

Appendix 2: English and Spanish Survey Instruments

Study Information

Study ID

Survey Windows

First Name: [baseline_arm_1][ci_ptgivname]

Last Name: [baseline_arm_1][ci_ptsurname]

Hospital Name: [baseline_arm_1][admit_site]

Enrollment Date: [baseline_arm1][enroll_coral_date]

Month 1 Start: [baseline_arm_1][m1beg]

Month 1 End: [baseline_arm_1][m1end]

Month 3 Start: [baseline_arm_1][m3beg]

Month 3 End: [baseline_arm_1][m3end]

Month 6 Start: [baseline_arm_1][m6beg]

Month 6 End: [baseline_arm_1][m6end]

Study Status

Study Status

- Consented
- Withdrawn
- Deceased before LTO follow-up
- Deceased after LTO follow-up
- Excluded

Date of Death (after LTO follow-up)

Exclusion Date

Exclusion Reason

- Homeless
- Not English OR Spanish Speaking
- Excluded Based on Pre-Screen

Exclusion Comment

Withdrawn Date

Withdrawn Reason

Exit Interview

Who is providing information?

- Relative
- Friend
- Obituary
- Study Coordinator
- Other

Please specify other:

Informed of death by study coordinator

Yes

What was your relationship with the patient?

- Spouse
- Other

Please specify other:

Our research team wishes to extend our deepest sympathy for the passing of [patient's name]. We greatly appreciate [patient's name] participation in our research study as we try to improve the healthcare of patients across the United States

Message delivered

Date condolence letter was sent

When did the patient die? (Get an exact date if possible. Otherwise, try to get an approximate date or enter as mid-month).

Where did they die? (Record as open text and then classify according to one of the categories below).

Choose from list of categories:

- Hospital
- Hospital - PETAL
- Home
- Nursing Home
- Other

Please specify other:

Choose state, or DC, or Overseas

- AL
- AK
- AZ
- AR
- CA
- CO
- CT
- DE
- DC
- FL
- GA
- HI
- ID
- IL
- IN
- IA
- KS
- KY
- LA
- ME
- MD
- MA
- MI
- MN
- MS
- MO
- MT
- NE
- NV
- NH
- NJ
- NM
- NY
- NC
- ND
- OH
- OK
- OR
- PA
- RI
- SC
- SD
- TN
- TX
- UT
- VT
- VA
- WA
- WV
- WI
- WY
- PR
- Overseas

Is there anyone else in the family who has been involved with the this study that we should express our condolences to? (If so, send condolence letter to this person).

Date other condolence letter was sent

Demographics

Date of Birth

Age

Sex

- Male
 Female

Race

- American Indian/Alaska Native
 Asian
 Black/African American
 Native Hawaiian/Pacific Islander
 White
 Multiple
 Other/declined
 Unknown/unavailable

Ethnicity

- Hispanic or Latino
 Not Hispanic or Latino
 Unknown

Enrollment Date

Recent Living Status

- Home independently
 Home with help
 Home with professional help
 Intermediate care or rehab facility (e.g. goal is to get patient better)
 Nursing facility (e.g. goal is to meet patient's ongoing needs)
 Acute care hospital
 Homeless or living in a temporary shelter
 Adult Family Home or other non-medical institutional setting
 Other

Please specify:

Homeless

- Yes
 No

What is the patient's preferred language?

- English
 Spanish
 Other

Please specify preferred language:

Does the patient speak English fluently? Yes
 No

Does the patient speak Spanish fluently? Yes
 No

SSN _____

Local MRN or hospital unique identifier _____

Enrolled in Medicare? Yes
 No
 Unknown

Medicare ID number _____

Co-Enrolled? Yes
 No

Study Name _____

Disposition

Hospital disposition at discharge Died
 Palliative discharge/hospice (any destination)
 Discharge to home
 Discharge to home with home services
 Discharge to nursing home
 Discharge to LTACH
 Discharge to rehab
 Transfer to another acute care facility
 Transfer to inpatient psychiatric facility
 Other
 Still in hospital

"Other" hospital discharge _____

Date/time of first admission to study hospital _____

Hospital discharge/death date/time _____

Is patient known to have died after hospital discharge? Yes
 No

Date of Death (if patient is known to have died after hospital discharge)

Date of last data update

(Update weekly after enrollment.)

Windows

Month 1 Start

Month 1 End

Month 1 - Suspended Catch Date

Month 3 Post Card

Month 3 Start

Month 3 End

Month 3 - Suspended Catch Date

Month 6 Post Card

Month 6 Start

Month 6 End

Month 6 - Suspended Catch Date

Additional Information

Staff Assignment

- Mary
- Peggy
- Spanish
- Caylin
- Steven
- Stacy

Date Added to Database

Date of Death (before LTO follow-up):

[baseline_arm_1][admit_dc_dt]
[baseline_arm_1][dispo_death_date]

COVID Recovery (0-100) Month 1 to Month 3 Difference

Eligibility Screener

Patient Information:

First Name: [baseline_arm_1][ci_ptgivname]

Last Name: [baseline_arm_1][ci_ptsurname]

Hospital Name: [baseline_arm_1][admit_site]

Enrollment Date: [baseline_arm1][enroll_coral_date]

ADL/IADL

	Yes	No	Don't do	Can't do	Don't know	Refused to answer	Missing
Dressing, including putting on shoes and socks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking across a room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bathing or showering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating, such as cutting up their food?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in or out of bed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using the toilet, including getting up and down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a map to figure out how to get around in a strange place?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preparing a hot meal?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping for groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making phone calls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managing their money such as paying their bills and keeping track of expenses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stooping, kneeling, or crouching?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting or carrying weights over 10 pounds, like a heavy bag of groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ADL Total

(Exclude if total ≥ 4 (total is greater than or equal to 4))

AD8

	Yes, a change	No, no change	Don't know	Missing
Problems with judgement (eg, problems making decisions, bad financial decisions, problems with thinking)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Less interest in hobbies/activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeats the same things over and over (questions, stories, or statements)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble learning how to use a tool, appliance, or gadget (eg, VCR, computer, microwave, remote control)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forgets correct month or year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble handling complicated financial affairs (eg, balancing checkbook, income taxes, paying bills)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble remembering appointments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daily problems with thinking and/or memory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Was the patient consented by a surrogate or LAR?

- Yes
 No
 Missing

Proxy AD8 Score

(Exclude if total >4 (total is greater than 4))

Information not provided by site

not provided

Contact Information

Patient Information:

First Name: [baseline_arm_1][ci_ptgivname]

Last Name: [baseline_arm_1][ci_ptsurname]

Hospital Name: [baseline_arm_1][admit_site]

Enrollment Date: [baseline_arm1][enroll_coral_date]

Patient

Enrolling Site

- ALIGNE - Baystate Medical Center [A01]
- ALIGNE - Brigham and Women's Hospital [A03]
- ALIGNE - MaineHealth [A04]
- ALIGNE - University of Florida Health [A06]
- Boston - Beth Israel Medical Center [B01]
- Boston - Massachusetts General Hospital [B02]
- Boston - University of Mississippi Medical Center [B04]
- California - UCSF San Francisco [C01]
- California - UCSF Fresno [C02]
- California - UC Davis [C03]
- California - Stanford University Hospital [C04]
- California - UCLA Ronald Reagan [C05]
- California - U Texas Health Science Center [C06]
- Colorado - University of Colorado Hospital [D01]
- Colorado - Denver Health Medical Center [D04]
- Colorado - St. Joseph Hospital (National Jewish) [D06]
- Michigan - University of Michigan Medical Center [M01]
- Michigan - Henry Ford Medical Center [M02]
- Michigan - Sinai-Grace Hospital [M04]
- Michigan - Detroit Receiving Hospital [M05]
- Michigan - Harper University Hospital [M06]
- Montefiore-Sinai - Montefiore Moses [N01]
- Montefiore-Sinai - Mt. Sinai Hospital [N02]
- Montefiore-Sinai - Montefiore Weiler [N03]
- Montefiore-Sinai - University of Arizona [N05]
- Ohio - Cleveland Clinic Foundation [H01]
- Ohio - University of Cincinnati Medical Center [H03]
- Pacific NW - Harborview Medical Center [W01]
- Pacific NW - University of Washington Medical Center [W02]
- Pacific NW - Swedish Hospital First Hill [W03]
- Pacific NW - Oregon Health and Science University OHSU [W05]
- Pacific NW - Cedars-Sinai Medical Center [W07]
- Pittsburgh - UPMC Presbyterian [P01]
- Pittsburgh - UPMC Mercy [P02]
- Pittsburgh - UPMC Shadyside [P03]
- Pittsburgh - Penn State [P05]
- Southeast - Wake Forest Baptist Health [S01]
- Southeast - University Virginia Medical Center [S04]
- Southeast - VCU Medical Center [S05]
- Southeast - University of Kentucky [S06]
- Southeast - Medical University of South Carolina [S07]
- Utah - Intermountain Medical Center [U01]
- Utah - University of Utah Health Sciences Center [U05]
- Utah - LDS Hospital [U02]
- Utah - McKay-Dee Hospital [U03]
- Utah - Utah Valley Regional Medical Center [U04]
- Vanderbilt - Vanderbilt University Medical Center [V01]
- Vanderbilt - University Medical Center (LSU) [V02]
- Vanderbilt - Duke University Medical Center [V04]
- Clinical Coordinating Center [CCC]

First Name

Last Name _____

Address 1 _____

Address 2 _____

Address 3 _____

City _____

State _____

Time zone _____

1, Eastern Standard Time
2, Central Standard Time
3, Pacific Standard Time
4, Alaska Standard Time
5, Hawaii Standard Time
6, Mountain Standard Time
7, Central and Mountain Time
8, Pacific and Mountain Time
9, Central and Eastern Time
10, Atlantic

Zip _____

Phone 1 (home) _____

Phone 2 (cell) _____

Phone 3 (work) _____

No Phone

Email _____

Add patient to late night call report

Late Night Call

Late night call note _____

Proxy

First Name _____

Last Name _____

Address 1 _____

Address 2 _____

Address 3 _____

City _____

State _____

Zip _____

Phone 1 (home) _____

Phone 2 (cell) _____

Phone 3 (work) _____

No phone

Alternate 1

Alternate Source Patient
 Spouse
 Other

Alternate Source Other _____

Alternate Source (Y/N) Yes
 No

Alternate First Name _____

Alternate Last Name _____

Alternate Relationship

Alt Address 1

Alt Address 2

Alt Address 3

Alt City

Alt State

Alt Zip

Alt Phone (home)

Alt Phone (cell)

Alt Phone (work)

No phone

Alt Email

Alternate 2

Alternate Source (Y/N)

Yes
 No

Alternate First Name

Alternate Last Name

Alternate Relationship

Alt Address 1

Alt Address 2 _____

Alt Address 3 _____

Alt City _____

Alt State _____

Alt Zip _____

Alt Phone (home) _____

Alt Phone (cell) _____

Alt Phone (work) _____

No phone

Alt Email _____

Caregiver Contact Information

Relationship to Patient

- Significant Other
- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Friend
- Other

Please specify other:

First Name _____

Last Name _____

Address 1

Address 2

Address 3

City

State

- AL
- AK
- AZ
- AR
- CA
- CO
- CT
- DC
- DE
- FL
- GA
- HI
- ID
- IL
- IN
- IA
- KS
- KY
- LA
- ME
- MD
- MA
- MI
- MN
- MS
- MO
- MT
- NE
- NV
- NH
- NJ
- NM
- NY
- NC
- ND
- OH
- OK
- OR
- PA
- RI
- SC
- SD
- TN
- TX
- UT
- VT
- VA
- WA
- WV
- WI
- WY

Zip

Phone 1 (Home Phone)

Phone 2 (Cell Phone)

Phone 3 (Work Phone)

No phone

BLUE CORAL Mailings Completed

Updated Contact Information

Survey Month

- Month 1
- Month 3
- Month 6

Notes

Method Received

- Postcard
- EMR
- Alternate Contact
- Patient
- Mailed Survey

Date Received

No changes to contact information

Select Contact

- Patient
- Proxy
- Caregiver
- Alternate

[ci_update_contact]

First Name

Last Name

Alternate Relationship

Address 1

Address 2

Address 3

City

State

- AL
- AK
- AZ
- AR
- CA
- CO
- CT
- DC
- DE
- FL
- GA
- HI
- ID
- IL
- IN
- IA
- KS
- KY
- LA
- ME
- MD
- MA
- MI
- MN
- MS
- MO
- MT
- NE
- NV
- NH
- NJ
- NM
- NY
- NC
- ND
- OH
- OK
- OR
- PA
- RI
- SC
- SD
- TN
- TX
- UT
- VT
- VA
- WA
- WV
- WI
- WY

Zip

Phone 1 (home)

Phone 2 (cell)

Phone 3 (work)

No Phone

Email

Call Log

Patient Information: First Name: [baseline_arm_1][ci_ptgivname]
 Last Name: [baseline_arm_1][ci_ptsurname]
 Gender: [baseline_arm_1][sex]
 Date of Birth: [baseline_arm_1][ci_ptdob]
 Preferred Language: [baseline_arm_1][ci_language]
 Preferred Language (Other): [baseline_arm_1][ci_languagespec]
 Speaks English? [baseline_arm_1][ci_english]
 Speaks Spanish? [baseline_arm_1][ci_spanish]

Enrollment Date: [baseline_arm1][enroll_coral_date]
 Discharge Date: [baseline_arm_1][admit_dc_dt]
 Hospital Name: [baseline_arm_1][admit_site]
 Zip code: [baseline_arm_1][ci_ptaddrzip]

Month 1 Start: [baseline_arm_1][m1beg]
 Month 1 End: [baseline_arm_1][m1end]

Month 3 Start: [baseline_arm_1][m3beg]
 Month 3 End: [baseline_arm_1][m3end]

Month 6 Start: [baseline_arm_1][m6beg]
 Month 6 End: [baseline_arm_1][m6end]

Last Call Log Survey Month: [call_surv_month][last-instance] Who was contacted? [callog_contact][last-instance]
 Call purpose: [call_purpose][last-instance] Interviewer: [interviewer][last-instance] Call start time:
 [call_start_time][last-instance] Call disposition: [calldisposition][last-instance] Call comments:
 [callcomments][last-instance]

Survey Month

- Month 1
 Month 3
 Month 6

Who are you contacting?

