# Medicare Health Outcomes Survey Questionnaire (English)

HOS 3.0 2018

**Insert Cover Art (English)** 

# Medicare Health Outcomes Survey Instructions

This survey asks about you and your health. Answer each question, thinking about <u>yourself</u>. Please take the time to complete this survey. Your answers are very important to us. If you are unable to complete this survey, a family member or "proxy" can fill out the survey about you.

#### Please return the survey with your answers in the enclosed postage-paid envelope.

Answer the questions by putting an 'X' in the box next to the appropriate answer like the example below.

Are you male or female?

1	Male
2	Female

- > Be sure to read <u>all</u> the answer choices given before marking a box with an 'X'.
- You are sometimes told to skip over some questions in this survey. When this happens you will see a note that tells you what question to answer next, like this:



Yes → Go to Question 35

No → Go to Question 36

All information that would permit identification of any person who completes this survey is protected by the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). This information will be used only for purposes permitted by law and will not be disclosed or released for any other reason. If you have any questions or want to know more about the study, please call [vendor name] at [toll-free number].

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information that does not display a valid OMB control number. The valid OMB control number for this information collection is 0938-0701. The time required to complete this information collection is estimated to average 20 minutes including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, C1-25-05, Baltimore, Maryland 21244-1850."

#### OMB 0938-0701 Version 02-1

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Items 1–9: The VR-12 Health Survey item content was developed and modified from a 36-item health survey.

# Medicare Health Outcomes Survey

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



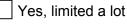
- 2. The following items are about activities you might do during a typical day. Does **your** health <u>now</u> limit you in these activities? If so, how much?
  - a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

Yes, limited a lot

Yes, limited a little

No, not limited at all

b. Climbing several flights of stairs



Yes, limited a little

No, not limited at all

- 3. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?
  - a. Accomplished less than you would like as a result of your physical health?
    - No, none of the time

Yes, a little of the time

Yes, some of the time

] Yes, most of the time

\_\_\_ Yes, all of the time

- b. Were limited in the kind of work or other activities as a result of your physical health?
- No, none of the time No, none of the time Yes, a little of the time Yes, some of the time Yes, most of the time Yes, all of the time
- 4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?
  - a. Accomplished less than you would like as a result of any emotional problems

No,	none	of the	time

Yes, a little of the time

Yes, some of the time

- Yes, most of the time
- Yes, all of the time
- b. Didn't do work or other activities as carefully as usual as a result of any emotional problems
  - No, none of the time  $\begin{array}{c} 1 \\ 2 \\ \end{array}$  Yes, a little of the time  $\begin{array}{c} 3 \\ 3 \\ \end{array}$  Yes, some of the time  $\begin{array}{c} 4 \\ 4 \\ \end{array}$  Yes, most of the time  $\begin{array}{c} 4 \\ 4 \\ \end{array}$  Yes, all of the time
- 5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?



These questions are about how you feel and how things have been with you during the **past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling.

- 6. How much of the time during the **past 4** weeks:
  - a. Have you felt calm and peaceful?

All of the time None of the time

- b. Did you have a lot of energy?
  - All of the time None of the time
- c. Have you felt downhearted and blue?
  - All of the time
  - Most of the time
  - A good bit of the time
  - Some of the time
  - A little of the time
  - None of the time

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

$_{1}$ All of the time
$_{2}$ Most of the time
$_{3}$ Some of the time
$\int_{4}^{3}$ A little of the time
5 None of the time

Now, we'd like to ask you some questions about how your health may have changed.

 Compared to <u>one year ago</u>, how would you rate your physical health in general now?

₁⊔	Much better
2	Slightly better
3	About the same
4	Slightly worse
5	Much worse

9. Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed, or irritable) in general now?

1 Much better
2 Slightly better
$_{3}$ About the same
Slightly worse
5 Much worse

Earlier in the survey you were asked to indicate whether you have any limitations in your activities. We are now going to ask a few additional questions in this area.

