The Patient's View On Health Care

Statement Of Confidentiality

All information that would permit identification of you will be regarded as strictly confidential, will be used only for the purposes of operating and evaluating the study, and will not be disclosed or released for any other purposes without your prior consent, except as required by law.

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Instructions For Filling Out Questionnaire

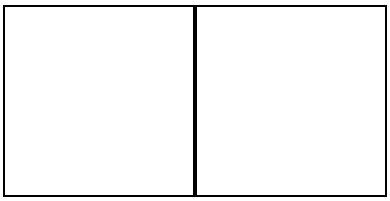
You have been randomly selected for this survey. It is important to us that every person selected to participate do so in order to obtain accurate results. Your responses will be treated as confidential but will be combined with those of other participants to help improve your health care.

1. Please answer every question (unless you are asked to skip questions because they don't apply to you). Some questions may look like others, but each one is different.

2. Answer the questions by circling the appropriate number or by filling in the answer as requested.

   Example: Have you ever been to the moon?

   (Mark One Number)



3. If you are unsure about how to answer a question, please give the best answer you can.

In order to obtain accurate information, we need to ask you several questions. The questions ask for your opinions about the health care you receive from your medical group and about your health plan. By **medical group** we mean the place you go for your regular health care. By **health plan** we mean the health insurance plan provided by your employer or that you have purchased yourself. Please keep this distinction in mind when answering these questions.

Thank You For Taking Part In This Study

1. What is the name of your medical group, that is, the place you go to for your regular health care (e.g., Mullikin Medical Center)?

_____

2. During the **last 4 weeks**, how many times did you see a health care provider (person who gave you health care) at your medical group? **(Mark One)**

None 1

1 time 2

2 times 3

3 to 5 times 4

6 or more times 5

3. How **long** has it been since you last visited a health care provider in your medical group? **(Mark One)**

Less than 1 month 1

1 to 3 months 2

4 to 6 months 3

7 to 12 months 4

More than 12 months 5

4. Once you arrive for a scheduled appointment with your primary care provider, how long do you **usually** have to wait (including the reception room and the exam room) to see her or him? **(Mark One)**

Less than 10 minutes 1

10 to 15 minutes 2

16 to 30 minutes 3

31 to 45 minutes 4

46 to 60 minutes 5

More than 1 hour, but less than 2 hours 6

2 hours or more 7

Don’t know or not applicable 8

5. While you are waiting to see your primary care provider for a scheduled appointment, does the office staff keep you informed if there is a delay? **(Mark One)**

- Always 1
- Most of the time 2
- About half the time 3
- Sometimes 4
- Rarely or never 5
- Don't know or not applicable 6

6. When you go for routine scheduled health care (such as a physical or regular checkup), how often do you see the **same** doctor? **(Mark One)**

- Always 1
- Most of the time 2
- About half the time 3
- Sometimes 4
- Rarely or never 5

7. How long do you **usually** have to wait between the time you make an appointment for care and the day you actually see the provider for routine scheduled care (such as a physical or regular checkup)? **(Mark One)**

- Same day 1
- 1-3 days 2
- 4-7 days 3
- 8-14 days 4
- 15-30 days 5
- 31 days to 2 months 6
- More than 2 months 7

8. How long do you **usually** have to wait to see your primary care provider if you need sick care (like treatment for a sore throat or flu)? **(Mark One)**

- Can come to the office or clinic the same day 1
- 1 day 2
- 2 to 3 days 3
- 4 to 5 days 4
- 6 to 7 days 5
- More than 7 days 6
- Don't know or not applicable 7

9. How long do you **usually** have to wait to see a health care provider once you arrive for urgent care (e.g., for a broken arm or shortness of breath)? **(Mark One)**

- No wait at all 1
- Less than 15 minutes..... 2
- 15-30 minutes 3
- 31-60 minutes 4
- 1-2 hours..... 5
- More than 2 hours..... 6
- Don't know or not applicable..... 7

Your Health Care

The questions below refer to the health services you have received from your medical group. Thinking about the place you go for your regular health care (that is, your medical group), how do you rate the items listed below? For each question, please grade the care you receive from Very Poor (F) to The Best (A+) by circling one number on each line. If something does not apply to you, mark "Does Not Apply to Me."

