THE QUESTIONS OF HOWSYOURHEALTH GERIATRIC

AND SCORING CONVENTIONS 1/17 (Additions at the end of the report)

** ARE USED IN THE CALCULATION SHOWN IN THE CUMULATIVE REPORTS*
++ ARE USED IN THE WHAT MATTERS INDEX

Gender: Male Female
Age Groups: '70-79', "80+' [65-69 items are in the adult assessment)

DAILY ACTIVITIES (Q1)
During the past 4 weeks how much difficulty have you had doing your usual activities or tasks, both inside and outside the house because of your physical and emotional health?
No difficulty at all A little bit of difficulty Some difficulty Much difficulty* Could not do*

DAILY ACTIVITIES (Q1A) You answered that you had greater than average difficulty doing your usual activities or tasks. Is your doctor or nurse aware of the problem?
Yes No
DAILY ACTIVITIES (Q1B)
You answered that you had greater than average difficulty doing your usual activities or tasks. How would you rate your doctor's or nurse's explanation of the problem(s)?
Excellent* Very good* Good Fair Poor
DAILY ACTIVITIES (Q1C) You answered that you had greater than average difficulty doing your usual activities or tasks. Treatment has made these problems:
No treatment has been given to me for these problems Much better* A little better*
No different
A little worse
Much worse

FEELINGS (Q2)
During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
Not at all Slightly Moderately Quite a bit* Extremely*

FEELINGS (Q2A)
You answered that you have been bothered by more than average emotional problems. Is your doctor or nurse aware of the problem?
Yes No
FEELINGS (Q2A) You answered that you have been bothered by more than average emotional problems. How would you rate your doctor's or nurse's explanation of the problem(s)?
Excellent* Very good* Good Fair Poor
FEELINGS (Q2C) You answered that you have been bothered by more than average emotional problems. Treatment has made these problems:

No treatment has been given to me for these problems Much better* A little better* No different A little worse Much worse

SOCIAL ACTIVITIES (Q3)

During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?

Not at all Slightly Moderately Quite a bit* Extremely*

SOCIAL ACTIVITIES (Q3A) You answered that your social activities have been limited more than average. Is your doctor or nurse aware of the problem?

Yes

No

SOCIAL ACTIVITIES (Q3B) You answered that your social activities have been limited more than average. How would you rate your doctor's or nurse's explanation of the problem(s)?

Excellent* Very good* Good Fair Poor

SOCIAL ACTIVITIES (Q3C) You answered that your social activities have been limited more than average. Treatment has made these problems:

No treatment has been given to me for these problems

Much better* A little better* No different A little worse Much worse

PAIN (Q4)

During the past 4 weeks, how much bodily pain have you generally had?

No pain Very mild pain Mild pain Moderate pain*++ Severe pain*++

PAIN (Q4A)

You answered that you had greater than average bodily pain. Is your doctor or nurse aware of the problem?

Yes No

PAIN (Q4B)

You answered that you had greater than average bodily pain. How would you rate your doctor's or nurse's explanation of the problem(s)?

Excellent* Very good* Good Fair Poor

PAIN (Q4C) You answered that you had greater than average bodily pain. Treatment has made these problems:

No treatment has been given to me for these problems Much better* A little better* No different A little worse Much worse

SOCIAL SUPPORT (Q5)

During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you: felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself

Yes, as much as I wanted Yes, quite a bit Yes, some Yes, a little* No, not at all*

SOCIAL SUPPORT (Q5A)

You answered that you had very little or no social support. Is your doctor or nurse aware of the problem?
Yes No
SOCIAL SUPPORT (Q5B) You answered that you had very little or no social support. How would you rate your doctor's explanation of the problem(s)?
Excellent* Very good* Good Fair Poor
SOCIAL SUPPORT (Q5C) You answered that you had very little or no social support. Treatment has made these problems:
No treatment has been given to me for these problems Much better* A little better* No different A little worse Much worse

PHYSICAL FITNESS (Q6)
During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes
Very heavy Heavy Moderate Light* Very light*

PHYSICAL FITNESS (Q6A)
You answered that you had greater than average difficulty doing physical activities. Is your doctor or nurse aware of the problem?
Yes No
PHYSICAL FITNESS (Q6B)
You answered that you had greater than average difficulty doing physical activities. How would you rate your doctor's or nurse's explanation of the problem(s)?
Excellent* Very good* Good Fair Poor
PHYSICAL FITNESS (Q6C) You answered that you had greater than average difficulty doing physical activities.
Treatment has made these problems: No treatment has been given to me for these problems Much better* A little better* No different A little worse Much worse

How often during the PAST FOUR WEEKS have you been **bothered** by any of the following problems?
Never Seldom Sometimes Often* Always*

Trouble thinking or remembering
Trouble urinating or wetting
Trouble hearing
Trouble seeing
Falling or dizzy when standing up
Trouble sleeping
Sexual Problems
Foot problems
Constipation
Trouble eating well

Do you use any of the following:
(Please mark all that apply)*

A cane, wheelchair, or walker
Brace(s) or prosthesis
A hearing aid
Dentures
Reading glasses
Raised toilet seat, bathtub bars, toilet bars
Devices for dressing, eating, or bathing
Emergency Alert System

If you became too sick to speak for yourself, who would decide about medical treatment for you?

