OMB 2900-XXXX
Estimated Burden 3 minutes
Expiration Date: XX/XX/XXXX

The Continuity of Medication Management (COMM) Patient Survey

1

2 **OMB 2900-0770**

Estimated Burden: 30 min.

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7 **The Paperwork Reduction Act of 1995:** This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this survey will average 30 minutes. This includes the time it will take to follow instructions, gather the necessary facts and respond to questions asked. Customer satisfaction is used to gauge customer perceptions of VA services as well as customer expectations and desires. The results of this telephone/mail survey will lead to improvements in the quality of service delivery by helping to achieve continuity of prescription medical management services. Participation in this survey is voluntary and failure to respond will have no impact on benefits to which you may be entitled.

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A. The following questions are about your current health insurance coverage.

1. Do you currently obtain health care service from VA?
01 Yes
02 No
98 Don't know
99 Prefer not to answer

2. Is any hospital care service you receive outside VA currently covered by Medicare?
01 Yes
02 No
98 Don't know
99 Prefer not to answer

3. Are any doctor's office visits you have outside VA currently covered by Medicare?
01 Yes
02 No
98 Don't know
99 Prefer not to answer

4. Do you have Medicare prescription service drug coverage, "Part D"?
01 Yes
02 No
98 Don't know
99 Prefer not to answer

5. Is any care service you receive outside VA currently covered by Medicaid?
01 Yes
02 No
98 Don't know
99 Prefer not to answer

6. Is any care you receive outside VA currently covered by the Department of Defense's TRICARE service or TRICARE for Life health care programs?
01 Yes
02 No
98 Don't know
99 Prefer not to answer

7. Is any care you receive currently covered by any other individual or group health plan that either you, or an employer, or someone else, such as a family member obtains for you?

01 Yes
02 No
98 Don't know
99 Prefer not to answer

8. Does this coverage include prescription drug coverage?

01 Yes
02 No
98 Don't know
99 Prefer not to answer

B. <u>The following questions are about where you go to obtain health care service.</u>

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

01 Yes
02 No
03 I usually go to more than one location or doctor for medical care or advice

2. Over the past six months, how many different places have you gone to obtain medical care service or medical advice outside VA?

01 0
02 1
03 2
04 3 or more

3. Which of the following best represents the location you usually go to receive medical care service or advice?

01 VA Medical Center
02 VA community based outpatient clinic or satellite clinic
03 Non-VA Clinic or health center
04 Non-VA Doctor's office or HMO
05 Non-VA Hospital Emergency Room
06 Non-VA Hospital Outpatient Department
07 Other (please specify)_____

4. From October through December 2011, did you use **any** medical or mental health care services that were **not** provided by or paid for by VA? Please include **ANY** service at all, such as a flu shot, a single prescription, a test of some sort, etc.

01 Yes
02 No
98 Don't know
99 Prefer not to answer

5. From October through December 2011, how many overnight stays, if any, did you have that were not provided by or paid for by the VA? ***A "stay" is a single trip into and out or admission into and discharge out of the hospital***. Your best guess is fine.

01 ENTER NUMBER _____
98 Don't know
99 Prefer not to answer

6. From October through December 2011, how many outpatient visits or trips, did you have that were not provided by or paid for by the VA? ***Please do not count dental, mental health, substance abuse visits or any visits paid for by VA.*** Your best guess is fine.

01 ENTER NUMBER _____
98 Don't know
99 Prefer not to answer

C. <u>The following questions are about where you get prescriptions filled.</u>

1. Is there one particular pharmacy that you usually go to if you need to fill a prescription?

01 Yes
02 No
98 Don't know
99 Prefer not to answer

2. How many different pharmacies do you usually go to when picking up prescriptions?

0	1	2	3	More than 3
☐	☐	☐	☐	☐

3. How likely are you to fill prescriptions at a VA pharmacy?

Very Unlikely	Unlikely	Neutral	Likely	Very Likely
☐	☐	☐	☐	☐

4. How likely are you to fill VA prescriptions at a mail-order pharmacy service?

Very Unlikely	Unlikely	Neutral	Likely	Very Likely
☐	☐	☐	☐	☐

D. <u>The following items are about your military service.</u>

1. How many terms of active duty military service have you served? [*A one-time discharge from the military after continuous service is one term of service. Each enlistment after discharge is a new term of service*]. Please do not include Reserve or National Guard training or drill periods unless "activated" at the time.