- Patient
 Caregiver
 Proxy
 Other

Please specify other:

Call Purpose

- Survey
 Verified Information
 Consent
 Other
 LIFT COVID

Please specify other:

Interviewer

- Lee
- Mary
- Max
- Peggy
- Tiffany
- Stephany
- Caylin
- Steven
- Stacy

Call Start

Call End

Call Disposition

- Complete Interview
- Accepted Partial Interview
- Answering Machine, No Message Left
- Answering Machine, Message Left
- Wrong Number
- Number no longer in service
- Mail returned, forwarding address given
- Mail returned, no forwarding address
- Complete silence
- Ring no answer/no one home
- Phone busy
- General callback
- Contact, Best Time Known
- Contact, Appt made
- Contact, Initial Resistance
- Contact, Released Final Refusal for calling
- Hold, Technical Problems
- Calls Staff Back
- Leaves staff a message
- Staff calls to follow-up on mailed survey
- Spoke to INF - R is deceased
- Spoke to INF - Caregiver is deceased
- Texted recipient
- Received text
- Other non-call note
- Other non-call note - in hospital

Call Comments

Total call time

Call Back Information

Call back date/time

Call back notes

MONTH 1 SURVEY STATUS

Patient Information:

First Name: [baseline_arm_1][ci_ptgivname]
Last Name: [baseline_arm_1][ci_ptsurname]
Hospital Name: [baseline_arm_1][admit_site]
Enrollment Date: [baseline_arm_1][enroll_coral_date]

[Attachment: "BLUE.CORAL_PhoneScript_Patient_26MAY2020.docx"]

Month 1 start: [baseline_arm_1][m1beg]
Month 1 end: [baseline_arm_1][m1end]

Do you think the patient remembers being in the study?

Note to RA: Don't ask the patient this question. Make choice based on best judgement.

- Yes
 - No
 - Unsure
-

If no or unsure, please explain why:

Month 1 Survey Status

- Completed Survey
 - Withdrew from this survey, but willing to do subsequent survey
 - Wants to withdraw from study
 - Pending
 - Recontact later
 - Suspended
 - Hard to reach
 - In hospital - recontact later
 - Proxy completed; try R still
-

Suspended Date

Suspended Code

- No contact with R or INF at all
- Contact made with R, but unable to reach again for survey
- Contact made with R, but unwilling to do survey for this window; will try again in next window
- Contact made with R, but unwilling to do survey for this window; contact with INF, but unable to reach again for proxy survey
- Contact made with R, but unwilling to do survey for this window; no contact with INF at all
- No contact made with R; contact with INF, but unable to reach again for proxy survey
- No contact made with R; contact with INF, but INF unwilling to be proxy
- Data download delay
- Contact made with R, but unwilling to do survey for this window; contact with INF, but unwilling to do survey for this window

Confirmed Alive?

Yes

Suspended Note

Survey Method

- Patient Phone
- Proxy Phone
- Patient Mail
- Proxy Mail 1
- Proxy Mail 2

Mental Health Letter Sent?

Mental Health Letter Sent Date

Patient Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Proxy Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Patient Mail

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

Proxy Mail #1

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

Proxy Mail #2

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

MONTH 3 SURVEY STATUS

Patient Information:

First Name: [baseline_arm_1][ci_ptgivname]
Last Name: [baseline_arm_1][ci_ptsurname]
Hospital Name: [baseline_arm_1][admit_site]
Enrollment Date: [baseline_arm_1][enroll_coral_date]

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Month 3 start: [baseline_arm_1][m3beg]
Month 3 end: [baseline_arm_1][m3end]

Do you think the patient remembers being in the study?

Note to RA: Don't ask the patient this question. Make choice based on best judgement.

- Yes
 - No
 - Unsure
-

If no or unsure, please explain why:

Month 3 Survey Status

- Completed Survey
 - Withdrew from this survey, but willing to do subsequent survey
 - Wants to withdraw from study
 - Pending
 - Recontact later
 - Suspended
 - Hard to reach
 - In hospital - recontact later
 - Proxy completed; try R still
-

Suspended Date

Suspended Code

- No contact with R or INF at all
- Contact made with R, but unable to reach again for survey
- Contact made with R, but unwilling to do survey for this window; will try again in next window
- Contact made with R, but unwilling to do survey for this window; contact with INF, but unable to reach again for proxy survey
- Contact made with R, but unwilling to do survey for this window; no contact with INF at all
- No contact made with R; contact with INF, but unable to reach again for proxy survey
- No contact made with R; contact with INF, but INF unwilling to be proxy
- Data download delay
- Contact made with R, but unwilling to do survey for this window; contact with INF, but unwilling to do survey for this window

Confirmed Alive?

Yes

Suspended Note

Survey Method

- Patient Phone
- Proxy Phone
- Patient Mail
- Proxy Mail 1
- Proxy Mail 2

Mental Health Letter Sent?

Mental Health Letter Sent Date

Patient Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Proxy Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Patient Mail

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

Proxy Mail #1

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

Proxy Mail #2

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

MONTH 6 SURVEY STATUS

Patient Information:

First Name: [baseline_arm_1][ci_ptgivname]
Last Name: [baseline_arm_1][ci_ptsurname]
Hospital Name: [baseline_arm_1][admit_site]
Enrollment Date: [baseline_arm_1][enroll_coral_date]

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Month 6 start: [baseline_arm_1][m6beg]
Month 6 end: [baseline_arm_1][m6end]

Do you think the patient remembers being in the study?

Note to RA: Don't ask the patient this question. Make choice based on best judgement.

- Yes
 - No
 - Unsure
-

If no or unsure, please explain why:

Month 6 Survey Status

- Completed Survey
 - Withdrew from this survey, but willing to do subsequent survey
 - Wants to withdraw from study
 - Pending
 - Recontact later
 - Suspended
 - Hard to reach
 - In hospital - recontact later
 - Proxy completed; try R still
-

Suspended Date

Suspended Code

- No contact with R or INF at all
- Contact made with R, but unable to reach again for survey
- Contact made with R, but unwilling to do survey for this window; will try again in next window
- Contact made with R, but unwilling to do survey for this window; contact with INF, but unable to reach again for proxy survey
- Contact made with R, but unwilling to do survey for this window; no contact with INF at all
- No contact made with R; contact with INF, but unable to reach again for proxy survey
- No contact made with R; contact with INF, but INF unwilling to be proxy
- Data download delay
- Contact made with R, but unwilling to do survey for this window; contact with INF, but unwilling to do survey for this window

Confirmed Alive?

Yes

Suspended Note

Survey Method

- Patient Phone
- Proxy Phone
- Patient Mail
- Proxy Mail 1
- Proxy Mail 2

Mental Health Letter Sent?

Mental Health Letter Sent Date

Patient Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Proxy Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Patient Mail

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

Proxy Mail #1

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

Proxy Mail #2

Mail Survey - Date Sent

Mail Survey - Date Received

Mail Survey - Date Completed

Comment

Caregiver Survey Status

Caregiver Information

Caregiver First Name: [baseline_arm_1][ci_ptgivname]
Caregiver Last Name: [baseline_arm_1][ci_ptsurname]
Patient Hospital Name: [baseline_arm_1][admit_site]
Patient Enrollment Date: [baseline_arm1][enroll_coral_date]

[Attachment: "BLUE.CORAL_PhoneScript_Caregiver_26MAY2020.docx"]

Study Status

- Consented
- Refused
- Excluded
- Deceased
- Patient Declined Caregiver Participation
- Eligible

Unable to reach for consent

Caregiver consent date/time

Deceased after consented?

Refused Date

Refused Reason

- Concerned with confidentiality
- Too sick, stressed or in too much pain
- Not interested in research study; no time
- Other

Please specify other:

Refused Comment

Exclusion Date

Exclusion Reason

- Less than 18 years old
- Not English OR Spanish Speaking
- No Phone

Exclusion Comment

Date of Death

Month 1

Month 1 start: [baseline_arm_1][m1beg]

Month 1 end: [baseline_arm_1][m1end]

Caregiver Survey Status

- Completed Survey
- Withdrew from this survey, but willing to do subsequent survey
- Wants to withdraw from study
- Pending
- Recontact later
- Suspended
- Hard to reach
- In hospital - recontact later
- Proxy completed; try R still

Suspended Date

Suspended Code

- No contact with caregiver at all
- Contact made with caregiver, but unable to reach again for survey
- Contact made with caregiver, but unwilling to do survey for this window; will try again next window

Suspended Note

Survey Method

- Phone
- Mail

Mental Health Letter Sent?

Mental Health Letter Sent Date

Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Mail

Mailed Survey - Date Sent

Mailed Survey - Date Received

Comment

Month 3

Month 3 start: [baseline_arm_1][m3beg]

Month 3 end: [baseline_arm_1][m3end]

Caregiver Survey Status

- Completed Survey
- Withdrew from this survey, but willing to do subsequent survey
- Wants to withdraw from study
- Pending
- Recontact later
- Suspended
- Hard to reach
- In hospital - recontact later

Suspended Date

Suspended Code

- No contact with caregiver at all
- Contact made with caregiver, but unable to reach again for survey
- Contact made with caregiver, but unwilling to do survey for this window; will try again next window

Suspended Note

Survey Method

- Phone
- Mail

Mental Health Letter Sent?

Mental Health Letter Sent Date

Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Mail

Mailed Survey - Date Sent

Mailed Survey - Date Received

Comment

Month 6

Month 6 start: [baseline_arm_1][m6beg]

Month 6 end: [baseline_arm_1][m6end]

Caregiver Survey Status

- Completed Survey
- Withdrew from this survey, but willing to do subsequent survey
- Wants to withdraw from study
- Pending
- Recontact later
- Suspended
- Hard to reach
- In hospital - recontact later

Suspended Date

Suspended Code

- No contact with caregiver at all
- Contact made with caregiver, but unable to reach again for survey
- Contact made with caregiver, but unwilling to do survey for this window; will try again next window

Suspended Note

Survey Method

- Phone
- Mail

Mental Health Letter Sent?

Mental Health Letter Sent Date

Phone

Phone Survey - Date Sent

Phone Survey - Date Received

Mail

Mailed Survey - Date Sent

Mailed Survey - Date Received

Comment

Month 3 Postcard Details

Month 3 Postcard Details

Postcard Send Date: [baseline_arm_1][m3pc_opendate]

Postcard Sent (date)

Postcard Received (date)

No address to send PC

No address

Month 6 Postcard Details

Month 6 Postcard Details

Postcard Send Date: [baseline_arm_1][m6pc_opendate]

Postcard Sent (date)

Postcard Received (date)

No address to send PC

No address

Patient: Post-Hospital Survey

General Comments

Survey Start

COVID Recovery

Think about what you could do physically and mentally before your COVID hospitalization.

On a scale of 1 to 100, with 100 being all the way back to what you could do before COVID, how close to being back are you?

EQ-5D-5L

Now I am going to read out some questions and each question has a choice of five answers. Please tell me which answer best describes your health today. Do not choose more than one answer in each group of questions.

First, I'd like to ask you about mobility. Would you say that:

- You have no problems walking?
- You have slight problems walking?
- You have moderate problems walking?
- You have severe problems walking?
- You are unable to walk?

Next, I'd like to ask you about self-care. Would you say that:

- You have no problems washing or dressing yourself?
- You have slight problems washing or dressing yourself?
- You have moderate problems washing or dressing yourself?
- You have severe problems washing or dressing yourself?
- You are unable to wash or dress yourself?

Next, I'd like to ask you about your usual activities, for example work, study, housework, family or leisure activities. Would you say that:

- You have no problems doing your usual activities?
- You have slight problems doing your usual activities?
- You have moderate problems doing your usual activities?
- You have severe problems doing your usual activities?
- You are unable to do your usual activities?

Next I'd like to ask you about pain or discomfort. Would you say that:

- You have no pain or discomfort?
 You have slight pain or discomfort?
 You have moderate pain or discomfort?
 You have severe pain or discomfort?
 You have extreme pain or discomfort?

Finally I'd like to ask you about anxiety or depression. Would you say that:

- You are not anxious or depressed?
 You are slightly anxious or depressed?
 You are moderately anxious or depressed?
 You are severely anxious or depressed?
 You are extremely anxious or depressed?

Activities of Daily Living (ADLs) and Instrumental ADLs

Now, I'm going to read off a few everyday activities. Please let me know if you have any difficulty with these because of a physical, mental, emotional or memory problem.

Because of a health or memory problem do you have any difficulty with:

	Yes	No	Don't do	Can't do	Don't know	Refused to answer
Dressing, including putting on shoes and socks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking across a room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bathing or showering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating, such as cutting up your food?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in or out of bed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using the toilet, including getting up and down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a map to figure out how to get around in a strange place?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preparing a hot meal?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping for groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making phone calls?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managing your money such as paying your bills and keeping track of expenses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stooping, kneeling, or crouching?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Lifting or carrying weights over 10 pounds, like a heavy bag of groceries?

ADL Score

Difference in ADL/IADL versus before hospitalization

Financial Toxicity

Because of the financial cost of dealing with your COVID hospitalization and related care, did any of the following things happen? Please respond with Yes or No

Discharge Date: [baseline_arm_1][admit_dc_dt]

	Yes	No
Used up all or most of your savings	<input type="radio"/>	<input type="radio"/>
Were unable to pay for necessities like food, heat, or housing	<input type="radio"/>	<input type="radio"/>
Were contacted by a collection agency	<input type="radio"/>	<input type="radio"/>
Declared bankruptcy	<input type="radio"/>	<input type="radio"/>
Skipped or delayed getting medical care you thought you needed because of the cost	<input type="radio"/>	<input type="radio"/>
Took less medication than was prescribed to you because of the cost	<input type="radio"/>	<input type="radio"/>

Since your COVID hospitalization / Since we talked with you last, have you:

	Yes	No
Lost a job?	<input type="radio"/>	<input type="radio"/>
Had to change the kind of work you can do?	<input type="radio"/>	<input type="radio"/>
Had a loved one take time off of work to care for you?	<input type="radio"/>	<input type="radio"/>
Been told that your insurance would not cover starting or continuing therapy or rehabilitation?	<input type="radio"/>	<input type="radio"/>

Been told that your insurance would not cover equipment for the home - like a bed or wheelchair - that you needed because of the hospitalization?

Since your COVID hospitalization, how much has your health been a drain on the financial resources of you or your family?

- None
- Mild
- Moderate
- Severe
- Extreme

Cardiopulmonary Symptoms and Respiratory Support

Answer Yes or No for each question:

	Yes	No
Do you cough often during the day?	<input type="radio"/>	<input type="radio"/>
Do you get chest problems when you come into contact with strong smells, exhaust fumes, cigarette smoke, perfume, etc.?	<input type="radio"/>	<input type="radio"/>
Do you feel breathless when trying to sleep?	<input type="radio"/>	<input type="radio"/>
Does getting emotionally upset make your chest trouble worse?	<input type="radio"/>	<input type="radio"/>
Are there times when you have difficulty getting around the house because of your chest trouble?	<input type="radio"/>	<input type="radio"/>
Does your chest trouble make you go home sooner than others after a night out?	<input type="radio"/>	<input type="radio"/>
Do you suffer from breathlessness when you laugh?	<input type="radio"/>	<input type="radio"/>
Do you use home oxygen?	<input type="radio"/>	<input type="radio"/>
Do you use a CPAP or breathing machine when you sleep?	<input type="radio"/>	<input type="radio"/>

Better

Worse

About the same

Cough often during the day:
Compared to 1 month before
your COVID hospitalization, is
this better, worse, or about the
same?

Chest problems when in contact
with strong smells: Compared to
1 month before your COVID
hospitalization, is this better,
worse, or about the same?

Breathless when trying to sleep:
Compared to 1 month before
your COVID hospitalization, is
this better, worse, or about the
same?