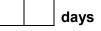
- 10. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person?
  - a. Bathing
    - No, I do not have difficulty
    - \_\_\_ Yes, I have difficulty
    - I am unable to do this activity
  - b. Dressing
    - No, I do not have difficulty
    - Yes, I have difficulty
    - I am unable to do this activity
  - c. Eating
    - No, I do not have difficulty
    - Yes, I have difficulty
    - I am unable to do this activity
  - d. Getting in or out of chairs
    - No, I do not have difficulty
    - Yes, I have difficulty
    - I am unable to do this activity
  - e. Walking
    - No, I do not have difficulty
    - Yes, I have difficulty
    - \_\_\_ I am unable to do this activity
  - f. Using the toilet
    - No, I do not have difficulty
      - Yes, I have difficulty
    - I am unable to do this activity

- 11. Because of a health or physical problem, do you have any difficulty doing the following activities?
  - a. Preparing meals
  - No, I do not have difficulty  $_{2}$  Yes, I have difficulty  $_{3}$  I don't do this activity b. Managing money  $_{1}$  No, I do not have difficulty  $_{2}$  Yes, I have difficulty  $_{3}$  I don't do this activity c. Taking medication as prescribed
  - c. Taking medication as prescribed
    - No, I do not have difficulty
      - ] Yes, I have difficulty
    - I don't do this activity

These next questions ask about your physical and mental health during the past 30 days.

12. Now, thinking about your physical health, which includes physical illness and injury, for how many days during the <u>past 30</u> <u>days</u> was your **physical health not** good?

Please enter a number between "0" and "30" days. If no days, please enter "0" days. Your best estimate would be fine.



13. Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the **past 30 days** was your **mental health not** good?

Please enter a number between "0" and "30" days. If no days, please enter "0" days. Your best estimate would be fine.

days

14. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
Please enter a number between "0" and

"30" days. If no days, please enter "0" and days. Your best estimate would be fine.



Now we are going to ask some questions about specific medical conditions.

15. Are you blind or do you have serious difficulty seeing, even when wearing glasses?



16. Are you deaf or do you have serious difficulty hearing, even with a hearing aid?



17. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?



18. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?



19. In the **past month**, how often did memory problems interfere with your daily activities?

₁  Every day (7 days a week)
$_2$ Most days (5-6 days a week)
$_{3}$ Some days (2-4 days a week)
$_{4}$ Rarely (once a week or less)
<sub>5</sub> Never
-

## Has a doctor ever told you that you had:

20. Hypertension or high blood pressure

1	Yes
2	No

21. Angina pectoris or coronary artery disease

	es
N	о

22. Congestive heart failure

	Yes
1	No
24	

23. A myocardial infarction or heart attack

1	Yes
2	No

24. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat

1	Yes
2	No

25. A stroke



### Has a doctor ever told you that you had:

- 26. Emphysema, or asthma, or COPD (chronic obstructive pulmonary disease)
  - ₁ Yes ∫ No
- 27. Crohn's disease, ulcerative colitis, or inflammatory bowel disease

Yes

28. Arthritis of the hip or knee



29. Arthritis of the hand or wrist



- 30. Osteoporosis, sometimes called thin or brittle bones
  - \_\_\_\_Yes
- 31. Sciatica (pain or numbness that travels down your leg to below your knee)



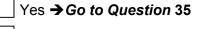
32. Diabetes, high blood sugar, or sugar in the urine



33. Depression

Yes
No

34. Any cancer (other than skin cancer)



No →Go to Question 36

- 35. Are you currently under treatment for:
  - a. Colon or rectal cancer

1 Yes 2 No
b. Lung cancer
1 Yes
c. Breast cancer
1 Yes
d. Prostate cancer
1 Yes

e. Other cancer (other than skin cancer)

	Yes
2	] No

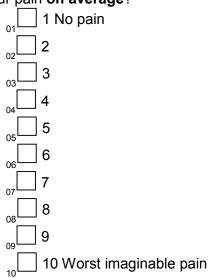
36. In the **<u>past 7 days</u>**, how much did pain interfere with your day to day activities?



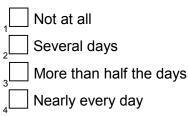
37. In the **past 7 days**, how often did pain keep you from socializing with others?



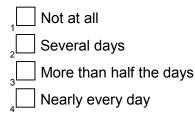
38. In the **past 7 days**, how would you rate your pain **on average**?



- 39. Over the **past 2 weeks**, how often have you been bothered by any of the following problems?
  - a. Little interest or pleasure in doing things



b. Feeling down, depressed, or hopeless



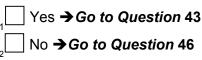
40. In general, compared to other people your age, would you say that your health is:



41. Do you <u>now</u> smoke every day, some days, or not at all?



42. Many people experience leakage of urine, also called urinary incontinence. In the **past six months**, have you experienced leaking of urine?



43. During the **past six months**, how much did leaking of urine make you change your daily activities or interfere with your sleep?



