipped with an intermittent flow device, who <u>adjusted</u> the device? (Please check all that apply.)

- □₁ Home oxygen supplier or a respiratory therapist from the supplier
- \square_2 Doctor
- \square_3 Other medical personnel
- \square_4 No one
- □₅ Don't remember if anyone did
- \square_{98} I don't know who it was

D. MEDICAL EXPENSES

D1. In the past year, have you bought any oxygen equipment or supplies with your own money because your insurance did not cover it? (This does not include any copay or deductible amounts that are due from you.)

- □₁ Yes
- \square_2 No (\rightarrow Skip to SECTION E)
- \square_{98} I don't know (\rightarrow Skip to SECTION E)

D2. In the past year, what oxygen equipment or supplies did you buy with your own money? (Please check all that apply.)

- □₁ Extra portable oxygen system
- □₂ Extra stationary oxygen system
- □₃ Oxygen conserving/intermittent flow device
- □₄ Special nasal cannula
- □₅ Transtracheal supplies
- □₉₈ I don't know
- \square_{96} Other, please specify:

- D3. Thinking about everything you paid for with your own money in the past year for the oxygen equipment and supplies that were not covered by insurance, how much did you spend? (This does not include any copay or deductible amounts.)
- \square_1 Less than \$100
- **Q**₂ \$100-\$500
- \square_3 \$500 to \$1,000
- □₄ \$1,000 to \$2,000
- □₉₈ I don't know

E. YOUR SUPPLIER

- E1. Considering the oxygen equipment you have now, did you have any problems finding an equipment supplier to get it from?
- □₁ Yes
- \square_2 No (\rightarrow Skip to E2)
- \square_{98} I don't know (\rightarrow Skip to E2)
- E1a.What kinds of problems did you have finding an oxygen supplier? (Please check all that apply.)
- □₁ Hard to find a supplier who covered my area
- □₂ Supplier did not carry what I needed
- □₃ Supplier could not deliver equipment when I needed it
- □₄ Supplier did not accept Medicare
- □₉₆ Other, please describe:
- □₉₈ I don't know
- E2. Considering the oxygen equipment you have now, did you have a choice of suppliers?
- □₁ Yes, many
- □₂ Yes, a few
- \square_3 No, only one supplier available
- □₉₈ I don't know

\Box_1 \Box_2 \Box_3 \Box_4	Considering the oxygen equipment you have now, when you asked your supplier questions, did you get answers that you could understand? Yes, completely Yes, somewhat No I did not ask any questions I don't know	\Box_1 \Box_2 \Box_3 \Box_4	After the order was placed for your oxygen equipment, how long did it take to arrive? Same day Next day Within a week More than 1 week later I don't know
E4.	Before deciding on the oxygen equipment you use now, did your supplier tell you as much as you wanted to know about the options for your oxygen equipment?	E6.	When you got the oxygen equipment you use now, what kind of training or help did the supplier give you or the person who takes care of you? (Please check all that apply.) Did he/she
\square_1 \square_2 \square_3	Yes, completely Yes, somewhat No	\square_1	to use the equipment or supplies Show you how to use the equipment
E4a	4a.Before you decided on the oxygen equipment that you use now, did your supplier tell you about all the equipment designs available to you, even those which the supplier did not have in stock?		to store the equipment or supplies
\square_1 \square_2 \square_3	Yes, all equipment designs were explained No, the supplier only told me what he/she has in stock No, I already knew the equipment		your equipment and supplies while they watched Give you the manufacturer's customer assistance toll-free
	designs available to me I don't know		telephone number I did not get any training or help from my oxygen supplier (→ Skip to E7) I don't know (→ Skip to E7)

□ ₁ □ ₂ □ ₃ □ ₄ □ ₅	. As a result of that training, how comfortable do you feel using and maintaining your oxygen equipment? Very comfortable Comfortable Uncomfortable Very uncomfortable Wery uncomfortable My comfort level has nothing to do with the training that my supplier gave me	\square_1 \square_2	In the first 3 months after you got the oxygen equipment you use now, how often did your supplier send someone to your home to check the equipment? (Do not include times when you called them.) Once in the 3 months after you got the oxygen equipment More than once in the 3 months after you got the oxygen equipment Not at all in the 3 months after you got the oxygen equipment
	In the first 3 months after you got the oxygen equipment you use now, how often did a <u>nurse or respiratory therapist</u> come to your home to <u>check on how you are doing and if you are getting enough oxygen?</u>	E9 . □ ₁ □ ₂ □ ₃	How do you get your oxygen refills and supplies? (Please check all that apply.) Delivered to my home by my supplier Mailed to my home by my supplier I pick them up from my oxygen
\square_1	Once in the 3 months after you got the oxygen equipment		supplier
\square_2	More than once in the 3 months after you got the oxygen equipment	□ ₉₈	Someone picks them up for me I don't know Some other way, please tell us how:
\square_3	Not at all in the 3 months after you got the oxygen equipment		
\square_4	I don't know or recall the clinical specialty of the person who came to my home.		

	Considering the oxygen equipment you have now, how much time and energy does it take to get your oxygen equipment, supplies, maintenance and repairs from your supplier? No time and energy	E12. □₁ □₂ □₃ □₄ □₅	Overall, how would you rate the supplier that you use most? Poor Fair Good Very good Excellent
\square_3 \square_4	A little time and energy Some time and energy A lot of time and energy I don't know	E13.	Would you recommend this oxygen supplier to a friend who needed similar services?
E11	Do you currently get your current oxygen equipment, supplies, maintenance and repairs from more than one equipment supplier?		Yes No
\square_2	Yes No I don't know		

F.	RECENT EXPERIENCES	F3.	In the past six months, have you contacted your oxygen supplier to
F1.	During the past six months , how		get emergency service or advice?
	reliable was your oxygen supplier in making deliveries?	\square_1 \square_2	Yes No (→ Skip to F4)
\square_1	Very reliable	\square_{98}	I don't know (→ Skip to F4)
\square_2	Somewhat reliable		
\square_3	Not reliable at all	F3a.	In general, how fast did the
\square_4	Does not apply		supplier respond to your needs, either by phone or in person?
F2.	In the past six months, have you		Would you say
	contacted your oxygen supplier	\square_1	Within 1 day
	with a complaint or a problem?	\square_2	Within 2 days
_		\square_3	Within 1 week
-	Yes	\square_4	Longer than 1 week
	No (→ Skip to F4)	□ 98	I don't know
	I don't know (→ Skip to F4)		
U 4	Don't know how to contact my oxygen supplier (→ Skip to F4)	F3b.	Were you able to get the emergency service or advice you needed?
F2a	.When you contacted your oxygen		
	supplier, was your complaint or	\square_1	Yes
	problem settled to your	\square_2	No
	satisfaction?	\square_{98}	I don't know
\square_2 \square_3	Yes No I am waiting for it to be settled	F4.	In the past six months, have you needed to contact your supplier after regular business hours?
4 98	I don't know	\square_1	Yes
		\square_2	No (→ Skip to F5)
		□98	No (→ Skip to F5) I don't know (→ Skip to F5)

F4a.	supplier after business hours, in general were you able to get the	F6a.	Why did you change your oxygen supplier? (Please check all that apply.)
	service or advice you needed?	\square_1	I moved
□ ₁ □ ₂ □ ₉₈ F5.	Yes No I don't know In the past six months, how reliable has your oxygen equipment been? Would you say	$ \begin{array}{c} \square_2\\ \square_3\\ \square_4\\ \square_5\\ \square_6 \end{array} $	Supplier no longer accepted Medicare Supplier went out of business I was not happy with the quality of service I was not happy with equipment I was not happy with the choices of equipment or service I could get
	-	\square_7	I was not happy with the assistance I
$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_3 \\ \square_4 \\ \square_{98} \end{array} $	Very reliable Somewhat reliable Somewhat unreliable Very unreliable I don't know	\square_8 \square_9	got in handling the insurance Supplier did not provide the oxygen equipment or accessories I needed I was not happy with the amount of oxygen my supplier was delivering to
F6.	In the past six months, have you changed your oxygen supplier?	□ ₁₀	my home for my stationary oxygen unit I was not happy with the amount of
□ ₁ □ ₂ □ ₉₈	Yes No (→ Skip to SECTION G) I don't know (→ Skip to SECTION G)		oxygen my supplier was delivering for my portable unit I changed to an HMO and had to use a different supplier Supplier became ineligible to provide the equipment under Medicare
		□ 96	Other, please specify:

Section G is about you, the person whose name is on the mailing label of this survey.		G5.	What is the highest grade or level of sch that you have <u>completed</u> ?			
$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_3 \\ \square_4 \end{array} $	In general, how would you rate your overall health? Excellent Very good Good Fair Poor	$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_3 \\ \square_4 \\ \square_5 \\ \square_6 \end{array} $	8 th grade or less Some high school but did not graduate High school graduate or GED Some college or technical school College graduate More than a 4-year college degree			
G2.	Compared to 1 year ago, how would you rate your health now?	G6.	What was your household's annual income during 2009 before taxes?			
□ ₁	Much better now Somewhat better now About the same Somewhat worse now Much worse now Do you currently live alone? Yes (→Skip to G5) No	$ \begin{array}{c c} \square_1 \\ \square_2 \\ \square_3 \\ \square_4 \\ \square_5 \\ \square_6 \end{array} $	Less than \$5,000 (\$416 per month) Between \$5,001 and \$10,000 (\$417–\$833 per month) Between \$10,001 and \$20,000 (\$834–\$1,666 per month) Between \$20,001 and \$30,000 (\$1,667–2,500 per month) Between \$30,001 and \$50,000 (\$2,501–\$4,167 per month) Over \$50,000 (over \$4,168 per month)			
G4.	Which best describes your living situation <u>now</u> ? (Please check all that apply.) I live	G7.	Are you of Hispanic or Latino heritage?			
□ ₁ □ ₂ □ ₃ □ ₄ □ ₅ □ ₆	With spouse/partner With parent/step-parent With child/children With other relative(s) With friend With other person(s) not related to me		Yes No			

G. ABOUT YOU

G8.	How would you describe your race? (Please check all that apply.)	H1.	Please check t
\square_1	American Indian or Alaskan Native		statement:
\square_2	Asian	\square_1	I am the person
\square_3	Black or African American		was addressed
\square_4	Native Hawaiian or other Pacific Islander	\square_2	I filled this surve
\square_5	White or Caucasian		
□ 99	Other, please tell us:	H2.	How did you he this survey?
		\square_1	I wrote the answ

H. OTHER INFORMATION

he correct

- to whom this survey (→ Skip to END)
- ey out or helped fill it e else

elp the person with

- wers that the person told me
- \square_2 I answered the questions myself based on my knowledge of the person's condition
- Both of the above

END

Thank you for completing the survey. Please return the completed survey in the postage-paid envelope addressed to:

Survey of Medicare Patients Abt Associates Inc. 55 Wheeler Street, Cambridge, MA 02138

If you have any questions about the survey, please call toll-free 1-xxx-xxx-xxxx.

