Attachment E2: Post-Discharge Patient Questionnaire (Days 14/30/60)

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

Thank you for participating in this important study. As you remember, we are asking patients about their physical function, emotional function, and pain as a way to understand how to improve care. Your responses to this questionnaire will be kept confidential and will not be shared outside our research and quality-improvement team.

This survey asks about events (Since you left the hospital/in the last 30 days) and should take no more than 10 minutes to complete.

If you have questions please call Dr. Andrew Auerbach (4155021414) or email (TBD)

1. Have you seen your primary provider (Doctor, Nurse Practitioner, or physician Assistant) in clinic since you left the hospital/in the last month PCPVISIT_1MO — **Y** ☐ 1 **N** ☐ 0 **DK** ☐ 99

2. 3. **If yes,** "Was this a planned clinic visit or did you need to see your primary doctor because of a problem?" PLANPCPVIS_1MO

   Planned ☐ 1 Problem ☐ 0

4. Have you had any hospitalizations at any hospitals **including** UCSF since you left the hospital/in the last month?" HOSP_1MO — **Y** ☐ 1 **N** ☐ 0 **DK** ☐ 99
5. "Have you had any emergency room visits since you left the hospital/in the last month?" ER_VISITS_1MO — **Y** ☐ 1 **N** ☐ 0 **DK** ☐ 99

Have you had any of the following happen in the week since you left the hospital/in the last month?

6. A heart attack MI_1MO — **Y** ☐ 1 **N** ☐ 0
7. A stroke, or TIA (these are sometimes called "mini-strokes") CVA_TIA_1MO — **Y** ☐ 1 **N** ☐ 0
8. A blood clot in your leg or calf DVT_1MO — **Y** ☐ 1 **N** ☐ 0
9. A blood clot in your lung PE_1MO — **Y** ☐ 1 **N** ☐ 0
10. Urinary tract infection UTI_1MO — **Y** ☐ 1 **N** ☐ 0
11. Pneumonia PNA_1MO — **Y** ☐ 1 **N** ☐ 0

12. A fall fall_1MO Y ☐ 1 N ☐ 0

IF NO → SKIP TO 17 below

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13. How many falls have you had since you left the hospital/In the last month	None ☐ 1	One ☐ 2	Two ☐ 3	Three ☐ 4	More than 3 ☐ 5
14. How many of these falls led to injury that caused you to limit your activity for at least a day?	None ☐ 1	One ☐ 2	Two ☐ 3	Three ☐ 4	More than 3 ☐ 5
15. How many of these falls caused you to see a doctor, nurse practitioner, or Physicians assistant in a clinic?	None ☐ 1	One ☐ 2	Two ☐ 3	Three ☐ 4	More than 3 ☐ 5
16. How many of these falls caused you to seek care in an emergency room?	None ☐ 1	One ☐ 2	Two ☐ 3	Three ☐ 4	More than 3 ☐ 5
17. How many of these falls resulted in hospital stays?	None ☐ 1	One ☐ 2	Two ☐ 3	Three ☐ 4	More than 3 ☐ 5

I would like to ask you some questions about how things have happened since you left the hospital/In the last month.

18. In general, would you say your health **since you left the hospital/In the last month** has been:

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 since you left the hospital/In the last month?** If so, how much?

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

Since you left the hospital/In the last month, 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
21. **Accomplish less** than you would like SF12_PHYS_ACCOMPLISH_LESS_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
22. **Were limited** in the kind of work or other activities SF12_PHYS_LIMIT_WORK_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Since you left the hospital/In the last month, 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
23. **Accomplish less** than you would like SF12_EMOT_ACCOMPLISH_LESS_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
24. Did work or activities **less carefully** than usual SF_12_EMOT_CAREFULLY_INT	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

25. **Since you left the hospital/In the last month**, 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 time **since you left the hospital/In the last month**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during **since you left the hospital/In the last month**.

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

29. **Since you left the hospital/In the last month**, how often did your <u>physical health or emotional problem(s)</u> 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 time since you left the hospital/In the last month:

	Yes	No	DK/Refused/NA
30. Did you use any equipment to walk such as a cane, crutches, or walker? ADL_CANE_INT	☐ 1	☐ 2	☐ 99
31. Did you need help washing or bathing yourself? ADL_BATHE_INT	☐ 1	☐ 2	☐ 99
32. Did you need help dressing and undressing? ADL_DRESS_INT	☐ 1	☐ 2	☐ 99
33. Did you need help eating, including cutting food? ADL_EAT_INT	☐ 1	☐ 2	☐ 99
34. Did you need help getting in and out the bed or the chair? ADL_BED_INT	☐ 1	☐ 2	☐ 99

Thinking about the time since you left the hospital/In the last month, were you able to do the following things <u>without help</u> or <u>difficulty</u>?

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

40. **(IF ANSWERS 'Need No Help' or NO to 30-39)→**

If you needed help with basic personal care activities like eating or dressing, do you have relatives or friends (besides your husband/wife/partner) who would be willing and able to help you over a long period of time?

Y ☐ 1 **N** ☐ 0 **Don't Know** ☐ 1 **REFUSE** ☐ 0 **NA** ☐ 1

41. During your stay in the hospital, who talked to you about your risk of falling? (Only asked during first post discharge at 14 days) check 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

42. During your stay in the hospital, who talked to you about medications that might make you fall? (Only asked during first post discharge at 14 days) check 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

43. During your stay in the hospital (or as part of you discharge instructions), did a healthcare provider recommend any of the following to help your strength and balance or to reduce risk of falling? (Only asked during first post discharge at 14 days) check all that apply

Physical therapy	Occupational therapy	Exercise programs (or yoga or Tai Chi)	Visiting an Eye doctor	Visiting a Foot doctor	Medication changes	None
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

44. Since you left the hospital, who 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

45. Since you left the hospital, has any health provider recommended any of the following to help your strength, balance, or to reduce risk of falling? (Check all that apply)

Physical therapy	Occupational therapy	Exercise programs (or yoga or Tai Chi)	Visiting an Eye doctor	Visiting a Foot doctor	Medication changes	None
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

46. If physical therapy = yes either questions then ask "In the last two weeks, how many times have you attended physical therapy sessions to help your strength, balance, or to reduce risk of falling?

None ☐ 0	One ☐ 1	Two ☐ 2	Three ☐	More than 3 ☐

47. If occupation therapy = yes either questions then ask "In the last two weeks, how many times have you attended occupational therapy sessions to help your strength, balance, or to reduce risk of falling?

None ☐ 0	One ☐ 1	Two ☐ 2	Three ☐	More than 3 ☐

48. If exercise program = yes either questions then ask "In the last two weeks, how many times have you attended an exercise program to help your strength, balance, or to reduce risk of falling?

None ☐ 0	One ☐ 1	Two ☐ 2	Three ☐	More than 3 ☐

49. If eye doctor = yes on either question, ask "In the last two weeks, have you visited an eye doctor to evaluate your vision or reduce your risk of falling?

Yes ☐ 0	No ☐ 1	I plan to ☐ 2		

50. If foot doctor = yes on either question, ask "In the last two weeks, have you visited a foot doctor to evaluate your feet or reduce your risk of falling?

Yes ☐ 0	No ☐ 1	I plan to ☐ 2		

51. During the past 30 days, on average, how many days per week have you had 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

52. Considering all types of alcoholic beverages, how many times during the last three months did you have 5 or more drinks on an occasion?

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

Questions about Pain and how you take care of your Pain

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

YES ☐ 1 **NO** ☐ 2

IF NO → SKIP TO END

54. In the last 2 weeks, approximately 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 pain every day, but not all the time
- I have had pain all day, every day, without break

55. 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

56. 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

57. 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

57. Do you do any of the following for your pain? (Select all that apply)

Yoga, stretching, or range of motion exercises	Massage or chiropractic	Acupuncture or cupping	Meditation or counseling	Prayer or spiritual practices	Marijuana in any form	other
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	6

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

IF NO, SKIP TO XX/END

59. 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)

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

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

61. Have you tried to decrease your prescribed pain medication on your own?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
62. Has your doctor instructed you on how to reduce your pain medication use?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
63.Do you ever experience unwanted side effects from your pain medications that might interfere with your daily activities?	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
64. 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
65. Do you ever need early refills for your pain medication? Prescription Opioid Misuse Index	**Y** ☐ 1	**N** ☐ 0	**REFUSE** ☐ 2
66. 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
67. 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
68. 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

69. 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.

IF this is day 14 or 30 →

As a reminder - will be contacting you again in a month 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.