

2014 KAISER PERMANENTE MEMBER HEALTH SURVEY**CONFIDENTIAL**

*Do we have your correct information?
Please print any CHANGES below.*

Address: _____

Daytime phone: (_____) _____

Email address: _____

Study ID:

We are doing this survey to learn about our adult membership's health-related needs and preferred methods of communication with Kaiser Permanente about their health and health care.

IMPORTANT:

- ☞ **YOUR information is very important** even if you are healthy, rarely use Kaiser Permanente services, or are not totally happy with the services you have received.
- ☞ **YOU will be entered into a drawing for one of 100 \$100 gift cards** when we receive your completed questionnaire.
- ☞ This questionnaire should be filled out only **by or for YOU** (the person named above).
- ☞ **To complete this online**, go to www.mhs2014.kaiser.org/f or email me at nancy.gordon@kp.org and I will email you a link to the online questionnaire.
- ☞ **Mark the box with an X or ✓ to indicate your answer.** If none of the answers in a list applies to you, leave that question blank.

Your answers are absolutely confidential. They will not become part of your health records or shared with your doctors or anyone outside the Division of Research in a way that identifies you. Your name and Study ID are on the questionnaire so we can note that you returned it and contact you if needed. If you have any questions about the survey, please call toll-free: **(800) 723-8055 (choose Member Health Surveys)** or email me at nancy.gordon@kp.org.

Please return your completed survey in the enclosed postage-paid envelope to:
Kaiser Permanente Division of Research, 2000 Broadway, Oakland, CA 94612 attn: NPG

Thank you for you taking the time to do this!

Dr. Nancy Gordon
Member Health Survey Director

Which of these \$100 gift cards would you choose if you win the drawing?

- Target Safeway Starbucks Amazon.com

Your Health and Health-Related Habits

1. In general, would you say your health is:

- Excellent
 Very good
 Good
 Fair
 Poor

2. Health can be thought of as having two components, physical health (including pain) and emotional well-being or mental health (such as whether you feel depressed or anxious). In general, how would you rate:

- | | Excellent | Very Good | Good | Fair | Poor |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Your physical health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your emotional/mental health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. How much does your health interfere with your work or other regular daily activities?

- | | Not at All | A Little Bit | Moderately | Quite a Bit |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Your physical health (including pain) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your emotional/mental health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. During the past 12 months, which of the following health problems or conditions did you have or were you treated for? (Check **ALL** you had, were treated for, or used medication or special diet for)

- | | |
|---|---|
| <input type="checkbox"/> High blood pressure (<i>diagnosed by a clinician</i>)
<input type="checkbox"/> Heart disease (e.g., heart attack, angina, blocked artery, atrial fibrillation, congestive heart failure)
<input type="checkbox"/> Diabetes (<i>other than only during pregnancy</i>)
<input type="checkbox"/> Prediabetes
<input type="checkbox"/> High cholesterol (<i>diagnosed by a clinician</i>)
<input type="checkbox"/> Stroke
<input type="checkbox"/> TIA (Trans Ischemic Attack or "mini-stroke")
<input type="checkbox"/> Cancer (<i>specify type</i>): _____
<input type="checkbox"/> Asthma
<input type="checkbox"/> COPD, emphysema, or chronic bronchitis
<input type="checkbox"/> Environmental (pets, plants, etc.) or food allergies
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Osteoporosis (<i>brittle or thinning bones</i>)
<input type="checkbox"/> Osteoarthritis (<i>"wear and tear" arthritis</i>)
<input type="checkbox"/> Frequent heartburn or acid reflux (GERD)
<input type="checkbox"/> Severe back pain or sciatica
<input type="checkbox"/> Severe neck or shoulder pain
<input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Other type of severe headaches
<input type="checkbox"/> Chronic (frequent or ongoing) pain (<i>describe</i>): _____
<input type="checkbox"/> Urine leakage at least once a week:
<input type="checkbox"/> After feeling pressure to urinate
<input type="checkbox"/> When coughing, lifting, exercising, etc.
<input type="checkbox"/> Vision problem (with or without glasses/lenses)
<input type="checkbox"/> Problems with hearing and/or deafness
<input type="checkbox"/> Frequent problems with balance or walking
<input type="checkbox"/> Frequent problems with memory
<input type="checkbox"/> Frequent problems falling or staying asleep
<input type="checkbox"/> Frequent problems with fatigue/daytime tiredness
<input type="checkbox"/> Depression, sadness, or very low spirits lasting at least 2 weeks
<input type="checkbox"/> Anxiety or panic lasting at least 2 weeks
<input type="checkbox"/> Problem with alcohol or drugs
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> None of these problems or conditions |
|---|---|

