

2011 KAISER PERMANENTE MEMBER HEALTH SURVEY

CONFIDENTIAL

<Name>

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

<Street Address>

Address: _____

<City, State, Zipcode>

Daytime phone: (_____) _____

Email address: _____

Study ID:

Passcode:

We are doing this survey to learn about our adult membership's health-related needs and preferred methods for communicating about health. The survey has 4 sections:

1. Your Health and Health-Related Habits
2. Health Services You've Received In and Outside Kaiser Permanente
3. Your Communication Tools and Preferences
4. Information Describing Who Participated In This Survey

PLEASE NOTE:

- ☞ **Even if you rarely use Kaiser for your medical care, it is very important for us to hear from you; the survey results must accurately represent our entire membership.**
- ☞ **This questionnaire should be filled out ONLY by or for the person named above.**
- ☞ **You will be entered into a drawing for one of 100 \$50 gift certificates when we receive your completed questionnaire by mail or online.**

Your answers are absolutely confidential. Your name and Study ID are on the questionnaire so we can note that you returned the questionnaire and contact you, if needed, to make sure we understand your answers. If you have any questions about the survey, please call toll-free: **(800) 723-8055 (choose Member Health Surveys)** or email the survey staff at: dor.mhs@kp.org.

If you prefer to complete the questionnaire online at our secure website, please type the following url into your browser's address box: www.dor.kaiser.org/studies/mhs2011/ To enter your survey, you will need to use the Study ID and Passcode printed above.

Thank you for your participation!



**Nancy Gordon, ScD
Member Health Survey Director**

Please return your survey in the enclosed postage-paid envelope or send to:

Kaiser Permanente Division of Research
Attn: Member Health Survey
2000 Broadway, Oakland, CA 94612

Section 1: 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 did you have or were you treated for? (Check **ALL** you had, were treated for, or took medication for)

- | | |
|--|---|
| <input type="checkbox"/> Heart attack or myocardial infarction
<input type="checkbox"/> Heart problems, including angina
<input type="checkbox"/> TIA (Trans Ischemic Attack)
<input type="checkbox"/> High blood pressure (<i>diagnosed by a clinician</i>)
<input type="checkbox"/> High cholesterol (<i>diagnosed by a clinician</i>)
<input type="checkbox"/> Cancer (<i>specify type</i>): _____
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma
<input type="checkbox"/> Chronic bronchitis
<input type="checkbox"/> Emphysema/COPD
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Osteoporosis (<i>brittle bones</i>)
<input type="checkbox"/> Arthritis or rheumatism
<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) after feeling pressure to urinate or when coughing, lifting, exercising, etc.
<input type="checkbox"/> Vision problem (with or without glasses/lenses)
<input type="checkbox"/> Hearing problem or deafness
<input type="checkbox"/> Frequent problems falling or staying asleep
<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"/> None of these problems |
|--|---|

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

- | | |
|---|--|
| <input type="checkbox"/> Heart problems or a heart attack
<input type="checkbox"/> A stroke
<input type="checkbox"/> A TIA (Trans Ischemic Attack)
<input type="checkbox"/> High blood pressure (hypertension) | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer (<i>specify type</i>): _____
<input type="checkbox"/> Adult depression lasting at least 2 weeks
<input type="checkbox"/> Problems with alcohol or drugs
<input type="checkbox"/> Chronic (ongoing) pain (<i>describe</i>): _____ |
|---|--|

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

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

7. 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 Vitamin D | <input type="checkbox"/> Melatonin / sleep formula containing melatonin |
| <input type="checkbox"/> Calcium without Vitamin D (incl. Tums or Rolaids) | <input type="checkbox"/> Herbal or homeopathic cold/flu remedies |
| <input type="checkbox"/> Vitamin C (separate from in a multivitamin) | <input type="checkbox"/> Other herbals (List: _____) |
| <input type="checkbox"/> Vitamin D (not with calcium or in a multivitamin) | _____ |
| <input type="checkbox"/> Fish oil, flaxseed oil, other Omega-e Fatty Acids | <input type="checkbox"/> Other vitamins, minerals, or supplements |
| <input type="checkbox"/> Ginkgo biloba | (List): _____ |