If you have any **questions about <u>Medicare</u>**, please visit the website of the Center for Medicare Services at: http://www.medicare.gov/, or call 1-800-MEDICARE.

1001

Survey of Medicare Patients Who Use a Continuous Positive Airway Pressure (CPAP) Machine

The purpose of the study is to learn more about your satisfaction with the equipment, supplies, and service you receive from your CPAP machine supplier. We also hope to better understand your experiences in obtaining and using this equipment.

□ 1	If the person this survey was mailed to cannot complete the survey, and there is no one else who can do so for him or her, please check here and return the blank survey in the enclosed postage-paid envelope.

Please return by	
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Instructions

The questions in this survey ask about your experiences as a person who uses a CPAP machine.

To complete the survey, please answer the questions by checking the box to the left of your answer (as shown below). You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow beside your response with a note that tells you which question to answer next, like this:

П	Yes	:

I don't know

If there is no arrow next to your response, please proceed to the next question.

Some people might ask someone else (maybe a spouse, child, or friend) to help them complete this survey. If someone is helping you fill out the survey, remember that the questions always refer to <u>you</u> and <u>your</u> experience with your CPAP machine.

Confidentiality

All information that would let someone identify you or your family will be kept confidential. You may choose to answer this survey or not. If you choose not to, this will not affect the Medicare benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we won't send you reminders.

If you have any questions about the survey, please call Abt Associates, the survey company, at 1-888-XXX-XXXX.

This is a toll-free call.

	When did you begin using a CPAP machine?	АЗа.	why did you stop using your CPAP machine? (Please check all that apply and then skip to SECTION E on page 11.)
□₄	2010	\square_1	My condition got better so I did not need it anymore
\square_2	2009 2008	\square_2	My condition got worse so I couldn't use it anymore
•	Before 2008 I have <u>never</u> used a CPAP machine (Skip to SECTION E on page 13)	\square_3 \square_4 \square_6	I was embarrassed to use it I was not comfortable using it I just did not like using it
A2 .	When you first began using a CPAP machine, how long did you expect to use it?	$ \begin{array}{c} \square_7 \\ \square_8 \\ \square_9 \\ \square_{10} \\ \square_{96} \end{array} $	It was too difficult to use It kept breaking down The mask did not fit properly It did not have the features I needed Other, please specify:
\square_2 \square_3 \square_4	Less than 1 month 1 to 6 months More than 6 months Forever I don't know		R CURRENT USE OF CPAP
A 3.	Do you use a CPAP machine now?	A4.	When did you first get the CPAP machine you use now?
	This includes using a CPAP machine all of the time or just occasionally.	\square_1 \square_2	Less than 6 months ago 6-12 months ago
	Yes (→ Skip to A4) No, I no longer use a CPAP machine	\square_3	More than 12 months ago
- 2	110, The longer doe a of At Thachine	A5.	Did you get your current CPAP machine when you were in a nursing home or hospital?
		\square_1 \square_2	Yes No

A6. Does someone regularly help you use your CPAP machine (for example, a relative, friend or home health aide)? □₁ Yes □₂ No	A8. When was the last time you discussed your needs or issues related to your CPAP machine with a respiratory therapist or another medical person like a doctor or nurse?
A <u>respiratory therapist</u> is a specially trained professional who helps you improve your breathing.	 □₁ Within the last 6 months □₂ Between 6 months and 1 year ago □₃ Between 1 and 3 years ago □₄ More than 3 years ago □₃ I don't know
A7. Did a respiratory therapist or another medical person like a doctor or nurse ever explain the following to you (Please check all that apply):	A9. Have you had more than one CPAP machine in the past year, or changed accessories (for example, hoses, mas in the past year? (Please check all tha
 □₁ Why you needed to use a CPAP machine □₂ The different types of CPAP machines, control options, and accessories □₃ None of these things were explained by a medical person □₃I don't know or don't recall if a medical person explained anything to me 	 apply.) □₁ No (→Skip to A10) □₂ Yes, I changed my CPAP machine □₃ Yes, I changed or added accessories □₉₈ I don't know (→Skip to A10)

A9a	i.Why did you make this (these) change(s)	? A11a	a. What is it about your CPAP
	(Please check all that apply.)		machine that makes it difficult or
\square_1	My CPAP machine needed to be replaced because the original one did		uncomfortable to use? (Please check all that apply.)
\square_2	not work My medical condition changed, so I needed something different	□ ₁	Equipment makes it difficult to move in my sleep
\square_3	I found a new CPAP machine that was better for me	□ ₂	Equipment makes it difficult to sleep well
\square_4	I found new features/accessories that were better for me	\square_3	CPAP machine is too noisy (for me or my partner)
\square_5	My doctor/ health care provider prescribed a different type of CPAP	\square_4 \square_5	The mask is uncomfortable It's difficult to take the machine with me when I travel away from home
\square_6	machine My supplier became ineligible to provide my equipment under Medicare	\square_6	Do not like to be dependent on a machine
\square_7	My supplier did not tell me why they changed my equipment		Do not understand the controls or controls hard to use
□ 96	Other, please specify:	□ ₉₆	Other, please tell us what else:
A10	Do you believe that you now have the		
	CPAP machine that is right for you?	A12.	In general, how often do you use your CPAP machine?
\square_1	Yes		
_	I don't know	\square_1	Less than one day or night each week
	.ls using your CPAP machine difficult or uncomfortable?	\square_2 \square_3 \square_4	1-2 days or nights per week3-4 days or nights per week5-6 days or nights per week
	Yes No (→ Skip to A13)	\square_5	Every day or night
	I don't know (→Skip to A13)		

A13. On the days that you do use your CPAP machine, for how long do you use it (out of 24 hours)?	A15a. How many times did you have these kinds of problems in the past year?
hours per day A14. How reliable is the CPAP machine you use now? Would you say	 □₁ One time □₂ 2 or 3 times □₃ 4 or more times □₄ Don't recall the exact number of times
 □₁ Very reliable □₂ Somewhat reliable □₃ Somewhat unreliable □₄ Very unreliable □₃8 I don't know 	A15b. Can you describe the kind of problem(s) that you had? (Please check all that apply.) CPAP machine did not work CPAP accessories did not work
A15. In the past year, did you have any problems that made you stop using your CPAP machine or switch to a different CPAP machine?	 □₇ Reservoir/humidifier did not work □₈ Did not understand the controls □₉₆ Other, please specify:
 □₁ Yes □₂ No (→Skip to SECTION B) □₃8 I don't know (→Skip to SECTION B) 	

B MEDICAL EXPENSES

- B1. In the past year, have you bought any accessories or parts for your current CPAP machine with your own money, or paid for maintenance or repairs with your own money, because your insurance did not cover it? (This does not include any copay or deductible amounts that are due from you.)
- □₁ Yes
- \square_2 No (\rightarrow Skip to SECTION C)
- \square_{98} I don't know (\rightarrow Skip to SECTION C)
- B2. In the past year, what parts or service did you buy with your own money for your CPAP machine? (Please check all that apply.)
- □₁ Mask
- \square_2 Tubing
- \square_3 Power supply or battery
- □₄ Head or chin straps / Headgear
- □₅ Repairs
- □₆ Routine maintenance
- □₇ Filters
- □₈ Humidifier or reservoir
- \square_{96} Other, please specify:

- B3. Thinking about everything you paid for with your own money in the past year for your CPAP machine accessories, parts, maintenance or repairs not covered by insurance, how much did you spend? (This does not include any copay or deductible amounts.)
- \square_1 Less than \$100
- **□**₂ \$100-\$500
- \square_3 \$500 or more
- □₉₈ I don't know

C.	YOUR SUPPLIER	C3.	Considering the CPAP machine you use now, when you asked
C1.	Considering the CPAP machine you		your supplier questions, did
	use now, did you have any problems		you get answers that you could
	finding an equipment supplier to get		understand?
	your CPAP machine from?		
_			Yes, completely
	Yes		Yes, somewhat
	No (→Skip to C2)	\square_3	No
□ 98	I don't know (→Skip to C2)		I did not ask any questions
		 98	I don't know
C1a	.What kinds of problems did you have		
	finding a CPAP machine supplier?	C4.	Before deciding on the CPAP
	(Please check all that apply.)		machine you use now, did your
	Lland to find a compliant who covered may		supplier tell you as much as
L 1	Hard to find a supplier who covered my		you wanted to know about the
\Box	area		options for your CPAP
\square_3	Supplier did not carry what I needed Supplier could not deliver equipment		machine?
— 3	when I needed it		Yes, completely
Π.	Supplier did not accept Medicare		Yes, somewhat
	Other, please specify:	\square_3	No
— 96	Other, please specify.	\square_{98}	I don't know
		— 98	I don't know
		C4a.	Before you decided on the
C2.	Considering the CPAP machine you		CPAP machine that you use now, did your supplier tell you
	use now, did you have a choice of		about all the equipment designs
	suppliers?		available to you, even those
	••		which the supplier did not have
	Yes, many		in stock?
_	Yes, a few		Yes, all equipment designs were
	No, only one supplier available		explained
⊔ 98	I don't know	\square_2	No, the supplier only told me what
			he/she has in stock
		\square_3	No, I already knew the equipment
		_5	designs available to me
		Пос	I don't know