10. How do you rate… **(Mark One Number on Each Line)**

		Very Poor (F)	Poor (D)	Fair (C)	Good (B)	Very Good (B+)	Excellent (A)	The Best (A+)	Does Not Apply to Me
a.	Convenience of the location where you get care	1	2	3	4	5	6	7	0
b.	Quality of treatment you receive	1	2	3	4	5	6	7	0
c.	Medical staff listening to what you say	1	2	3	4	5	6	7	0
d.	Arrangements for parking	1	2	3	4	5	6	7	0
e.	Answers to your questions	1	2	3	4	5	6	7	0
f.	Medical staff's effort to make your visit comfortable and pleasant	1	2	3	4	5	6	7	0
g.	Hours that the place you get care is open	1	2	3	4	5	6	7	0
h.	Ease of getting prescriptions refilled	1	2	3	4	5	6	7	0
i.	Quality of examinations you receive	1	2	3	4	5	6	7	0
j.	Ease of reaching the medical staff by phone when you have problems	1	2	3	4	5	6	7	0

10. How do you rate… **(Mark One Number on Each Line)**

		Very Poor (F)	Poor (D)	Fair (C)	Good (B)	Very Good (B+)	Excellent (A)	The Best (A+)	Does Not Apply to Me
k.	Ease of speaking with your primary care provider by phone	1	2	3	4	5	6	7	0
l.	Thoroughness and accuracy of diagnoses	1	2	3	4	5	6	7	0
m.	Friendliness and courtesy shown to you by the receptionist and other front desk staff	1	2	3	4	5	6	7	0
n.	Ease of seeing the primary care provider of your choice	1	2	3	4	5	6	7	0
o.	Explanations about prescribed medicines	1	2	3	4	5	6	7	0
p.	Access to a specialist when needed	1	2	3	4	5	6	7	0
q.	Explanations of medical procedures and test results	1	2	3	4	5	6	7	0
r.	How long you wait in the reception area	1	2	3	4	5	6	7	0
s.	Amount of time spent waiting in the exam room before seeing your primary care provider	1	2	3	4	5	6	7	0
t.	Friendliness and courtesy shown to you by your primary care provider	1	2	3	4	5	6	7	0
u.	Ease of getting hospital care when needed	1	2	3	4	5	6	7	0
v.	Advice you get about ways to avoid illness and stay healthy	1	2	3	4	5	6	7	0
w.	Ease of getting medical care in an emergency	1	2	3	4	5	6	7	0
x.	Friendliness and courtesy shown to you by nurses and other medical staff	1	2	3	4	5	6	7	0

11. For each of the following, could the health care you now receive be: i**mproved a lot**, **some**, **not much**, or is **no improvement** needed? **(Mark One Number on Each Line)**

	A Lot Of Improvement Needed	Some Improvement Needed	Not Much Improvement Needed	No Improvement Needed	Does Not Apply to Me
a. Ability to choose your primary care provider	1	2	3	4	0
b. Ability to obtain the treatment you need	1	2	3	4	0
c. Communication between the medical staff (doctors, nurses, etc.) who treat you	1	2	3	4	0
d. Availability of services tailored to your needs	1	2	3	4	0
e. Reminders or encouragement to use timely preventative services (such as blood pressure checks, mammograms, etc.)	1	2	3	4	0
f. Amount of time you wait for health care services to be approved	1	2	3	4	0
g. Amount of time you wait before being able to get an appointment with a specialist when you need one	1	2	3	4	0

12. How do you rate… **(Mark One Number on Each Line)**

	Very Poor (F)	Poor (D)	Fair (C)	Good (B)	Very Good (B+)	Excellent (A)	The Best (A+)	Does Not Apply to Me
a. Reassurance and support offered to you by doctors and staff	1	2	3	4	5	6	7	0
b. Ease of scheduling appointments by phone	1	2	3	4	5	6	7	0
c. How well your primary care provider informs you about the costs of care	1	2	3	4	5	6	7	0
d. Amount of time you must wait between scheduling an appointment for routine care and the day of your visit	1	2	3	4	5	6	7	0
e. Number of primary care providers you have to choose from	1	2	3	4	5	6	7	0
f. Amount of time you have with doctors and staff during your visits	1	2	3	4	5	6	7	0