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

- | | |
|---|---|
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Any herbal medicines/remedies |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Chinese, Indian, or Native American medicines |
| <input type="checkbox"/> Acupressure | <input type="checkbox"/> Megavitamin (very high dose vitamin) therapy |
| <input type="checkbox"/> Massage therapy | <input type="checkbox"/> Very low fat diet (Pritikin, Dean Ornish, etc.) |
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Very low carb diet (Atkins, South Beach, etc.) |
| <input type="checkbox"/> Body work (Feldenkrais method, etc.) | <input type="checkbox"/> Other special diet: _____ |
| <input type="checkbox"/> Tai Chi, Chi Gong, other movement therapies | <input type="checkbox"/> Energy healing (magnets, laying on of hands, special energy-emitting machines, etc.) |
| <input type="checkbox"/> Deep breathing, mindfulness, or other relaxation or meditation technique | <input type="checkbox"/> Prayer or spiritual practice you do yourself |
| <input type="checkbox"/> Guided imagery / visualization techniques | <input type="checkbox"/> Religious or spiritual healing by others |
| <input type="checkbox"/> Hypnosis or self-hypnosis | <input type="checkbox"/> Psychological counseling or therapy |
| <input type="checkbox"/> Any homeopathic medicines | <input type="checkbox"/> 12-Step program or other type of self-help group |

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

10. How much do you weigh without your shoes and clothes? _____ Pounds

11a. Compared to this time **last year**, do you weigh: About the same More Less

11. 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

12. 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

13. 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

14. How often do you usually get physical exercise (such as walking, swimming, gardening, golf, tennis, etc.)?

- 5 or more times a week 1 to 2 times a week Once a month or less
 3 to 4 times a week 2 to 4 times a month Never (**Go to Question 15**)

14a. On days you exercise, how many **total minutes** do you usually exercise? _____ Minutes per Day

14b. On days you exercise, what type of exercise do you usually get? (Check **ONE** answer only)

- Low impact (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)

15. How many total hours of sleep do you usually get **in a 24-hour day**, including naps? _____ Hours

Section 2: Health Services You've Received In and Outside Kaiser Permanente

26. 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 |

27. Did you get a flu (influenza) shot or intranasal FluMist immunization between **September 2010 and March 31, 2011**? Yes, at Kaiser Permanente Yes, outside Kaiser Permanente No

28. For each of these screening tests below, please indicate whether your most recent one was done at Kaiser Permanente (KP), done outside KP, or that you have never had this test.

	Last Done at KP	Last Done Outside KP	Never Had This Test
a. Blood pressure check by a doctor or nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Blood cholesterol test (check of both HDL and LDL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood glucose test (checks for diabetes or pre-diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. FOBT/FIT colorectal cancer screening (tests a bowel movement ("poop") sample for blood; often done at home and sent to lab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Sigmoidoscopy or colonoscopy (doctor examines colon and rectum for cancerous polyps using a flexible tube)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. How would you rate Kaiser Permanente on:

- | | <u>EXCELLENT</u> | <u>VERY GOOD</u> | <u>GOOD</u> | <u>FAIR</u> | <u>POOR</u> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 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"/> |

30. 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

31. Do you have insurance that covers the cost of dental check-ups and cleaning? Yes No

32. **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

33. Do you have insurance that covers the cost of non-Kaiser Permanente medical visits? Yes No

34. **During the past 12 months**, how many of **your own** prescriptions did you get filled at non-Kaiser Permanente pharmacies (including through **non-KP** websites)? _____ Prescriptions

35. 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

Section 3: Your Communication Tools and Preferences

36. Do you have a mobile phone (cell phone or a smart phone like Blackberry, iPhone, or Droid)?

- Yes → **Can you receive text messages on this phone?** Yes No
 No

37. Are you able to access a computer (desktop, laptop, or netbook) if you want to use one?

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

38. Are you able to use the Internet to get information from websites, and if so, how?

(Check **All** that apply)

- Yes, at home
 Yes, at another location
 Someone does this for me

- No Internet access

What is usually used to get onto the Internet? (Check **All** that apply)

- Computer, laptop, netbook Cell phone Smart phone
 Tablet (iPad, iTouch, etc.) Other: _____

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

- Yes
 Someone does this for me
 No

What is usually used to send/check your email? (Check **All** that apply)

- Computer, laptop, netbook Cell phone Smart phone
 Tablet (iPad, iTouch, etc.) Other: _____