ENTER NUMBER _____
98 Don't know
99 Prefer not to answer

3. What year did each term of active duty military service start?

01 ENTER YEAR 1st_____ 2nd_____ 3rd_____ 4th_____
98 Don't know
99 Prefer not to answer

4. What year did each term of active duty military service end?

01 ENTER YEAR 1st_____ 2nd_____ 3rd_____ 4th_____
98 Don't kno
99 Prefer not to answer

5. During this term of military service were you ever in or exposed to combat?
01 Yes
02 No
98 Don't know
99 Prefer not to answer

E. The following items are about your health.

1. Would you say in general your health is Excellent, Very Good, Good, Fair or Poor?

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. How tall are you without shoes?

Enter height in feet and inches

|___| enter number of feet

and

|___|___| enter number of inches

98 Don't know
99 Prefer not to answer

3. How much weigh without clothes or shoes

|___|___|___| pounds

98 Don't know
99 Prefer not to answer

4. How often did you have a drink containing alcohol in the past year?

01 Never (0 points)*
02 Monthly or less (1 point)
03 Two to four times a month (2 points)
04 Two to three times per week (3 points)
05 Four or more times a week (4 points)

5. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

01 0 drinks (0 points)*
02 1 or 2 (0 points)
03 3 or 4 (1 point)
04 5 or 6 (2 points)
05 7 to 9 (3 points)
06 10 or more (4 points)

6. How often did you have six or more drinks on one occasion in the past year?

01 Never (0 points)
02 Less than monthly (1 point)
03 Monthly (2 points)
04 Weekly (3 points)
05 Daily or almost daily (4 points)

7. Have you smoked at least 100 cigarettes in your entire life?

01 Yes
02 No
98 Don't know
99 Prefer not to answer

8. Do you now smoke cigarettes every day, some days, or not at all?

01 Every day
02 Some days
03 Not at all
98 Don't know
99 Prefer not to answer

9. During the past 12 months, have you stopped smoking for more than one day because you were trying to quit smoking?

01 Yes
02 No
98 Don't know
99 Prefer not to answer

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Please answer the following questions about your mood over the past month.

10. During the past month, how much of the time were you a happy person?					
☐	☐	☐	☐	☐	☐
None of the time	*A little of the time*	*Some of the time*	*A good bit of the time*	*Most of the time*	*All of the time*
11. How much of the time, during the past month, have you felt calm and peaceful?					
☐	☐	☐	☐	☐	☐
None of the time	*A little of the time*	*Some of the time*	*A good bit of the time*	*Most of the time*	*All of the time*
12. How much of the time, during the past month, have you been a very nervous person?					
☐	☐	☐	☐	☐	☐
None of the time	*A little of the time*	*Some of the time*	*A good bit of the time*	*Most of the time*	*All of the time*
13. How much of the time, during the past month, have you felt downhearted and blue?					
☐	☐	☐	☐	☐	☐
None of the time	*A little of the time*	*Some of the time*	*A good bit of the time*	*Most of the time*	*All of the time*
14. How much of the time, during the past month, did you feel so down in the dumps that nothing could cheer you up?					
☐	☐	☐	☐	☐	☐
None of the time	*A little of the time*	*Some of the time*	*A good bit of the time*	*Most of the time*	*All of the time*

F. The following questions are about medications that you take.

F1. Do you have a current prescription for blood pressure medications?

Yes: Continue to F1 below.
No: Go to F2.

F1. In order for blood pressure medication to work best, people should take it according to the doctor's instructions. For one reason or another, people can't or don't always take all of their pills as prescribed. We want to know *how often* you have missed your blood pressure medication. When answering these questions, please think about all of your blood pressure medications. Please rate your agreement with the following statements.