Getting emotionally upset makes
your chest troubles worse:
Compared to 1 month before
your COVID hospitalization, is
this better, worse, or about the
same?

Difficulty getting around the
house because of chest trouble:
Compared to 1 month before
your COVID hospitalization, is
this better, worse, or about the
same?

Chest trouble makes you go
home sooner than others after a
night out: Compared to 1 month
before your COVID
hospitalization, is this better,
worse, or about the same?

Breathlessness when you laugh:
Compared to 1 month before
your COVID hospitalization, is
this better, worse, or about the
same?

New More About the same

Use home oxygen: Compared to
1 month before your COVID
hospitalization, is your oxygen
use new, more, or about the
same?

Use a CPAP or breathing
machine when you sleep:
Compared to 1 month before
your COVID hospitalization, is
your use of a breathing machine
new, more, or about the same?

Over the last 2 weeks, how often have you been bothered by any of the following problems?**Answer Not at all/Several days/More than half the days/Nearly every day**

	Not at all	Several days	More than half the days	Nearly every day
Swelling in your feet, ankles or legs when you woke up in the morning?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been forced to sleep sitting up in a chair or with at least 3 pillows to prop you up because of shortness of breath?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Had a rapid or irregular heartbeat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Had chest pain, chest tightness or angina?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Better	Worse	About the same
Swelling: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortness of breath: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rapid or irregular heartbeat: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest pain, chest tightness or angina: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Current Medication Treatment**Do you currently take any of the following medications?****"Note to RA: ONLY if the patient asks, the time frame is in the prior month"**

	Yes	No
Blood pressure medicine, such as diuretics, water pills, ACE-inhibitors?	<input type="radio"/>	<input type="radio"/>
Aspirin?	<input type="radio"/>	<input type="radio"/>

Statins or cholesterol medications?	<input type="radio"/>	<input type="radio"/>
Medicines to help with your blood sugar, like insulin or metformin?	<input type="radio"/>	<input type="radio"/>
Chronic steroids?	<input type="radio"/>	<input type="radio"/>
Inhaler for your breathing?	<input type="radio"/>	<input type="radio"/>
Medicine for your mood?	<input type="radio"/>	<input type="radio"/>
Opioids like morphine, Vicodin, dilaudid, or oxycodone?	<input type="radio"/>	<input type="radio"/>
Benzodiazepines, like Ativan, Xanax, or Valium?	<input type="radio"/>	<input type="radio"/>

PHQ9

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Answer Not at all/Several days/More than half the days/Nearly every day**

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself -- or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Better	Worse	About the same
Feeling tired or having little energy: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Safety Screen

Select the link and follow the PHQ9 protocol.

Complete the PHQ9 Patient Safety Screen

National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

[Attachment: "PHQ9 Suicide Ideation Protocol (1).docx"]

Date:

Patient indicates they have some thoughts of hurting themselves. Select the means by which you obtained this information.

- By mail
 - Over the phone
 - Other
-

Upon screening, the patient indicates (select and explain):

- Past, but no current suicidal ideation
 - Suicidal ideation only (vague feelings of wishing to be dead, gone or not wake up, without specific suicidal thoughts)
 - Suicidal thoughts (General non-specific thoughts of wanting to end one's life/commit suicide)
 - Suicidal thoughts with method (without specific plan or intent to act) (Endorses both thoughts of suicide and at least one method)
 - Suicidal intent (without specific plan) (Active suicidal thoughts of killing oneself and reports some intent to act on such thoughts)
 - Suicidal intent with specific plan (Plan partially or fully worked out and person has intent to carry it out)
-

Explain why you selected [phq9_screenindication]:

Actions taken by program specialist:

Screen completion and alert:

Select response, then select "Save & Stay" to send an alert to Jack and Lee.

- Complete screen
- Incomplete screen

 PHQ9 Score _____
GAD7

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Answer Not at all/Several days/More than half the days/Nearly every day**

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it's hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

 GAD 7 Score _____
Healthcare Utilization

Since your COVID hospitalization / our last interview on DDMMYY, have you been hospitalized again?

(do not include an overnight stay in the emergency room)

Month 1 Survey Completion Date: [month_1_arm_1][pt_surv_end_time]

Month 3 Survey Completion Date: [month_3_arm_1][pt_surv_end_time]

Discharge Date: [baseline_arm_1][admit_dc_dt]

(Review the date of the last survey prior to the 3 month and 6 month interview. If the patient completed a 1 month survey, but not the 3 month, anchor the 6 month question using the optimal date of the 3 month survey (90 days post-discharge). If they didn't complete the 1 month, then the 3 month question should use the "Since your COVID hospitalization.")

- Yes
 No

 About how many nights were you in the hospital? _____

 Were any of these at a hospital other than
 [baseline_arm_1][admit_site]?

- Yes
 No

Demographics

Caregiver Study Status: [baseline_arm_1][cg_studystatus]

Note to RA: If caregiver's study status is left blank, proceed with questions. If a status is populated, skip to the next section (Education).

Do you have someone who helps you when you are sick?

- Yes
 No

We are also conducting a study of what recovery is like for helpers. Do we have your permission to contact them and ask them questions like the ones we just did?

- Yes
 No

Reminder: update caregiver's Study Status to "Patient Declined Caregiver Participation"

Caregiver Eligibility

Note to RA: The caregiver must meet the following eligibility criteria to participate

- 18 years of age or older
 Speaks English or Spanish
 Has a working phone

Who would you most call upon for help if you got sick?

Could we please have their name and contact information?

Note to RA: Click on the link below and scroll to the end of the form to enter caregiver contact information.

[baseline_arm_1][form-link:contact_information]

Education

How many years of education do you have?

- Less than or equal to 12
 More than 12

Are you a military Veteran? (Did you serve in the US military?)

- Yes
 No
 Don't Know

If yes, in what Branch and Component did you serve? Select all that apply.

- Army (Active Component)
- Army National Guard
- Army Reserve
- Navy (Active Component)
- Navy Reserve
- Marine Corps (Active Component)
- Marine Corps Reserve
- Air Force (Active Component)
- Air National Guard
- Air Force Reserve
- Coast Guard (Active Component)
- Coast Guard Reserve

Survey End

Total call time

LIFT COVID

This patient is eligible for participation in LIFT COVID.

Please complete the BLUE CORAL Survey (Post-Hospital, MOCA, Hayling) before inviting participation into LIFT COVID.

Invite participants to join LIFT COVID at Month 1 only. Do not invite participation at Month 3 or Month 6.

LIFT COVID Status: [month_1_arm_1][liftcovid_status]

[form-link:lift_covid]

Patient: MOCA

General Comments

Survey Start

Memory

Next, I am going to be asking you some questions that will require you to remember some words, do things quickly, and focus your attention. Similar to the other questions in this survey, we are just trying to get a sense of your overall health and how you are doing today. You may find some of these questions challenging, but I would like you to try your best and ask questions if you are unsure what you are supposed to do.

These are thinking and memory questions. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn't matter in what order you say them.

Face, Velvet, Church, Daisy, Red

Face

Velvet

Church

Daisy

Red

I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time.

Face, Velvet, Church, Daisy, Red

Face

Velvet

Church

Daisy

Red

I will ask you to recall those words again at the end of the section.

I am going to say some numbers and when I am through, repeat them to me exactly as I said them.

2 1 8 5 4

Did the subject repeat them in FORWARD order?

- Yes
 No

Now I am going to say some more numbers, but when I am through you must repeat them to me in the backwards order.

7 4 2

Did the subject repeat them in BACKWARD order?

- Yes
 No

Digit Span Score _____

I am going to read a sequence of letters. Every time I say the letter A please say yes. If I say a different letter, do not say yes.

	Said	Didn't say
F	<input type="radio"/>	<input type="radio"/>
B	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
C	<input type="radio"/>	<input type="radio"/>
M	<input type="radio"/>	<input type="radio"/>
N	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
J	<input type="radio"/>	<input type="radio"/>
K	<input type="radio"/>	<input type="radio"/>
L	<input type="radio"/>	<input type="radio"/>
B	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
F	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
K	<input type="radio"/>	<input type="radio"/>
D	<input type="radio"/>	<input type="radio"/>
E	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
J	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
M	<input type="radio"/>	<input type="radio"/>
O	<input type="radio"/>	<input type="radio"/>
F	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
B	<input type="radio"/>	<input type="radio"/>

How many errors did the participant have? (an error is a "yes" on a wrong letter or a failure to say "yes" on letter A) _____

Vigilance Score _____

Now, I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop.

100 - 7 = what?
Record R's answer
(correct answer: 93) _____

And seven from that?

Record R's answer _____
 (correct answer: 86)

And seven from that?

Record R's answer _____
 (correct answer: 79)

And seven from that?

Record R's answer _____
 (correct answer: 72)

And seven from that?

Record R's answer _____
 (correct answer: 65)

Score _____

Score Instructions

[Attachment: "Subtraction Scoring.pdf"]

Language

I am going to read you a sentence. Repeat it after me, exactly as I say it:

I only know that John is the one to help today

Did the subject repeat the sentence correctly?

- Yes
 No

Now I am going to read you another sentence. Repeat it after me, exactly as I say it:

The cat always hid under the couch when dogs were in the room

Did the subject repeat the sentence correctly?

- Yes
 No

Sentence Repetition Score _____

Fluency

Tell me as many words as you can think of that begin with a certain letter of the alphabet that I will tell you in a moment. You can say any kind of word you want, except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix, for example, love, lover, loving. I will tell you to stop after one minute. Are you ready? Now, tell me as many words as you can think of that begin with the letter F.

60 Second Timer

Turn On

Time for 60 seconds

Type "F" words here

Type wrong "F" words in box to the right

How many words that begin with the letter "F" did the subject name?

Verbal Fluency Score

Abstraction

(Practice Test): "Tell me how an orange and a banana are alike". If the subject answers in a concrete manner, then say only one additional time: "Tell me another way in which those items are alike". If the subject does not give the appropriate response (fruit), say, "Yes, and they are also both fruit."

Train-bicycle = means of transportation, means of travelling, you take trips in both;

Ruler-watch = measuring instruments, used to measure.

The following responses are not acceptable: Train-bicycle = they have wheels; Ruler-watch = they have numbers.

Now, tell me how a train and a bicycle are alike?

Did they get the similarity?

Yes
 No

Now, tell me how a ruler and a watch are alike?

Did they get the similarity?

Yes
 No

Abstraction Score

Delayed Recall

I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember.

Face

Velvet

Church

Daisy

Red

Patient forgot or refused to answer

 Did not remember Refused to answer

Delayed Recall Score _____

Tell me the date today. (prompt accordingly by saying): Tell me the (year, month, exact date, and day of the week). Now, tell me where you are right now and which city/state is it in?

Day

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Correct Day?

 Correct

Date

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
- 28
- 29
- 30
- 31

Correct Date?

Correct

Month

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Correct Month?

Correct

Year

- 2023
- 2022
- 2021
- 2020
- 2019
- 2018
- 2017
- 2016
- 2015
- 2014
- 2013
- 2012
- 2011
- 2010
- 2009
- 2008
- 2007
- 2006
- 2005
- 2004
- 2003
- 2002
- 2001
- 2000
- 1999
- 1998
- 1997
- 1996
- 1995
- 1994
- 1993
- 1992
- 1991
- 1990
- 1989
- 1988
- 1987
- 1986
- 1985
- 1984
- 1983
- 1982
- 1981
- 1980

Correct Year?

Correct

Place

Correct Place?

Correct

City/State

Correct City/State?

Correct

Orientation Score

MOCA Score

Survey End

Total call time

LIFT COVID

This patient is eligible for participation in LIFT COVID.

Please complete the BLUE CORAL Survey (Post-Hospital, MOCA, Hayling) before inviting participation into LIFT COVID.

Invite participants to join LIFT COVID at Month 1 only. Do not invite participation at Month 3 or Month 6.

LIFT COVID Status: [month_1_arm_1][liftcovid_status]

[form-link:lift_covid]

Patient: Hayling

General Comments

Survey Start

Section 1

In a moment I am going to read you a series of sentences, each of which has the last word missing from it. I want you to listen carefully to each sentence, and when I have finished each one; your job is to give me a word which completes the sentence. Do you understand?

If the subject doesn't fully understand, repeat the instructions again.

Practice

Before we start, I'll give you a couple of practice sentences so you can get the hang of it. Are you ready?

The rich child attended a private

Start Time

End Time

Total Time

The crime rate has gone up this

Start Time

End Time

Total Time

Okay, that's the end of the practice items.

The next few sentences I'll read aren't really any more difficult than the two you've just done. But the important thing is that I want you to give me your answers as quickly as you can -- the faster the better. Is that clear?

1. He mailed a letter without a _____

Start Time _____

End Time _____

Total Time _____

2. In the first blank enter your _____

Start Time _____

End Time _____

Total Time _____

3. The old house will be torn _____

Start Time _____

End Time _____

Total Time _____

4. It's hard to admit when one is _____

Start Time _____

End Time _____

Total Time _____

5. The job was easy most of the

Start Time

End Time

Total Time

6. When you go to bed turn off the

Start Time

End Time

Total Time

7. The game was stopped when it started to

Start Time

End Time

Total Time

8. He scraped the cold food from his

Start Time

End Time

Total Time

9. The dispute was settled by a third

Start Time

End Time _____

Total Time _____

10. Three people were killed in an interstate _____

Start Time _____

End Time _____

Total Time _____

11. The baby cried and upset her _____

Start Time _____

End Time _____

Total Time _____

12. George could not believe that his son had stolen a _____

Start Time _____

End Time _____

Total Time _____

13. He crept into the room without a _____

Start Time _____

End Time _____

Total Time _____

14. Billy hit his sister on the

Start Time

End Time

Total Time

15. Too many men are out of

Start Time

End Time

Total Time

Section 2

Now we are going to move onto the second section. In this section I will read you a set of sentences with the last word missing just like the one you have already done, but this time I want you to give me a word that does not fit the sentence -- I want the word you give me to be completely unconnected to the sentence in every way. Do you understand?

If the subject does not understand, give all reasonable help

Practice

Before we start, I'll give you a couple of practice sentences so that you can get the hang of what is required.

London is a very busy

Start Time

End Time

Total Time

If the participant fails the first practice item by producing responses such as "city" or "town." If this happens, say to the subject:

The word you have just given me does fit the end of the sentence. But what I want is a word that doesn't fit at the end; one which is completely unconnected to it. So for instance if you had given me the word "banana," that would be right, because "banana" is unconnected to the sentence "London is a very busy..."

Let the participant try again; then move on to the next practice item, regardless of whether they produce an unconnected word. Move on to the next practice item.

Her new shoes were the wrong

Start Time

End Time

Total Time

If the response is not acceptable (i.e. is strongly connected to the sentence) say:

Well, that word is still connected to the sentence, isn't it? So, it is not an ideal kind of answer. But I'll give you another practice sentence to see if you can get the hang of it.

Okay, that's the end of the practice items. Remember that the words you give me must be unconnected to the sentence and that it is important for you to give me your answers as quickly as you can. Are you ready?

16. The captain wanted to stay with the sinking

Start Time

End Time

Total Time

Response Category

- Error A
 Error B
 Correct

17. They went as far as they

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

18. Most cats see very well at

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

19. Jean was glad the affair was

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

20. The whole town came to hear the mayor

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

21. Most sharks attack very close to _____

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

22. None of the books made any _____

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

23. The dough was put in the hot _____

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

24. She called her husband at his _____

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

25. All the guests had a very good

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

26. He bought them in the candy

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

27. His leaving home amazed all his

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

28. At last the time for action had _____

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

29. The dog chased our cat up the _____

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

30. At night they often took a short _____

Start Time _____

End Time _____

Total Time _____

Response Category Error A
 Error B
 Correct

Hayling Section 1 Total Time _____

Hayling Section 2 Total Time

Total Number Correct

Total Number of Error A

Total Number of Error B

Your continued participation is vital to the success of this research study. Thus, we would like to record the names and contact information of two people who do not live with you and who may be able to help us locate/contact you in the future. These people can be a relative, friend, neighbor, etc. - whomever you feel comfortable for us to contact.

Contact #1

Name

Address

Phone Number

Additional Information

Relationship

Contact #2

Name

Address

Phone Number

Additional Information

Relationship

Survey End

Total call time

LIFT COVID

This patient is eligible for participation in LIFT COVID.

Please complete the BLUE CORAL Survey (Post-Hospital, MOCA, Hayling) before inviting participation into LIFT COVID.

Invite participants to join LIFT COVID at Month 1 only. Do not invite participation at Month 3 or Month 6.

LIFT COVID Status: [month_1_arm_1][liftcovid_status]

[form-link:lift_covid]

Caregiver: Post-Hospital Survey

General Comments

Survey Start

COVID Impact on Caregiver and Family

Were you also diagnosed with COVID-19? Yes
 No

How sick were you? Intensive Care Unit
 Hospitalized
 Very sick at home
 Mildly ill
 No symptoms

Do you think you were sick with COVID-19 but not diagnosed? Yes
 No

How sick were you? Very sick
 Moderately sick
 Mildly sick

Did you care for other family members with COVID-19 in addition to your relative? Yes
 No

On a scale of 1 to 100, with 100 being all the way back to what you could do before COVID, how close to being back are you? _____

EQ-5D-5L

Now I am going to read out some questions and each question has a choice of five answers. Please tell me which answer best describes your health today. Do not choose more than one answer in each group of questions.

First, I'd like to ask you about mobility. Would you say that:

- You have no problems walking?
- You have slight problems walking?
- You have moderate problems walking?
- You have severe problems walking?
- You are unable to walk?

Next, I'd like to ask you about self-care. Would you say that:

- You have no problems washing or dressing yourself?
- You have slight problems washing or dressing yourself?
- You have moderate problems washing or dressing yourself?
- You have severe problems washing or dressing yourself?
- You are unable to wash or dress yourself?

Next, I'd like to ask you about your usual activities, for example work, study, housework, family or leisure activities. Would you say that:

- You have no problems doing your usual activities?
- You have slight problems doing your usual activities?
- You have moderate problems doing your usual activities?
- You have severe problems doing your usual activities?
- You are unable to do your usual activities?

Next I'd like to ask you about pain or discomfort. Would you say that:

- You have no pain or discomfort?
- You have slight pain or discomfort?
- You have moderate pain or discomfort?
- You have severe pain or discomfort?
- You have extreme pain or discomfort?

Finally I'd like to ask you about anxiety or depression. Would you say that:

- You are not anxious or depressed?
- You are slightly anxious or depressed?
- You are moderately anxious or depressed?
- You are severely anxious or depressed?
- You are extremely anxious or depressed?

Financial Toxicity

Since your relative or patient's COVID hospitalization, how much has their health been a drain on the financial resources of you or your family?

Discharge Date: [baseline_arm_1][admit_dc_dt]

- None
- Mild
- Moderate
- Severe
- Extreme

Because of the financial cost of dealing with your relative or patient's COVID hospitalization and related care, did any of the following things happen? Please respond with Yes or No

	Yes	No
Used up all or most of your savings	<input type="radio"/>	<input type="radio"/>

Were unable to pay for necessities like food, heat, or housing	<input type="radio"/>	<input type="radio"/>
Were contacted by a collection agency	<input type="radio"/>	<input type="radio"/>
Declared bankruptcy	<input type="radio"/>	<input type="radio"/>
Skipped or delayed getting medical care you thought you needed because of the cost	<input type="radio"/>	<input type="radio"/>
Took less medication than was prescribed to you because of the cost	<input type="radio"/>	<input type="radio"/>

Since your relative or patient's COVID hospitalization / Since we talked with you last, have you:

	Yes	No
Lost a job?	<input type="radio"/>	<input type="radio"/>
Had to change the kind of work you can do?	<input type="radio"/>	<input type="radio"/>
Had a loved one take time off of work to care for you?	<input type="radio"/>	<input type="radio"/>
Been told that your insurance would not cover starting or continuing therapy or rehabilitation?	<input type="radio"/>	<input type="radio"/>
Been told that your insurance would not cover equipment for the home -- like a bed or wheelchair -- that you needed because of hospitalization?	<input type="radio"/>	<input type="radio"/>

PHQ9

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

Answer Not at all / Several days / More than half the days / Nearly every day

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself -- or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Safety Screen

Select the link and follow the PHQ9 protocol.

Complete the PHQ9 Patient Safety Screen

National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

[Attachment: "PHQ9 Suicide Ideation Protocol (2).docx"]

Date:

Patient indicates they have some thoughts of hurting themselves. Select the means by which you obtained this information.

- By mail
- Over the phone
- Other

Upon screening, the patient indicates (select and explain):

- Past, but no current suicidal ideation
- Suicidal ideation only (vague feelings of wishing to be dead, gone or not wake up, without specific suicidal thoughts)
- Suicidal thoughts (General non-specific thoughts of wanting to end one's life/commit suicide)
- Suicidal thoughts with method (without specific plan or intent to act) (Endorses both thoughts of suicide and at least one method)
- Suicidal intent (without specific plan) (Active suicidal thoughts of killing oneself and reports some intent to act on such thoughts)
- Suicidal intent with specific plan (Plan partially or fully worked out and person has intent to carry it out)

Explain why you selected, [phq9_screenindication_cg]:

Actions taken by program specialist:

Screen completion and alert:

Select response, then select "Save & Stay"

("send alert" will send Jack and Lee an automated message about the risk screen.)

- Complete screen
 Incomplete screen

PHQ9 Score

GAD7

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

Answer Not at all / Several days / More than half the days / Nearly every day

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it's hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Zarit Caregiver Burden

The following is a list of statements, which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way; never, rarely, sometimes, quite frequently, or nearly always. There are no right or wrong answers.

Do you feel...

Never Rarely Sometimes Quite Frequently Nearly Always

that because of the time you spend with your relative that you don't have enough time for yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
stressed between caring for your relative and trying to meet other responsibilities (work/family)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
angry when you are around your relative?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
that your relative currently affects your relationship with family members or friends in a negative way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
strained when you are around your relative?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
that your health has suffered because of your involvement with your relative?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
that you don't have as much privacy as you would like because of your relative?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
that your social life has suffered because you are caring for your relative?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
that you have lost control of your life since your relative's illness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
uncertain about what to do about your relative?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
you should be doing more for your relative?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
you could do a better job in caring for your relative?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Activities of Daily Living (ADLs) and Instrumental ADLs

Now I'm going to read off a few everyday activities. Please let me know if you think your relative has any difficulty with these because of a physical, mental, emotional or memory problem. Answer Yes or No for each question.

Because of a health or memory problem, do you think your relative has any difficulty with:

Yes	No	Don't do	Can't do	Don't know	Refused to answer
-----	----	----------	----------	------------	-------------------

Dressing, including putting on shoes and socks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking across a room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bathing or showering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating, such as cutting up their food?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in or out of bed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using the toilet, including getting up and down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a map to figure out how to get around in a strange place?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preparing a hot meal?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping for groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making phone calls?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managing their money such as paying their bills and keeping track of expenses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stooping, kneeling, or crouching?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting or carrying weights over 10 pounds, like a heavy bag of groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Healthcare Utilization

Since your relative or patient's COVID hospitalization / our last interview on DDMMYY, have they been hospitalized again?

(do not include an overnight stay in the emergency room)

Month 1 Survey Completion Date: [month_1_arm_1][cg_surv_end_time]

Month 3 Survey Completion Date: [month_3_arm_1][cg_surv_end_time]

Discharge Date: [baseline_arm_1][admit_dc_dt]

(Review the date of the last survey prior to the 3 month and 6 month interview. If the patient completed a 1 month survey, but not the 3 month, anchor the 6 month question using the optimal date of the 3 month survey (90 days post-discharge). If they didn't complete the 1 month, then the 3 month question should use the "Since your COVID hospitalization.")

- Yes
- No

About how many nights were they in the hospital?

Were any of these at a hospital other than [baseline_arm_1][admit_site]?

- Yes
- No

AD8

Thinking of the time before your relative or patient was hospitalized for COVID, had there been a change in the last several years caused by cognitive (thinking and memory) problems?

Answer Yes/No for each question

	Yes, a change	No, no change	Don't know
Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Less interest in hobbies/activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeats the same things over and over (questions, stories, or statements)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forgets correct month or year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble remembering appointments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daily problems with thinking and/or memory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Education

How many years of education do you have?

- Less than or equal to 12
 More than 12

Are you a military Veteran? (Did you serve in the US military?)

- Yes
 No
 Don't Know

If yes, in what Branch and Component did you serve? Select all that apply.

- Army (Active Component)
- Army National Guard
- Army Reserve
- Navy (Active Component)
- Navy Reserve
- Marine Corps (Active Component)
- Marine Corps Reserve
- Air Force (Active Component)
- Air National Guard
- Air Force Reserve
- Coast Guard (Active Component)
- Coast Guard Reserve

Your continued participation is vital to the success of this research study. Thus, we would like to record the names and contact information of two people who do not live with you and who may be able to help us locate/contact you in the future. These people can be a relative, friend, neighbor, etc. - whomever you feel comfortable for us to contact.

Contact #1

Name

Address

Phone Number

Additional Information

Relationship

Contact #2

Name

Address

Phone Number

Additional Information

Relationship

Survey End

Total call time

Proxy: Post-Hospital Survey

General Comments

Proxy Relationship to Patient

- Significant Other
- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Friend
- Other

Please specify other:

Survey Start

COVID Recovery

Think about what the patient could do physically and mentally before their COVID hospitalization.

On a scale of 1 to 100, with 100 being all the way back to what the patient could do before COVID, how close to being back are they?

EQ-5D-5L

Now I am going to read out some questions and each question has a choice of five answers. Please tell me which answer best describes the patient's health today. Do not choose more than one answer in each group of questions.

First, I'd like to ask you about mobility. Would you say that:

- The patient has no problems walking?
- The patient has slight problems walking?
- The patient has moderate problems walking?
- The patient has severe problems walking?
- The patient is unable to walk?

Next, I'd like to ask you about self-care. Would you say that:

- The patient has no problems washing or dressing yourself?
- The patient has slight problems washing or dressing yourself?
- The patient has moderate problems washing or dressing yourself?
- The patient has severe problems washing or dressing yourself?
- The patient is unable to wash or dress themselves?

Next, I'd like to ask you about the patient's usual activities, for example work, study, housework, family or leisure activities. Would you say that:

- The patient has no problems doing your usual activities?
- The patient has slight problems doing your usual activities?
- The patient has moderate problems doing your usual activities?
- The patient has severe problems doing your usual activities?
- The patient is unable to do their usual activities?

Next I'd like to ask you about the patient's pain or discomfort. Would you say that:

- The patient has no pain or discomfort?
- The patient has slight pain or discomfort?
- The patient has moderate pain or discomfort?
- The patient has severe pain or discomfort?
- The patient has extreme pain or discomfort?

Finally I'd like to ask you about the patient's anxiety or depression. Would you say that:

- The patient is not anxious or depressed?
- The patient is slightly anxious or depressed?
- The patient is moderately anxious or depressed?
- The patient is severely anxious or depressed?
- The patient is extremely anxious or depressed?

Activities of Daily Living (ADLs) and Instrumental ADLs

Now, I'm going to read off a few everyday activities. Please let me know if the patient has any difficulty with these because of a physical, mental, emotional or memory problem.

Because of a health or memory problem does the patient have any difficulty with:

	Yes	No	Don't do	Can't do	Don't know	Refused to answer
Dressing, including putting on shoes and socks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking across a room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bathing or showering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating, such as cutting up their food?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in or out of bed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using the toilet, including getting up and down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Using a map to figure out how to get around in a strange place?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preparing a hot meal?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping for groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making phone calls?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managing their money such as paying their bills and keeping track of expenses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stooping, kneeling, or crouching?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting or carrying weights over 10 pounds, like a heavy bag of groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Financial Toxicity

Because of the financial cost of dealing with the patient's COVID hospitalization and related care, did any of the following things happen? Please respond with Yes or No

Note to RA: Do not offer the Don't Know option, but select if the proxy says it.

Discharge Date: [baseline_arm_1][admit_dc_dt]

	Yes	No	Don't Know
Used up all or most of their savings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were unable to pay for necessities like food, heat, or housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were contacted by a collection agency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Declared bankruptcy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skipped or delayed getting medical care they thought they needed because of the cost	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Took less medication than was prescribed to them because of the cost	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Since the patient's COVID hospitalization / Since we talked with you last, has the patient:

Note to RA: Do not offer the Don't Know option, but select if the proxy says it.

	Yes	No	Don't Know
--	-----	----	------------

- | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| Lost a job? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Had to change the kind of work they can do? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Had a loved one take time off of work to care for them? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Been told that their insurance would not cover starting or continuing therapy or rehabilitation? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Been told that their insurance would not cover equipment for the home - like a bed or wheelchair - that they needed because of the hospitalization? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Since the patient's COVID hospitalization, how much has their health been a drain on the financial resources of them or their family?

- None
 Mild
 Moderate
 Severe
 Extreme

Cardiopulmonary Symptoms and Respiratory Support

Answer Yes or No for each question:

Note to RA: Do not offer the Don't Know option, but select if the proxy says it.

- | | Yes | No | Don't Know |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| Does the patient cough often during the day? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Does the patient get chest problems when they come into contact with strong smells, exhaust fumes, cigarette smoke, perfume, etc.? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Does the patient feel breathless when trying to sleep? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Does getting emotionally upset make the patient's chest trouble worse? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Are there times when the patient has difficulty getting around the house because of their chest trouble?

Does the patient's chest trouble make them go home sooner than others after a night out?

Does the patient suffer from breathlessness when they laugh?
Does the patient use home oxygen?

Does the patient use a CPAP or breathing machine when they sleep?

	Better	Worse	About the same
Cough often during the day: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest problems when in contact with strong smells: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breathless when trying to sleep: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting emotionally upset makes your chest troubles worse: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty getting around the house because of chest troubles: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Chest trouble makes you go home sooner than others after a night out: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?

