

## Round 2 (Follow-up) Patient Written Survey

### Directions

Please read each question carefully and place an "X" in the box that most closely reflects your experience. Please use a black pen. Depending on your answers, you might be asked to skip some of the questions on this survey.

### Example:

**How important are my answers to this study?**

- Extremely important**  
 **Somewhat important**  
 **Important**

1. If female, are you currently pregnant?

- No  
 Yes *(If yes, this survey is complete. Please return in the envelope provided.)*  
 Unsure *(If unsure, this survey is complete. Please return in the envelope provided.)*

2. Is <HP> still your health insurance plan?

- No *(If no, skip to question 3.)*  
 Yes

2a. Is this your main health insurance plan? Your main health insurance plan is the one that you use for most or all of your health care.

- No  
 Yes *(If yes, skip to question 6.)*

3. What is the name of your main health insurance plan?

NAME: \_\_\_\_\_

4. In what month and year was your most recent health plan insurance change?

Month: \_\_\_\_\_ Year: \_\_\_\_\_ *(Skip to question 5.)*

4a. If you cannot remember the month and year, was it more than 6 months ago or less than 6 months ago?

- More than 6 months ago  
 Less than 6 months ago  
 Unsure

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5. What were the reasons you changed health plans? Please check all that apply.

- <sub>1</sub> My employer stopped offering this plan
- <sub>2</sub> My doctor left this plan
- <sub>3</sub> Unhappy with benefits/Coverage
- <sub>4</sub> Too difficult to get care
- <sub>5</sub> I moved
- <sub>6</sub> I changed jobs
- <sub>7</sub> Other (specify) \_\_\_\_\_

6. What is your birth date?    \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
MM - DD - YYYY

7. How much do you weigh without clothes? \_\_\_\_\_ pounds  
*\*National Center for Health Statistics. [Health, United States, 2000](#). Hyattsville, Maryland: Public Health Service. 2000.*

8. How do you currently manage or control your diabetes? ***Check all that apply.***

- <sub>1</sub> Diet and/or exercise
- <sub>2</sub> Oral medications
- <sub>3</sub> Insulin injection
- <sub>4</sub> Insulin pump
- <sub>5</sub> Other (*please specify*) \_\_\_\_\_

9. **If you use insulin injections**, how many times per day do you usually take your insulin?

- <sub>1</sub> Once a day
- <sub>2</sub> Twice a day
- <sub>3</sub> Three times a day
- <sub>4</sub> Four or more times a day

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10. For the next set of items, please indicate if your current doctor or other health professional (such as a diabetes educator or nurse) may have explained to you, shown you, or given you information about the following in the past 18 months.

	<u>Yes</u>	<u>No</u>	<u>Unsure</u>
	1	0	0
8			
A. How to care for your feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. What to do for symptoms of low blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. How to exercise appropriately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. What a good number is for your blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. How to adjust your diabetes medications in response to blood sugar values or sick days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Do you test your blood sugar levels at home?

- No     *(If no, skip to question 15.)*  
 Yes

12. How many **days a week** do you test your blood sugar? *Please choose one.*

- 1    2    3    4    5    6    7

13. When you test your blood sugar level, how many **times per day** do you usually test?

- 1    2    3    4 or more

14. During the past year, how often did your doctor or some other health care professional review your home blood or urine sugar test results?

- 1 Every visit  
2 Most of the visits  
3 At least one of the visits  
4 None of the visits  
8 Not sure

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15. When was the last time you had an eye exam in which your pupils were dilated? This means that drops, making you temporarily sensitive to bright light, were put into your eyes.

- <sub>1</sub> During the past 12 months  
<sub>2</sub> More than a year but less than 2 years  
<sub>3</sub> More than 2 years  
<sub>4</sub> Never  
<sub>8</sub> Not sure

16. During the past year, how often did your doctor or some other health care professional examine your feet with your socks off?

- <sub>1</sub> Every visit  
<sub>2</sub> Most of the visits  
<sub>3</sub> At least one of the visits  
<sub>4</sub> None of the visits  
<sub>8</sub> Not sure

17. When was the last time a doctor or other health professional tested the feeling in your feet or legs by touching them with a monofilament, which looks like a short piece of fishing line ?

- <sub>1</sub> During the past 12 months  
<sub>2</sub> More than a year but less than 2 years  
<sub>3</sub> More than 2 years  
<sub>4</sub> Never  
<sub>8</sub> Not sure

18. Has your doctor or some other health care professional told you to take aspirin regularly to lower your risk of developing heart disease or stroke?