I am not sure Family members* Friends* My doctor* Other*

You answered that you knew who would decide about medical treatment for you:

Do they know what you would want?

Yes* No I am not sure

Is what you want in writing?

Yes* No I am not sure

Have you ever had a shot to prevent pneumonia(Pneumovax), in the past five years?

Yes* No I am not sure

Do you have a flu shot to prevent flu every year?

Yes* No I am not sure

Have you had a tetanus shot in the past 10 years?

Yes* No I am not sure

In the past two years, have you had a test for cancer of the bowel?
Yes * No No, but I have had a colonoscopy in the past nine years

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Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

Yes* No

Keeping track of your medications?

Yes* No

During the PAST FOUR WEEKS, have you seen any of the following health care workers?
(Please mark all that apply)

I have not seen any other health care workers
Your own or another doctor
Home health aid or a nurse in your home
Social worker
Podiatrist (foot doctor)
Chiropractor
Mental health worker or psychiatrist or psychologist or counselor
Physical therapist or occupational therapist
Nurse practitioner or physician's assistant

Can you get to places out of walking distance without help? (for example, can you travel alone on buses, taxis, or drive your own car)

Yes No*

Can you go shopping for groceries or clothes without someone's help?

Yes No*

Can you prepare your own meals?

Yes No*

Can you do your housework without help?

Yes No*

Can you handle your own money without help?

Yes No*

Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing or getting around the house?

'Yes', 'No' *

Do you have enough money to buy the things that you need to live everyday such as food, clothing, or housing?

Yes, usually Yes, sometimes* No*

Are you having difficulties driving your car?

Yes, often* Sometimes* No Not applicable, I do not use a car

Do you fasten your seat belt when you are in a car?
'Yes, almost always', 'Yes, sometimes', 'No'

Are you a smoker?

No Yes, and I might quit* Yes, but I'm not ready to quit*

During the PAST 4 WEEKS, how many drinks of wine, beer or other alcoholic beverages did you have?

10 or more per week * 6-9 per week* 2-5 per week 1 drink or less per week No alcohol at all

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How often do you eat food that is healthy (such as fresh fruits, fish and vegetables) instead of unhealthy food (such as fried foods, sweets and "junk food")?

In the last week my evening meals were:

Always Healthy Meals* Most of the time Healthy Meals* Some of the time Healthy Meals A little of the time Healthy Meals'Almost never Healthy Meals

Do you **exercise** for about 20 minutes 3 or more days a week? (Q Exercise)

*Yes, most of the time Yes, some of the time No, I usually do not exercise this much.

HEALTH HABIT CHANGE (Depending on previous responses)
If you are interested in making a change in a risk to your health during the next two months, please check the one most important to you at this time.

I wish to quit smoking I wish to lose weight I wish to cut back on drinking alcohol I wish to exercise more regularly I wish to have better health habits such as eating right or avoiding accident risks I do not wish to make any change in a risk to my health at this time

HEALTH HABIT CONFIDENCE IN CHANGE (Depending on previous choice)
You checked that during the next two months you….(filled in by choice)
How confident are you that in two months you will be successful

Very confident* Somewhat confident Not very confident

How many different prescription medications are you currently taking more than three days a week?

None 1-2 3-5 More than 5*++

Do you believe any of your medications are making you ill?

Yes*++ No Maybe, I am not sure*++ I am not taking any medications

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How often do you have trouble taking medicines the way you have been told to take them?
I do not have to take medicines', 'I always take them as prescribed', 'Sometimes I take them as prescribed', 'I seldom take them as prescribed']

Have you fallen 2 or more times in the past year?

'Yes', 'No'

Are you afraid of falling?

'Yes', 'No'

OVERALL HEALTH

During the past 4 weeks, how would you rate your health in general?

Excellent Very good Good Fair* Poor*

QUALITY OF LIFE

How have things been going for you during the past four weeks?