Breathlessness when you laugh: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?

Use home oxygen: Compared to 1 month before your COVID hospitalization, is your oxygen use new, more, or about the same?

Use a CPAP or breathing machine: Compared to 1 month before your COVID hospitalization, is your use of a breathing machine new, more, or about the same?

Over the last 2 weeks, how often has the patient been bothered by any of the following problems?

Answer Not at all/Several days/More than half the days/Nearly every day

Note to RA: Do not offer the Don't Know option, but select if the proxy says it.

	Not at all	Several days	More than half the days	Nearly every day	Don't Know
Swelling in their feet, ankles or legs when they woke up in the morning?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been forced to sleep sitting up in a chair or with at least 3 pillows to prop them up because of shortness of breath?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Had a rapid or irregular heartbeat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Had chest pain, chest tightness or angina?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Better		Worse		About the same

Swelling: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?

Shortness of breath: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?

Rapid or irregular heartbeat: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?

Chest pain, chest tightness or angina: Compared to 1 month before your COVID hospitalization, is this better, worse, or about the same?

Current Medication Treatment

Does the patient currently take any of the following medications?

Note to RA: ONLY if the patient asks, the time frame is in the prior month; Do not offer the "Don't Know" option, but select if the proxy says it.

	Yes	No	Don't Know
Blood pressure medicine, such as diuretics, water pills, ACE-inhibitors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aspirin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Statins or cholesterol medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicines to help with their blood sugar, like insulin or metformin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic steroids?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inhaler for their breathing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicine for their mood?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opioids like morphine, Vicodin, dilaudid, or oxycodone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benzodiazepines, like Ativan, Xanax, or Valium?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Healthcare Utilization

Since the patient's COVID hospitalization / our last interview on DDMMYY, has the patient been hospitalized again?

(do not include an overnight stay in the emergency room)

Month 1 Survey Completion Date: [month_1_arm_1][prox_surv_end_time]

Month 3 Survey Completion Date: [month_3_arm_1][prox_surv_end_time]

Discharge Date: [baseline_arm_1][admit_dc_dt]

(Review the date of the last survey prior to the 3 month and 6 month interview. If the patient completed a 1 month survey, but not the 3 month, anchor the 6 month question using the optimal date of the 3 month survey (90 days post-discharge). If they didn't complete the 1 month, then the 3 month question should use the "Since your COVID hospitalization.")

Yes

No

About how many nights were they in the hospital?

Were any of these at a hospital other than
[baseline_arm_1][admit_site]?

Yes

No

AD8

Thinking of the time before your relative or patient was hospitalized for COVID, had there been a change in the last several years caused by cognitive (thinking and memory) problems?

Answer Yes/No for each question

	Yes, a change	No, no change	Don't know
Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Less interest in hobbies/activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeats the same things over and over (questions, stories, or statements)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forgets correct month or year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble remembering appointments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Daily problems with thinking
and/or memory

Education

How many years of education does the patient have?

Less than or equal to 12

More than 12

Is the patient a military Veteran? (Did the patient serve in the US military?)

Yes

No

Don't Know

If yes, in what Branch and Component did the patient serve? Select all that apply.

Army (Active Component)

Army National Guard

Army Reserve

Navy (Active Component)

Navy Reserve

Marine Corps (Active Component)

Marine Corps Reserve

Air Force (Active Component)

Air National Guard

Air Force Reserve

Coast Guard (Active Component)

Coast Guard Reserve

Your continued participation is vital to the success of this research study. Thus, we would like to record the names and contact information of two people who do not live with you and who may be able to help us locate/contact you in the future. These people can be a relative, friend, neighbor, etc. - whomever you feel comfortable for us to contact.

Contact #1

Name

Address

Phone Number

Additional Information

Relationship

Contact #2

Name

Address

Phone Number

Additional Information

Relationship

Survey End

Total call time

(Spanish) Patient: Post-Hospital Survey

General Comments

Survey Start

Recuperación de COVID

Pensando en lo que podía hacer física y mentalmente antes de su hospitalización con COVID.

En una escala del 1 al 100, 100 siendo su estado habitual antes de COVID, ¿que tan cerca esta a su estado habitual?

EQ-5D-5L

Primero le voy a leer unas preguntas. Cada pregunta ofrece cinco respuestas. Por favor dígame qué respuesta describe mejor su salud EN EL DÍA DE HOY. No elija más de una respuesta en cada grupo de preguntas.

(Nota para el/la entrevistador/a: es posible que sea necesario recordarle con regularidad a la persona que responde que el período de tiempo es EL DÍA DE HOY. También es posible que sea necesario repetir las preguntas literalmente)

En primer lugar, quisiera preguntarle sobre la movilidad. ¿Diría usted que...

- No tiene problemas para caminar?
- Tiene problemas leves para caminar?
- Tiene problemas moderados para caminar?
- Tiene problemas graves/severos para caminar?
- No puede caminar?

Ahora quisiera preguntarle sobre el cuidado personal. ¿Diría usted que...

- No tiene problemas para lavarse o vestirse solo/a?
- Tiene problemas leves para lavarse o vestirse solo/a?
- Tiene problemas moderados para lavarse o vestirse solo/a?
- Tiene problemas graves/severos para lavarse o vestirse solo/a?
- No puede lavarse o vestirse solo/a?

Ahora quisiera preguntarle sobre las actividades que realiza todos los días, por ejemplo trabajar, estudiar, hacer tareas domésticas, actividades familiares o actividades realizadas durante el tiempo libre. ¿Diría usted que...

- No tiene problemas para realizar sus actividades de todos los días?
 Tiene problemas leves para realizar sus actividades de todos los días?
 Tiene problemas moderados para realizar sus actividades de todos los días?
 Tiene problemas graves/severos para realizar sus actividades de todos los días?
 No puede realizar sus actividades de todos los días?

Ahora quisiera preguntarle sobre el dolor o malestar. ¿Diría usted que...

- No tiene dolor ni malestar?
 Tiene dolor o malestar leve?
 Tiene dolor o malestar moderado?
 Tiene dolor o malestar intenso/severos?
 Tiene dolor o malestar extremo?

Por último, quisiera preguntarle sobre la ansiedad o depresión. ¿Diría usted que...

- No está ansioso/a ni deprimido/a?
 Está levemente ansioso/a o deprimido/a?
 Está moderadamente ansioso/a o deprimido/a?
 Está muy ansioso/a o deprimido/a?
 Está extremadamente ansioso/a o deprimido/a?

Actividades de todos los días (ADLs) y Instrumentos de ADLs

Ahora voy a leer algunas actividades de la vida diaria. Por favor dígame si tiene alguna dificultad con esta actividades debido a un problema físico, mental, emocional o de memoria.

Debido a algun problema de salud o de memoria, ¿tien alguna dificultad:

	Yes	No	Don't do	Can't do	Don't know	Refused to answer
Vistiendos, incluyendo ponerse zapatos y calcetines?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caminado a traves de un cuatro?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Banadose o duchandose?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
en comer, como por ejemplo, en cortar la comida?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
acostandose o levantandose de la cama?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
en usar el inodoro/excusado, incluyendo levantarse y sentarse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿tiene dificultad usando un mapa para descubrir cómo moverse en un lugar extraño?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preparandose comidas calientes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Haciendo las compras? (de alimentos)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Haciendo llamadas telefonicas?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
En tomar los medicamentos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿tiene dificultad administrando su dinero como pagando sus facturas o haciendo un seguimiento de los gastos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inclinarse, arrodillarse o agacharse (ponerse en cuclillas)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Levantar o transportar/cargar objetos que pesen mas de 10 libras, como una bolsa pesada de compras? (de alimentos)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Toxicidad Financiera

Por encargarse de los costos financieros relacionados con su hospitalización u otro tratamiento de COVID ¿Ocurrieron algunos de los siguientes eventos? Por favor responda con Si/No

Discharge Date: [baseline_arm_1][admit_dc_dt]

	Yes	No
Uso todo o la mayoría de sus ahorros	<input type="radio"/>	<input type="radio"/>
Incapaz de pagar por necesidades como comida, energía de calor, o hogar	<input type="radio"/>	<input type="radio"/>
Fue contactado por una agencia de colecciones	<input type="radio"/>	<input type="radio"/>
Declaro bancarrota	<input type="radio"/>	<input type="radio"/>
Falto o se retraso en recibir atención medica que usted necesitaba por el costo	<input type="radio"/>	<input type="radio"/>
Tomo menos medicamentos recetados por el costo	<input type="radio"/>	<input type="radio"/>

Desde su hospitalización con COVID / Desde la ultima vez que hablamos con usted, usted a

	Yes	No
¿Perdido su trabajo?	<input type="radio"/>	<input type="radio"/>
¿Tuvo que cambiar el tipo de trabajo que puede hace?	<input type="radio"/>	<input type="radio"/>

- ¿Tenido a un familiar tomar tiempo de descanso en el trabajo por cuidarlo/a?
- ¿Le han dicho que su seguro no cubriría empezar o continuar con terapia o rehabilitación?
- ¿Le han dicho que su seguro no cubriría el equipo para su hogar - por ejemplo, una cama o silla de ruedas - que usted necesitaba por su hospitalización?

¿Desde su hospitalización con COVID, cuanto han sido afectados los recursos financieros de usted o su familia por su salud?

Responde: Nada/Un poco/Moderado/Severo/Extremo

- None
 Mild
 Moderate
 Severe
 Extreme

Síntomas cardiopulmonares y apoyo respiratorio

Responde Si o No por cada pregunta

- | | Yes | No |
|-----------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| ¿Durante el día, tose frecuentemente? | <input type="radio"/> | <input type="radio"/> |
| ¿Tiene dolores en el pecho cuando viene en contacto con olores fuertes, gases de escape, humo de cigarrillo, perfume, etc.? | <input type="radio"/> | <input type="radio"/> |
| ¿Cuándo intenta dormir, se siente sin aliento? | <input type="radio"/> | <input type="radio"/> |
| ¿Sus dolores de pecho empeoran cuando se siente emocionalmente molesto/a? | <input type="radio"/> | <input type="radio"/> |
| ¿Hay veces que tiene dificultad moverse en casa por el dolor de pecho? | <input type="radio"/> | <input type="radio"/> |
| ¿Después de una salida nocturna, sus dolores de pecho hacen que regrese a casa cuanto antes? | <input type="radio"/> | <input type="radio"/> |
| ¿Sufre de disnea cuando se ríe? | <input type="radio"/> | <input type="radio"/> |

¿Usa oxígeno en el hogar?

¿Usa CPAP o una maquina de respiración cuando va a dormir?

	Mejor	Peor	Casi igual
Durante el día, tose frecuentemente: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tiene dolores en el pecho cuando viene en contacto con olores fuertes, gases de escape, humo de cigarrillo, perfume, etc: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cuándo intenta dormir, se siente sin aliento: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sus dolores de pecho empeoran cuándo se siente emocionalmente molesto/a: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hay veces que tiene dificultad moverse en casa por el dolor de pecho: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Después de una salida nocturna, sus dolores de pecho hacen que regrese a casa cuanto antes: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sufre de disnea cuando se ríe: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Nuevo	Mas	Casi igual
Usa oxigeno en el hogar: Comparado a un mes antes de su hospitalización debido a COVID, ¿su uso de oxigeno es nuevo, mas, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Usa CPAP o una maquina de respiración cuando va a dormir: Comparado a un mes antes de su hospitalización debido a COVID, ¿su uso de maquina de respiración es nuevo, mas, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Sobre las ultimas dos semanas, ¿con que frecuencia a sido molestado/a por algunos de los siguientes problemas?

Responde: Ningún día/Varios días/Más de la mitad de los días/Casi todos los días

	Not at all	Several days	More than half the days	Nearly every day
¿Hinchazón en sus pies, tobillos, ¿o piernas por la mañana cuando despierta?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Forzado a dormir en una silla sentado o por lo menos con 3 almohadas para apoyar la falta de aliento?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Tenia un rápido o latido irregular del corazón?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Tenia dolor de pecho, opresión en el pecho o angina?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Mejor	Peor	Casi igual
Hinchazón: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
la falta de aliento: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
rápido o latido irregular del corazón: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

dolor de pecho, opresión en el pecho o angina: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?

Tratamiento medico actual

¿Actualmente toma algunos de los siguientes medicamentos?

"Note to RA: ONLY if the patient asks, the time frame is in the prior month"

	Yes	No
Medicamentos de presión arteria alta, por ejemplo, diurético, facturas de agua, ¿ACE-inhibidores	<input type="radio"/>	<input type="radio"/>
¿Aspirina?	<input type="radio"/>	<input type="radio"/>
¿Estatinas o medicamentos de colesterol?	<input type="radio"/>	<input type="radio"/>
¿Medicamentos que ayudan a controlar el azúcar en la sangre, por ejemplo, insulina o metformina?	<input type="radio"/>	<input type="radio"/>
¿Esteroides crónicos?	<input type="radio"/>	<input type="radio"/>
¿Inhalador para respirar?	<input type="radio"/>	<input type="radio"/>
¿Medicamentos para el animo?	<input type="radio"/>	<input type="radio"/>
¿Opioides, por ejemplo, morfina, vicodina, dilaudido, o oxicodona?	<input type="radio"/>	<input type="radio"/>
¿Benzodiacepinas, por ejemplo, Ativan, Xanax, o Valium?	<input type="radio"/>	<input type="radio"/>

PHQ9

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Responde: Ningún día/Varios días/Más de la mitad de los días/Casi todos los días

	Not at all	Several days	More than half the days	Nearly every day
Poco interés o placer en hacer cosas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha sentido decaído(a), deprimido(a) o sin esperanzas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado

Se ha sentido cansado(a) o con poca energía

Sin apetito o ha comido en exceso
 Se ha sentido mal con usted mismo(a) - o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia

Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión

¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario - muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal

Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera

	Mejor		Peor	Casi igual
Se ha sentido cansado(a) o con poca energía: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

Patient Safety Screen
 Select the link and follow the PHQ9 protocol.

Complete the PHQ9 Patient Safety Screen

National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

[Attachment: "PHQ9 Suicide Ideation Protocol (3).docx"]

Date:

Patient indicates they have some thoughts of hurting themselves. Select the means by which you obtained this information.

- By mail
 Over the phone
 Other

Upon screening, the patient indicates (select and explain):

- Past, but no current suicidal ideation
 Suicidal ideation only (vague feelings of wishing to be dead, gone or not wake up, without specific suicidal thoughts)
 Suicidal thoughts (General non-specific thoughts of wanting to end one's life/commit suicide)
 Suicidal thoughts with method (without specific plan or intent to act) (Endorses both thoughts of suicide and at least one method)
 Suicidal intent (without specific plan) (Active suicidal thoughts of killing oneself and reports some intent to act on such thoughts)
 Suicidal intent with specific plan (Plan partially or fully worked out and person has intent to carry it out)

Explain why you selected [phq9_screenindication]:

Actions taken by program specialist:

Screen completion and alert:

Select response, then select "Save & Stay"
 ("send alert" will send Jack and Lee an automated message about the risk screen.)