Over the past 7 days…

	Never	Rarely	Sometimes	Often	Always
1. I took all does of my blood pressure medication.	☐	☐	☐	☐	☐
2. I missed or skipped at least one dose of my blood pressure medication.	☐	☐	☐	☐	☐
3. I was not able to take all of my blood pressure medication.	☐	☐	☐	☐	☐

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Situations come up that make it difficult for people to take their blood pressure medications as prescribed by their doctors. Below is a list of those situations. We want to know how much these situations contributed to you missing a dose of your blood pressure medication. Only one of these situations may apply to you, or many may apply to you.

In the past 7 days, how much did each situation contribute to you missing a dose of your blood pressure medication?

	Not at All				Very Much
1. I was busy	☐	☐	☐	☐	☐
2. I forgot	☐	☐	☐	☐	☐
3. The medication caused some side effects	☐	☐	☐	☐	☐
4. I worried about taking them for the rest of my life	☐	☐	☐	☐	☐
5. They cost a lot of money	☐	☐	☐	☐	☐
6. I came home late	☐	☐	☐	☐	☐
7. I did not have any symptoms of high blood pressure	☐	☐	☐	☐	☐
8. I was with friends or family members	☐	☐	☐	☐	☐
9. I was in a public place	☐	☐	☐	☐	☐
10. I was afraid of becoming dependent on them	☐	☐	☐	☐	☐
11. I was afraid they may affect my sexual performance	☐	☐	☐	☐	☐
12. The time to take them was between my meals	☐	☐	☐	☐	☐
13. I felt I did not need them	☐	☐	☐	☐	☐

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	Not at all				Very Much
14. I was traveling	☐	☐	☐	☐	☐
15. I was supposed to take them too many times a day	☐	☐	☐	☐	☐
16. I had other medications to take	☐	☐	☐	☐	☐
17. They make me need to urinate too often	☐	☐	☐	☐	☐
18. I ran out of medication	☐	☐	☐	☐	☐
19. I was afraid the medication would interact with other medication I take.	☐	☐	☐	☐	☐
20. My blood pressure was too low	☐	☐	☐	☐	☐
21. I was feeling too ill to take them	☐	☐	☐	☐	☐

Of the situations that contributed to you missing at least one dose of your blood pressure medication, we would like to know which are the most important or influential. Please rank the top three most important or influential reasons below. You may write the number that corresponds to the reason listed above (e.g., if running out of medication was the most important reason, then write “18” on the top line).

Most important or influential situation: _____

2nd Most important or influential situation: _____

3rd Most important or influential situation: _____

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F2. Do you have a current prescription for cholesterol medications?

Yes: Continue F2 below.
No: Go to F3.

F2. In order for cholesterol medication to work best, people should take it according to the doctor's instructions. For one reason or another, people can't or don't always take all of their pills as prescribed. We want to know *how often* you have missed your cholesterol medication. When answering these questions, please think about all of your cholesterol medications. Please rate your agreement with the following statements.

Over the past 7 days…

	Never	**Rarely**	**Sometimes**	**Often**	**Always**
1. I took all does of my cholesterol medication.	☐	☐	☐	☐	☐
2. I missed or skipped at least one dose of my cholesterol medication.	☐	☐	☐	☐	☐
3. I was not able to take all of my cholesterol medication.	☐	☐	☐	☐	☐

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Situations come up that make it difficult for people to take their cholesterol medications as prescribed by their doctors. Below is a list of those situations. We want to know how much these situations contributed to you missing a dose of your cholesterol medication. Only one of these situations may apply to you, or many may apply to you.

In the past 7 days, how much did each situation contribute to you missing a dose of your cholesterol medication?

	Not at All				Very Much
1. I was busy	☐	☐	☐	☐	☐
2. I forgot	☐	☐	☐	☐	☐
3. The medication caused some side effects	☐	☐	☐	☐	☐
4. I worried about taking them for the rest of my life	☐	☐	☐	☐	☐
5. They cost a lot of money	☐	☐	☐	☐	☐
6. I came home late	☐	☐	☐	☐	☐
7. I did not have any symptoms of high cholesterol	☐	☐	☐	☐	☐
8. I was with friends or family members	☐	☐	☐	☐	☐
9. I was in a public place	☐	☐	☐	☐	☐
10. I was afraid of becoming dependent on them	☐	☐	☐	☐	☐
11. I was afraid they may affect my sexual performance	☐	☐	☐	☐	☐
12. The time to take them was between my meals	☐	☐	☐	☐	☐
13. I felt I did not need them	☐	☐	☐	☐	☐

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	Not at all				Very Much
14. I was traveling	☐	☐	☐	☐	☐
15. I was supposed to take them too many times a day	☐	☐	☐	☐	☐
16. I had other medications to take	☐	☐	☐	☐	☐
17. They make me need to urinate too often	☐	☐	☐	☐	☐
18. I ran out of medication	☐	☐	☐	☐	☐
19. I was afraid the medication would interact with other medication I take.	☐	☐	☐	☐	☐
20. My cholesterol was low	☐	☐	☐	☐	☐
21. I was feeling too ill to take them	☐	☐	☐	☐	☐

Of the situations that contributed to you missing at least one dose of your cholesterol medication, we would like to know which are the most important or influential. Please rank the top three most important or influential reasons below. You may write the number that corresponds to the reason listed above (e.g., if running out of medication was the most important reason, then write “18” on the top line).

Most important or influential situation: _____

2nd Most important or influential situation: _____

3rd Most important or influential situation: _____

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F3. Do you have a current prescription for diabetes medications?

Yes: Continue F3 below.
No: Go to F4.

F3. In order for diabetes medication to work best, people should take it according to the doctor's instructions. For one reason or another, people can't or don't always take all of their pills as prescribed. We want to know *how often* you have missed your diabetes medication. When answering these questions, please think about all of your diabetes medications. Please rate your agreement with the following statements.

Over the past 7 days…

	Never	Rarely	Sometimes	Often	Always
1. I took all does of my diabetes medication.	☐	☐	☐	☐	☐
2. I missed or skipped at least one dose of my diabetes medication.	☐	☐	☐	☐	☐
3. I was not able to take all of my diabetes medication.	☐	☐	☐	☐	☐

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Situations come up that make it difficult for people to take their diabetes medications as prescribed by their doctors. Below is a list of those situations. We want to know how much these situations contributed to you missing a dose of your diabetes medication. Only one of these situations may apply to you, or many may apply to you.

In the past 7 days, how much did each situation contribute to you missing a dose of your diabetes medication?

	Not at All				Very Much
1. I was busy	☐	☐	☐	☐	☐
2. I forgot	☐	☐	☐	☐	☐
3. The medication caused some side effects	☐	☐	☐	☐	☐
4. I worried about taking them for the rest of my life	☐	☐	☐	☐	☐
5. They cost a lot of money	☐	☐	☐	☐	☐
6. I came home late	☐	☐	☐	☐	☐
7. I did not have any symptoms of high blood sugar	☐	☐	☐	☐	☐
8. I was with friends or family members	☐	☐	☐	☐	☐
9. I was in a public place	☐	☐	☐	☐	☐
10. I was afraid of becoming dependent on them	☐	☐	☐	☐	☐
11. I was afraid they may affect my sexual performance	☐	☐	☐	☐	☐
12. The time to take them was between my meals	☐	☐	☐	☐	☐
13. I felt I did not need them	☐	☐	☐	☐	☐

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	Not at all				Very Much
14. I was traveling	☐	☐	☐	☐	☐
15. I was supposed to take them too many times a day	☐	☐	☐	☐	☐
16. I had other medications to take	☐	☐	☐	☐	☐
17. They make me need to urinate too often	☐	☐	☐	☐	☐
18. I ran out of medication	☐	☐	☐	☐	☐
19. I was afraid the medication would interact with other medication I take.	☐	☐	☐	☐	☐
20. My blood sugar was too low	☐	☐	☐	☐	☐
21. I was feeling too ill to take them	☐	☐	☐	☐	☐

Of the situations that contributed to you missing at least one dose of your diabetes medication, we would like to know which are the most important or influential. Please rank the top three most important or influential reasons below. You may write the number that corresponds to the reason listed above (e.g., if running out of medication was the most important reason, then write “18” on the top line).

Most important or influential situation: _____

2nd Most important or influential situation: _____

3rd Most important or influential situation: _____

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F4. Do you have a current prescription for medications for chronic obstructive pulmonary disease (COPD)?

Yes: Continue F4 below.
No: Go to F5.

F4. In order for COPD medication to work best, people should take it according to the doctor's instructions. For one reason or another, people can't or don't always take all of their pills as prescribed. We want to know *how often* you have missed your COPD medication. When answering these questions, please think about all of your COPD medications. Please rate your agreement with the following statements.

Over the past 7 days…

	Never	**Rarely**	**Sometimes**	**Often**	**Always**
1. I took all does of my COPD medication.	☐	☐	☐	☐	☐
2. I missed or skipped at least one dose of my COPD medication.	☐	☐	☐	☐	☐
3. I was not able to take all of my COPD medication.	☐	☐	☐	☐	☐

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Situations come up that make it difficult for people to take their COPD medications as prescribed by their doctors. Below is a list of those situations. We want to know how much these situations contributed to you missing a dose of your COPD medication. Only one of these situations may apply to you, or many may apply to you.

In the past 7 days, how much did each situation contribute to you missing a dose of your COPD medication?

	Not at All				Very Much
1. I was busy	☐	☐	☐	☐	☐
2. I forgot	☐	☐	☐	☐	☐
3. The medication caused some side effects	☐	☐	☐	☐	☐
4. I worried about taking them for the rest of my life	☐	☐	☐	☐	☐
5. They cost a lot of money	☐	☐	☐	☐	☐
6. I came home late	☐	☐	☐	☐	☐
7. I did not have any symptoms of COPD	☐	☐	☐	☐	☐
8. I was with friends or family members	☐	☐	☐	☐	☐
9. I was in a public place	☐	☐	☐	☐	☐
10. I was afraid of becoming dependent on them	☐	☐	☐	☐	☐
11. I was afraid they may affect my sexual performance	☐	☐	☐	☐	☐
12. The time to take them was between my meals	☐	☐	☐	☐	☐
13. I felt I did not need them	☐	☐	☐	☐	☐

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	Not at all				Very Much
14. I was traveling	☐	☐	☐	☐	☐
15. I was supposed to take them too many times a day	☐	☐	☐	☐	☐
16. I had other medications to take	☐	☐	☐	☐	☐
17. They make me need to urinate too often	☐	☐	☐	☐	☐
18. I ran out of medication	☐	☐	☐	☐	☐
19. I was afraid the medication would interact with other medication I take.	☐	☐	☐	☐	☐
20. I was feeling too ill to take them	☐	☐	☐	☐	☐

Of the situations that contributed to you missing at least one dose of your COPD medication, we would like to know which are the most important or influential. Please rank the top three most important or influential reasons below. You may write the number that corresponds to the reason listed above (e.g., if running out of medication was the most important reason, then write “18” on the top line).

Most important or influential situation: _____

2nd Most important or influential situation: _____

3rd Most important or influential situation: _____

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F5. We would like to ask you about your personal views about your medicine(s). These are statements other people have made about their medicines. Please indicate the extent to which you agree or disagree with them. There are no right or wrong answers. We are interested in your personal views about your medicine(s). When answering these, please think about all of your medicine(s).

	Strongly Agree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Having to take medicines worries me.	☐	☐	☐	☐	☐
2. I sometimes worry about becoming too dependent on medicines.	☐	☐	☐	☐	☐
3. I sometimes worry about long-term effects of my medicines.	☐	☐	☐	☐	☐
4. My medicines disrupt my life	☐	☐	☐	☐	☐
5. My life will be impossible without my medicines.	☐	☐	☐	☐	☐
6. My health, at present, depends on my medicines.	☐	☐	☐	☐	☐
7. Without my medicines, I would be very ill.	☐	☐	☐	☐	☐
8. My health in the future will depend on my medicines.	☐	☐	☐	☐	☐
9. My medicines protect me from becoming worse.	☐	☐	☐	☐	☐
10. If doctors had more time with patients, they would prescribe fewer medicines.	☐	☐	☐	☐	☐
11. Doctors place too much trust in medicines.	☐	☐	☐	☐	☐
12. Doctors use too many medicines.	☐	☐	☐	☐	☐
13. Natural remedies are safer than medicines.	☐	☐	☐	☐	☐
14. Most medicines are addictive.	☐	☐	☐	☐	☐
15. Medicines do more harm than good.	☐	☐	☐	☐	☐
16. All medicines are poison.	☐	☐	☐	☐	☐
17. My medicines are a mystery to me.	☐	☐	☐	☐	☐
18. People who take medicines should stop their treatment for a while every now and again.	☐	☐	☐	☐	☐

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G. **<u>The following questions are about your primary care doctor.</u>** Please rate how much you agree with the following statements about your ***<u>primary care doctor</u>***.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. My doctor will do whatever it takes to get me all the care I need.	☐	☐	☐	☐	☐
2. Sometimes my doctor cares more about what is convenient for (him/her) than about my medical needs.	☐	☐	☐	☐	☐
3. My doctor's medical skills are not as good as they should be.	☐	☐	☐	☐	☐
4. My doctor is extremely thorough and careful.	☐	☐	☐	☐	☐
5. I completely trust my doctor's decisions about which medical treatments are best for me.	☐	☐	☐	☐	☐
6. My doctor is totally honest in telling me about all of the different treatment options available for my condition.	☐	☐	☐	☐	☐
7. My doctor only thinks about what is best for me.	☐	☐	☐	☐	☐
8. Sometimes my doctor does not pay full attention to what I am trying to tell (him/her).	☐	☐	☐	☐	☐
9. I have no worries about putting my life in my doctor's hands.	☐	☐	☐	☐	☐
10. All in all, I have complete trust in my doctor.	☐	☐	☐	☐	☐

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H. <u>Finally, we have a few questions to help us describe the people who completed this survey.</u>

1. Are you of Hispanic and Latino origin?

☐ NO ☐ YES

2. Looking at the options below, which best describes your race? Please select only one option.

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

3. What is highest degree or level of school completed? Please select only one option.

☐ No Schooling completed

☐ Nursery school to 8th grade

☐ 9th-12th Grade, no Diploma

☐ High School Graduate (High School Diploma or the Equivalent)

☐ Vocational/Technical/Business/Trade School Certificate or Diploma (Beyond the High School Level)

☐ Some College, but no Degree

☐ Associate Degree

☐ Bachelor's Degree

☐ Master's, Professional or Doctorate Degree

4. How would you best characterize your current employment status?

01 Employed Fulltime
02 Self-employed fulltime
03 Employed part-time
04 Self employed part-time
05 Unemployed, looking for work, or laid off
06 Currently not employed – either retired, a homemaker, student, etc.
98 Don't Know
99 Prefer not to answer

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5. Please be assured that your response to this question is private, and your answer will not affect your benefits. Your best guess or estimate is fine. Could you please indicate which of the following best describes your 2011 total annual household income from *all sources*.

01 UNDER $11,00
02 $11,000-$15,999
03 $16,000-$20,999
04 $21,000-$25,999
05 $26,000-$30,999
06 $31,000-$35,999
07 $36,000-$40-999
08 $41,000-$45,999
09 $46,000-$50,999
10 $51,000-$55,999
11 $56,000 or over
13 Don't know
14 Prefer not to answer

THANK YOU FOR TAKING TIME TO COMPLETE THIS SURVEY

VA Form 10-0526
November 2011