C5.	After you ordered your CPAP machine, how long did it take to arrive?	C
\square_2	Next day Within a week 1-2 weeks later	
•	More than 2 weeks later I don't know	
C6.	How did you get your CPAP machine?	
\square_2	Delivered to my home by my supplier Mailed to my home by my supplier I (or someone on my behalf) picked it up	
	from my supplier I don't know	

7. When you got the CPAP machine you use now, what kind of <u>training or help</u> did the supplier give you or the person who takes care of you? Did he/she ... (Please check all that apply.) Give you written instructions on 1 how to use the CPAP machine Show you how to use the CPAP 2 machine Choose a safe and convenient place to store and charge the CPAP machine Show you how to clean and 4 maintain the CPAP machine Let you practice how to use and \square_5 maintain your CPAP machine while they watched \square_6 Gave me the manufacturer's customer assistance toll-free telephone number \square_7 Sent someone to my home to explain how to use it I did not get any training or help \square_8

from my supplier (→Skip to C8)

I don't know (→Skip to C8)

 \square_{98}

C7a. □₁ □₂ □₃ □₄ □₅	As a result of that training, how comfortable do you feel using and maintaining your CPAP machine? Very comfortable Comfortable Uncomfortable Very uncomfortable My comfort level has nothing to do with the training that my supplier gave me	C9 . □₁ □₂ □₃ □₄ □ ₉₈	Considering the CPAP machine you use now, how much time and energy did it take to get the CPAP machine, accessories, parts, maintenance and repairs from your supplier? No time and energy A little time and energy Some time and energy A lot of time and energy I don't know
C8.	In the 3 months after you got the CPAP machine you use now, how often did your supplier send someone like a nurse or a respiratory therapist to your home to check the equipment or see how well you are doing with the equipment? (Do not include times when you called them.)	C10. □₁ □₂	Would you recommend this CPAP machine supplier to a friend who needed similar equipment and services? Yes No
\square_1 \square_2 \square_3	Once in the 3 months after you got the CPAP machine More than once in the 3 months after you got the CPAP machine Not at all in the 3 months after you got the CPAP machine		

D.	RECENT EXPERIENCES		
	Please answer the following questions about the supplier that you use most often for your CPAP	D3.	In the past six months, have you contacted your supplier to get emergency service or advice?
D1.	During the past six months, how reliable was your supplier in making deliveries or repairs?	□ ₁ □ ₂ □ ₉₈	Yes No (→Skip to D4) I don't know (→Skip to D4) In general, how fast did the
\Box_1 \Box_2 \Box_3 \Box_4	Very reliable Somewhat reliable Not reliable at all Does not apply	□ 1	supplier respond to your needs, either by phone or in person? Would you say Within 1 day
D2.	In the past six months, have you contacted your supplier with a complaint or a problem?	$ \begin{array}{c} \square_2\\ \square_3\\ \square_4\\ \square_{98} \end{array} $	Within 2 days Within 1 week Longer than 1 week I don't know
$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_{98} \\ \square_4 \end{array} $	Yes No (→Skip to D5) I don't know (→Skip to D5) Don't know how to contact my supplier (→Skip to D5)	D3b. □₁ □₂	Were you able to get the emergency service or advice you needed? Yes No
D2a.	When you contacted your supplier, was your complaint or problem settled to your satisfaction?	_2 □ ₉₈	I don't know
$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_3 \\ \square_{98} \end{array} $	Yes No I am waiting for it to be settled I don't know		

D4.	you needed to contact your supplier after regular business hours?	D6a.	Why did you change your CPAP machine supplier? (Please check all that apply.)
\square_2	Yes No (→ Skip to D5) I don't know (→ Skip to D5)		I moved Supplier became ineligible to provide the equipment under Medicare
D4a	supplier after business hours,	□ ₃ □ ₄	Supplier went out of business I was not happy with the quality of service
	were you able to get the service or advice you needed?	\square_5 \square_6	I was not happy with equipment I was not happy with the choices
\square_2	Yes No I don't know	□ ₇	of equipment or service I could get I was not happy with the assistance I got in handling the insurance
D5.	Overall, how would you rate the supplier that you use most?	□8	Supplier did not provide CPAP machine, accessories or repair service I needed
\square_1	Poor	 9	I changed to an HMO and had to use a different supplier
\square_2 \square_3	Fair Good	□ ₉₆	Other, please specify:
	Very good Excellent		
D6.	In the past six months, have you changed your CPAP machine supplier?		
\square_2	Yes No (→Skip to SECTION E) I don't know (→Skip to SECTION E)		

E. ABOUT YOU

Section E is about you, the person whose name is on the mailing label of this survey.

E1.	In general, how would you rate
	your overall health?

- □₁ Excellent
- \square_2 Very good
- \square_3 Good
- □₄ Fair
- \square_5 Poor
- E2. Compared to 1 year ago, how would you rate your health now? Would you say ...
- □₁ Much better now
- □₂ Somewhat better now
- □₃ About the same
- □₄ Somewhat worse now
- \square_5 Much worse now
- E3. Do you currently live alone?
- \square_1 Yes (\rightarrow Skip to E5)
- \square_2 No

- E4. Which best describes your living situation now? (Please check all that apply.) I live....
- \square_1 With spouse/partner
- \square_2 With parent/step-parent
- □₃ With child/children
- \square_4 With other relative(s)
- \square_5 With friend
- □₆ With other person(s) not related to me
- E5. What is the highest grade or level of school that you have completed?
- \Box_1 8th grade or less
- \square_2 Some high school but did not graduate
- □₃ High school graduate or GED
- □₄ Some college or technical school
- □₅ College graduate
- \square_6 More than a 4-year college degree
- E6. What was your household's annual income during 2009, before taxes?
- \square_1 Less than \$5,000 (\$416 per month)
- □₂ Between \$5,001 and \$10,000 (\$417–\$833 per month)
- □₃ Between \$10,001 and \$20,000 (\$834–\$1,666 per month)
- □₄ Between \$20,001 and \$30,000 (\$1,667–2,500 per month)
- □₅ Between \$30,001 and \$50,000 (\$2,501–\$4,167 per month)
- □₆ Over \$50,000 (over \$4,168 per month)

E7. Are you of Hispanic or Latino F. OTHER INFORMATION origin or descent? \square_1 Yes, Hispanic or Latino F1. Please check the correct \square_2 No. not Hispanic or Latino statement: I am the person to whom this \square_1 E8. How would you describe your survey was addressed (→Skip to race? (Please check all that END) I filled this survey out or helped fill it apply.) \square_2 out for someone else \square_1 American Indian or Alaskan Native \square_2 Asian \square_3 Black or African American F2. How did you help the person Native Hawaiian or other Pacific with this survey? \square_4 Islander White or Caucasian I wrote the answers that the person \square_5 \Box_1 Other, please tell us: told me \square_{96} I answered the questions myself \square_2 based on my knowledge of the person's condition \square_3 Both of the above

Thank you for completing the survey. Please return the completed survey in the postage-paid envelope addressed to:

Survey of Medicare Patients Abt Associates Inc. 55 Wheeler Street, Cambridge, MA 02138 If you have any **questions about the \underline{survey}**, please call toll-free 1-888-XXX-XXXX.

Survey of Medicare Patients Who Use a Hospital Bed

The purpose of the study is to learn more about your satisfaction with the equipment, supplies, and service you receive from your hospital bed supplier. We also hope to better understand your experiences in obtaining and using this equipment.

□ ₁	there	person this survey was mailed to cannot complete the survey, at is no one else who can do so for him or her, please check here in the blank survey in the enclosed postage-paid envelope.	
		Please return by	

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-NEW. The time required to complete this information collection is estimated to average 30 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.

Instructions

The questions in this survey ask about your experiences as a person who uses a hospital bed.

To complete the survey, please answer the questions by checking the box to the left of your answer (as shown below). You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow beside your response with a note that tells you which question to answer next, like this:

- Yes
- I don't know

If there is no arrow next to your response, please proceed to the next question.

Some people might ask someone else (maybe a spouse, child, or friend) to help them complete this survey. If someone is helping you fill out the survey, remember that the questions always refer to <u>you</u> and <u>your</u> experience with your hospital bed.

Confidentiality

All information that would let someone identify you or your family will be kept confidential. You may choose to answer this survey or not. If you choose not to, this will not affect the Medicare benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we won't send you reminders.

If you have any questions about the survey, please call Abt Associates, the survey company, at 1-888-XXX-XXXX.

This is a toll-free call.

Α.	USE OF HOSPITAL BEDS		
		A3a.	Why did you stop using your
A 1.	When did you begin using a		hospital bed? (Please check all
	hospital bed?		that apply and then skip to
			SECTION E on page 10)
	□ ₁ 2010		
	□ ₂ 2009		□₁ My condition got better so I
	□ ₃ 2008		did not need it anymore
	□ ₄ Before 2008		□ ₂ My condition got worse
	□ ₅ I have <u>never</u> used a hospital bed		□ ₃ I was not comfortable in it
	(Skip to SECTION E on page		□ ₅ I did not feel safe in it
	<mark>10</mark>)		□ ₆ I just did not like it
			\square_7 It was too difficult to use
A2 .	When you first began using a		□ ₈ It kept breaking
	hospital bed, how long did you		□ ₁₀ It did not have the features I
	expect to use it?		needed
			□ ₉₆ Other, please specify:
	□ ₁ Less than 1 month		
	□ ₂ 2 to 6 months		
	□ ₃ More than 6 months		
	□ ₄ Forever	YOU	R CURRENT USE OF HOSPITAL BEI
	□ ₉₈ I don't know	A 4	When did you first get the beenitel
		A4.	When did you first get the hospital
A3.	Do you use a hospital bed now?		bed you use now?
	This includes using a hospital bed		□ ₁ Less than 6 months ago
	all of the time or just occasionally.		
			□ ₂ 6-12 months ago
	□ ₁ Yes (→ Skip to A4)		\square_3 More than 12 months ago
	\square_2 No, I no longer use a hospital bed		
		A5.	Does someone regularly help you
			use your hospital bed (for
			example, a relative, friend or home
			health aide)?
			□₁ Yes
			\square_2 No
	A		_
		I	

A6.	Did a doctor or another medical person like a nurse or	A8.	Have you had more than one hospital bed in the past year?
	physical/occupational therapist		
	<u>ever</u> explain the following to you	\square_1	No (→ Skip to SECTION B)
	(Please check all that apply):	\square_2	Yes, I changed my hospital bed
		\square_{98}	I don't know (→ Skip to SECTION B)
\square_1	Why you needed to have a hospital		
	bed	A8a.	Why did you make this (these)
\square_2	The different types of hospital beds		change(s)? (Please check all that
	and controls		apply.)
\square_3	None of these things were explained		
	by a medical person	\square_1	Hospital bed needed to be
\square_{98}	I don't know or don't recall if a medical		replaced because the original
	person explained anything to me		one did not work
		\square_2	My medical condition changed,
			so I needed something different
A 7.	When was the <u>last time</u> you	\square_3	Found a new hospital bed that
	discussed your needs or issues		was better for me
	related to your medical bed with a	\square_4	Found new features / controls
	doctor or another medical person		that were better for me
	like a nurse or physical /	\square_5	Doctor/ health care provider
	occupational therapist?		prescribed a different type of
	·		hospital bed
\square_1	Within the last 6 months	\square_6	My supplier became ineligible to
\square_2	Between 6 months and 1 year ago		provide my equipment under
\square_3^-	Between 1 and 3 years ago		Medicare
\square_4	More than 3 years ago	\square_7	My supplier did not tell me why
□ ₉₈	I don't know	'	they changed my equipment
-30		\square_{96}	Other, please specify:
		A9.	Do you believe that you now
			have the hospital bed that is right for you?
			Yes
		\square_2	No
			I don't know

A10.	Is using your hospital bed difficult or uncomfortable?	A12.	On the days that you are in your hospital bed, for how long do you use it (out of 24 hours)?
\square_1	Yes		
\square_2	No (→Skip to A11)		hours per day
\square_{98}	I don't know (→Skip to A11)		
		A13.	How reliable is the hospital bed
			you use now? Would you say
A10a.	What is it about your hospital bed that		
	makes it difficult or uncomfortable for	\square_1	Very reliable
	you to use? (Please check all that	\square_2	Somewhat reliable
	apply.)	\square_3	Somewhat unreliable
\square_1	It is difficult for me to sit up	\square_4	Very unreliable
\square_2	It is difficult for me to reach controls	\square_{98}	I don't know
\square_3	It is difficult for me to shift my weight		
	for pressure relief		
\square_4	It is difficult for me to transfer in and	A14.	In the past year, did you have
	out of the hospital bed easily		any problems that made you
\square_5	I cannot lie comfortably in it		stop using a hospital bed or
\square_6	The tray or other attachments are		switch to a different hospital
	hard to adjust or use		bed?
\square_8	It takes up a lot of space		Vaa
\square_{96}	Other, please tell us what else:		Yes
			No (→ Skip to SECTION B)
		\square_{98}	I don't know (→ Skip to
			SECTION B)
A11.	In general, how often do you use your	A14a	How many times did you have
	hospital bed?	A 14a.	these kinds of problems in the
\square_1	Less than one day or night per week		past year?
\square_2	1-2 days or nights per week		past year:
\square_3	3-4 days or nights per week		One time
\square_4	5-6 days or nights per week		2 or 3 times
\square_5	Every or night day		4 or more times
		\square_4	Don't recall the exact number of
			times

A14b.	Can you describe the kind of problem(s) that you had? (Please	В.	MEDICAL EXPENSES
□ ₁ □ ₂ □ ₉₆	check all that apply.) Hospital bed did not work Hospital bed adjustments did not work Other, please specify:	B1.	In the past year, have you bought any accessories or parts for your current hospital bed with your own money, or paid for maintenance or repairs with your own money, because your insurance did not cover it? (This does not include the copay amounts that are due from you.)
		\square_1 \square_2 \square_{98}	Yes No (→ Skip to SECTION C) I don't know (→ Skip to SECTION C)
		B2.	In the past year, what parts or service did you buy with your own money for your hospital bed? (Please check all that apply.)
		□ ₁ □ ₂ □ ₃ □ ₄ □ ₅ □ ₆ □ ₇ □ ₈ □ ₉₆	Mattress Bed board Bed cradle Bed side rails Safety enclosure frame Trapeze bars Repairs Routine maintenance Other, please specify:

B3.	Thinking about everything you paid for with your own money in the past	C.	YOUR SUPPLIER
	year for your hospital bed accessories, parts, maintenance or repairs not covered by insurance, how much did you spend on your current hospital bed? (This does not include any copay or deductible	C1.	Considering the hospital bed you use now, did you have any problems finding an equipment supplier to get your hospital bed from?
	amounts.)	□₁	Yes
	,	\square_2	No (→Skip to C7)
	□₁ Less than \$100	\square_{98}^-	I don't know (→Skip to C7)
	1 2 \$100-\$500		, ,
	□ ₃ \$500 or more □ ₉₈ I don't know	C1a.	What kinds of problems did you have finding a hospital bed supplier? (Please check all that apply.)
			Hard to find a supplier who covered my area
		\square_2	Supplier did not carry what I needed
		 3	Supplier could not deliver equipment when I needed it
		\square_4	Supplier did not accept Medicare
		□ 96	Other, please describe:
		C2.	Considering the hospital bed you use now, did you have a choice of suppliers?
			Yes, many
			Yes, a few
		□ ₃ □ ₉₈	No, only one supplier available I don't know

C3.	Considering the hospital bed you use now, when you asked your supplier questions, did you get answers that you could	C5.	After you ordered your hospital bed, how long did it take to arrive?
$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_3 \\ \square_4 \\ \square_{98} \end{array} $	understand? Yes, completely Yes, somewhat No I did not ask any questions I don't know	$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_3 \\ \square_4 \\ \square_{98} \end{array} $	Same day Next day Within a week More than 1 week later I don't know
C4.	Before deciding on the hospital bed you use now, did your supplier tell	C6.	How did you get your hospital bed?
	you as much as you wanted to know about the options for your hospital bed?		Delivered or shipped to my home by my supplier
\square_1 \square_2 \square_3 \square_{98}	Yes, completely Yes, somewhat No I don't know	\square_2 \square_{98} \square_{96}	I (or someone on my behalf) picked it up from my supplier I don't know Some other way, please specify:
C4a.	Before you decided on the hospital bed that you use now, did your supplier tell you about all the equipment designs available to you, even those which the supplier did not have in stock?		
\square_1	Yes, all equipment designs were explained		
\square_2	No, the supplier only told me what he/she has in stock		
\square_3	No, I already knew the equipment designs available to me		
□ 98	I don't know		

Cī	7. When you got your the hospital bed you use now, what kind of training or help did the supplier give you or the person who takes care of you? Did he/she (Please check all that apply.)	C8.	Considering the hospital bed you use now, how much time and energy did it take to get the hospital bed, accessories, parts, maintenance and repairs from your supplier?
	Give you <u>written instructions</u> on how to use the hospital bed		No time and energy A little time and energy
	Show you how to <u>use</u> the hospital bed	\square_3 \square_4	Some time and energy A lot of time and energy
□ ;	Choose a safe and convenient place to <u>place</u> the hospital bed	□ ₉₈	I don't know
	Show you how to <u>clean and maintain</u> the hospital bed	C9.	Overall, how would you rate the supplier that you use most?
	Show you how to use the hospital bed safely		Poor
	Let you <u>practice</u> how to use and maintain your hospital bed while they	\square_2 \square_3	Fair Good
	watched Give you the manufacturer's customer assistance toll-free	\square_4 \square_5	Very good Excellent
_	telephone number	C10.	Would you recommend this hospital bed supplier to a friend
	my supplier (→Skip to C8)		who needed similar equipment and services?
	₉₈ I don't know (→ Skip to C8)		Yes
C7a.	As a result of that training, how comfortable do you feel using and maintaining your hospital bed?		No
\square_1	Very comfortable		
\square_2 \square_3	Comfortable Uncomfortable		
\square_3 \square_4	Very uncomfortable		
\square_5	My comfort level has nothing to do with		
J	the training that my supplier gave me		

D. RECENT EXPERIENCES

Please answer the following questions about the supplier that you use most often if you use more than one supplier for your walker and accessories.

•			advice?
D1.	<u>During the past six months</u> , how reliable was your supplier in making deliveries or repairs?		es o (→ Skip to D5) don't know (→ Skip to D5)
\Box_1	Very reliable		
\square_2	Somewhat reliable	D3a.	In general, how fast did the
\square_3	Not reliable at all		supplier respond to your needs,
 99	Does not apply		either by phone or in person? Would you say
D2.	In the past six months, have		
	you contacted your supplier	\square_1 W	/ithin 1 day
	with a complaint or a problem?	\square_2 W	/ithin 2 days
		\square_3 W	ithin 1 week
\square_1	Yes	\square_4 Lo	onger than 1 week
\square_2	No (→Skip to D5)		don't know
\square_{98}	I don't know (→Skip to D5)		
\square_4	I don't know how to contact my		
	supplier (→Skip to D5)	D3b.	Were you able to get the
			emergency service or advice you
D2a.	When you contacted your		needed?
	supplier, was your complaint or	_	
	problem settled to your		Yes
	satisfaction?		No
_		 98	I don't know
□ ₁	Yes		
\square_2	No		
\square_3	I am waiting for it to be settled		
\square_{98}	I don't know		

D3.

In the past six months, have

get emergency service or

you contacted your supplier to

		บวล.	willy did you change your
D4.	In the past six months, have you		hospital bed supplier? (Please
	needed to contact your supplier		check all that apply.)
	after regular business hours?		
		\square_1	I moved
\square_1	Yes	\square_2	Supplier no longer accepted
\square_2	No (→ Skip to D5)		Medicare
\square_{98}	I don't know (→ Skip to D5)	\square_3	Supplier went out of business
		\square_4	I was not happy with the quality of
D4a.	When you contacted your supplier		service
	Question the requirement for this	\square_5	I was not happy with equipment
	after business hours, were you	\square_6	I was not happy with the choices of
	able to get the service or advice		equipment or service I could get
	you needed?	\square_7	I was not happy with the assistance
			I got in handling the insurance
\square_1	Yes	□8	Supplier did not provide hospital
\square_2	No		bed, accessories or repair service I
\square_{98}	I don't know		needed
		\square_9	I changed to an HMO and had to
D5.	In the past six months, have you		use a different supplier
	changed your hospital bed	□ ₁₀	Supplier became ineligible to
	supplier?		provide the equipment under
			Medicare
\square_1	Yes	\square_{96}	Other, please specify:
\square_2	No (→ Skip to SECTION E on		
	page 10)		
□ 98	I don't know (→ Skip to SECTION		
	E on page 10)		

E.	ABOUT YOU	E4.	Which best describes your living situation <u>now</u> ? (Please check all
	Section E is about you, the person		that apply.) I live
	whose name is on the mailing		
	label of this survey.	\square_1	With spouse/partner
	·	\square_2	With parent/step-parent
E1.	In general, how would you rate	\square_3	With child/children
	your overall health?	\square_4	With other relative(s)
		\square_5	With friend
\square_1	Excellent	\square_6	With other person(s) not related to
\square_2	Very good		me
\square_3	Good		
\square_4	Fair	E5.	What is the highest grade or
\square_5	Poor		level of school that you have completed ?
E2 .	Compared to 1 year ago, how		
	would you rate your health now?	\square_1	8 th grade or less
	Would you say	\square_2	Some high school but did not graduate
\square_1	Much better now	\square_3	High school graduate or GED
\square_2	Somewhat better now	\square_4	Some college or technical school
\square_3	About the same	\square_5	College graduate
\square_4	Somewhat worse now	\square_6	More than a 4-year college degree
\Box_5	Much worse now		
3		E6 .	What was your household's
E3.	Do you currently live alone?		annual income during 2006 before taxes?
\square_1	Yes (→Skip to E5)		
\square_2	No	\square_1	Less than \$5,000 (\$416 per month)
_		\square_2	Between \$5,001 and \$10,000 (\$417–\$833 per month)
		\square_3	Between \$10,001 and \$20,000
			(\$834-\$1,666 per month)
		\square_4	Between \$20,001 and \$30,000
			(\$1,667-2,500 per month)
		\square_5	Between \$30,001 and \$50,000
			(\$2,501-\$4,167 per month)
		\square_6	Over \$50,000 (over \$4,168 per
			month)

E7. Are you of Hispanic or Latino origin or descent? Yes, Hispanic or Latino No, not Hispanic or Latino \square_2 E8. How would you describe your race? (Please check all that apply.) American Indian or Alaskan Native \square_2 Asian \square_3 Black or African American \square_{Λ} Native Hawaiian or other Pacific Islander White or Caucasian \square_5 \square_{96} Other, please tell us:

F. OTHER INFORMATION

F1. Please check the correct statement:

- □₁ I am the person to whom this survey was addressed (→Skip to END)
- □₂ I filled this survey out or helped fill it out for someone else

F2. How did you help the person with this survey?

- □₁ I wrote the answers that the person told me
- □₂ I answered the questions myself based on my knowledge of the person's condition
- \square_3 Both of the above

Thank you for completing the survey. Please return the completed survey in the postage-paid envelope addressed to:

CMS Survey of Medicare Beneficiaries
Abt Associates Inc.
55 Wheeler Street,
Cambridge, MA 02138

If you have any **questions about the <u>survey</u>**, please call toll-free 1-888-XXX-XXXX.

1001

Survey of Medicare Patients Who Use a Power Wheelchair

The purpose of the study is to learn more about your satisfaction with the equipment, supplies, and service you receive from your oxygen (or other durable medical equipment) supplier. We also hope to better understand your experiences in obtaining and using this equipment.

□ ₁	If the person this survey was mailed to cannot complete the survey, and there is no one else who can do so for him or her, please check here and return the blank survey in the enclosed postage-paid envelope.
	Please return by

Instructions

The questions in this survey ask about your experiences as a person who uses a power wheelchair.

To complete the survey, please answer the questions by checking the box to the left of your answer (as shown below). You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow beside your response with a note that tells you which question to answer next, like this:

Yes

I don't know

If there is no arrow next to your response, please proceed to the next question.

Some people might ask someone else (maybe a spouse, child, or friend) to help them complete this survey. If someone is helping you fill out the survey, remember that the questions always refer to <u>you</u> and <u>your</u> experience with oxygen treatment and equipment.

Confidentiality

All information that would let someone identify you or your family will be kept confidential. You may choose to answer this survey or not. If you choose not to, this will not affect the Medicare benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we won't send you reminders.

	if you have any questions about the survey, please call Abt Associates, the				
	survey company, at 1-888-XXX-XXXX.				
	This is	a tol	l-free call.		
Α.	USE OF POWER WHEELCHAIRS	\Box_2	2009		
		\square_3	2008		
A 1.	When did you begin using a power	\Box_4	Before 2008		
	wheelchair?	\square_5	I have <u>never</u> used a power wheelchair		
			(Skip to SECTION E on page 11)		
\square_1	2010				

A2 .	When you first began using a power wheelchair, how long did you expect to use it?	AJa.	power wheelchair, why did you stop? (Please check all that apply and then skip to SECTION E on page 11.)
□ ₁ □ ₂ □ ₃ □ ₄ □ ₉₈ A3 .	Less than 1 month 1 to 6 months More than 6 months Forever I don't know Do you use a power wheelchair now? This includes using a power wheelchair all of the time or just occasionally. Yes (→Skip to A4) No, I have never used a power wheelchair	$ \begin{array}{c} \square_1 \\ \square_2 \\ \square_3 \\ \square_4 \\ \square_5 \\ \square_6 \\ \square_7 \\ \square_8 \\ \square_9 \\ \square_{10} \end{array} $	My condition got better so I did not need it anymore My condition got worse so I couldn't use it anymore I was embarrassed to use it I was not comfortable sitting in it I did not feel safe driving it I just did not like using it It was too difficult to use It kept breaking down I had no place to charge it and/or store it It did not have the features I needed
			Of YOUR CURRENT POWER ELCHAIR When did you first get the power wheelchair you use now? Less than 6 months ago 6-12 months ago More than 12 months ago Did you get your current power wheelchair while you were in a nursing home or hospital? Yes No

A6.	Does someone regularly help you use your power wheelchair (e.g. a relative, friend or home health aide)?	A9.	Have you had more than one power wheelchair in the past year or changed accessories (for example,
	relative, mend of nome health alder:		controls, cushion) in the past year?
\square_1	Yes		
\square_2	No	\Box_1	No (→Skip to A10)
		\square_2	Yes, I changed my power
			wheelchair
A7.	Did a doctor or another medical	\square_3	Yes, I changed or added
	person like a nurse or		accessories
	physical/occupational therapist ever	□ 98	I don't know (→Skip to A10)
	explain the following to you (Please		
	check all that apply): why you	A9a.	Why did you make this (these)
	needed to use a power wheelchair?		change(s)? (Please check all that apply.)
\square_1	Why you needed to use a power		
	wheelchair	\square_1	Wheelchair needed to be replaced
\square_2	The different types of power		because the original one did not
	wheelchairs, control options, and		work
	accessories that exist	\square_2	My medical condition changed, so I
\square_3	None of these things were explained by		needed something different
	a medical person	\square_3	Found a new wheelchair that was
\square_{98}	I don't know or don't recall if a medical		better for me
	person explained anything to me	\square_4	Found new features/accessories
			that were better for me
A8 .	When was the <u>last time</u> you discussed	\square_5	Doctor or health care provider
	your needs or issues related to your		prescribed a different type of
	power wheelchair with a doctor or		wheelchair or different accessories
	another medical person like a nurse or	\square_6	My supplier did not tell me why they
	physical/ occupational therapist?		changed my equipment
		\square_6	My supplier became ineligible to
\square_1	Within the last 6 months		provide my equipment under
\square_2	Between 6 months and 1 year ago		Medicare
\square_3	Between 1 and 3 years ago	\square_{96}	Other, please specify:
\square_4	More than 3 years ago		
\square_{98}	I don't know		

A10.	Do you believe that you now have the power wheelchair that is right for you?	A11a	a. What is it about your power wheelchair that makes it difficult or uncomfortable to use? (Please check all that apply.)
\square_1 \square_2	Yes No		Battery range not sufficient for daily activities
□ ₉₈	I don't know	\square_2	Not enough power to get over barriers such as ramps, thresholds and curbs
A11.	Is using your power wheelchair difficult or uncomfortable?	\square_3	Not enough speed to safely cross the street during a traffic light change
\square_1 \square_2	Yes No (→ Skip to A12)	\square_4	It is difficult to shift my weight for pressure relief
□ 98	I don't know (→Skip to A12)	\square_5	It is difficult to use the chair easily inside my home
		\square_6	It is difficult to use the chair easily outside of my home
		\square_7	It is difficult to transport the chair to where I want to go
		□8	It is difficult sit comfortably in it for a long time
		\square_9	It is difficult transfer in and out of the wheelchair easily
		□ ₁₀	It is too heavy and cumbersome to

