Attachment E1: Pre-discharge patient questionnaire

Form Approved
OMB No: 0920-XXXX
Exp. Date: xx-xx-xxxx

Public Reporting burden of this collection of information is estimated at 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NW, MS D-74, Atlanta, GA 30333; Attn: PRA (0920-XXXX).

Thank you for participating in this important study. We are asking older adult patients (those age 65 or older) about their physical and emotional function, and pain as a way to understand how to improve care at UCSF. Your responses to this questionnaire will be kept confidential and will not be shared outside our research and quality-improvement team.

This survey should take no more than 10 minutes to complete.

If you have questions, please call Dr. Andrew Auerbach (415-502-1414) or email (TBD)

I would like to ask you some questions about (your/his/her) health over the month or so before you came to the hospital.

1. In general, would you say your health **in the month before you came to the hospital** was: SF12_HEALTH _INTAKE

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

The following questions are about activities you might do during a typical day. Did your health limit you in these activities **in the month before you came to the hospital**? If so, how much?

	Yes, limited a lot	**Yes, limited a little**	**Not limited at all**
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf SF12_ MODERATE_INT	☐ 1	☐ 2	☐ 3
3. Climbing several flights of stairs SF12_STAIRS_INT	☐ 1	☐ 2	☐ 3

In the month or so before you came to the hospital, how often did you have any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4. **Accomplish less** than you would like SF12_PHYS_ACCOMPLISH_LESS_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. **Were limited** in the kind of work or other activities SF12_PHYS_LIMIT_WORK_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the month or so before you came to the hospital, how often did you have any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6. **Accomplish less** than you would like SF12_EMOT_ACCOMPLISH_LESS_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Did work or activities **less carefully** than usual SF_12_EMOT_CAREFULLY_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

8. In the month or so before you came to the hospital, how much did pain interfere with your normal work (including both work outside the home and housework)? SF12_PAIN_INTERFERE_INT

Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

These questions are about how you feel and how things have been with you during the month or so before you came to the hospital. For each question, please give the one answer that comes closest to the way you have been feeling. How often during the month or so before you were admitted to the hospital:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful SF12_CALM_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. Did you have a lot of energy SF12_ENERGY_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. Have you felt downhearted and depressed SF12_DEPRESSED_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

12. In the month or so before you came to the hospital, how often did your physical health or emotional problem(s) interfere with your social activities (like visiting with friends, relatives, etc.)? SF12_SOCIAL_INT

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Thinking about the month or so before you came to the hospital:

	Yes	**No**	**DK/Refused/NA**

13. Did you use any equipment to walk, such as a cane, crutches, or walker? ADL_CANE_INT ☐ 1 ☐ 2 ☐ 99
14. Did you need help washing or bathing yourself? ADL_BATHE_INT ☐ 1 ☐ 2 ☐ 99
15. Did you need help dressing and undressing? ADL_DRESS_INT ☐ 1 ☐ 2 ☐ 99
16. Did you need help eating, including cutting food? ADL_EAT_INT ☐ 1 ☐ 2 ☐ 99
17. Did you need help getting in and out the bed or the chair? ADL_BED_INT ☐ 1 ☐ 2 ☐ 99

Thinking about the <u>month or so before you came to the hospital</u>, were you able to do the following things <u>without help</u> or <u>difficulty</u>?

	Yes	**No**	**Cannot do**	**Do not do**
18. Shop for groceries or clothes? IADL_SHOP_INT	☐ 1	☐ 2	☐ 3	☐ 4
19. Prepare, serve and provide meals for yourself? IADL_COOK_INT	☐ 1	☐ 2	☐ 3	☐ 4
20. Do light housework, such as dusting or doing dishes? IADL_HOUSEWORK_INT	☐ 1	☐ 2	☐ 3	☐ 4
21. Get to places out of walking distance by using public transportation or driving a car? IADL_CAR_INT	☐ 1	☐ 2	☐ 3	☐ 4
22. Take pills or medicines in the correct amounts and at the correct times? IADL_MEDS_INT	☐ 1	☐ 2	☐ 3	☐ 4

23. (IF ANSWERS ‘Need No Help’ or NO to 14-23)→

If you needed help with basic personal care activities like eating or dressing, do you have relatives or friends (besides your spouse/partner) who would be willing and able to help you over a long period of time (3 months or more)? **Y** ☐ 1 **N** ☐ 0 **Don’t Know** ☐ 1 **REFUSE** ☐ 0 **NA** ☐ 1

24. In the past 12 months, how many times have you fallen?	**O** ☐ 1	**1** ☐ 0	**2** ☐ 1	**3** ☐ 0	**4+** ☐ 1
25. How many of these falls caused an injury? By injury, we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor?	**0** ☐ 1	**1** ☐ 0	**2** ☐ 1	**3** ☐ 0	**4+** ☐ 1

26. In the past 12 months, has anyone talked to you about your risk of falling? (Select all that apply)

Doctor	Nurse Practitioner, or Physician assistant	Pharmacist	Nurse	Another Healthcare Provider	Family Member or Caregiver	Other	No one has talked to me
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

27. In the past 12 months, has anyone talked to you about medicines, such as pain medicines, that might make you fall? (Select all that apply)

Doctor	Nurse Practitioner, or Physician assistant	Pharmacist	Nurse	Another Healthcare Provider	Family Member or Caregiver	Other	No one has talked to me
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

28. On a scale from 1 to 5, where 1 means “strongly disagree” and 5 means “strongly agree”, indicate your agreement with the following statement: “Older people fall and there is nothing that can be done about it.”