Very well - could hardly be better Pretty good Good and bad parts about equal*

Pretty bad* Very bad - could hardly be worse*

Has a doctor told you that you have any of these problems:
(Please mark all that apply)

High blood pressure
Heart trouble or hardening of the arteries
(Sugar) Diabetes
Arthritis
Asthma, bronchitis or emphysema
Serious obesity (more than 15% overweight)

You checked that you have high blood pressure, heart trouble, diabetes, or breathing problems.

In the past year have you been in the hospital or visited an emergency room because of any of these problems?

Yes * No

You checked that you have high blood pressure, heart trouble, diabetes, or breathing problems.

In general, how would you rate the information given to you about these problem(s) by your doctor or a nurse?

Excellent* Very Good* Good Fair Poor I do not remember receiving any information

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You checked that you have high blood pressure, heart trouble, diabetes, or breathing problems.

In general, how much have any of the doctors or nurses helped you live with these problems?

A lot* Some A little Not much I have not needed any help

You checked that you have high blood pressure, heart trouble, diabetes, or breathing problems.

What is your weight in pounds (kilograms)?

less than 100 (45)
100-120 (46-55)
121-140 (56-64)
141-160 (65-73)
161-180 (74-82)
181-200 (83-91)
201-220 (92-100)
221-240 (101-109)
240 or more (>110)

What is your height in inches (within 2 inches)?

Feet: Inches:

You indicated earlier that you have breathing problems.

How would you **rate the information** your doctor or a nurse gave you about: Excellent* Very Good* Good Fair Poor I do not remember receiving any information

How to **adjust medicines** for your shortness of breath?(Q Breathing 1A)
How to **use inhaled** medicines? (Q Breathing 1B)

Do you use an **inhaled steroid**? (Q Breathing 2)
Yes* No Not sure

You indicated earlier that you have diabetes.

How often do you keep your **blood sugar (glucose) in normal range** (between 80 and 150)? (Q Diabetes 1)
I do not test my blood sugar *All of the time *Often Sometimes Rarely Never

How would **you rate the information** your doctor or a nurse gave you about: *Excellent *Very Good Good Fair Poor I do not remember receiving any information

Having your **eyes checked**? (Q Diabetes 2A)
How to **check feet** and choose proper shoes? (Q Diabetes 2B)
How to **adjust medicines for diabetes** and recognize when to call a doctor or nurse for help? (Q Diabetes 2C)

If your **blood sugar level before eating** was checked in the past four weeks, what was it? (Q Diabetes 3) Less than 100 101-120 121-140 141-160 161-180 181-200 201-250 Over 250

You indicated earlier that you have high blood pressure
How would you rate the **blood pressure information** your doctor or nurse has given you? *Excellent *Very Good
Good Fair Poor I do not remember receiving any information

What to do if you **miss a dose** of your medicine? (Q HBP 1A)
The effect of **weight and salt** on our blood pressure? (Q HBP 1B)
The **problems blood pressure medications** might cause you? (Q HBP 1C)

Do you **check your own blood pressure**? (Q HBP 2)
*Yes, often Yes, sometimes Almost never Never

What was your last blood pressure? (Q HBP 3A)
High Number (systolic) Under 100 100-120 121-130 131-140 141-150 151-160 161-170 Over 171 I don't know
Low Number (diastolic) (Q HBP 3B)
Less than 60 60-70 71-80 81-90 91-100 101-110 Over 110 I don't know

[For Hypertension, Diabetes, and Heart Disease]

What was your **last total cholesterol level**? (Q Heart 0)
Less than 100 101-130 131-160 161-180 181-200 201-220 221-240 Over 240 I don't know

You indicated earlier that you have heart trouble.

Have you ever had a **heart attack**? (Q Heart 1A)
Yes No

If you answered yes, are you taking aspirin and a "beta blocker" such as propanolol (Inderal), or other "beta blocker" drugs that end with a 'lol'? (Q Heart 1B) Yes* No I am not sure

Have you had a **stroke, paralysis or "shock"?** (Q Heart 2A)
Yes No

In the last month, have you **used nitroglycerin for chest pain**, tightness or angina? (Q Heart 3A)
Yes No
If you answered yes, how satisfied are you that everything is being done for your chest pain, tightness or angina? (Q Heart 3B)
*Completely satisfied *Mostly satisfied Somewhat satisfied Mostly dissatisfied Not satisfied at all

Have you been told that you have **heart failure**? (Q Heart 4A)
Yes No
If you answered yes, how would you rate the information your doctor or a nurse gave you about
*Excellent *Very Good Good Fair Poor I do not remember receiving any information

The effect of **weight and salt** on your heart failure? (Q Heart 4B)
How to **adjust medicines** for your weight, shortness of breath and leg swelling? (Q Heart 4C)

Describe here any **medical errors (mistakes)** that you or your family have experienced. Errors include such things as mixed up medications or poor treatment that result in harm or additional problems. If possible, be sure to tell us the cause of the error and how it might have been avoided. Your response will help us to improve future care delivery.
If you wrote in an error or harm, please help us by choosing ANY of the following categories for this error. (Please mark all that apply)

*ALL MUST BE PRESENT TO BE CODED A HARM
*It caused harm, hurt or injury (Q Open 1) *It happenend within the last year (Q Open 2) *It happened to me (Q Open 3)

How **confident** are you that you can control and manage most of your health problems? (Q Control)

*Very confident Somewhat confident++ Not very confident++ I do not have any health problems.