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

- Participated in a Kaiser Permanente group or individual **health education program**
 Visited a Kaiser Permanente **Health Education Center** or **Resource Desk**
 Used Kaiser Permanente or other **smoking cessation service** (group, one-on-one, or online/email)
 Used a Kaiser Permanente or other **weight loss or Healthy Eating, Active Living program** (group, one-on-one counseling/coaching, online program, or email-based program)
 Got **health information** or advice at **kp.org** (Kaiser Permanente's website) or **other Internet websites**
 Got **one-on-one counseling** from Kaiser Permanente to help **change health-related behaviors** (smoking, diet, etc.) or **manage a chronic health condition** (diabetes, hypertension, heart disease, etc.)
 Used Kaiser Permanente **print health education materials** (handouts, pamphlets, DVDs, etc.)
 Read one of Kaiser Permanente's **member newsletters** (like *Partners in Health* or *Senior Outlook*)
 Used the **online Health Encyclopedia** or **Drug Encyclopedia** on the **kp.org** website
 Used **online health education programs** (preparing for a procedure, health calculator, or Healthy Lifestyle programs for nutrition, weight, stress, physical activity) on **kp.org**
 Got health information from your **doctors' home page** on the **kp.org** website (**kp.org/my doctor**)
 Used the **kp.org website** to **view lab results, refill prescriptions, or email doctors**

41. In addition to talking or emailing with your doctor, how would you **prefer** to learn about taking care of health problems and improving your health? (Check **ALL** that apply)

- | | |
|---|--|
| <input type="checkbox"/> Small group appointments with a clinician or health educator (for diabetes, etc.) | <input type="checkbox"/> Use an interactive computer program |
| <input type="checkbox"/> Individual counseling with a health educator | <input type="checkbox"/> Watch live " webinar " programs/talks on kp.org |
| <input type="checkbox"/> Brief telephone counseling sessions | <input type="checkbox"/> Podcasts and online (kp.org) audio programs |
| <input type="checkbox"/> Communications using secure email | <input type="checkbox"/> Watch health videos on kp.org/other websites |
| <input type="checkbox"/> One session health education workshop | <input type="checkbox"/> Watch health DVDs at home |
| <input type="checkbox"/> Multi-session class/group in-person program | <input type="checkbox"/> Get Information from Internet websites |
| <input type="checkbox"/> Multi-session group program over the phone | <input type="checkbox"/> Get information from your doctor's home page |
| <input type="checkbox"/> One session program using email/internet | <input type="checkbox"/> Get information text messaged to your cell phone |
| <input type="checkbox"/> Multi-session program using email/Internet | <input type="checkbox"/> Health newsletters and tip sheets emailed to you |
| | <input type="checkbox"/> Health newsletters and tip sheets mailed to you |

Section 4: Information Describing Who Participated In This Survey

42. What is your sex? Male Female Transgender (describe): _____
43. What is your date of birth? (Year should **not** be 2011) ____ / ____ / ____
MONTH DAY YEAR
44. 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"/> Hawaiian/Pacific Islander (specify): _____ |
| <input type="checkbox"/> South Asian (Indian, Pakistani, etc.) | <input type="checkbox"/> Native American Indian or Alaska Native |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Other (specify): _____ |
45. 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 (AA, AS, etc.) |
| <input type="checkbox"/> 12th grade (high school graduate or G.E.D.) | <input type="checkbox"/> Bachelor's degree (BA, BS, etc.) |
| <input type="checkbox"/> Technical/trade school certificate | <input type="checkbox"/> Graduate or professional degree (MA, MD, etc.) |
46. What language do you most prefer to use when talking about or learning about your health?
- English Spanish Chinese Other: _____
47. What is your current work status?
- | | |
|---|---|
| <input type="checkbox"/> Working for pay → How many hours/week? ____ | <input type="checkbox"/> Fulltime homemaker, parent 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"/> Part-time or full-time volunteer |
| <input type="checkbox"/> Retired or unable to work due to health/disability | <input type="checkbox"/> Other (specify): _____ |
48. Are you currently: (Check only **ONE** answer)
- Married In a committed relationship Widowed Single, divorced, or separated
49. (Optional) Are you gay or bisexual? No Yes, gay Yes, bisexual
50. Which of the following best describes your total household (family) income from all sources in 2010, 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 |
51. 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.