- Complete screen
 Incomplete screen

PHQ9 Score

GAD7

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Responde: Ningún día/Varios días/Mas de la mitad de los días/Casi todos los días

	Not at all	Several days	More than half the days	Nearly every day
Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

No ha sido capaz de parar o controlar su preocupación	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha preocupado demasiado por motivos diferentes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ha tenido dificultad para relajarse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha molestado o irritado fácilmente	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ha tenido miedo de que algo terrible fuera a pasar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Utilización de atención medica

¿Desde su hospitalización con COVID / la ultima entrevista en DDMMYY, de nuevo a sido hospitalizado/a?

(No incluye pasar la noche en una sala de emergencias)

Month 1 Survey Completion Date: [month_1_arm_1][pt_surv_end_time_sp]

Month 3 Survey Completion Date: [month_3_arm_1][pt_surv_end_time_sp]

Discharge Date: [baseline_arm_1][admit_dc_dt]

(Review the date of the last survey prior to the 3 month and 6 month interview. If the patient completed a 1 month survey, but not the 3 month, anchor the 6 month question using the optimal date of the 3 month survey (90 days post-discharge). If they didn't complete the 1 month, then the 3 month question should use the "Since your COVID hospitalization.")

Yes

No

Cuantas noches paso en el hospital?

Algunas de estas noches las paso en otro hospital que no fue donde se registro en el estudio?

Yes

No

[baseline_arm_1][admit_site]?

Demográficas

Caregiver Study Status: [baseline_arm_1][cg_studystatus]

Note to RA: If caregiver's study status is left blank, proceed with questions. If a status is populated, skip to the next section (Education).

¿Hay una persona que le ayuda cuando esta enfermo/a?

Yes

No

También estamos conduciendo una investigación sobre las experiencias de recuperación para los ayudantes.

Yes

No

¿Tenemos su permiso de contactar al ayudante y hacerle preguntas similares como las que acaba de contestar?

Reminder: update caregiver's Study Status to "Patient Declined Caregiver Participation"

Caregiver Eligibility

Note to RA: The caregiver must meet the following eligibility criteria to participate

- 18 years of age or older
- Speaks English or Spanish
- Has a working phone

¿Cuándo usted se enferma, a quien llama para que le ayude? _____

Could we please have their name and contact information?

Note to RA: Click on the link below and scroll to the end of the form to enter caregiver contact information.

[baseline_arm_1][form-link:contact_information]

Educación

¿Cuántos años de educación tiene?

- Less than or equal to 12
- More than 12

¿Menos de o equivalente a un bachillerato? o ¿Mas de un bachillerato?

¿Es usted un veterano/a militar? (¿Usted sirvió en el ejército estadounidense?)

- Si
- No
- Inseguro

Si responde sí, ¿en que sucursal y componente sirvió usted? Seleccionar todas las que correspondan

- Army (Active Component)
- Army National Guard
- Army Reserve
- Navy (Active Component)
- Navy Reserve
- Marine Corps (Active Component)
- Marine Corps Reserve
- Air Force (Active Component)
- Air National Guard
- Air Force Reserve
- Coast Guard (Active Component)
- Coast Guard Reserve

Survey End

Total call time

(Spanish) Patient: MOCA

General Comments

Survey Start

Memory

Ésta es una prueba de memoria. Voy a leerle una lista de palabras que tendrá que recordar ahora y también le voy a solicitar que lo haga posteriormente. Escuche atentamente y cuando yo haya finalizado, por favor dígame todas las palabras que recuerde usted. No importa el orden.

Rostro, Terciopelo, Iglesia, Margarita, Rojo

Rostro

Terciopelo

Iglesia

Margarita

Rojo

Ahora voy a leerle la misma lista una segunda vez. Trate de recordar y decirme tantas palabras como pueda, incluyendo las que me dijo la primera vez.

Rostro, Terciopelo, Iglesia, Margarita, Rojo

Rostro

Terciopelo

Iglesia

Margarita

Rojo

Le voy a pedir que recuerde estas palabras al final de la prueba.

Voy a decirle algunos números y cuando haya terminado, le pido me los repita exactamente como los he dicho.

2 1 8 5 4

Did the subject repeat them in FORWARD order?

- Yes
 No

Ahora voy a decir algunos números más, pero cuando haya terminado, usted me los repetirá en orden invertido (del final hacia el principio).

7 4 2

Did the subject repeat them in BACKWARD order?

- Yes
 No

Voy a leerle una secuencia de letras. Cada vez que digo la letra "A," por favor diga sí. Si digo otra letra que no sea la "A," no diga nada.

	Said	Didn't say
F	<input type="radio"/>	<input type="radio"/>
B	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
C	<input type="radio"/>	<input type="radio"/>
M	<input type="radio"/>	<input type="radio"/>
N	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
J	<input type="radio"/>	<input type="radio"/>

K	<input type="radio"/>	<input type="radio"/>
L	<input type="radio"/>	<input type="radio"/>
B	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
F	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
K	<input type="radio"/>	<input type="radio"/>
D	<input type="radio"/>	<input type="radio"/>
E	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
J	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
M	<input type="radio"/>	<input type="radio"/>
O	<input type="radio"/>	<input type="radio"/>
F	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
A	<input type="radio"/>	<input type="radio"/>
B	<input type="radio"/>	<input type="radio"/>

How many errors did the participant have? (an error is a "yes" on a wrong letter or a failure to say "yes" on letter A) _____

Ahora le voy a pedir que al número 100 le reste 7 y así sucesivamente, por favor continúe hasta que yo le indique que se detenga.

100 - 7 = what?
Record R's answer
(correct answer: 93) _____

And seven from that?
Record R's answer
(correct answer: 86) _____

And seven from that?
Record R's answer
(correct answer: 79) _____

And seven from that?
Record R's answer
(correct answer: 72) _____

And seven from that?
Record R's answer
(correct answer: 65) _____

Score _____

Score Instructions

[Attachment: "Subtraction Scoring.pdf"]

Language

Ahora voy a leerle una oración, por favor repítala después de mí exactamente de la misma forma en que yo la he dicho [pausa]:

Sólo sé que Juan es el único que necesita ayuda hoy.

Did the subject repeat the sentence correctly?

- Yes
 No

Ahora voy a leerle otra oración, por favor repítala después de mí exactamente como yo la digo [pausa]:

El gato siempre se escondió debajo de la cama cuando los perros estaban en la habitación".

Did the subject repeat the sentence correctly?

- Yes
 No

Fluency

Dígame el mayor número de palabras posibles que comiencen con una letra del abecedario (alfabeto) que yo le indicaré en un momento. Puede decir cualquier clase de palabras que quiera, excepto nombres propios (ejemplo España, Enrique), números o palabras que comiencen con el mismo sonido pero diferente terminación, ejemplo amo amor amoroso, correr, corriendo, corrí. En un minuto le pediré que se detenga. ¿Está listo? [pausa] ahora, dígame el mayor número de palabras posible que comiencen con la letra "P". [cronometre 60 segundos y pida que se detenga].

60 Second Timer

- Turn On

Time for 60 seconds

Type "P" words here

Type wrong "P" words in box to the right

How many words that begin with the letter "P" did the subject name?

Abstraction

(Practice Test): "Podría decirme en qué se parecen un plátano y una naranja", si el paciente contesta concretamente, añade: "dígame otra semejanza entre ellos". Si el paciente no da una respuesta apropiada (frutas), diga, "Sí, y ambos también son frutas".

Train-bicycle = means of transportation, means of travelling, you take trips in both;

Ruler-watch = measuring instruments, used to measure.

The following responses are not acceptable: Train-bicycle = they have wheels; Ruler-watch = they have numbers.

Ahora puede decirme qué tienen en común un tren y una bicicleta.

Did they get the similarity?

- Yes
 No

Ahora dígame qué tienen en común un reloj y una regla.

Did they get the similarity?

- Yes
 No

Delayed Recall

Con anterioridad le leí algunas palabras, y le pedí las recordara. Dígame ahora todas las palabras que recuerde.

Rostro

Terciopelo

Iglesia

Margarita

Rojo

Patient forgot or refused to answer

- Did not remember
 Refused to answer

Por favor dígame la fecha de hoy". Si el paciente no proporciona una respuesta completa, solicitará rápidamente que la indique diciendo; "Dígame (año, mes, fecha exacta y día de la semana)". Luego añadirá: "Ahora dígame el nombre del lugar en el que esta ahora, y en qué ciudad/estado está".

Day

- Monday
 - Tuesday
 - Wednesday
 - Thursday
 - Friday
 - Saturday
 - Sunday
-

Correct Day?

Correct

Date

- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10
 - 11
 - 12
 - 13
 - 14
 - 15
 - 16
 - 17
 - 18
 - 19
 - 20
 - 21
 - 22
 - 23
 - 24
 - 25
 - 26
 - 27
 - 28
 - 29
 - 30
 - 31
-

Correct Date?

Correct

Month

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Correct Month?

- Correct

Year

- 2023
- 2022
- 2021
- 2020
- 2019
- 2018
- 2017
- 2016
- 2015
- 2014
- 2013
- 2012
- 2011
- 2010
- 2009
- 2008
- 2007
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- 2005
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- 1996
- 1995
- 1994
- 1993
- 1992
- 1991
- 1990
- 1989
- 1988
- 1987
- 1986
- 1985
- 1984
- 1983
- 1982
- 1981
- 1980

Correct Year?

Correct

Place

Correct Place?

Correct

City/State

Correct City/State?

Correct

Su participación continua es vital para el éxito de este estudio de investigación. Por lo tanto, nos gustaría registrar los nombres y la información de contacto de dos personas que no viven con usted y que pueden ayudarnos a localizarlo/a o contactarlo/a en el futuro. Estas personas pueden ser parientes, amigos, vecinos, etc., con quien se sienta cómodo/a para que nos comuniquemos.

Contacto #1

Nombre

Domicilio

Numero de Telefono

Informacion adicional

Relacion

Contacto #2

Nombre

Domicilio

Numero de Telefono

Informacion adicional

Relacion

Survey End

Total call time

(Spanish) Caregiver: Post-Hospital Survey

General Comments

Survey Start

Impacto de COVID en el Cuidador y Familia

También fue diagnosticado/a con COVID-19? Yes
 No

Que tan enfermo/a estuvo? Intensive Care Unit
 Hospitalized
Responde: ICU, hospitalizado/a, muy enfermo/a en casa, Very sick at home
levemente enfermo/a, sin síntomas Mildly ill
 No symptoms

Cree usted que estuvo enfermo/a con COVID-19 pero sin Yes
diagnostico? No

Que tan enfermo/a estuvo? Very sick
 Moderately sick
Responde: Muy enfermo/a, moderadamente enfermo/a, Mildly sick
levemente enfermo/a

Adicionalmente, aparte de su familiar, ¿cuido algún Yes
otro familiar diagnosticado con COVID-19? No

Pensando en lo que podía hacer física y mentalmente
antes de COVID.
En una escala del 1 al 100, 100 siendo su estado
habitual antes de COVID, ¿que tan cerca esta a su
estado habitual?

EQ-5D-5L

Primero le voy a leer unas preguntas. Cada pregunta ofrece cinco respuestas. Por favor dígame qué respuesta describe mejor su salud EN EL DÍA DE HOY. No elija más de una respuesta en cada grupo de preguntas.

(Nota para el/la entrevistador/a: es posible que sea necesario recordarle con regularidad a la persona que responde que el período de tiempo es EL DÍA DE HOY. También es posible que sea necesario repetir las preguntas literalmente)

En primer lugar, quisiera preguntarle sobre la movilidad. ¿Diría usted que...

- No tiene problemas para caminar?
- Tiene problemas leves para caminar?
- Tiene problemas moderados para caminar?
- Tiene problemas graves/severos para caminar?
- No puede caminar?

Ahora quisiera preguntarle sobre el cuidado personal. ¿Diría usted que...

- No tiene problemas para lavarse o vestirse solo/a?
- Tiene problemas leves para lavarse o vestirse solo/a?
- Tiene problemas moderados para lavarse o vestirse solo/a?
- Tiene problemas graves/severos para lavarse o vestirse solo/a?
- No puede lavarse o vestirse solo/a?

Ahora quisiera preguntarle sobre las actividades que realiza todos los días, por ejemplo trabajar, estudiar, hacer tareas domésticas, actividades familiares o actividades realizadas durante el tiempo libre. ¿Diría usted que...

- No tiene problemas para realizar sus actividades de todos los días?
- Tiene problemas leves para realizar sus actividades de todos los días?
- Tiene problemas moderados para realizar sus actividades de todos los días?
- Tiene problemas graves/severos para realizar sus actividades de todos los días?
- No puede realizar sus actividades de todos los días?

Ahora quisiera preguntarle sobre el dolor o malestar. ¿Diría usted que...

- No tiene dolor ni malestar?
- Tiene dolor o malestar leve?
- Tiene dolor o malestar moderado?
- Tiene dolor o malestar intenso/severos?
- Tiene dolor o malestar extremo?

Por último, quisiera preguntarle sobre la ansiedad o depresión. ¿Diría usted que...

- No está ansioso/a ni deprimido/a?
- Está levemente ansioso/a o deprimido/a?
- Está moderadamente ansioso/a o deprimido/a?
- Está muy ansioso/a o deprimido/a?
- Está extremadamente ansioso/a o deprimido/a?

Toxicidad Financiera

1.Desde que su paciente fue hospitalizado/a con COVID, cuanto han sido afectados los recursos financieros de usted o su familia por su salud?

Responde: Nada/Un poco/Moderado/Severo/Extremo

Discharge Date: [baseline_arm_1][admit_dc_dt]

- None
- Mild
- Moderate
- Severe
- Extreme

Por encargarse de los costos financieros relacionados con la hospitalización de su paciente u otro tratamiento de COVID ¿Ocurrieron algunos de los siguientes eventos? Por favor responda con Si/No

	Yes	No
Uso todo o la mayoría de sus ahorros	<input type="radio"/>	<input type="radio"/>
Incapaz de pagar por necesidades como comida, energía de calor, o hogar	<input type="radio"/>	<input type="radio"/>
Declaro bancarota	<input type="radio"/>	<input type="radio"/>
Fue contactado por una agencia de colecciones	<input type="radio"/>	<input type="radio"/>
Falto o se retraso en recibir atención medica que usted necesitaba por el costo	<input type="radio"/>	<input type="radio"/>
Tomo menos medicamentos recetados debido al costo	<input type="radio"/>	<input type="radio"/>

Desde que su paciente fue hospitalizado/a con COVID / Desde la ultima vez que hablamos con usted, usted a

	Yes	No
¿Perdido su trabajo?	<input type="radio"/>	<input type="radio"/>
¿Tuvo que cambiar el tipo de trabajo que puede hacer?	<input type="radio"/>	<input type="radio"/>
¿Tenido a un familiar tomar tiempo de descanso en el trabajo por cuidarlo/a?	<input type="radio"/>	<input type="radio"/>
¿Le han dicho que su seguro no cubriría empezar o continuar con terapia o rehabilitación?	<input type="radio"/>	<input type="radio"/>
¿Le han dicho que su seguro no cubriría el equipo para su hogar - por ejemplo, una cama o silla de ruedas - que usted necesitaba por su hospitalización?	<input type="radio"/>	<input type="radio"/>

PHQ9

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Responde: Ningun Dia/Varios Dias/Mas de la Mitad de los Dias/Casi todos los dias

Not at all Several days More than half the days Nearly every day

Poco interés o placer en hacer cosas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha sentido decaído(a), deprimido(a) o sin esperanzas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha sentido cansado(a) o con poca energía	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sin apetito o ha comido en exceso	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha sentido mal con usted mismo(a) - o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario - muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Safety Screen

Select the link and follow the PHQ9 protocol.