□₁₁ I have trouble charging it
 □₉₆ Other, please tell us what else:

A12.	In general, how often do you use	A16	a. How many times did you have
	your power wheelchair?		these kinds of problems <u>in the</u>
			past year?
\square_1	Less than one day a week		
\square_2	1-2 days per week		One time
\square_3	3-4 days per week	\square_2	2 or 3 times
\square_4	5-6 days per week	\square_3	4 or more times
\square_5	Every day		
		A16	b. Can you describe the kind of
A13.	On the days that you do use your		problem(s) that you had? (Please
	power wheelchair, for how long do		check all that apply.)
	you use it? (out of 24 hours in a		
	day)?	\square_1	Batteries did not work
		\square_2	Motor did not work
	hours per day	\square_3	Controls or joystick did not work
		□ 96	Other, please specify:
A14.	How reliable is the power wheelchair		
	you use now? Would you say	3.	
\square_1	Very reliable		
\square_2	Somewhat reliable		
\square_3	Somewhat unreliable		
\square_4	Very unreliable		
□ 98	I don't know		
A15.	In the past year, did you have any		
	problems that made you stop using		
	your power wheelchair or switch to a		
	different power wheelchair?		
\square_1	Yes		
\square_2	No (→Skip to SECTION B)		
\square_{98}	I don't know (→Skip to SECTION B)		

MEDICAL EXPENSES

- B1. In the past year, have you bought any accessories or parts for your current power wheelchair with your own money, or paid for maintenance or repairs with your own money because your insurance did not cover it? (This does not include any copay or deductible amounts that are due from you.)
- □₁ Yes
- \square_2 No (\rightarrow Skip to SECTION C)
- \square_{98} I don't know (\rightarrow Skip to SECTION C)
- B2. In the past year, what parts or service did you buy with your own money for your current power wheelchair?
 (Please check all that apply.)
- \Box_1 Seat or back cushions
- \square_2 Tires
- \square_3 Batteries
- \square_4 Motors
- □₅ Crutch holder
- □₆ Lap tray
- □₇ Repairs
- □₈ Routine maintenance
- \square_{96} Other, please specify:

- B3. Thinking about everything you paid for with your own money in the past year for your wheelchair accessories, parts, maintenance or repairs not covered by insurance, how much did you spend on your current power wheelchair? (This does not include any copay or deductible amounts.)
 - □₁ Less than \$100
 - **□**₂ \$100-\$500
 - \square_3 \$500 or \$1,000
 - **□**₄ \$1,000- \$2,000
 - □₉₈ I don't know

C.	YOUR SUPPLIER	C3.	Considering the power wheelchair you use now, when
C1.	Considering the power wheelchair		you asked your supplier
	you use now, did you have any		questions, did you get <u>answers</u>
	problems finding an equipment		that you could understand?
	supplier to get your wheelchair from?		
	cappiner to got your innocional from	\square_1	Yes, completely
	□₁ Yes	\square_2	Yes, somewhat
	□ ₂ No (→Skip to C2)	\square_3	No
	□ ₉₈ I don't know (→Skip to C2)	\Box_4	I did not ask any questions
		□ ₉₈	I don't know
C1a.	What kinds of problems did you have finding a power wheelchair supplier?	 90	
	(Please check all that apply.)	C4.	Before deciding on the power
			wheelchair you use now, did your
	□₁ Hard to find a supplier who covered		supplier tell you as much as you
	my area		wanted to know about the options
	□ ₂ Supplier did not carry what I		for your power wheelchair?
	needed		
	□ ₃ Supplier could not deliver	\square_1	Yes, completely
	equipment when I needed it	\square_2	Yes, somewhat
	□ ₄ Supplier did not accept Medicare	\square_3	No
	□ ₉₆ Other, please specify:	\square_{98}	I don't know
		C4a.	Before you decided on the power wheelchair that you use now, did
C2.	Considering the power wheelchair		your supplier tell you about all the
	you use now, did you have a <u>choice</u>		equipment designs available to you,
	of suppliers?		even those which the supplier did
			not have in stock?
	□ ₁ Yes, many		Vac all applications of decimal ways
	□ ₂ Yes, a few	\square_1	Yes, all equipment designs were
	□ ₃ No, only one supplier available	\square_2	explained No, the supplier only told me what
	□ ₉₈ I don't know	- 2	he/she has in stock
		\square_3	No, I already knew the equipment
		J	designs available to me
		\square_{98}	I don't know

C5.	After you ordered your power	C7.	When you got the power wheelchai
	wheelchair, how long did it take to		you use now, what kind of training
	arrive?		or help did the supplier give you or
			the person who cares for you?
\square_1	less than 2 weeks		Did he/she (Please check all that
\square_2	2 weeks to 1 month		apply.)
\square_3	1 to 2 months		
\square_4	2 to 3 months	\square_1	Give you written instructions on how to
\square_5	More than 3 months		use the power wheelchair
□ 98	I don't know	\square_2	Show you how to drive the power
			wheelchair
C6.	How did you get the power wheelchair	\square_3	Show you how to charge your chair
	you use now?	Ū	battery
		\square_4	Show you how to <u>clean and maintain</u>
\square_1	Delivered to my home by my supplier	7	the power wheelchair
\square_2	Mailed/shipped to my home by my supplier	\square_5	Show you how to use the power
\square_3	I (or someone on my behalf) picked it up	_5	wheelchair <u>safely</u>
_5	from my supplier	\square_6	Let you <u>practice</u> how to use and
\square_4	I picked it up at a seating clinic or	—0	maintain your power wheelchair while
- 4	rehabilitation center		they watched
□ 98	I don't know	\square_7	Gave me the manufacturer's <u>custome</u>
—90 □ ₉₆	Some other way, please specify:	— /	assistance toll-free telephone number
— 90	come outer way, please speeny.	\square_8	I did not get any training or help from
		- 0	my supplier (→ Skip to C8)
		□ 98	I don't know (→ Skip to C8)
		- 98	radir throw () shap to so;
		C7a	As a result of that training, how
		Oru.	comfortable do you feel using and
			maintaining your power
			wheelchair?
			Wilecician:
			Very comfortable
			Comfortable
		\square_3	Uncomfortable
		Ŭ	Very uncomfortable
		\square_5	My comfort level has nothing to do
		- 5	-
			with the training that my supplier
			gave me

C8.	In the 3 months after you got the power wheelchair you use now, how often did your supplier send someone to your home to check the equipment or see how well you are doing with the equipment? (Do not include times when you called them.)	C10.	Considering the power wheelcha you use now, do you get your accessories, parts, maintenance and repairs from more than one equipment supplier? Yes No
□ ₁	Once in the 3 months after you got the power wheelchair	□ ₉₈	I don't know
\square_2 \square_3	More than once in the 3 months after you got the power wheelchair Not at all in the 3 months after you got	C11.	Overall, how would you rate the supplier that you use most?
	the power wheelchair	\square_1 \square_2 \square_3	Poor Fair Good
C9.	Considering the power wheelchair you use now, how much time and energy did it take to get the power wheelchair, accessories, parts,	\square_4 \square_5	Very good Excellent
	maintenance and repairs from the supplier?	C12.	Would you recommend this power wheelchair supplier to a friend who needed similar equipment and
\square_1 \square_2	No time and energy A little time and energy		services?
\square_3	Some time and energy	\square_1	Yes
□ ₄ □ ₉₈	A lot of time and energy I don't know	\square_2	No

D. RECENT EXPERIENCES

If you use more than one supplier for your wheelchair and accessories, please answer the following questions about the supplier that you use most often.

- D1. <u>During the past six months</u>, how reliable was your supplier in making repairs, if needed?
- \Box_1 Very reliable
- \square_2 Somewhat reliable
- \square_3 Not reliable at all
- □₉₉ Does not apply
- D2. <u>In past six months</u>, have you contacted your supplier with a complaint or a problem?
- □₁ Yes
- \square_2 No (\rightarrow Skip to D3)
- \square_{98} I don't know (\rightarrow Skip to D3)
- □₄ Don't know how to contact my supplier (→**Skip to D3**)
- D2a. When you contacted your supplier, was your complaint or problem settled to your satisfaction?
- □₁ Yes
- \square_2 No
- \square_3 I am waiting for it to be settled
- □₉₈ I don't know

- D3. <u>In the past six months</u>, have you contacted your supplier to get emergency service or advice?
- □₁ Yes
- \square_2 No (\rightarrow Skip to D5)
- \square_{98} I don't know (\rightarrow Skip to D5)
- D3a. In general, how fast did the supplier respond to your needs, either by phone or in person?
 Would you say ...
- \square_1 Within 1 day
- \square_2 Within 2 days
- \square_3 Within 1 week
- \square_4 Longer than 1 week
- □₉₈ I don't know
- D3b. Were you able to get the emergency service or advice you needed?
- □₁ Yes
- \square_2 No
- \square_{98} I don't know

D4.	In the past six months, did you need to contact your supplier after regular business hours?	D5a.	Why did you change your power wheelchair supplier? (Please check all that apply.)
\square_1	Yes		I moved
\square_2	No (→ Skip to D5)	\square_2	Supplier no longer accepted
\square_{98}	I don't know (→Skip to D5)		Medicare
		\square_3	Supplier went out of business
		\square_4	I was not happy with the quality of service
D4a.	When you contacted your supplier	\square_5	I was not happy with equipment
	after business hours, were you able	\square_6	I was not happy with the choices of
	to get the service or advice you		equipment or service I could get
	needed?	\square_7	I was not happy with the assistance
			I got in handling the insurance
\square_1	Yes	\square_8	Supplier did not provide power
\square_2	No		wheelchair, accessories or repair
\square_{98}	I don't know		service I needed
D5.	In the past six months, have you	 9	I changed to an HMO and had to use a different supplier
	changed your power wheelchair supplier?	□ ₁₀	Supplier became ineligible to provide the equipment under Medicare
\square_1	Yes	\square_{96}	Other, please describe:
\square_2	No (→Skip to SECTION E on page 11)		
□ 98	I don't know (→Skip to SECTION E on page 11)		

⊏.	ABOUT TOU		
		E4.	Which best describes your living
	Section E is about you, the		situation <u>now</u> ? (Please check all
	person whose name is on the		that apply.)
	mailing label of this survey.	l live)
		\square_1	With spouse/partner
E1.	In general, how would you rate <u>your</u>	\square_2	With parent/step-parent
	overall health?	\square_3	With child/children
		\square_4	With other relative(s)
\square_1	Excellent	\square_5	With friend
\square_2	Very good	\square_6	With other person(s) not related to
\square_3	Good		me
\square_4	Fair		
\square_5	Poor	E5.	What is the highest grade or level
			of school that you have
E2 .	Compared to 1 year ago, how would		completed?
	you rate your health now? Would		
	you say	\square_1	8 th grade or less
		\square_2	Some high school but did not
\square_1	Much better now		graduate
\square_2	Somewhat better now	\square_3	High school graduate or GED
\square_3	About the same	\square_4	Some college or technical school
\square_4	Somewhat worse now	\square_5	College graduate
\square_5	Much worse now	\square_6	More than a 4-year college degree
J		•	, 5
E3.	Do you currently live alone?		
\square_1	Yes (→ Skip to E5)		

 \square_2 No

E6. What was your household's annual income during 2006 before taxes?