5. Have you **EVER** had: (Check **ALL** that apply)

- | | |
|--|---|
| <input type="checkbox"/> Heart disease, heart surgery, or a heart attack
<input type="checkbox"/> Cancer (<i>specify type</i>): _____
<hr/> <input type="checkbox"/> A Stroke
<input type="checkbox"/> A TIA (Trans Ischemic Attack or "mini-stroke")
<input type="checkbox"/> High blood pressure (hypertension)
<input type="checkbox"/> Diabetes (<i>other than only during pregnancy</i>) | <input type="checkbox"/> Adult depression lasting at least 2 weeks
<input type="checkbox"/> Chronic (ongoing) pain (<i>describe</i>): _____
<hr/> <input type="checkbox"/> Problems with alcohol or drugs
<input type="checkbox"/> A hysterectomy (<i>surgery to remove womb/uterus</i>)
<input type="checkbox"/> An unplanned pregnancy
<input type="checkbox"/> None of these |
|--|---|

6. Are you past menopause -- "the change of life" -- meaning you have not had a menstrual period for at least 12 months?

- Yes No

7. During the **past 12 months**, did you use any of the following prescription or OTC (not requiring a prescription) medicines **at least twice a week**? (Check **ALL** that apply)

- | | |
|---|--|
| <input type="checkbox"/> Asthma medicine or spray | <input type="checkbox"/> Prescription or OTC sleep medicine |
| <input type="checkbox"/> Heart medicine (not including aspirin) | <input type="checkbox"/> Prescription or OTC quit smoking medicine |
| <input type="checkbox"/> Aspirin (low dose) to prevent stroke/heart attack | <input type="checkbox"/> Prescription or OTC weight loss medicine |
| <input type="checkbox"/> High blood pressure medicine | <input type="checkbox"/> Prescription pain medicine |
| <input type="checkbox"/> Insulin or other diabetes medicine | <input type="checkbox"/> OTC pain medicine |
| <input type="checkbox"/> Cholesterol/lipid lowering medicine | <input type="checkbox"/> Anti-inflammatory medicine for joint/muscle or arthritis pain (<i>Advil, ibuprofen, etc.</i>) |
| <input type="checkbox"/> Osteoporosis medicine | <input type="checkbox"/> Prescription medicine for depression |
| <input type="checkbox"/> Heartburn/acid reflux medicine (<i>Pepcid, etc.</i>) | <input type="checkbox"/> Prescription medicine for anxiety or panic |
| <input type="checkbox"/> Antacids for upset stomach | |

8. How many **prescription** medicines do you regularly take? _____ Prescription medicines

9. During the **past 12 months**, did you use any of these forms of birth control? (Check **ALL** that apply)

- Birth control pills Contraceptive patch Vaginal Ring Birth control shot IUD Condoms

10. During the **past 12 months**, did you use any herbals, nutritional supplements, or other "natural" remedies **to treat or prevent your own health problems**? (Check **ALL** that apply and list others)

- | | |
|--|--|
| <input type="checkbox"/> Daily multivitamin | <input type="checkbox"/> Glucosamine |
| <input type="checkbox"/> Calcium with or without Vitamin D included | <input type="checkbox"/> Melatonin or sleep formula containing melatonin |
| <input type="checkbox"/> Vitamin D (separate from calcium or multivitamin) | <input type="checkbox"/> Other supplements (<i>List</i>): _____ |
| <input type="checkbox"/> Vitamin C (separate from in a multivitamin) | |
| <input type="checkbox"/> Fish oil, flaxseed oil, other Omega-3 fatty acids | _____ |