12. How do you rate… **(Mark One Number on Each Line)**

	Very Poor (F)	Poor (D)	Fair (C)	Good (B)	Very Good (B+)	Excellent (A)	The Best (A+)	Does Not Apply to Me
g. Training, skill and experience of the nursing staff	1	2	3	4	5	6	7	0
h. Your primary care provider's concern for your mental health or emotional well-being	1	2	3	4	5	6	7	0
i. Availability of educational materials or programs to enhance your health	1	2	3	4	5	6	7	0
j. Comprehensiveness of routine checkups and physicals	1	2	3	4	5	6	7	0
k. Ease of getting lab and radiology work completed when ordered by your primary care provider	1	2	3	4	5	6	7	0
l. Ease of getting a referral to a medical specialist	1	2	3	4	5	6	7	0
m. Ease of getting a referral to a mental health specialist	1	2	3	4	5	6	7	0
n. The office environment (cleanliness, comfort, lighting, temperature) where you get care	1	2	3	4	5	6	7	0
o. How well your care meets your needs	1	2	3	4	5	6	7	0
p. Overall quality of care and service provided by your medical group	1	2	3	4	5	6	7	0

13. **During the last 6 months**, how many times in total did you use your medical group's "after hours or urgent care services"? **(Mark One)**

- Not at all 1
- 1 time 2
- 2 times 3
- 3 to 5 times 4
- 6 or more times 5

14. Do you plan to switch to a different **medical group** when you next have an opportunity? **(Mark One)**

- Definitely yes 1
- Probably yes 2
- Probably not 3

Definitely not 4

15. What is the name of your health plan (e.g., Health Net, CIGNA, etc.)?

_____

16. How long have you been enrolled in your current health plan? **(Mark One)**

Less than one year 1

1 to 2 years 2

3 to 3 years 3

More than 5 years 4

Your Health Plan

The next questions refer to your health plan. By your health plan we mean the health insurance plan provided by your employer, your spouse's or parent's employer, or that you or someone else purchased for you. Thinking about <u>your health plan</u>, how do you rate the following?

17. How do you rate… **(Mark One Number on Each Line)**

		Very Poor (F)	Poor (D)	Fair (C)	Good (B)	Very Good (B+)	Excellent (A)	The Best (A+)	Does Not Apply to Me
a.	The range of different services your plan covers	1	2	3	4	5	6	7	0
b.	How well your plan informs you about the costs of care	1	2	3	4	5	6	7	0
c.	Coverage for preventative care	1	2	3	4	5	6	7	0
d.	The <u>total cost</u> to you for the care you receive (including monthly payment for coverage, co-payments, and deductibles)	1	2	3	4	5	6	7	0
e.	Ease of completing claim forms or other paperwork	1	2	3	4	5	6	7	0
f.	Extent to which illness visits, treatments, and hospitalizations are covered	1	2	3	4	5	6	7	0
g.	Coverage for supplementary services (e.g., physical therapy, chiropractic)	1	2	3	4	5	6	7	0
h.	Coverage for mental health care services	1	2	3	4	5	6	7	0
i.	Overall quality of service provided by your health plan	1	2	3	4	5	6	7	0

18. Have any of the following been a problem for you when getting services covered by your health plan? If yes, how much of a problem? **(Mark One Number on Each Line)**

		Yes, A Big Problem	Yes, A Small Problem	No, Not A Problem	Don't Know
a.	Confusion about what services are covered by your health plan?	1	2	3	0
b.	Treatment or services recommended by your doctor are not approved by your health plan?	1	2	3	0
c.	Confusion about necessary paperwork to get treatment?	1	2	3	0
d.	Having to pay for services that have not been approved by your health plan?	1	2	3	0

19. Do you plan to switch to a different **health plan** when you next have an opportunity? **(Mark One)**

Definitely yes 1

Probably yes 2

Probably not 3

Definitely not 4

Health And Daily Activities

This section asks about your health now and your current daily activities. Please try to answer every question as accurately as you can.

20. In general, would you say your health is: **(Mark One)**

Excellent 1

Very good 2

Good 3

Fair 4

Poor 5

21. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If yes, how much? **(Mark One Number on Each Line)**

Activities	Limited A Lot	Yes, Limited A Little	Yes, Limited At All	No, Not Limited
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3	
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3	
c. Lifting or carrying groceries	1	2	3	
d. Climbing several flights of stairs	1	2	3	
e. Climbing one flight of stairs	1	2	3	
f. Bending, kneeling, or stooping	1	2	3	
g. Walking more than a mile	1	2	3	
h. Walking several blocks	1	2	3	
i. Walking one block	1	2	3	
j. Bathing or dressing yourself	1	2	3	

22. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? **(Mark One Number on Each Line)**

	Yes	No
a. Cut down the **amount of time** you spent on work or other activities?	1	2
b. **Accomplished less** than you would like?	1	2
c. Were limited in the **kind** of work or other activities?	1	2
d. Had **difficulty** performing the work or other activities (for example, it took longer)?	1	2

23. During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? **(Mark One Number on Each Line)**

	Yes	No
a. Cut down the **amount of time** you spent on work or other activities?	1	2
b. **Accomplished less** than you would like?	1	2

c..... Didn’t do work or other activities as **carefully** as usual? 1
2

24. During the past 4 weeks, how much have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? **(Mark One)**

Not at all 1

Slightly 2

Moderately 3

Quite a bit 4

Extremely 5

25. How much bodily pain have you had during the past 4 weeks? **(Mark One)**

None 1

Very mild 2

Mild 3

Moderate 4

Severe 5

Very severe 6

26. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? **(Mark One)**

Not at all 1

A little bit 2

Moderately 3

Quite a bit 4

Extremely 5

27. During the past 4 weeks, how much of the time have your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? **(Mark One)**

All of the time 1

Most of the time 2

Some of the time 3

A little of the time 4

None of the time 5

28. How TRUE or FALSE is each of the following statements for you?
(Mark One Number on Each Line)

	Definitely True		Mostly True	Don't Know	Mostly False	Definitely False
a.	I seem to get sick a little easier than other people	1	2	3	4	5
b.	I am as healthy as anybody I know	1	2	3	4	5
c.	I expect my health to get worse	1	2	3	4	5
d.	My health is excellent	1	2	3	4	5

Your Feelings

These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

29. How much of the time during the past 4 weeks:
(Mark One Number on Each Line)

		All Of The Time	Most Of The Time	Bit Of The Time	Some Of The Time	A Good A Little Of The Time	None Of The Time		
a.	Did you feel full of pep?	1	2	3	4	5	6		
b.	Have you been a very nervous person?	1	2	3	4	5	6		
c.	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6		
d.	Have you felt calm and peaceful?	1	2	3	4	5	6		
e.	Did you have a lot of energy?		1	2	3	4	5	6	
f.	Have you felt down-hearted and blue?	1	2	3	4	5	6		
g.	Did you feel worn out?	1	2	3	4	5	6		
h.	Have you been a happy person?	1	2	3	4	5	6		
i.	Did you feel tired?	1	2	3	4	5	6		

30. Overall, how would you rate your health? **(Mark One Number)**

31. Compared to one year ago, how would you rate your health in general **now?** **(Mark One)**

Much better now than one year ago 1

Somewhat better now than one year ago..... 2

About the same as one year ago..... 3

Somewhat worse now than one year ago 4

Much worse now than one year ago..... 5

32. Have you had your blood pressure taken by a health care provider any time in the last 2 years? **(Mark One)**

No..... 1

Yes 2

Don't Know..... 3

33. Have you had your blood cholesterol measured by a health care provider any time in the last 5 years? **(Mark One)**

No..... 1

Yes 2

Don't Know..... 3

Information About You

The following questions will help us to insure that the opinions of different people are represented in this study.