Complete the PHQ9 Patient Safety Screen

National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

[Attachment: "PHQ9 Suicide Ideation Protocol (4).docx"]

Date:

Patient indicates they have some thoughts of hurting themselves. Select the means by which you obtained this information.

- By mail
 Over the phone
 Other

Upon screening, the patient indicates (select and explain):

- Past, but no current suicidal ideation
- Suicidal ideation only (vague feelings of wishing to be dead, gone or not wake up, without specific suicidal thoughts)
- Suicidal thoughts (General non-specific thoughts of wanting to end one's life/commit suicide)
- Suicidal thoughts with method (without specific plan or intent to act) (Endorses both thoughts of suicide and at least one method)
- Suicidal intent (without specific plan) (Active suicidal thoughts of killing oneself and reports some intent to act on such thoughts)
- Suicidal intent with specific plan (Plan partially or fully worked out and person has intent to carry it out)

Explain why you selected, [phq9_screenindication_cg]:

Actions taken by program specialist:

Screen completion and alert:

Select response, then select "Save & Stay"
("send alert" will send Jack and Lee an automated message about the risk screen.)

- Complete screen
- Incomplete screen

PHQ9 Score _____

GAD7

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

Responde: Ningún día/Varios días/Más de la mitad de los días/Casi todos los días

	Not at all	Several days	More than half the days	Nearly every day
Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No ha sido capaz de parar o controlar su preocupación	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha preocupado demasiado por motivos diferentes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ha tenido dificultad para relajarse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Se ha molestado o irritado fácilmente	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ha tenido miedo de que algo terrible fuera a pasar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Zarit Caregiver Burden

La siguiente es una lista de preguntas que reflejan lo que a veces sienten las personas cuando cuidan de otra persona. Después de cada pregunta, indique con qué frecuencia se ha sentido de esa manera: nunca, casi nunca, algunas veces, muchas veces o casi siempre. No hay respuestas correctas ni incorrectas.

Responde: Nunca/Casi Nunca/Algunas Veces/Muchas Veces/Casi Siempre

	Never	Rarely	Sometimes	Quite Frequently	Nearly Always
¿Cree que debido al tiempo que pasa con su pariente no tiene suficiente tiempo para usted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Se siente estresado/a por cuidar de su pariente y a la vez tratar de cumplir con otras responsabilidades de familia o trabajo?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Se siente enojado/a con su pariente cuando está con él/ella?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Cree que su pariente afecta actualmente su relación con otros miembros de la familia o amigos de manera negativa?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Se siente tenso/a cuando está con su pariente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Cree que su propia salud se ha deteriorado debido al cuidado que usted provee a su pariente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Cree que no tiene tanta privacidad como quisiera debido a su pariente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Cree que su vida social se ha deteriorado debido al cuidado que usted provee a su pariente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

¿Cree que usted ha perdido el control de su propia vida desde que se enfermó su pariente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Se siente inseguro/a de lo que debe hacer por su pariente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Cree que debería hacer más por su pariente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Cree que podría cuidar mejor de su pariente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Actividades de todos los días (ADLs) y Instrumentos de ADLS

Responde Si o No a cada pregunta

(Please encourage caregivers to say "yes" or "no" to the best of their ability. Do not offer the other response categories [Can't Do, Don't Do, Don't Know, Refused]- only check them if the caregiver cannot say "yes" or "no" to the question).

	Yes	No	Don't do	Can't do	Don't know	Refused to answer
Por problemas de salud o memoria, ¿usted piensa que su familiar tiene dificultad vistiéndose, por ejemplo, poniéndose calcetines o zapatos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Por problemas de salud o memoria, ¿usted piensa que su familiar tiene dificultad caminando a través de una habitación?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Por problemas de salud o memoria, ¿usted piensa que su familiar tiene dificultad para bañarse o ducharse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad comiendo, por ejemplo, cortando la comida?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad acostándose o levantándose de la cama?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad usando el baño, incluyendo, levantándose o sentándose?

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad usando un mapa para averiguar como moverse en un lugar desconocido?

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad preparando una comida caliente?

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad con compras de supermercado?

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad haciendo llamadas?

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad tomando medicamentos?

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad administrando su dinero como pagando sus facturas o haciendo un seguimiento de los gastos?

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad inclinándose, arrodillarse, o agacharse?

Por problemas de salud o memoria ¿usted piensa que su familiar tiene dificultad levantar o transportar mas de 10 libras, por ejemplo, una bolsa pesada del supermercado?

Utilización de atención médica

¿Desde que su paciente fue hospitalizado/a con COVID / la ultima entrevista en DDMMYY, de nuevo han sido hospitalizado/a?

(No incluye pasar la noche en una sala de emergencias)

Month 1 Survey Completion Date: [month_1_arm_1][cg_surv_end_time_sp]

Month 3 Survey Completion Date: [month_3_arm_1][cg_surv_end_time_sp]

Discharge Date: [baseline_arm_1][admit_dc_dt]

(Review the date of the last survey prior to the 3 month and 6 month interview. If the patient completed a 1 month survey, but not the 3 month, anchor the 6 month question using the optimal date of the 3 month survey (90 days post-discharge). If they didn't complete the 1 month, then the 3 month question should use the "Since your COVID hospitalization.")

Yes

No

Cuántas noches paso en el hospital?

Algunas de estas noches las paso en otro hospital que no fue donde se registro en el estudio?

Yes

No

[baseline_arm_1][admit_site]

AD8

Recuerde: "sí. Hay cambios." significa que ha habido un cambio en los últimos años debido a problemas cognitivos (pensamiento y memoria).

Pensando en el tiempo antes de que su familiar fuera hospitalizado por COVID, ¿hubo algún cambio en los últimos años causado por problemas cognitivos (pensamiento y memoria)?

Responde: si / no

	Yes, a change	No, no change	Don't know
Problemas de juicio (ejemplo: compra regalos inadecuados, ha sido estafado/a, toma malas decisiones en lo económico)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menor interés en realizar actividades o sus pasatiempos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repite las preguntas, historias	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tiene dificultad para aprender a usar instrumentos tecnológicos, electrodomésticos (como el control remoto TV, computador, microondas, video grabadora)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Olvida el mes o año	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- | | | | |
|------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| Tiene di cultad en el manejo de asuntos nancieros complejos (pagar las cuentas, llevar la chequera, pago de impuestos) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Tiene di cultad para acordarse de los compromisos (citas al doctor etc.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Problema persistente de memoria y pensamiento (no ocasional) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Educación

- ¿Cuantos años de educación tiene? Less than or equal to 12
 More than 12
- Responde: ¿Menos de o equivalente a un bachillerato?
 / ¿Mas de un bachillerato?

¿Es usted un veterano/a militar? (¿Usted sirvió en el ejército estadounidense?)

- Si
 No
 Inseguro

Si responde sí, ¿en que sucursal y componente sirvió usted? Seleccionar todas las que correspondan

- Army (Active Component)
 Army National Guard
 Army Reserve
 Navy (Active Component)
 Navy Reserve
 Marine Corps (Active Component)
 Marine Corps Reserve
 Air Force (Active Component)
 Air National Guard
 Air Force Reserve
 Coast Guard (Active Component)
 Coast Guard Reserve

Su participación continua es vital para el éxito de este estudio de investigación. Por lo tanto, nos gustaría registrar los nombres y la información de contacto de dos personas que no viven con usted y que pueden ayudarnos a localizarlo/a o contactarlo/a en el futuro. Estas personas pueden ser parientes, amigos, vecinos, etc., con quien se sienta cómodo/a para que nos comuniquemos.

Contacto #1

Nombre

Domicilio

Numero de Telefono

Relacion

Contacto #2

Nombre

Domicilio

Numero de Telefono

Informacion adicional

Relacion

Survey End

Total call time

(Spanish) Proxy: Post-Hospital Survey

General Comments

Proxy Relationship to Patient

- Significant Other
- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Friend
- Other

Please specify other:

Survey Start

Recuperación de COVID

Pensando en lo que el paciente podía hacer física y mentalmente antes de su hospitalización con COVID.

En una escala del 1 al 100, 100 siendo su estado habitual antes de COVID, ¿que tan cerca esta a su estado habitual?

EQ-5D-5L

Primero le voy a leer unas preguntas. Cada pregunta ofrece cinco respuestas. Por favor dígame qué respuesta describe mejor la salud de el paciente EN EL DÍA DE HOY. No elija más de una respuesta en cada grupo de preguntas.

(Nota para el/la entrevistador/a: es posible que sea necesario recordarle con regularidad a la persona que responde que el período de tiempo es EL DÍA DE HOY. También es posible que sea necesario repetir las preguntas literalmente)

En primer lugar, quisiera preguntarle sobre la movilidad. ¿Diría usted que el paciente ...

- No tiene problemas para caminar?
- Tiene problemas leves para caminar?
- Tiene problemas moderados para caminar?
- Tiene problemas graves/severos para caminar?
- No puede caminar?

Ahora quisiera preguntarle sobre el cuidado personal. ¿Diría usted que el paciente ...

- No tiene problemas para lavarse o vestirse solo/a?
- Tiene problemas leves para lavarse o vestirse solo/a?
- Tiene problemas moderados para lavarse o vestirse solo/a?
- Tiene problemas graves/severos para lavarse o vestirse solo/a?
- No puede lavarse o vestirse solo/a?

Ahora quisiera preguntarle sobre las actividades que realiza todos los días, por ejemplo trabajar, estudiar, hacer tareas domésticas, actividades familiares o actividades realizadas durante el tiempo libre. ¿Diría usted que el paciente ...

- No tiene problemas para realizar sus actividades de todos los días?
- Tiene problemas leves para realizar sus actividades de todos los días?
- Tiene problemas moderados para realizar sus actividades de todos los días?
- Tiene problemas graves/severos para realizar sus actividades de todos los días?
- No puede realizar sus actividades de todos los días?

Ahora quisiera preguntarle sobre el dolor o malestar. ¿Diría usted que el paciente ...

- No tiene dolor ni malestar?
- Tiene dolor o malestar leve?
- Tiene dolor o malestar moderado?
- Tiene dolor o malestar intenso/severos?
- Tiene dolor o malestar extremo?

Por último, quisiera preguntarle sobre la ansiedad o depresión. ¿Diría usted que el paciente ...

- No está ansioso/a ni deprimido/a?
- Está levemente ansioso/a o deprimido/a?
- Está moderadamente ansioso/a o deprimido/a?
- Está muy ansioso/a o deprimido/a?
- Está extremadamente ansioso/a o deprimido/a?

Actividades de todos los días (ADLs) y Instrumentos de ADLs

Ahora voy a leer algunas actividades de la vida diaria. Por favor dígame si el paciente tiene alguna dificultad con estas actividades debido a un problema físico, mental, emocional o de memoria.

Note to RA: Do not offer the Don't Know option, but select if the proxy says it.

Debido a algún problema de salud o de memoria, ¿tiene alguna dificultad:

Yes No Don't do Can't do Don't know Refused to answer

Vistiendos, incluyendo ponerse zapatos y calcetines?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caminado a traves de un cuatro?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Banadose o duchandose?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
en comer, como por ejemplo, en cortar la comida?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
acostandose o levantandose de la cama?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
en usar el inodoro/excusado, incluyendo levantarse y sentarse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿tiene dificultad usando un mapa para descubrir cómo moverse en un lugar extraño?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preparandose comidas calientes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Haciendo las compras? (de alimentos)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Haciendo llamadas telefonicas?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
En tomar los medicamentos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿tiene dificultad administrando su dinero como pagando sus facturas o haciendo un seguimiento de los gastos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inclinarse, arrodillarse o agacharse (ponerse en cuclillas)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Levantar o transportar/cargar objetos que pesen mas de 10 libras, como una bolsa pesada de compras? (de alimentos)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Toxicidad Financiera

Por encargarse de los costos financieros relacionados con su hospitalización u otro tratamiento de COVID ¿Al paciente le ocurrieron algunos de los siguientes eventos? Por favor responda con Si/No

Note to RA: Do not offer the Don't Know option, but select if the proxy says it.

Discharge Date: [baseline_arm_1][admit_dc_dt]

	Yes	No	Don't Know
Uso todo o la mayoría de sus ahorros	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Incapaz de pagar por necesidades como comida, energía de calor, o hogar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fue contactado por una agencia de colecciones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Declaro bancarota	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Falto o se retraso en recibir atención medica que usted necesitaba por el costo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tomo menos medicamentos recetados por el costo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Desde su hospitalización con COVID / Desde la ultima vez que hablamos con usted, el paciente

Note to RA: Do not offer the Don't Know option, but select if the proxy says it.

	Yes	No	Don't Know
¿Perdido su trabajo?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Tuvo que cambiar el tipo de trabajo que puede hacer?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Tenido a un familiar tomar tiempo de descanso en el trabajo por cuidarlo/a?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Le han dicho que su seguro no cubriría empezar o continuar con terapia o rehabilitación?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Le han dicho que su seguro no cubriría el equipo para su hogar - por ejemplo, una cama o silla de ruedas - que usted necesitaba por su hospitalización?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

¿Desde su hospitalización con COVID, cuanto han sido afectados los recursos financieros de usted o su familia por su salud?

Responde: Nada/Un poco/Moderado/Severo/Extremo

- None
- Mild
- Moderate
- Severe
- Extreme

Síntomas cardiopulmonares y apoyo respiratorio**Responde Si o No por cada pregunta****Note to RA: Do not offer the Don't Know option, but select if the proxy says it.**

	Yes	No	Don't Know
¿Durante el día, tose frecuentemente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Tiene dolores en el pecho cuando viene en contacto con olores fuertes, gases de escape, humo de cigarrillo, perfume, etc.?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Cuándo intenta dormir, se siente sin aliento?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Sus dolores de pecho empeoran cuando se siente emocionalmente molesto/a?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Hay veces que tiene dificultad moverse en casa por el dolor de pecho?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Después de una salida nocturna, sus dolores de pecho hacen que regrese a casa cuanto antes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Sufre de disnea cuando se ríe?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Usa oxígeno en el hogar?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Usa CPAP o una maquina de respiración cuando va a dormir?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Mejor	Peor	Casi igual
Durante el día, tose frecuentemente: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tiene dolores en el pecho cuando viene en contacto con olores fuertes, gases de escape, humo de cigarrillo, perfume, etc: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cuándo intenta dormir, se siente sin aliento: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?