11. During the **past 12 months**, did you use any of the following methods to **help manage or prevent your own health problems**? (Check **ALL** that apply)

- | | |
|--|---|
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Hypnosis or self-hypnosis |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Any herbal medicines/remedies/supplements |
| <input type="checkbox"/> Acupressure | <input type="checkbox"/> Any homeopathic medicines |
| <input type="checkbox"/> Massage therapy | <input type="checkbox"/> Vegetarian or vegan diet |
| <input type="checkbox"/> Yoga or Pilates | <input type="checkbox"/> Other special diet: _____ |
| <input type="checkbox"/> Tai Chi, Chi Gong | <input type="checkbox"/> Prayer or spiritual practice you do yourself |
| <input type="checkbox"/> Deep breathing, mindfulness, or other relaxation/meditation technique | <input type="checkbox"/> Religious or spiritual healing by others |
| <input type="checkbox"/> Guided imagery/visualization techniques | <input type="checkbox"/> Psychological counseling or therapy |
| | <input type="checkbox"/> 12-Step program or other self-help/support group |

12. How tall are you without shoes? _____ Feet _____ Inches

13. How much do you weigh without your shoes and clothes? _____ Pounds (*Skip if pregnant*)

14. During an average **day**, about how many servings of fruits and vegetables do you usually eat? (*1 serving = a half cup or a medium piece*) _____ Servings per day

15. How often do you **try to eat** reduced fat (low-fat or non-fat) foods?

- All the time Most of the time Some of the time A little of the time Never

16. How often do you **try to avoid eating** foods that are high in salt or sodium (like most canned, packaged, processed, and "fast" foods and foods seasoned with a lot of salt)?

- All the time Most of the time Some of the time A little of the time Never

17. How often do you usually do physical activity or exercise (such as walking, running, swimming, tennis, soccer, gardening, dancing, yoga, exercise class, etc.)?
- 7 days/week 5 days/week 3 days/week 1 day/week Never → *If NEVER, go to Question 18*
 6 days/week 4 days/week 2 days/week Less than once a week

17a. On days you exercise, how many **total minutes** do you usually exercise? ____ Minutes per Day

- 17b. On days you exercise, what type of exercise do you usually get? (Check **ONE** answer only)
- Light (barely increasing your breathing and heart rate, like an easy walk or swim)
 Moderate (noticeably increasing your breathing and heart rate, like walking fast or uphill)
 Vigorous (causing a large increase in your breathing and heart rate, like running or swimming fast)

18. Have you ever regularly smoked cigarettes (that is, smoked daily for at least a year)?

- Yes No I have never smoked cigarettes → *If Never, go to Question 20*

19. Do you smoke cigarettes now, even occasionally?

YES →
Please answer a-d

- a. How often do you usually smoke? Every day Some days Very rarely
b. How many cigarettes do you usually smoke per day? ____ Cigarettes
c. How many total years have you smoked? ____ Years
d. Have you made a serious attempt to quit in the **past 12 months**? Yes No

NO →
Please answer e-g

- e. How many cigarettes did you usually smoke per day? ____ Cigarettes
f. How many total years did you smoke? ____ Years
g. When did you last smoke? Less than 6 months ago 1-5 years ago
 6-12 months ago Over 5 years ago

20. During the **past 12 months**, how often have you usually had a drink containing alcohol?

- Almost every day 2-4 times a month
 5 to 6 times a week 1 time a month or less
 3 to 4 times a week Never in the past 12 months (*used to drink*)
 1 to 2 times a week Never in the past 12 months (*never drank as adult*) } *If NEVER, go to Question 21*

20a. On days when you had a drink, how many drinks did you usually have?