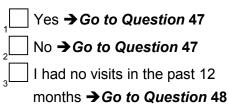
44. Have you <u>ever</u> talked with a doctor, nurse, or other health care provider about leaking of urine?



45. There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you **ever** talked with a doctor, nurse, or other health care provider about any of these approaches?



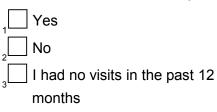
46. In the **past 12 months**, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.



47. In the **past 12 months**, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

	Yes
2	No

48. A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?



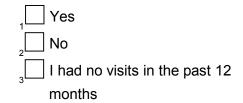
49. Did you fall in the **past 12 months?** 



50. In the **past 12 months,** have you had a problem with balance or walking?



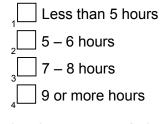
- 51. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
  - Suggest that you use a cane or walker.
  - Suggest that you do an exercise or physical therapy program.
  - Suggest a vision or hearing test.



52. Have you <u>ever</u> had a **bone density test** to check for **osteoporosis**, sometimes thought of as "brittle bones"? This test would have been done to your back or hip.

1	Yes
2	No

53. During the **past month**, on average, how many hours of actual sleep did you get at night? (This may be different from the number of hours you spent in bed.)

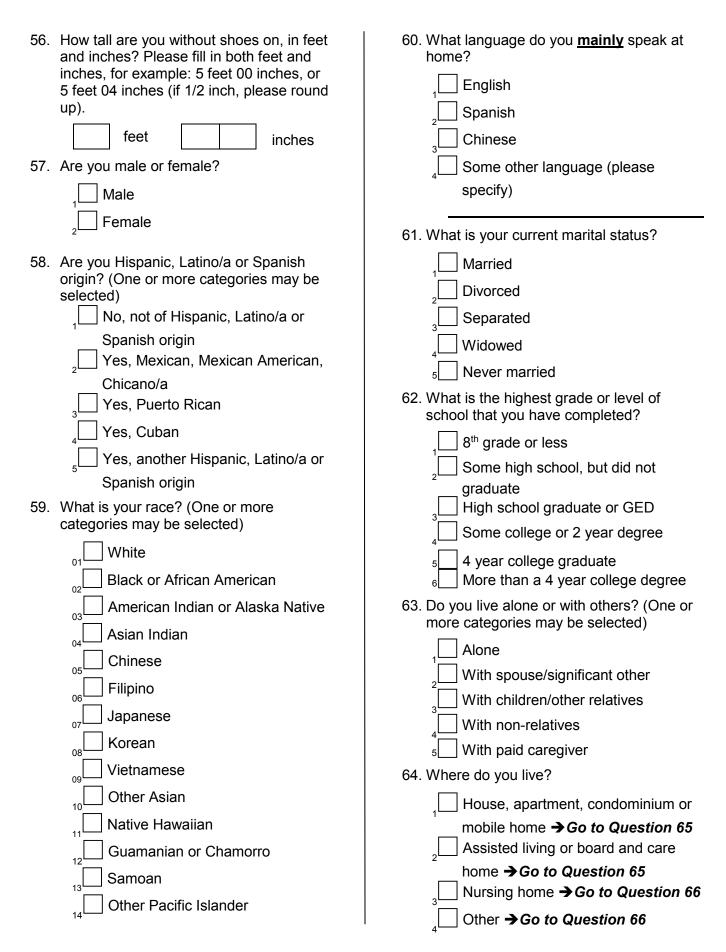


54. During the **past month**, how would you rate your overall sleep quality?



55. How much do you weigh in pounds (lbs.)?





65. Is the house or apartment you currently live in:
$_{1}$ Owned or being bought by you
, Owned or being bought by
someone in your family other than you
Rented for money
$\sqrt[4]{}$ Not owned and one in which you
live without payment of rent
₅ None of the above
66. Who completed this survey form?
Person to whom survey was
addressed → Go to Question 68
2 Family member or relative of
person to whom the survey was addressed
Friend of person to whom the
survey was addressed
Professional caregiver of person to
whom the survey was addressed
67. Did someone help you complete this survey? If so, please fill in that person's name.
<b>DO NOT</b> enter the name of the person to whom this survey was addressed.

Please print clearly.

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

68. Which of the following categories best represents the **combined income for all family members in your household** for the **past 12 months**?



### YOU HAVE COMPLETED THE SURVEY. THANK YOU.

Please use the enclosed prepaid envelope to mail your completed survey to:

Insert Survey Vendor Contact Information Here