34. How old were you on your last birthday?

Write in the number of years:

35. Are you male or female? **(Mark One)**

Male 1

Female 2

36. Which category best describes you? **(Mark One)**

African-American or Black 1

Hispanic or Latino 2

Native American or American Indian 3

Asian or Pacific Islander 4

White or Caucasian 5

Other 6

(Please specify: _____)

37. What is the highest level of school you have completed? **(Mark One)**

8th grade or less 1

Some high school 2

High school diploma or GED 3

Vocational school or some college 4

College degree..... 5

Professional or graduate degree 6

38.Counting yourself, how many people live in your house or apartment? Please include adults, babies, and children who usually stay with you as a member of your household.

Number of people ☐

39. At the present time, are you… **(Mark One)**

Married and living with spouse 1

Married, but separated from spouse..... 2

Living as married (but not married)..... 3

Divorced..... 4

Widowed 5

Never married 6

40. What kind of health insurance do you have?
(Circle All That Apply)

None 1

Medicare 2

Medicaid..... 3

Private, fee-for-service health insurance (e.g., Prudential) 4

HMO..... 5

PPO or IPA or other prepaid plan 6

Other 7

41.What was your total household income (income from all sources including child support, alimony, disability, SSI, unemployment) before taxes, in 1993? (Please remember your answers are confidential.)

(Mark One)

Less than $5,000	1
$5,000 to $9,999	2
$10,000 to $19,999	3
$20,000 to $39,999	4
$40,000 to $74,999	5
$75,000 to $99,999	6
$100,000 or more	7
Don't know	8

42. Females only (Males skip to Question 43):
(Mark One Number on Each Line)

		Yes	No
a.	Are you pregnant?	1	2
b.	Have you had a pap smear at any time in the last 3 years?	1	2
c.	Have you had a mammogram taken by a health care provider any time in the last 2 years?	1	2

Medical Conditions

43. Has a doctor EVER told you that you had any of the following conditions? **(Mark One Number on Each Line)**

		Yes	No
a.	Hypertension (sometimes called High blood pressure)	1	2
b.	Myocardial infarction (heart attack)	1	2
c.	Congestive heart failure (heart failure or enlarged heart)	1	2
d.	Diabetes (high blood sugar)	1	2
e.	Angina	1	2
f.	Cancer (except skin cancer)	1	2
g.	Migraines	1	2
h.	Cataracts	1	2

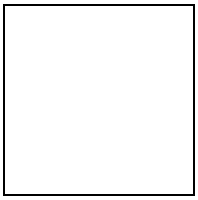
i.....Glaucoma 1 2

j..... Macular degeneration 1 2

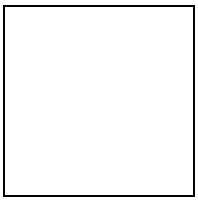
44. Do you NOW have any of the following conditions?
(Mark One Number on Each Line)

		Yes	No
a.	Chronic allergies or sinus trouble	1	2
b.	Seasonal allergies such as hay fever	1	2
c.	Arthritis or any kind of rheumatism	1	2
d.	Sciatica or chronic back problems	1	2
e.	Trouble seeing (even with glasses or contact lenses)	1	2
f.	Chronic lung disease (like chronic bronchitis, asthma or emphysema)	1	2
g.	Liver trouble (like gallstones, cirrhosis, yellow jaundice or hepatitis)	1	2
h.	Dermatitis or other chronic skin rash	1	2
i.	Stomach trouble (like frequent indigestion or ulcers)	1	2
j.	Deafness or other trouble hearing with one or both ears	1	2
k.	Kidney problems (like kidney stones or infections)	1	2
l.	Limitation in the use of an arm or leg (missing, paralyzed or weakness)	1	2
m.	Blurred vision (even with glasses or contact lenses)	1	2
n.	Epilepsy or other seizure disorders	1	2
o.	Thyroid problems	1	2
p.	Males only: problems with the prostate	1	2
q.	Females only: abnormal vaginal bleeding	1	2

45. What is today's date?



46. About how many minutes did it take you to fill out this questionnaire?

 minutes.

Thank You for completing this questionnaire

Please return your completed questionnaire in the enclosed prepaid envelope addressed to:

_____