(1 drink = a 12-oz. can of beer, 5 oz. of wine, or a 1 oz. shot of hard liquor) ____ Drinks

21. In a typical **weekday**, how many **total hours** of sleep do you usually get, including naps? ____ Hours

22. During a typical **weekday**, about how many **total hours** (out of 24 hours) are you usually **sitting or lying down**? Include time when you are sitting at work, eating, and riding in a vehicle; sitting or lying down while reading, talking, watching TV, and using a computer, tablet, or mobile phone; and lying down when you nap or sleep. ____ Hours

23. During the **past 12 months**, how often have you felt very stressed, tense or anxious?

- Never A little of the time Some of the time Much of the time Most of the time

24. In general, how satisfied are you with your life?

- Very satisfied Satisfied Dissatisfied Very dissatisfied

25. Taken all together, how would you say things are these days – would you say you are:

- Very happy Pretty happy Not very happy Not at all happy

26. Are you currently doing any of the following to improve or maintain your health?

(Check ALL that apply)

- Getting moderate or vigorous exercise most days Trying to eat mostly healthy foods
 Taking walks for at least 30 minutes most days Limiting alcohol to 1 drink a day or none at all
 Taking steps to quit smoking or stay off cigarettes Trying to manage stress effectively
 Taking steps to lose weight or maintain weight loss Trying to get enough sleep to feel well-rested
 Learning what is in food by reading labels/recipes Doing enjoyable activities at least once a week

27. How much do you think habits/lifestyle (such as exercise, what you eat, and your weight) can affect your health?
 Not at all A little bit Moderately Quite a bit Extremely
28. How much do you think stress and emotional troubles (such as depression or anxiety) can affect your health?
 Not at all A little bit Moderately Quite a bit Extremely
29. During the past 12 months, did any of these situations or problems occur? (Check ALL that apply)
 You were **physically hurt, abused or feared for your safety** because of anger or threats of a current or former spouse/partner or boyfriend/girlfriend → Did you get help from Kaiser? Yes No
 You felt **harassed or discriminated against**
 You worried about your or your family's **safety due to neighborhood violence**, robberies, etc.
 You worried a great deal about your or your family's **financial security**
 Other major life stress such as loss of a job, separation/divorce, death of a loved one, etc.
30. During the past 12 months, did you provide unpaid care to a relative or friend who is or was seriously ill or physically, developmentally, mentally, or emotionally disabled? (Helping with personal needs, managing finances, arranging for services, etc.) Yes No
31. Do you have an Advance Directive for Health Care and/or someone who will legally be able to make medical and end-of-life health care decisions for you if the need arises? Yes No

Health Services You've Received In and Outside Kaiser Permanente

32. In the past 12 months, have you received advice or counseling from a Kaiser Permanente (KP) doctor, nurse, health educator, wellness coach, or other KP health care professional about: (Check ALL that apply)
- | | |
|--|---|
| <input type="checkbox"/> Your diet (salt, fats, fiber, etc.) | <input type="checkbox"/> Quitting smoking |
| <input type="checkbox"/> Losing weight | <input type="checkbox"/> Stress or emotional problems (like depression) |
| <input type="checkbox"/> Getting enough exercise | <input type="checkbox"/> Health screening tests recommended for you |
| <input type="checkbox"/> Getting enough sleep | <input type="checkbox"/> Immunizations (shots) recommended for you |
33. Did you get a flu (influenza) shot or intranasal FluMist immunization between September 2013 and March 31, 2014?
 Yes, at Kaiser Permanente Yes, outside Kaiser Permanente No
34. How would you rate Kaiser Permanente on:
- | | Excellent | Very Good | Good | Fair | Poor |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Medical care you've received when sick or injured | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Preventive medicine services (screening tests, immunizations, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The information and advice you've received about how to improve your health and well-being | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
35. When did you last have your teeth cleaned and checked by a dentist or dental hygienist?
 Less than 7 months ago 7-12 months ago More than 1 year ago Never had this done
36. Do you have insurance that covers the cost of dental check-ups and cleaning? Yes No
37. During the past 12 months, how many visits to non-Kaiser Permanente health professionals (doctor, chiropractor, etc.) did you make for your own health? (Do NOT include dentists) _____ Visits
38. Do you have insurance that covers the cost of non-Kaiser Permanente medical visits? Yes No
39. During the past 12 months, how many of your own prescriptions did you get filled at non-Kaiser Permanente (KP) pharmacies and/or through non-KP websites? _____ Prescriptions