Strongly disagree				Strongly agree
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

29. On a scale from 1 to 5, where 1 means "not at all important" and 5 means "most important," how important is falling compared with your other health concerns?

Not at all important				Most Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

30. On a scale from 1 to 5, where 1 means "not at all likely" and 5 means "most likely," how likely are you to fall?

Not at all likely				Very likely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

31. On a scale from 1 to 5, where 1 means "not at all likely" and 5 means "most likely," if you fell, how likely would you be to get any type of injury? By injury that means anything from bruises and cuts to broken bones or concussion.?

Not at all likely				Very likely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

32. **In the 30 days before before you came to the hospital**, how many days per week did have you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?

Zero or less than 1day/wk ☐ 1	1day/wk ☐ 2	2days/wk ☐ 3	3 or more days per week ☐ 4	Don't know ☐ 5	Prefer not to answer ☐ 5

33. Considering all types of alcoholic beverages, how many times during the month or so before you came to the hospital did you have 5 or more drinks on an occasion?

None ☐ 1	One time ☐ 2	Two times ☐ 3	3 or more times ☐ 4	Don't know ☐ 5	Prefer not to answer ☐ 5

Questions about Pain and how you take care of your Pain

34. Do you have one or more conditions that cause you pain?

YES ☐ 1 **NO** ☐ 2

IF NO → SKIP TO 43/END, BELOW

35. Over the last 6 months, on about how many days have you had pain? NATIONALQFCHRONIC PAIN SCREENER QUESTION
- I have had pain, but on less than half of the days
- I have had pain on more than half of the days but not every day
- I have had every day, but not all the time
- I have had pain all day, every day, without break

36. What number best describes your pain on average in the past week? (from 0=no pain to 10=pain as bad as you can imagine)

0 ☐ 0 **1** ☐ 1 **2** ☐ 2 **3** ☐ 3 **4** ☐ 4 **5** ☐ 5 **6** ☐ 6 **7** ☐ 7 **8** ☐ 8 **9** ☐ 9 **10** ☐ 10

37. What number best describes how, during the past week, pain has interfered with your enjoyment of life? (from 0=does not interfere to 10=completely interferes)

0 ☐ 0 **1** ☐ 1 **2** ☐ 2 **3** ☐ 3 **4** ☐ 4 **5** ☐ 5 **6** ☐ 6 **7** ☐ 7 **8** ☐ 8 **9** ☐ 9 **10** ☐ 10

38. What number best describes how, during the past week, pain has interfered with your general activity? (from 0=does not interfere to 10=completely interferes)

0 ☐ 0 **1** ☐ 1 **2** ☐ 2 **3** ☐ 3 **4** ☐ 4 **5** ☐ 5 **6** ☐ 6 **7** ☐ 7 **8** ☐ 8 **9** ☐ 9 **10** ☐ 10

39. Do you do any of the following for your pain (select all that apply)

Yoga, stretching, or range of motion	Massage or chiropractic	Acupuncture or cupping	Meditation or counseling	Prayer or spiritual practices	Marijuana in any form	Other

exercises						
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

40. Do you regularly take medications for your pain?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2

IF NO, SKIP TO 43/END

41. In the past 12 months, which, if any, of these pain relievers have you used? (Select all that apply)

- Ibuprofen (e.g. Motrin, Advil) or acetaminophen (e.g. Tylenol) or naproxen (e.g. Aleve)
- Oxycodone (e.g. Roxycodone, Percocet) or hydrocodone (e.g. Lortab or Vicodin), or hydromorphone (e.g. Dilaudid)
- Long acting morphine (e.g. MS Contin), fentanyl patch, or Methadone
- Gabapentin (e.g. Neurontin), or nortriptyline, or baclofen
- Marijuana in any form (prescription or recreational)

42. What is the longest you have taken any one of these pain medications in the last 12 months?

- Less than a week
- More than a week less than a month
- More than a month

43. Have you ever tried to decrease your prescribed pain medication on your own?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
44. Has your doctor instructed you on how to reduce your pain medication use?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
45. Do you ever experience unwanted side effects from your pain medications that might interfere with your daily activities?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
46. Do you feel that your pain medicines cause side effects (e.g. dizziness, drowsiness, light headedness) that might make you fall?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
47. Do you ever need early refills for your pain medication? Prescription Opioid Misuse Index	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
48. Have you ever gotten enough pain medication to bring your pain to a tolerable level (as prescribed)? Prescription Opioid Misuse Index	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
49. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain? Prescription Opioid Misuse Index	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2

50. Do you ever take prescription pain relievers in any way that a doctor did not direct you to use them (e.g. taken medications from a friend or relative, or purchased them illegally)?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2

51. If there is anything else you would like to share with us about how your recovery is going, please feel free to type your thoughts below:

    TYPE HERE -→

END Comments:

Thank you for participating in this study – we are thankful for your help in making care at UCSF better.

As a reminder - will be contacting you again in two weeks to see how things are going. Please let us know if you would like to update your email address or phone numbers, and which you would prefer us to use to contact you

- No email change.
- New Email
- No phone number change
- New phone number

Which do you prefer we use for future surveys?

- Email contact.
- SMS with link to survey
- Phone call from study coordinator.