- \square_1 Less than \$5,000 (\$416 per month)
- □₂ Between \$5,001 and \$10,000 (\$417–\$833 per month)
- □₃ Between \$10,001 and \$20,000 (\$834–\$1,666 per month)
- □₄ Between \$20,001 and \$30,000 (\$1,667–2,500 per month)
- □₅ Between \$30,001 and \$50,000 (\$2,501–\$4,167 per month)
- □₆ Over \$50,000 (over \$4,168 per month)

E7. Are you of Hispanic or Latino origin or descent?

- □₁ Yes, Hispanic or Latino
- \square_2 No, not Hispanic or Latino

E8. How would you describe your race? (Please check all that apply.)

- □₁ American Indian or Alaskan Native
- □₂ Asian
- □₃ Black or African American
- □₄ Native Hawaiian or other Pacific Islander
- \square_5 White or Caucasian
- \square_{96} Other, please tell us:

F. OTHER INFORMATION

F1. Please check the correct statement:

- □₁ I am the person to whom this survey was addressed (→**Skip to END**)
- □₂ I filled this survey out or helped fill it out for someone else

F2. How did you help the person with this survey?

- □₁ I wrote the answers that the person told me
- □2 I answered the questions myself based on my knowledge of the person's condition
- \square_3 Both of the above

Thank you for completing the survey. Please return the completed survey in the postage-paid envelope addressed to:

Survey of Medicare Patients Abt Associates Inc. 55 Wheeler Street, Cambridge, MA 02138

If you have any **questions about the <u>survey</u>**, please call toll-free 1-888-XXX-XXXX.

Survey of Medicare Patients Who Use a Walker

The purpose of the study is to learn more about your satisfaction with the equipment, supplies, and service you receive from your walker supplier. We also hope to better understand your experiences in obtaining and using this equipment.

		Please return by		
\square_1	If the person this survey was mailed to cannot complete the surve there is no one else who can do so for him or her, please check return the blank survey in the enclosed postage-paid envelope.			

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-NEW. The time required to complete this information collection is estimated to average 30 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.

Instructions

The questions in this survey ask about your experiences as a person who uses a walker.

To complete the survey, please answer the questions by checking the box to the left of your answer (as shown below). You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow beside your response with a note that tells you which question to answer next, like this:

- Yes
- I don't know

If there is no arrow next to your response, please proceed to the next question.

Some people might ask someone else (maybe a spouse, child, or friend) to help them complete this survey. If someone is helping you fill out the survey, remember that the questions always refer to <u>you</u> and <u>your</u> experience with your walker.

Confidentiality

All information that would let someone identify you or your family will be kept confidential. You may choose to answer this survey or not. If you choose not to, this will not affect the Medicare benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we won't send you reminders.

If you have any questions about the survey, please call Abt Associates, the survey company, at 1-888-XXX-XXXX.

This is a toll-free call.

Walker Survey

A. A1.	USE OF WALKERS When did you begin using a walker?	A3a.	Why did you stop using your walker? (Please check all that apply and then skip to SECTION
ΛI.	Which did you begin asing a warker:		E on page 10.)
\square_1	2010		
\square_2	2009		My condition got better so I did not
\square_3	2008		need it anymore
\square_4	Before 2008	\square_2	My condition got worse so I couldn't use it anymore
\square_5	I have <u>never</u> used a walker (Skip to	\square_3	I was embarrassed to use it
	SECTION E on page 11)	\square_3	I was not comfortable using it
		\square_5	I did not feel safe using it
A2.	When you first began using a	\square_6	I just did not like using it
AZ.	When you first began using a	— ₀ □ ₇	It was too difficult to use
	<u>walker,</u> how long did you expect to use it?	- / □8	It kept breaking
	use it:	_。 □ ₉	It was not the type of walker I
\square_1	Less than 1 month	_3	needed
\square_2	1 to 6 months	\square_{96}	Other, please specify:
\square_3	More than 6 months		
_3 □ ₄	Forever		
□ ₉₈	I don't know		
		YOU	R CURRENT USE OF WALKER
A 3.	Do you use a walker now? This includes using a walker all of the time or just occasionally.	A4.	When did you first get the walker you use now?
			Less than 6 months ago
\square_1	Yes (→ Skip to A4)	\square_2	6-12 months ago
\square_2	No, I no longer use a walker	\square_3	More than 12 months ago
		A5.	Did you get your current walker while you were in a nursing home or hospital?
		□₁	Yes
		\square_2	No
		_	

A6.	Does someone regularly help you use your walker (for example, a relative, friend or home health aide)?	A9.	Have you had more than one walker in the past year, or changed accessories (e.g. glides, basket) in the past year? (Please check all that apply.)
\square_1	Yes		(i loude officer all that apply.)
\square_2	No	\square_1	No (→Skip to A10)
		\square_2	Yes, I changed my walker
A 7.	Did a doctor or another medical person like a nurse or	\square_3	Yes, I changed or added accessories
	physical/occupational therapist <u>ever</u> explain the following to you (Please	□98	I don't know (→Skip to A10)
	check all that apply):	A9a.	Why did you make this (these) change(s)? (Please check all that
\square_1	Why you needed to use a walker		apply.)
\square_2	The different types of walkers and		
	accessories that exist	\square_1	Walker needed to be replaced
\square_3	None of these things were explained by a medical person		because the original one did not work
□ 98	I don't know or don't recall if a medical person explained anything to me	\square_2	My medical condition changed, so I needed something different
	person explained any anning to me	\square_3	Found a new walker that was better for me
A 8.	When was the <u>last time</u> you discussed your mobility needs or	\square_4	Found new features/accessories that were better for me
	issues related to your walker with a doctor or another medical person like a nurse or physical/occupational	\square_5	Doctor or health care provider prescribed a different walker or different accessories
	therapist?	\square_6	My supplier became ineligible to provide my equipment under
\square_1	Within the last 6 months		Medicare
\square_2	Between 6 months and 1 year ago	\square_7	My supplier did not tell me why they
\square_3	Between 1 and 3 years ago	•	changed my equipment
□ ₄ □ ₉₈	More than 3 years ago I don't know	□ ₉₆	Other, please specify:

A10.	the walker that is right for you?	A12.	your walker?
\square_1 \square_2 \square_{98}	Yes No I don't know		Less than one day a week 1-2 days per week 3-4 days per week 5-6 days per week
A 11.	Is using your walker difficult or uncomfortable?	 5	Every day
□ ₁ □ ₂ □ ₉₈	Yes No (→Skip to A13) I don't know (→Skip to A13)	A13.	On the days that you do use your walker, how many times per day do you use it? times per day
A11a.	What is it about your walker that makes it difficult or uncomfortable to use? (Please check all that apply.)	A14.	How reliable is the walker you use now? Would you say
\square_1 \square_2 \square_3	It is difficult to support myself with my walker It is difficult to walk with my walker It is difficult to use the walker inside my home	□ ₁ □ ₂ □ ₃ □ ₄ □ ₉₈	Very reliable Somewhat reliable Somewhat unreliable Very unreliable I don't know
□ ₄ □ ₅ □ ₆	It is difficult to use the walker outside of my home It is difficult to put the walker in a car/taxi to go places It is difficult to get up from a sitting	A15.	In the past year, did you have any problems that made you stop using your walker or switch to a different walker instead?
□ ₇ □ ₉₆	position with my walker Walker is too heavy and cumbersome Other, please tell us what else:	□ ₁ □ ₂ □ ₉₈	Yes No (→Skip to SECTION B) I don't know (→Skip to SECTION B)
		1	

		B.	MEDICAL EXPENSES
	How many times did you have these kinds of problems in the past year?	B1.	In the past year, have you bought any accessories or parts
\square_1 \square_2 \square_3 \square_4	One time 2 or 3 times 4 or more times Don't recall the exact number of times		for your current walker with your own money, or paid for maintenance or repairs with your own money, because your
	Can you describe the kind of problem(s) that you had? (Please check all that apply.)		insurance did not cover it? (This does not include any copay or deductible amounts that are due from you.)
\square_1 \square_2 \square_3	The walker collapsed The wheels wouldn't turn or would stick The walker glides cracked or fell off The walker wouldn't easily fit through a	\square_1 \square_2 \square_{98}	Yes No (→Skip to SECTION C) I don't know (→Skip to SECTION C)
□ ₄ □ ₅	The walker wouldn't easily fit through a doorway It was difficult to move the walker around furniture	B2.	In the past year, what parts or service did you buy with your own money for your walker?
\square_6	It was difficult to move the walker in the bathroom		(Please check all that apply.)
\square_7	It was difficult to the walker lift up or down over roadside curbs	\square_1	Glide covers or skis
□8	It was difficult to move the walker up or down stairs	\square_2 \square_3	Hook (for example, to hang a bag) Bag or tote
□ ₉₆	Other, please specify:	$ \begin{array}{c c} \square_4\\ \square_5\\ \square_6\\ \square_7 \end{array} $	Basket Tray Repairs Routine maintenance
		□ ₉₆	Other (please specify)