40. During the past 12 months, did you:

- a. Start to take a medicine in smaller doses or less frequently than prescribed, or decide not to fill a prescription because of the cost? Yes No
- b. Delay or not get medical care you thought you needed because of the cost? Yes No
- c. Eat less fruit and vegetables than you wanted to because of the cost? Yes No

Section 3: Your Communication Tools and Preferences

41. Do you have a mobile phone?

- Yes → a. What type do you have? Cell phone Smartphone (e.g., iPhone, Android)
- No b. On your phone, are you able to: Get text messages Use apps

42. Do you have access to a desktop, laptop, or tablet computer if you want to use one?

- Yes, at home Yes, at work Yes, at another location (library, neighbor, etc.) No access

43. Do you use the Internet, e.g., to get information from websites? If so, how and where do you use it?

- Yes, I use it by myself
 Yes, but someone else helps or uses it for me
 No, I do not use the Internet
- a. What do you/your helper usually use to get on the Internet?
 Desktop or laptop computer Tablet (e.g., iPad) E-reader
 Cell phone Smartphone Other: _____
- b. Where do you use the Internet? Home Work Other: _____

44. Are you able to send and receive/check email, and if so, how?

- Yes, I do this myself
 Someone does this for me
 No, I do not use email
- What do you/your helper usually use to send/check your email?
 Desktop or laptop computer Cell phone Smartphone
 Tablet (e.g., iPad) Other: _____

45. During the past 12 months, have you done any of the following? (Check **ALL** that apply)

- Participated in any Kaiser Permanente group or individual **health education program/service**
- Used any **quit smoking program/service** (health coach, group, phone quit line, web-based, etc.)
- Used any **weight loss or Healthy Eating, Active Living program/service** (health coach, group, counseling, web-based, email-based, etc.)
- Got help from a Kaiser Permanente **patient educator** or **health coach** with **changing health-related behaviors** (e.g., diet, exercise) or **managing a chronic health condition** like diabetes
- Used Kaiser Permanente **print health education materials** (handouts, pamphlets, etc.)
- Read one of Kaiser Permanente's **member or patient newsletters**
- Got **health information** or advice from **kp.org** or **other Internet websites**
- Used the **kp.org online Health Encyclopedia** or **Drug Encyclopedia**
- Got health information from your **doctor's home page** on the kp.org website (**kp.org/my doctor**)
- Used any **kp.org online health education programs** (preparing for a procedure, health calculator, or Healthy Lifestyle programs for nutrition, weight, stress, physical activity, etc.)
- Listened to a **kp.org podcast**
- Used any **health app** to help with diet, exercise, sleep, monitoring a health condition, etc.
- Used the **kp.org website** to **view lab results, refill prescriptions, or email** doctors/other staff
- Used a **Kaiser Permanente app** to use kp.org secure features or get reminders
- Participated in an **online chat room or online community** to get advice/support for a health condition

46. In which of these ways would you like to get information and advice about how to manage health conditions and make changes in health behaviors (diet, exercise, etc.)? (Check **ALL** that apply)