What would it take to increase your health confidence so that you could say that you are "very confident" you can control and manage most of your health problems during the next 2 months? (Open ended)

MEDICAL HOME PROCESSES

When you visit your doctor's office, how often is it well organized, **efficient,** and does not waste your time? (Q Efficient)
*Most of the time Some of the time Almost never is it efficient. It often wastes my time. Does not apply to me. I seldom visit a doctor's office.

In the PAST 3 MONTHS did you have an **illness or injury** that kept you in bed for all or most of the day? (Q26)
Yes* No

In the PAST YEAR did you **stay in a hospital** overnight or longer? (Q27)
Yes* No

Do you have one person you think of as your **personal doctor or nurse**? (Q28)
Yes* No

Are you now also seeing a **specialist physician**?
Yes No I am not sure

If you are seeing a specialist physician and your primary physician do you have **one doctor who you feel is in charge** of your medical care?
Yes* No I am not sure

Overall, are there things about the **medical care from your specialist physician (or physicians)** that could be better?
No, the specialist(s) care is perfect* Yes, some things Yes, lots of thing

Are there things about your **medical care** that could be better? (Q29)
No, my care is perfect* Yes, some things Yes, a lot of things

How **easy is it for you to get medical care** when you need it? (Q30)

Very Easy* Easy Somewhat Difficult Very Difficult I have not needed medical care

When you think about your health care, how much do you agree or disagree with this statement:
I **receive exactly what I want and need** exactly when and how I want and need it.
Strongly Agree* Somewhat Agree Somewhat Disagree Strongly Disagree

You checked that you **have used the hospital or the emergency department in the past 12 months**. If this is true,

How many different times have you used the hospital or emergency department?
'1 time'2-4 times 5 or more times I have not used the hospital or emergency department in the past 12 months

Do you think that there was something you or a doctor **could have done to avoid** the hospital admission or visit to the emergency department?
Yes, I am sure that if I had received better medical care or information I might have avoided time in the hospital or emergency department Maybe, if I had received better medical care or information I might have avoided time in the hospital or emergency department No, I can think of nothing a doctor or I could have done to avoid it. My time in the hospital or emergency department was necessary*

OPTIONS: CAHPs (Can be activated completely or randomly to reduce response burden for patients. The template used is includes items 6-23 and 41-43 from 2016 PQRS that are comparable to the 2012 CAHPs). The many remaining PQRS items that focus on decision making for tests, medications, and surgical treatments and discussion of prescriptions are new, rely heavily on remote recall and are more directly assessed and or managed by HowsYourHealth. We have chosen three of these PQRS items for cross correlation about i) test follow-up information, ii) medication instruction intelligibility, and iii) sharing of personal health information.

OPTION: REVIEW OF SYSTEMS (Must be activated… Adds length to assessment but documents for billing purposes)

<u>Purpose of Doctor appointment</u>
Please complete the following:
Is your main purpose in coming to the office for a NEW concern or problem or a KNOWN (older) concern or problem?
NEW concern or problem
KNOWN (OLDER) concern or problem

What is the concern or problem?

What does the concern or problem mean to you?

Are you bothered by problems/symptoms in any of the following areas.

Check any that are new or bothersome.
Stomach or Bowel:
- sick to stomach
- vomiting
- abdominal pain
- constipation
- diarrhea
- blood in stools

Heart:
- chest pain
- heart 'pounding or skipping'

Eyes:
- double vision
- sudden loss of vision

Lungs:
- cough
- wheezing
- shortness of breath

Sexual:
- impotence
- irregular period
- vaginal bleeding after menopause

Urine:
- frequent or painful urination
- bloody urine

Feelings:
- depression

anxiety

Bones or Muscles:
joint pain
muscle weakness

Skin:
rash
changing mole
breast mass
new lumps or masses

General:
fever
weight loss
extreme fatigue
excessive thirst
bruising and bleeding

Nervous system:
headache
persistent weakness or numbness on one side of the body
falling

Ear, Nose, Mouth, or Throat:
sore throat
runny nose
ear pain

Other Concerns: