ATTACHMENT 3C

HELP PARTICIPANT POST QUESTIONNAIRE

Form Approved
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Lawndale Christian Health Center
Patient Centered Care Collaboration

Participant 1Post Questionnaire
Health Empowerment Lifestyle Program (HELP)

We would like to ask you some questions about your health, self-care activities, and diabetes knowledge. This information will be used to help us understand your service and informational needs, and to improve our health education program. Your answers are confidential. Do you have any questions before we begin?

Code name of participant: _____ Case Number __ __ __

Name of Interviewer (if needed): _____
HELP **program provided in:** ☐ Spanish ☐ English

Date of Completion: _____

A.	**The questions that follow ask about your self-care activities during the past 7 days. If you were sick during those 7 days, think back to the last 7 days that you were not sick. Please circle your answer.**								
Diet: On how many of the last 7 days did you …									
1.	Eat five or more servings of fruits and vegetables?	0	1	2	3	4	5	6	7
2.	Space carbohydrates (for example, bread, potatoes, pasta, or rice) evenly throughout the day?	0	1	2	3	4	5	6	7
3.	Eat high fat foods such as red meat or full-fat dairy products (for example, whole milk, sour cream, cheese or ice cream)?	0	1	2	3	4	5	6	7
4.	Add table salt to your meals?	0	1	2	3	4	5	6	7
5.	Avoid canned or pre-packaged food items?	0	1	2	3	4	5	6	7
Exercise: On how many of the last 7 days did you …									
6.	Participate in at least 30 minutes of physical activity? [Total minutes of continuous activity, including walking.]	0	1	2	3	4	5	6	7
7.	Participate in a specific exercise session (such as swimming, walking, biking) other than what you do around the house or as part of your work?	0	1	2	3	4	5	6	7
Blood Sugar Testing, Blood Pressure and Foot Care: On how many of the last 7 days did you …									

8.	Test your blood sugar?	0	1	2	3	4	5	6	7
9.	Test your blood sugar the number of times recommended by your health care provider?	0	1	2	3	4	5	6	7
10.	Test your blood pressure at home?	0	1	2	3	4	5	6	7
11.	Check your feet?	0	1	2	3	4	5	6	7
12.	Inspect the inside of your shoes?	0	1	2	3	4	5	6	7

A.	**The questions that follow ask about your self-care activities during the past 7 days. If you were sick during those 7 days, think back to the last 7 days that you were not sick. Please circle your answer. (continued)**								
Medication: On how many of the last 7 days did you …?									
13.	Take your recommended diabetes medication?	0	1	2	3	4	5	6	7
14.	Take your other recommended medications?	0	1	2	3	4	5	6	7
15.	Take at least one aspirin pill?	0	1	2	3	4	5	6	7
Smoking: On how many of the past 7 days did you…?									
16.	Smoke a cigarette-even one puff?	0	1	2	3	4	5	6	7
17**.**	How many cigarettes did you smoke on an average day? Number of cigarettes ___								

B.	**The next set of questions test your knowledge of DIABETES, and its causes and effects. Circle your answer T for True; F for False; DK for don't know.**	
1.	The choices I make can affect my blood sugar levels.	T F DK
2.	If I am diabetic, my children have a higher chance of being diabetic.	T F DK
3.	A person with diabetes should visit the eye doctor at least once a year.	T F DK
4.	Regular exercise will increase the need for insulin or other diabetic medication.	T F DK
5.	I can help another person with diabetes by sharing my medication with them.	T F DK
6.	A person with diabetes should drink plenty of water.	T F DK
7.	A person with diabetes should take extra care when cutting their toenails.	T F DK
8.	The way I prepare my food is as important as the food I eat.	T F DK
9.	Shaking and sweating are signs of high blood sugar.	T F DK
10.	Too low blood sugar should be treated immediately.	T F DK
11.	Tight elastic hose or socks are not bad for diabetics.	T F DK
12.	A diabetic diet consists mostly of special foods.	T F DK

C.	**The next set of questions test your knowledge of overweight/obesity, and its causes and effects. Circle your answer T for True; F for False; DK for don't know.**			
1.	Carrying extra weight affects blood pressure.	T	F	DK
2.	I can change my weight if I choose to.	T	F	DK
3.	Losing only 10% of extra weight is enough to improve my health.	T	F	DK
4.	The fat accumulated in the abdomen is different than the fat in the rest of the body.	T	F	DK
5.	Obesity is hereditary and there is nothing I can do to avoid being/becoming obese.	T	F	DK
6.	Obesity is a disease like diabetes or hypertension.	T	F	DK
7.	The portion sizes at restaurants have decreased over the last 30 years.	T	F	DK
8.	Cooking my own meals gives me control over what I eat.	T	F	DK
9.	Balance between diet and daily activity is an effective treatment for obesity	T	F	DK
10.	The ideal weight loss plan helps me lose 1 to 2 pounds per week.	T	F	DK

D.	**The next set of questions test your knowledge of high blood pressure, and its causes and effects. Circle your answer T for True; F for False; DK for don't know.**			
1.	High blood pressure may be associated with stroke.	T	F	DK
2.	High blood pressure is hereditary and there is nothing that can be done to reduce the chances of getting it.	T	F	DK
3.	People with high blood pressure need to reduce salt in their diet.	T	F	DK
4.	Cold and flu medicines may be dangerous for people with high blood pressure.	T	F	DK
5.	Exercise helps to reduce blood pressure.	T	F	DK
6.	A blood pressure of 140/110 is considered to be normal.	T	F	DK
7.	People who take fluid pills (diuretics) for high blood pressure may benefit from eating more bananas.	T	F	DK
8.	People with high blood pressure need to reduce animal fat in their diet.	T	F	DK
9.	Smoking does not affect the blood pressure.	T	F	DK
10.	People who are taking medication for high blood pressure should stop taking it if they feel well.	T	F	DK

E.	**The questions below are about HOW CONFIDENT you are in doing certain things to manage your diabetes or other health problems. Check the box in the column that best describes how you feel.**	**Ratings:** 1 = Not at all confident 2 = Somewhat confident 3 = Very confident		
How confident do you feel that you…..		**1**	**2**	**3**
1.	know how to read and understand food labels?			
2.	can follow your diet when you have to prepare or share food with other people who do not have diabetes or hypertension?			
3.	can choose the appropriate foods to eat when you are hungry (for example, snacks)?			
4.	can exercise 15 to 30 minutes, 4 to 5 times a week?			
5.	can do something to prevent your blood sugar level from dropping when you exercise?			
6.	know what to do when your blood sugar level goes higher or lower than it should be?			
7.	can judge when the changes in your illness mean you should visit the doctor?			
8.	can control your diabetes so that it does not interfere with the things you want to do?			
9.	know how to make healthy food choices?			
10.	know what to do to maintain your blood pressure			

under control?			

F.	**These questions are about HOW YOU FEEL and how things have been with you during the past month. For each question, please circle the one number that comes closest to the way you have been feeling.**	**Ratings:** 0 = Not at all 1 = Some of the time 2 = Most of the time		
How much in the past 4 weeks, has your health interfered with your...		**0**	**1**	**2**
1.	normal social activities with family, friends, neighbors, or groups?			
2.	hobbies or recreational activities?			
3.	household chores?			
4.	errands and shopping?			

G.	**These questions are about how you feel and how things have been with you during the past month. For each question, please circle the one number that comes closest to the way you have been feeling.**	**Ratings:** 0 = Not at all 1 = Some of the time 2 = Most of the time		
How much time during the past 4 weeks ...		**0**	**1**	**2**
1.	were you discouraged by your health problems?			
2.	were you fearful about your future health?			
3.	was your health a worry in your life?			
4.	were you frustrated by your health problems?			

H.	**To be completed by staff.**
1.	A1C Post: _____
2.	Weight _____ BMI _____
3.	Blood Pressure _____
4.	Waist Circumference _____

Lawndale Christian Health Center
Patient Centered Care Collaboration

Post-Intervention Questionnaire Health Empowerment Lifestyle Program (HELP)
Patient Centered Care Collaboration Project - Chicago

Please rate how strongly you agree or disagree with these statements about your expectations for the HELP program, by placing a check mark in the box.	4 = I strongly agree 3 = I somewhat agree 2 = I somewhat disagree 1 = I strongly disagree			
	4	3	2	1
1. The information I learned about my health condition was useful.				
2. I am putting what I learned from this program into practice.				
3. It is very important to take care of one's health condition.				
4. I can do something to improve my health condition.				
5. I see changes in myself already from being in this program.				
6. I'm ready to improve my health.				

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Please rate how strongly you agree or disagree with these statements about your preferences by placing a check mark in the box. 7. The best way for me to learn about my health is from a:	4 = I strongly agree 3 = I somewhat agree 2 = I somewhat disagree 1 = I strongly disagree			
	4	3	2	1
a. Brochure or pamphlet				
b. CD				
c. Mail				
d. Text message				
e. Facebook posting				
f. Webinar				
g. Wikipedia				
h. Direct mail				
i. Group classes				
j. One-on-one sessions at the clinic				
k. One-on-one sessions at home				

Please rate how strongly you agree or disagree with these statements about the HELP program by placing a check mark in the box. 8. What did you like about this program?	4 = I strongly agree 3 = I somewhat agree 2 = I somewhat disagree 1 = I strongly disagree

a.	Materials were easy to use.	4	3	2	1
b.	The information was easy to understand.				
c.	The materials were in my language.				
d.	The materials took my cultural practices into consideration.				
e.	The person who talked with me spoke in my language.				
f.	It was not time consuming.				
g.	The instructor/pharmacist was a good teacher.				
h.	Group classes.				
i.	One-on-one sessions at the clinic.				
j.	One-on-one sessions at my home.				

Please rate how strongly you agree or disagree with these statements about your satisfaction or dissatisfaction with the HELP program, by placing a check mark in the box.		4 = I strongly agree 3 = I somewhat agree 2 = I somewhat disagree 1 = I strongly disagree			
		4	3	2	1
9.	I am satisfied that what I learned helps me make good decisions to improve my health.				
10.	Overall, I am satisfied with the program.				