- | | |
|--|---|
| <input type="checkbox"/> Telephone sessions with a health coach | <input type="checkbox"/> Health newsletters/information <u>by email</u> |
| <input type="checkbox"/> In-person counseling with a patient educator | <input type="checkbox"/> Get information from Internet websites |
| <input type="checkbox"/> Video/Skype session with a patient educator | <input type="checkbox"/> Get information from your doctor's home page |
| <input type="checkbox"/> Communications using kp.org secure email | <input type="checkbox"/> Listen to podcasts or online audio programs |
| <input type="checkbox"/> One-session class, workshop or group program | <input type="checkbox"/> One-session online interactive program |
| <input type="checkbox"/> Multi-session class or group program | <input type="checkbox"/> Multi-session online interactive program |
| <input type="checkbox"/> Watch DVDs at home | <input type="checkbox"/> Watch online videos on kp.org , YouTube, etc. |
| <input type="checkbox"/> Interactive computer programs | <input type="checkbox"/> Watch live webinars or talks on kp.org |
| <input type="checkbox"/> Print materials (e.g., brochures, tip sheets) | <input type="checkbox"/> Use a health app on your tablet or smartphone |
| <input type="checkbox"/> Health newsletters/information <u>by mail</u> | <input type="checkbox"/> Join an online chat room/online community |

Section 4: Information Describing Who Participated In This Survey

47. What is your sex? Male Female Transgender (describe): _____

48. What is your date of birth? (Year should **not** be 2014) __ __ / __ __ / __ __ __ __
MONTH DAY YEAR

49. What describes your race and ethnicity? (Check **ALL** that apply)

- | | |
|--|--|
| <input type="checkbox"/> White or of European descent | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> African-American | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Other Black (specify): _____ | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Mexican or Central American ancestry | <input type="checkbox"/> Southeast Asian (specify): _____ |
| <input type="checkbox"/> Other Hispanic/Latino (specify): _____ | <input type="checkbox"/> Other Asian (specify): _____ |
| <input type="checkbox"/> Middle Eastern, North African, or Central Asian | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> South Asian (Indian, Pakistani, Afghan, etc.) | <input type="checkbox"/> Native American Indian or Alaska Native |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Other (specify): _____ |

50. What is the highest level of school you completed? (Check only **ONE** answer)

- | | |
|---|--|
| <input type="checkbox"/> 8th grade or less (primary or middle school) | <input type="checkbox"/> Some college (no degree) |
| <input type="checkbox"/> 9th - 11th grade (some high school) | <input type="checkbox"/> Associate's Degree (e.g., AA, AS) |
| <input type="checkbox"/> 12th grade (high school graduate or G.E.D.) | <input type="checkbox"/> Bachelor's Degree (e.g., BA), teaching credential |
| <input type="checkbox"/> Technical/trade school certificate | <input type="checkbox"/> Graduate or professional degree (e.g., MA, MD) |

51. What is your current work status? Do you do unpaid volunteer work on a regular basis?

- | | |
|---|--|
| <input type="checkbox"/> Working for pay → How many hours/week? ____ | <input type="checkbox"/> Full-time homemaker or unpaid caregiver |
| <input type="checkbox"/> Self-employed → How many hours/week? ____ | <input type="checkbox"/> Part-time or full-time student |
| <input type="checkbox"/> Unemployed or laid off | <input type="checkbox"/> Volunteer → How often? _____ |
| <input type="checkbox"/> Retired or unable to work due to health/disability | <input type="checkbox"/> Other (specify): _____ |

52. Are you currently: (Check only **ONE** answer)

- Married In a committed relationship Widowed Single, divorced, or separated

53. (Optional) Are you lesbian or bisexual? No Yes, lesbian Yes, bisexual

54. Which of the following best describes your total household (family) income from all sources in 2013, before taxes? (Check only **ONE** answer)

- | | | |
|--|--|--|
| <input type="checkbox"/> Under \$15,000 | <input type="checkbox"/> \$35,001 - \$50,000 | <input type="checkbox"/> \$80,001 - \$100,000 |
| <input type="checkbox"/> \$15,000 - \$25,000 | <input type="checkbox"/> \$50,001 - \$65,000 | <input type="checkbox"/> \$100,001 - \$150,000 |
| <input type="checkbox"/> \$25,001 - \$35,000 | <input type="checkbox"/> \$65,001 - \$80,000 | <input type="checkbox"/> More than \$150,000 |

55. Do you have any comments about health education and health improvement services Kaiser Permanente currently provides or that you would like Kaiser Permanente to consider offering?

Thank you for your help!