- <sub>0</sub> No  
<sub>1</sub> Yes  
<sub>8</sub> Not sure

19. Are you taking aspirin regularly (at least 3 days per week)?

- <sub>0</sub> No  
<sub>1</sub> Yes

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20. Did you get a flu shot during the past 12 months?

- No  
 Yes

21. In the past year, have you smoked cigarettes every day, some days, or not at all?

- Every day  
 Some days  
 Not at all      *(If Not at all, skip to question 25.)*

22. Were you advised by a doctor or other health care provider to quit?

- No      *(If no, skip to question 25.)*  
 Yes

23. Were you referred to a smoking cessation program by a doctor or other health care provider?

- No  
 Yes

24. Were medications recommended or prescribed by a doctor or other health care provider to help you quit smoking?

- No  
 Yes

25. During the past 12 months, have you received any of the following types of diabetes-related information from your doctor's office or health care plan:

	<u>Yes</u>	<u>No</u> 1	<u>Unsure</u> 0
8			
A. Diabetes materials (e.g., pamphlets or newsletters, audiotapes or videotapes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Reminders about upcoming diabetes-related appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Reminders that diabetes-related services or tests are due	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. A copy of diabetes-related laboratory results after or between visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Information about diabetes education (such as support groups or one-on-one counseling, advice services, or Internet sites)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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26. During the past 12 months, have you used any of the following diabetes-related services or attended any of the following diabetes-related programs:

	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
		1	0
8			
A. A diabetes support group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. One-on-one or group diabetes education class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. A diabetes-related Internet site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. A personal diabetes health record (also sometimes called a "passport") to remind you and your health care provider about your diabetes-related care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. Since you completed the first survey, approximately 18 months ago, have you been hospitalized? (*Does not include Emergency Room visits where you were not admitted to Hospital.*)

- No                      (*If no, skip to question 28.*)  
 Yes  
 Not sure                (*If not sure, skip to question 28.*)

27a. How many times were you hospitalized? \_\_\_\_\_

28. In the past 18 months, have you been told by a doctor or someone in your doctor's office that you have high cholesterol or triglycerides or elevated lipids (fatty substance in the blood)?

- No  
 Yes

29. In the past 18 months, have you been told by a doctor or someone in your doctor's office that you have had a heart attack, a "coronary" or a myocardial infarction?

- No  
 Yes

30. In the past 18 months, have you been told by a doctor or someone in your doctor's office that you have had a stroke, cerebrovascular accident, blood clot or bleeding in the brain, or a transient ischemic attack or "mini-stroke"?

- No  
 Yes

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31. In the past 18 months, have you had any of the following procedures done:

	<u>Yes</u>	<u>No</u>	<u>Unsure</u>
		1	0
8			
A. Angioplasty or balloon or bypass to unclog arteries to <b>your heart</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Angioplasty or balloon or bypass to unclog arteries to <b>your leg</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Angioplasty or balloon or bypass to unclog arteries to <b>your brain</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. A toe, foot or leg amputation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>If Yes, what did you have amputated?</i></b>			
1 <input type="checkbox"/> One or more toes, but neither foot			
2 <input type="checkbox"/> One foot (or leg), but not both feet			
3 <input type="checkbox"/> Both feet (or legs)			

32. Have you ever had kidney failure that required either dialysis or a kidney transplant?

0  No *(If no, skip to question 35.)*  
 1  Yes

33. Which treatments have you required?

33a. Dialysis?

0  No  
 1  Yes ***Please enter approximate date of first dialysis:***         -      -       
MM    DD    YYYY

33b. Kidney Transplant?

0  No  
 1  Yes ***Please enter approximate date of first kidney transplant***         -      -       
MM    DD    YYYY

34. Has a doctor told you that the kidney failure was caused by your diabetes?

0  No  
 1  Yes

35. Have you ever received treatment for depression, either medication or psychological counseling?

0  No

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Yes

36. During the PAST 4 WEEKS, how often have you experienced the following:

	<i>All of the Time</i> 1	<i>Most of the Time</i> 2	<i>Some of the Time</i> 3	<i>Little of the Time</i> 4	<i>None of the Time</i> 5
A. Dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Having to get up at night to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Excessive thirst?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Blurred or double vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Decreased ability to feel hot or cold with your hands or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***(SKIP TO QUESTION 39 IF YOU HAVE HAD BOTH FEET AMPUTATED.)***

	<i>All of the Time</i> 1	<i>Most of the Time</i> 2	<i>Some of the Time</i> 3	<i>Little of the Time</i> 4	<i>None of the Time</i> 5
F. Numbness or loss of feeling in your feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Tingling or burning sensation in your feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Sores or wounds on your feet that did not heal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. Do you or someone in your home check your feet for sores every day?

No  
 Yes

38. On a typical day, how many extra minutes do you spend caring for your feet?

Please enter number of minutes \_\_\_\_\_

**Question #39** was obtained from the SF-12®HealthSurvey – <http://www.sf-36.org/copyright.shtml>.  
Permissions obtained at: Quality Metric, 640 George Washington Highway, Suite 201, Lincoln, RI 02865,  
Telephone: 401-334-8800 or email at [license@qualitymetric.com](mailto:license@qualitymetric.com)

**The following questions ask about your emotions and your daily activities.**

40. Over the last 2 weeks, how often have you been bothered by any of the following problems:

	<i>Not at all</i> 1	<i>Several days</i> 2	<i>More than half the days</i> 3	<i>Nearly every day</i> 4
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| B. Feeling down, depressed, or hopeless  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Trouble falling or staying asleep, or sleeping too much   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Feeling tired or having little energy   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Poor appetite or overeating   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Feeling bad about yourself -- or that you are a failure or have let yourself or your family down  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Trouble concentrating on things, such as reading the newspaper or watching television   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Moving or speaking so slowly that other people could have noticed? Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**The next questions are about the type of health care professionals you see and the quality of medical service you receive from your health plan.**

41. In the past 18 months, did you get a new personal doctor? A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant.

- No *(If no, skip to question 49.)*
- Yes
- I don't have a personal doctor *(Skip to Question 51.)*

\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.

42. With the choices your health plan gave you, how much of a problem, if any, was it to get a new personal doctor or nurse you are happy with?

- A big problem
- A small problem
- Not a problem
- I didn't get a new personal doctor or nurse
- I don't have a health plan

\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.

43. What is your new personal doctor's name?

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44. Is this person:

- <sub>1</sub> A family practice physician
- <sub>2</sub> An internal medicine physician
- <sub>3</sub> An endocrinologist or diabetes specialist
- <sub>4</sub> Another type of physician
- <sub>5</sub> A nurse or physician's assistant (CDE, Diabetes Educator, or Nurse Practitioner)
- <sub>8</sub> Unsure

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

45. Is this person part of your health plan?

- <sub>0</sub> No
- <sub>1</sub> Yes
- <sub>7</sub> I don't have a health plan

46. Is this the person you go to for most of the care related to your diabetes?

- <sub>0</sub> No
- <sub>1</sub> Yes *(If yes, skip to question 49.)*

47. Would you say the person you go to for your diabetes care is:

- <sub>1</sub> A family practice physician
- <sub>2</sub> An internal medicine physician
- <sub>3</sub> An endocrinologist or diabetes specialist
- <sub>4</sub> Another type of physician
- <sub>5</sub> A nurse or physician's assistant (CDE, Diabetes Educator, or Nurse Practitioner)
- <sub>8</sub> Unsure

48. Is this person part of your health plan?

- <sub>0</sub> No
- <sub>1</sub> Yes
- <sub>7</sub> I don't have a health plan

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49. When you go to see your personal doctor, how often do you have to see someone else because your personal doctor isn't available?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- Never, I always get to see my personal doctor

50. On the average, how long does it take you to get to your doctor's office?

- Less than 15 minutes
- 15 to 30 minutes
- 31 to 45 minutes
- 46 minutes to 1 hour
- More than 1 hour to 2 hours
- More than 2 hours

**It is important that when you answer the next questions, you think about specialists, that is doctors who you may have seen for special health needs, like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care. For the purposes of this study, we are not including visits to your dentist.**

51. In the last 12 months, did you or a doctor think you needed to see a specialist?

- No (*If no, skip to question 53.*)
- Yes

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

52. In the last 12 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?

- A big problem
- A small problem
- Not a problem at all
- I didn't need to see a specialist in the last 12 months

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

53. In the last 12 months, did you see a specialist?

- No (*If no, skip to question 55.*)
- Yes

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**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

54. Was the specialist you saw the most often the same doctor as your personal doctor?

No

Yes

I don't have a personal doctor, or did not see a specialist in the last 12 months

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

55. In the last 12 months, how much of a problem, if any, was it to get the care you or your doctor believed necessary?

A big problem

A small problem

Not a problem at all

I had no visits in the last 12 months

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

56. In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?

A big problem

A small problem

Not a problem at all

I had no visits in the last 12 months

I don't have a health plan

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

57. In the last 12 months, how often did office staff at a doctor's office or clinic treat you with courtesy and respect?

Never

Sometimes

Usually

Always

I had no visits in the last 12 months

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

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58. In the last 12 months, how often was office staff at a doctor's office or clinic as helpful as you thought they should be?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always
- 5 I had no visits in the last 12 months

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

59. In the last 12 months, how often did doctors or other health providers listen carefully to you?

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always
- 5 I had no visits in the last 12 months

60. In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always
- 5 I had no visits in the last 12 months

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

61. In the last 12 months, how often did doctors or other health providers show respect for what you had to say?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always
- 5 I had no visits in the last 12 months

**\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

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62. In the last 12 months, how often did doctors or other health providers spend enough time with you?

- <sub>1</sub> Never
- <sub>2</sub> Sometimes
- <sub>3</sub> Usually
- <sub>4</sub> Always
- <sub>5</sub> I had no visits in the last 12 months

*\*US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.*

63. Over the last 12 months, how would you rate the quality of care you received for your diabetes?

- <sub>1</sub> Excellent
- <sub>2</sub> Very good
- <sub>3</sub> Good
- <sub>4</sub> Fair
- <sub>5</sub> Poor

64. Please read the next set of statements and indicate how you feel about each statement: *(Skip to Question 66 if you do not have a personal doctor.)*

	<i>Strongly Agree</i> 1	<i>Agree</i> 2	<i>Not Sure</i> 8	<i>Disagree</i> 4	<i>Strongly Disagree</i> 5
A. I can tell my doctor anything.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. I completely trust my doctor's judgment about my medical care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. My doctor cares more about holding costs down than about doing what is needed for my health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. My doctor would always tell me the truth about my health, even if there was bad news.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. If a mistake were made in my treatment, my doctor would try to hide it from me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

65. For this next question, please rate on a scale of 0 to 10, with 0 = Not at all and 10 = Completely: All things considered, how much do you trust your doctor? *(Please circle the number that corresponds to your answer.)*

0
1
2
3
4
5
6
7
8
9
10  
 Not At Completely  
 All

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66. Which of the following four activity classes best describes your present activity outside of your job or normal daily activities? Please consider transportation to and from work, school, or shopping; sporting activities; and other physical effort during your leisure time.

- <sub>1</sub> No physical activity weekly
- <sub>2</sub> Only light physical activity in most weeks
- <sub>3</sub> Vigorous physical activity for at least 20 minutes once or twice a week. (Vigorous activity causes shortness of breath, a rapid heart rate, and/or sweating)
- <sub>4</sub> Vigorous physical activity for at least 20 minutes three or more times per week

67. Approximately how many minutes per day do you spend walking?

- <sub>1</sub> 0-9 minutes
- <sub>2</sub> 10-19 minutes
- <sub>3</sub> 20-29 minutes
- <sub>4</sub> 30-39 minutes
- <sub>5</sub> 40 or more minutes
- <sub>8</sub> Don't know

**The following questions focus on how you would describe your health today. Please check the box that comes closest to your health today.**

**Question #68 to #72** was obtained from the ED-5Q (EuroQol) survey – <http://www.euroqol.org/>.  
 Permissions obtained at: EuroQol Group, PO Box 4443, 3006 AK Rotterdam, The Netherlands, Telephone +31 10 408 1545 and Fax +31 10 452 5303

73. If you needed help for your diabetes-related health conditions, how *often* would the following types of support be available to you?

	<i>All of the Time</i> 1	<i>Most of the Time</i> 2	<i>Some of the Time</i> 3	<i>Little of the Time</i> 4	<i>None of the Time</i> 5
A. Someone to confide in or talk to about myself or my diabetes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Someone to take me to the doctor when I need to go.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Someone to help me with my daily chores if I am unable to do them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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74. Please read the following statements and select the answer that comes closest to describing how you feel with each statement.

		<i>Agree Strongly</i> 1	<i>Agree Somewhat</i> 2	<i>Disagree Somewhat</i> 3	<i>Disagree Strongly</i> 4
A.	I feel it is impossible for me to reach the goals that I would like to strive for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	The future seems hopeless to me and I can't believe that things are changing for the better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Sometimes it is a problem to cover my share of the cost for a medical visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.	Sometimes I go without the medical care I need because it is too expensive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The next questions are about the cost of your health care.**

75. Some people have more than one type of insurance. Do you have any of the following types of health insurance? *Check all that apply:*

- <sub>1</sub> No, I do not have any other type of health insurance (*Go to question 76.*)
- <sub>2</sub> Other private health insurance
- <sub>3</sub> Regular Medicare
- <sub>4</sub> Supplemental Medicare
- <sub>5</sub> Medicaid [ for CA sites: or Medi-Cal]
- <sub>6</sub> Veterans Administration (VA)
- <sub>7</sub> Other: *Please specify* \_\_\_\_\_
- <sub>8</sub> Don't know

76. Do you have to pay a co-payment, or a fixed dollar amount that you pay yourself, every time you see your **regular doctor**?

- <sub>0</sub> No
- <sub>1</sub> Yes     If yes, how much is your co-payment?   \$ \_\_\_\_\_
- <sub>7</sub> Not applicable

77. Do you have to pay a co-payment, or fixed dollar amount that you pay yourself, every time **you see a specialist**?

- <sub>0</sub> No
- <sub>1</sub> Yes     If yes, how much is your co-payment?   \$ \_\_\_\_\_
- <sub>7</sub> Not applicable

## Round 2 (Follow-up) Patient Written Survey

78. Do you have to pay a co-payment, or fixed dollar amount that you pay yourself, every time **you buy a prescription medication**?

- No  
 Yes  
 Not applicable

79. Please check the box that best describes if your insurance plan pays for all, some or none of the following equipment or supplies related to your diabetes care. If you pay a small co-payment, choose “Insurance Pays Some.”

	<i>Insurance Pays All</i> 1	<i>Insurance Pays Some</i> 2	<i>Insurance Pays None</i> 3	<i>Unsure</i> 8	<i>Not Applicable</i> 7
A. Glucose monitor strips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Glucose monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Insulin syringes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Insulin pens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

80. Please check the box that best describes if your insurance plan pays for all, some or none of the following services related to your diabetes care. If you pay a small co-payment, choose “Insurance Pays Some.”

	<i>Insurance Pays All</i> 1	<i>Insurance Pays Some</i> 2	<i>Insurance Pays None</i> 3	<i>Unsure</i> 8	<i>Not Applicable</i> 7
A. Eye exams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Nutrition counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Diabetes education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Foot doctor or podiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Smoking cessation classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Psychiatrist or other mental health professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Round 2 (Follow-up) Patient Written Survey

Now we would like to ask you some questions about yourself. It is very important that this study represent the views of all people. Some of the questions that follow do not directly address your diabetes care. We are asking these questions in order to learn whether people from different backgrounds receive the same quality of medical care. For this reason, we need to know the answers to the following questions. Please remember that all of your answers are completely confidential.

81. When you were 12 years old, if you lived with your father, stepfather, or another man who helped to raise you, what was the highest grade of school or year of college he completed?

- Did not live with a male adult when I was 12 years old.
- 8<sup>th</sup> grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Trade school
- Some college or 2-year college degree
- 4-year college graduate
- More than 4-year college graduate
- Don't know

82. When you were 12 years old, if you lived with your mother, stepmother, or another woman who helped to raise you, what was the highest grade of school or year of college she completed?

- Did not live with a female adult when I was 12 years old.
- 8<sup>th</sup> grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Trade school
- Some college or 2-year college degree
- 4-year college graduate
- More than 4-year college graduate
- Don't know

83. Which of the following best describes your current employment situation?

- Self-employed
- Employed by others for wages
- Retired *(Skip to question 86.)*
- Homemaker *(Skip to question 86.)*
- Student *(Skip to question 86.)*
- Not employed due to poor health *(Skip to question 86.)*
- Not employed for other reasons *(Skip to question 86.)*

## Round 2 (Follow-up) Patient Written Survey

84. About how many hours do you work for pay in an AVERAGE WEEK on all of your jobs combined?

\_\_\_\_\_ Hours

85. What kind of work do you do? (For example, a car dealer, accountant, printer)

Enter name of occupation: \_\_\_\_\_ *(Skip to question 87.)*

- Never held job for wages *(Skip to question 90.)*

86. If you previously held a job outside the home, what kind of work did you do?

Enter name of occupation: \_\_\_\_\_

- Never held job outside the home *(Skip to question 90.)*

87. What is or was the most important activity in this job or business? (For example: sold cars, maintained account books, operated printing press.)

Enter type of activity: \_\_\_\_\_

88. Do you or did you make, or actively participate, in decisions about such things as the products or services delivered, number of employees, budgets, and so forth?

No

Yes

89. As an official part of that job, do you or did you supervise the work of other employees or tell other employees what work to do?

No

Yes

90. What is your current marital or domestic status?

Married

Living with someone as a couple, but not married

Divorced or separated *(Skip to question 96.)*

Widowed *(Skip to question 96.)*

Never married *(Skip to question 96.)*

## Round 2 (Follow-up) Patient Written Survey

91. What was the highest grade of school or year of college completed by your spouse or domestic partner?

- 1 8<sup>th</sup> grade or less
- 2 Some high school, but did not graduate
- 3 High school graduate or GED
- 4 Trade school
- 5 Some college or 2-year college degree
- 6 4-year college graduate
- 7 More than 4-year college graduate
- 8 Don't know

92. Which of the following best describes your spouse or domestic partner's current employment situation?

- 1 Self-employed
- 2 Employed by others for wages
- 3 Retired *(Skip to question 94.)*
- 4 Homemaker *(Skip to question 94.)*
- 5 Student *(Skip to question 94.)*
- 6 Not employed due to poor health *(Skip to question 94.)*
- 7 Not employed for other reasons *(Skip to question 94.)*
- 8 Don't know *(Skip to question 94.)*

93. What kind of work does your spouse or domestic partner do?

Enter name of occupation: \_\_\_\_\_ *(Skip to question 95.)*

- 1 Never held job for wages *(Skip to question 96.)*
- 8 Don't know *(Skip to question 96.)*

94. If your spouse or partner previously held a job outside the home, what kind of work did he or she do?

Enter name of occupation: \_\_\_\_\_

- 1 Never held job outside the home *(Skip to question 96.)*
- 8 Don't know *(Skip to question 96.)*

## Round 2 (Follow-up) Patient Written Survey

95. What is or was the most important activity on this job or business? (For example: sold cars, maintained account books, operated printing press.)

Enter type of activity: \_\_\_\_\_

Don't know

96. Including yourself, how many people live in your household? \_\_\_\_\_

97. Are there any children age 6 and under who live with you?

No *(If no, skip to question 99.)*

Yes

98. Are you primarily responsible for their care?

No

Yes

99. Is there anyone 7 years or older in your household who may require special care, such as a child or parent with special needs or disabilities?

No

Yes

100. Which country were you born in?  USA  Other, please specify \_\_\_\_\_  
*If you checked USA, please go to question 102.*

101. How long have you been living in the US? \_\_\_\_\_ years

102. Thinking about where you live, how much of a problem is each of the following?

	<i>Very Serious Problem</i> 1	<i>Somewhat Serious Problem</i> 2	<i>Minor Problem</i> 3	<i>Not Really a Problem</i> 4
A. Crime in the area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Access to recreational or exercise facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Trash and litter.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Lighting at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Access to public transportation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Access to a nearby supermarket.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Round 2 (Follow-up) Patient Written Survey

103. Please indicate which of the following income categories best describes your total household income, before taxes last year. Annual household income includes all before-tax wages and other earnings, interest and rental income, retirement income, government assistance programs (disability, welfare, etc.), pensions, child support, alimony, etc.

103a.  Under \$25,000:

- <sub>1</sub> Less than \$5,000
- <sub>2</sub> \$5,000 to under \$7,500
- <sub>3</sub> \$7,500 to under \$10,000
- <sub>4</sub> \$10,000 to under \$12,500
- <sub>5</sub> \$12,500 to under \$15,000
- <sub>6</sub> \$15,000 to under \$20,000
- <sub>7</sub> \$20,000 to under \$25,000

103b.  <sub>2</sub> Between \$25,000-\$50,000:

- <sub>1</sub> \$25,000 to under \$30,000
- <sub>2</sub> \$30,000 to under \$35,000
- <sub>3</sub> \$35,000 to under \$40,000
- <sub>4</sub> \$40,000 to under \$45,000
- <sub>5</sub> \$45,000 to \$50,000

103c.  <sub>3</sub> Over \$50,000:

- <sub>1</sub> \$50,000 to under \$60,000
- <sub>2</sub> \$60,000 to under \$75,000
- <sub>3</sub> \$75,000 to under \$100,000
- <sub>4</sub> \$100,000 to under \$125,000
- <sub>5</sub> \$125,000 and above

**Thank you for completing this survey!**