33.	Thinking about everything you paid for with your own money in the past	C.	YOUR SUPPLIER
	year for your walker accessories, parts, maintenance or repairs not covered by insurance, how much did you spend on your current walker? (This does not include any copay or	C1.	Considering the walker you use now, did you have any problems finding an equipment supplier to get your walker from?
_	deductible amounts.)	\square_1	Yes
] 1	Less than \$100	\square_2	No (→Skip to C2)
] 2	\$100-\$500 \$500 or more	□98	I don't know (→Skip to C2)
⊒ 3 ⊒ 98	\$500 or more I don't know		
		C1a.	What kinds of problems did you have finding a walker supplier? (Please check all that apply.)
			I didn't know how to find a supplier Hard to find a supplier who
			covered my area
		\square_3	Supplier did not carry what I needed
		\square_4	Supplier could not deliver
			equipment when I needed it
		\square_5	Supplier did not accept Medicare
		96	Other, please specify:
		C2.	Considering the walker you use now, did you have a choice of suppliers?
			Yes, many
			Yes, a few
		\square_3	,
		□98	I don't know

C3.	Considering the walker you use now, when you asked your supplier	C5.	After you ordered your walker, how long did it take to arrive?
	questions, did you get <u>answers that</u> you could understand?		Next day Within a week
\square_1 \square_2	Yes, completely Yes, somewhat	\square_3 \square_4	1-2 weeks later More than 2 weeks later
\square_3 \square_4	No I did not ask any questions		I don't know
□ 98	I don't know	C6.	How did you get your walker?
C4.	Before deciding on the walker you use now, did your supplier tell you		Delivered to my home by my supplier
	as much as you wanted to know about the options for your walker?	\square_2	Mailed/shipped to my home by my supplier
□ ₁	Yes, completely	\square_3	I (or someone on my behalf) picked it up from my supplier
\square_2 \square_3	Yes, somewhat No	\square_5	I picked it up at a clinic or rehabilitation center
□ 98	I don't know	□ ₉₈	I don't know
C4a.	Before you decided on the walker that you use now, did your supplier tell you about all the equipment designs available to you, even those which the supplier did not have in stock?	□ ₉₆	Some other way, please specify:
□ ₁	Yes, all equipment designs were explained		
\square_2	No, the supplier only told me what he/she has in stock		
□ ₃ □ ₉₈	No, I already knew the equipment designs available to me I don't know		
		I	

	C7.	When you got the walker you	C8.	Cor	nsidering the walker you use
		use now, what kind of training		nov	v, how much time and energy did
		or help did the supplier give yo	u	it ta	ke to get the walker,
		or the person who takes care of	f	acc	essories, parts, maintenance and
		you? Did he/she (Please		rep	airs from your supplier?
		check all that apply.)		-	
			\square_1	No	time and energy
	\square_1	Give you written instructions on	\square_2	A lit	tle time and energy
		how to use the walker	\square_3	Son	ne time and energy
	\square_2	Show you how to use the walker	\square_4	A lo	t of time and energy
		safely	□ ₉₈		n't know
	\square_3	Show you how to take care of the			
		walker		C9.	Considering the walker you use
	\square_4	Let you practice how to use your			now, do you get your
		walker while they watched			accessories, parts, maintenance
	\square_5	Give you the manufacturer's			and repairs from more than one
		customer assistance toll-free			equipment supplier?
		telephone number			
	\square_6	I did not get any training or help		□₁	Yes
		from my supplier (→Skip to C8)		\square_2	No
	\square_{98}	I don't know (→Skip to C8)		□ ₉₈	I don't know
	00	, ,			
C7a.	As	a result of that training, how		C10.	Overall, how would you rate the
		nfortable do you feel using and			supplier that you use most?
		intaining your walker?			
		3,7		□₁	Poor
\square_1	Ver	y comfortable		\square_2	Fair
\square_2		nfortable		\square_3	Good
\square_3	Unc	comfortable		\square_4	Very good
\square_4		y uncomfortable		\square_5	Excellent
\square_5		comfort level has nothing to do with	ı .		
3	-	training that my supplier gave me		C11	. Would you recommend this
		area and a series of the serie			supplier to a friend who needed
					similar equipment and
					services?
				□₁	Yes
				\square_2	No

D.	RECENT EXPERIENCES	D3.	In the past six months, have you contacted your supplier to get
	Please answer the following questions		emergency service or advice
	about the supplier that you use most		about your walker?
	often if you use more than one supplier		Voc
	for your walker and accessories.		Yes
D1.	During the past six menths, how	\square_2	No (→Skip to D4)
υı.	<u>During the past six months</u> , how reliable was your supplier in making	\square_{98}	I don't know (→Skip to D4)
	deliveries or repairs?		
	denveries of repairs:	D3a	In general, how fast did the
\square_1	Very reliable	Doa.	supplier respond to your needs,
\square_2	Somewhat reliable		either by phone or in person?
\square_3	Not reliable at all		Would you say
□ 99	Does not apply		
		\square_1	Within 1 day
		\square_2	Within 2 days
D2.	In the past six months, have you	\square_3	Within 1 week
	contacted your supplier with a	\square_4	Longer than 1 week
	complaint or a problem?	\square_{98}	I don't know
	Voo	D3b.	Were you able to get the
\square_1	Yes		emergency service or advice
\square_2	No (→Skip to D5)		you needed?
□ ₉₈	I don't know (→Skip to D5)		
\square_4	Don't know how to contact my supplier	\square_1	Yes
	(→Skip to D5)	\square_2	No
		\square_{98}	I don't know
D2a.	When you contacted your supplier,	D4.	In the past six months, have you
	was your complaint or problem		needed to contact your supplier
	settled to your satisfaction?		after regular business hours?
\square_1	Yes	_	
\square_2	No	\square_1	Yes
\square_3	I am waiting for it to be settled	\square_2	No (→Skip to D5)
□ ₉₈	I don't know	\square_{98}	I don't know (→ Skip to D5)

D4a.	When you contacted your supplier after business hours, were you able to get the service or advice you	D5a.	Why did you change your walker supplier? (Please check all that apply.)
	needed?	\square_1	I moved
		\square_2	Supplier no longer accepted Medicare
\square_1	Yes	\square_3	Supplier went out of business
\square_2	No	\square_4	I was not happy with the quality of
\square_{98}	I don't know		service
		\square_5	I was not happy with equipment
		\square_6	I was not happy with the choices of
D5.	In the past six months, have you		equipment or service I could get
	changed your walker supplier?	\square_7	I was not happy with the assistance I
			got in handling the insurance
\square_1	Yes	\square_8	Supplier did not provide walker,
\square_2	No (→Skip to SECTION E on page 11)	J	accessories or repair service I needed
\square_{98}	I don't know (→Skip to SECTION E on	\square_9	I changed to an HMO and had to use a
	page 11)	_9	different supplier
		□ ₁₀	Supplier became ineligible to provide
		—10	the equipment under Medicare
		□oe	Other, please specify:
		— 30	,

E.	ABOUT YOU		
	Section E is about you, the person whose name is on the mailing label of this survey.	E5.	What is the highest grade or level of school that you have completed?
		\square_1	8 th grade or less
E1.	In general, how would you rate <u>your</u> overall health?	\square_2	Some high school but did not graduate
\square_1	Excellent	\square_3	High school graduate or GED
\square_2	Very good	\square_4	Some college or technical school
\square_3	Good	\square_5	College graduate
\square_4	Fair	\square_6	More than a 4-year college degree
\square_5	Poor		
E2.	Compared to 1 year ago, how would you rate your health now? Would you say	E6.	What was your household's annual income during 2006 before taxes?
		□ ₁	Less than \$5,000 (\$416 per
\square_1	Much better now		month)
\square_2	Somewhat better now	\square_2	Between \$5,001 and \$10,000
\square_3	About the same		(\$417–\$833 per month)
\square_4	Somewhat worse now	\square_3	Between \$10,001 and \$20,000
\square_5	Much worse now		(\$834–\$1,666 per month)
E3.	Do you currently live alone?	\square_4	Between \$20,001 and \$30,000 (\$1,667–2,500 per month)
_		\square_5	Between \$30,001 and \$50,000
\square_1	Yes (→ Skip to E5)		(\$2,501-\$4,167 per month)
\square_2	No	\square_6	Over \$50,000 (over \$4,168 per month)
E4.	Which best describes your living		
	situation <u>now</u> ? (Please check all that		
	apply.) I live	E7.	Are you of Hispanic or Latino origin or descent?
\square_1	With spouse/partner		
\square_2	With parent/step-parent	\Box_1	Yes, Hispanic or Latino
\square_3	With child/children	\square_2	No, not Hispanic or Latino
\square_4	With other relative(s)		
\square_5	With friend		
\square_6	With other person(s) not related to me		

E8.	How would you describe your race? (Please check all that apply.)
\square_1	American Indian or Alaskan Native
\square_2	Asian
\square_3	Black or African American
\square_4	Native Hawaiian or other Pacific
	Islander
\square_5	White or Caucasian
\square_{96}	Other, please specify:

F. OTHER INFORMATION

F1. Please check the correct statement:

- \square_1 I am the person to whom this survey was addressed (\rightarrow Skip to END)
- \square_2 I filled this survey out or helped fill it out for someone else

F2. How did you help the person with this survey?

- □₁ I wrote the answers that the person told me
- □₂ I answered the questions myself based on my knowledge of the person's condition
- \square_3 Both of the above

END

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