Sus dolores de pecho empeoran cuándo se siente emocionalmente molesto/a: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?

Hay veces que tiene dificultad moverse en casa por el dolor de pecho: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?

Después de una salida nocturna, sus dolores de pecho hacen que regrese a casa cuanto antes: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?

Sufre de disnea cuando se ríe: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?

Nuevo

Mas

Casi igual

Usa oxígeno en el hogar: Comparado a un mes antes de su hospitalización debido a COVID, ¿su uso de oxígeno es nuevo, mas, o casi igual?

Usa CPAP o una maquina de respiración cuando va a dormir: Comparado a un mes antes de su hospitalización debido a COVID, ¿su uso de maquina de respiración es nuevo, mas, o casi igual?

Sobre las ultimas dos semanas, ¿con que frecuencia a sido molestado/a por algunos de los siguientes problemas?

Responde: Ningún día/Varios días/Más de la mitad de los días/Casi todos los días

Note to RA: Do not offer the Don't Know option, but select if the proxy says it.

	Not at all	Several days	More than half the days	Nearly every day	Don't Know
¿Hinchazón en sus pies, tobillos, ¿o piernas por la mañana cuando despierta?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Forzado a dormir en una silla sentado o por lo menos con 3 almohadas para apoyar la falta de aliento?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Tenia un rápido o latido irregular del corazón?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Tenia dolor de pecho, opresión en el pecho o angina?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Mejor	Peor	Casi igual
Hinchazón: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
falta de aliento: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
rápido o latido irregular del corazón: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
dolor de pecho, opresión en el pecho o angina: Comparado a un mes antes de su hospitalización debido a COVID, ¿es mejor, peor, o casi igual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Tratamiento medico actual

¿Actualmente, el paciente toma algunos de los siguientes medicamentos?

Note to RA: ONLY if the patient asks, the time frame is in the prior month; do not offer the Don't Know option, but select if the proxy says it.

Yes No Don't Know

Medicamentos de presión arteria alta, por ejemplo, diurético, facturas de agua, ¿ACE-inhibidores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Aspirina?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Estatinas o medicamentos de colesterol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Medicamentos que ayudan a controlar el azúcar en la sangre, por ejemplo, insulina o metformina?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Esteroides crónicos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Inhalador para respirar?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Medicamentos para el animo?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Opioides, por ejemplo, morfina, vicodina, dilaudido, o oxicodona?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
¿Benzodiacepinas, por ejemplo, Ativan, Xanax, o Valium?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Utilización de atención medica

¿Desde la hospitalización del paciente con COVID / la ultima entrevista en DDMMYY, de nuevo a sido hospitalizado/a?

(No incluye pasar la noche en una sala de emergencias)

Month 1 Survey Completion Date: [month_1_arm_1][px_surv_end_time_sp]

Month 3 Survey Completion Date: [month_3_arm_1][px_surv_end_time_sp]

Discharge Date: [baseline_arm_1][admit_dc_dt]

(Review the date of the last survey prior to the 3 month and 6 month interview. If the patient completed a 1 month survey, but not the 3 month, anchor the 6 month question using the optimal date of the 3 month survey (90 days post-discharge). If they didn't complete the 1 month, then the 3 month question should use the "Since your COVID hospitalization.")

Yes

No

Cuantas noches paso en el hospital?

Algunas de estas noches las paso en otro hospital que no fue donde se registro en el estudio?
[baseline_arm_1][admit_site]?

Yes

No

AD8

Recuerde: "sí. Hay cambios." significa que ha habido un cambio en los últimos años debido a problemas cognitivos (pensamiento y memoria).

Pensando en el tiempo antes de que su familiar fuera hospitalizado por COVID, ¿hubo algún cambio en los últimos años causado por problemas cognitivos (pensamiento y memoria)?

Responde: si / no

	Yes, a change	No, no change	Don't know
Problemas de juicio (ejemplo: compra regalos inadecuados, ha sido estafado/a, toma malas decisiones en lo económico)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menor interés en realizar actividades o sus pasatiempos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repite las preguntas, historias	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tiene dificultad para aprender a usar instrumentos tecnológicos, electrodomésticos (como el control remoto TV, computador, microondas, video grabadora)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Olvida el mes o año	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tiene dificultad en el manejo de asuntos financieros complejos (pagar las cuentas, llevar la chequera, pago de impuestos)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tiene dificultad para acordarse de los compromisos (citas al doctor etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problema persistente de memoria y pensamiento (no ocasional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Educación

¿Cuántos años de educación tiene el paciente? Less than or equal to 12
 More than 12

¿Menos de o equivalente a un bachillerato? o ¿Mas de un bachillerato?

¿El paciente es un veterano/a militar? (¿El paciente sirvió en el ejército estadounidense?)

- Si
 No
 Inseguro

Si responde sí, ¿en que sucursal y componente sirvió el paciente? Seleccionar todas las que correspondan.

- Army (Active Component)
- Army National Guard
- Army Reserve
- Navy (Active Component)
- Navy Reserve
- Marine Corps (Active Component)
- Marine Corps Reserve
- Air Force (Active Component)
- Air National Guard
- Air Force Reserve
- Coast Guard (Active Component)
- Coast Guard Reserve

Su participación continua es vital para el éxito de este estudio de investigación. Por lo tanto, nos gustaría registrar los nombres y la información de contacto de dos personas que no viven con usted y que pueden ayudarnos a localizarlo/a o contactarlo/a en el futuro. Estas personas pueden ser parientes, amigos, vecinos, etc., con quien se sienta cómodo/a para que nos comuniquemos.

Contacto #1

Nombre

Domicilio

Numero de Telefono

Informacion adicional

Relacion

Contacto #2

Nombre

Domicilio

Numero de Telefono

Informacion adicional

Relacion

Survey End

Total call time

Payment Details

REMINDER: LIFT COVID PATIENTS RECEIVE \$30 PER SURVEY

Payment Notes

Reason for Payment

- Phone Survey
 - Mailed Survey
 - Postcard
-

Person Paid

- Patient
 - Caregiver
 - Proxy
-

Proxy First Name

Proxy Last Name

Payment Type

- HSIP Giftcard
 - Refused payment
-

Date Payment Issued

Payment Amount
do not include dollar sign (\$)

Payment Quantity

Payment HSIP #

LIFT COVID

Before I tell you about another study that you're eligible for, can you confirm that you have access to a working telephone and smartphone, tablet, or computer with wifi or internet connection?

Instructions to RA: If confirmed, check the box and proceed with the script. If not confirmed, mark the patient as excluded.

Proceed with LIFT COVID if PHQ9 score is ≥ 5 .

Patient's PHQ9 Score: [month_1_arm_1][pt_phq9_score]

Start Consent Script

A. Background, purpose, procedures

I just noticed that based on your survey responses, you're eligible for a new research study called Lift that is funded by the National Institutes of Health and being conducted by Duke University, the University of Colorado, Oregon Health & Sciences University, and the University of Michigan. Lift is a study for patients who have been hospitalized from COVID-19. The Lift study is testing a mobile app that's designed to address common problems related to COVID illness like high levels of stress and physical symptoms like pain, fatigue, and breathlessness-problems that make it harder to get back into the swing of family life, work, or school. Lift may help people use mindfulness to manage their reactions, emotions, and attitudes. Mindfulness is simply the practice of training the mind to be more aware of the negative ways we often react to thoughts and symptoms. Mindfulness has been used by professional athletes, the military, and even school aged children to improve well-being and quality of life.

This study is being conducted because although many people have been impacted by COVID, there are few easily accessible resources to help people after leaving the hospital. Your participation will help to determine if LIFT helps people to recover faster and more completely. If it does, Lift could represent a way for many hundreds of thousands of people across the country who are struggling with COVID. But first we have to do a research study to determine if this is the case.

If you agree to participate, you'll be randomly assigned (like flipping a coin) to either the LIFT program or traditional care.

If you are in the LIFT group, you'll receive an email with a link to download the free Lift mobile app on your phone. You'll be asked to use the app for 1 month to practice mindfulness for 5 minutes a day. Once a week, you'll complete a single 2-minute survey. If you are in the traditional care group, you will have no required app activities. But when you finish the study, you'll receive an email that provides access to the LIFT mobile app. You don't need to provide any medical information for the Lift study in addition to the BLUE CORAL telephone surveys that are already planned for 2 and 5 months from now. To see whether the Lift app or traditional care work better, the Lift team will analyze your BLUE CORAL survey data. These data will be transferred to Duke without identifiers from the BLUE CORAL teams at the Massachusetts General Hospital and at the University of Michigan through a secure password-protected data system located on a Duke University server. To access the Lift app and ensure that only you can access it, you need to provide your date of birth and phone number.

Would you be interested in hearing a little more about the Lift study?

Yes > Great! [Continue]

No > Thanks for your time. If you change your mind, please check out Lift.duke.edu to learn more and see how to contact us.

- Yes
 No

B. Risks or discomforts

There are no known physical risks associated with this study. There is a very small chance that this study could increase emotional distress.

The mobile app used in this study was developed by Pattern Health (Durham, NC) specifically for use in this study. As with any website you view or software that you download, there may be potential security risks and Duke cannot guarantee that the website/software is free of risk. However, if you run a current operating system on your device, review the privacy/security settings often, and restrict any unnecessary access, this risk is very small.

We are not asking you to make any health decisions based on the use of this mobile app. Please use good judgment and follow prevailing laws. Do not perform study-related activities while you are driving, only in a safe environment.

C. Benefits

If you agree to take part in this study, there may be direct medical benefit to you such as improving physical and emotional symptoms-though this is not certain. We hope the information learned from this study will benefit other COVID patients.

D. Alternative procedures

You can choose to not participate and continue receiving your normal standard of care.

E. Confidentiality and data security / safety

Participation in research involves some loss of privacy. We will do our best to make sure that information about you is kept confidential as required by law and safeguarded by Federal Privacy Regulations, but we cannot guarantee total confidentiality. Your personal information may be viewed by individuals who are conducting, funding, or regulating the study. However, we will share only the minimum necessary information in order to conduct the research.

Except when required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier in study records disclosed outside of Duke University Health System (DUHS) including during reporting of study results. The study results will be retained in your research record for at least six years and then either destroyed or have your identifying private information removed.

The Department of Health and Human Services (HHS) has issued a Certificate of Confidentiality to further protect your privacy. With this Certificate, the investigators may not disclose research information that may identify you in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings, unless you have consented for this use. Research information protected by this Certificate cannot be disclosed to anyone else who is not connected with the research unless:

There is a law that requires disclosure (such as to report child abuse or communicable diseases but not for legal proceedings); You have consented to the disclosure, including for your medical treatment; or The research information is used for other scientific research, as allowed by federal regulations protecting research subjects. Disclosure is required, however, for audit or program evaluation requested by the agency that is funding this project or for information that is required by the Food and Drug Administration (FDA). You should understand that a Confidentiality Certificate does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If you want your research information released to an insurer, medical care provider, or any other person not connected with the research, you must provide consent to allow the researchers to release it. This means that you and your family must also actively protect your own privacy.

F. Compensation

You will receive \$20 per survey you complete for the Lift study, up to \$60 to compensate you for your time. This is in addition to the compensation you receive for the BLUE CORAL study.

G. Whom to contact

For general questions about the study, contact Dr. Christopher Cox at 919-681-7232 during regular business hours and at 919-684-8111 after hours or email him at LiftCOVID@duke.edu.

For questions about your rights as a research participant or to discuss concerns, contact the Duke University Health System Institutional Review Board (IRB) Office at (919) 668-5111.

H. Voluntary statement

You may choose not to be in the study, or, if you agree to be in the study, you may withdraw from the study at any time by notifying the study team by phone or email (liftcovid@duke.edu). If you withdraw from the study, no new data about you will be collected for study purposes other than data needed to keep track of your withdrawal.

Do you have any questions about the study?

- Yes
 No
-

FAQs

What is mindfulness?

Mindfulness is simply the practice of training the mind to be more aware in an open, nonjudgmental way. It can help to change the negative ways we often react to thoughts and symptoms-and control our emotions and attitudes much better.

Is the mobile app secure?

The Lift mobile app meets all standards for digital security at Duke University. You can set up touch ID if you like. The Lift app was developed by researchers at Duke and mobile app developers (Pattern Health) located in Durham, NC.

Does the Lift study conflict with BLUE CORAL-and do the BLUE CORAL study teams approve it?

The National Institutes of Health fund both Lift and BLUE CORAL. Investigators work on both studies. It is perfectly fine to do both studies.

Do you agree to participate in this research study?

Yes > Great! We will send you an email today or tomorrow that describes what group you will be in and how to access any study activities you need to get started. Thanks so much.

Maybe > Sounds like you might need a little time to think about it. What would be a good time and phone number where we could call you back in the next couple of days? Also, please check out the study informational video at Lift.duke.edu/COVID.

No > Thanks for your time. If you change your mind, please check out Lift.duke.edu/COVID to learn more and see how to contact us.

- Yes
 Maybe
 No
-

Note to RA: Change status to "Refused."

End Consent Script

Note to RA: Change status to "Eligible."

Call-back phone number:

Call-back date/time:

Note to RA: Change status to "Refused."

Verbal Consent Date/Time

Would you prefer if we email or mail you a copy of your informed consent document?

Note to RA: Confirm we have their most recent address or email in BLUE CORAL.

- Mail
 Email
 Declined copy of informed consent document
-

Date mailed:

Date emailed:

Application Download Process

I'd like to enroll you in the App right now and help you download the App on your phone. It should only take a few more minutes of your time.

Instructions to RA: Proceed with entering information in Pattern Health website. If the patient does not have time, enter their information after you hang up and tell the patient they will be receiving instructions via email. CONFIRM EMAIL ADDRESS AND ENTER IN THE CONTACT INFORMATION FORM.

[Click here to open Pattern Health website](#)

Completed application download (check this box after you help patient download the App)

Start App Download Process

LIFT COVID Participant Management

[Attachment: "LIFT for COVID Participant Management.pdf"]

Patient's Email: [baseline_1_arm_1][ci_ptemail]

Note to RA: If email is blank, open Updated Contact Information Form in a new tab to capture email.

[baseline_1_arm_1][form-link:updated_contact_information]

Patient's PHQ9 Score: [month_1_arm_1][pt_phq9_score]

Reminder: The patient is only eligible if their PHQ9 is ≥ 5 .

Stop App Download Process (enter date/end time after you help patient download the App)

LIFT COVID Status

LIFT COVID Status

- Consented
- Refused
- Excluded
- Eligible
- Wants more information from Duke
- Not contacted, study hadn't started
- Missed (eligible, never consented)
- Returned mailed survey - not contacted

Refused Date

Refused Reason

- Not interested in research
- No time
- Concerned with confidentiality
- Other

If other, please specify:

Excluded Date

Excluded Reason

- No access to a smartphone, tablet, or computer with wifi or internet connection
- Other
- Suicidal ideation at time of 1-month interview

If other, please specify:

Verbal Consent Total Time (Agreed to participate)

Verbal Consent Total Time (no or maybe response)

App Download Process Total Time

Scores & Calculations

Date/Time of Most Recent Call:
