Medicare Health Outcomes Survey (HOS) Field Test Questionnaire Version B (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 because your answers are very important to us. If you need help to complete this survey, a family member or friend can help 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:

1	\boxtimes	
_		

Yes → Go to Question 29

No →Go to Question 32

If you are filling out this survey for someone else, please answer each question the way you think the person you are helping would answer about themselves.

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. This applies to both mandatory and voluntary collections of information. The OMB control number for this information collection is [**OMB Control Number**] [expiration date]. 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.

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Medicare Health Outcomes Survey

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

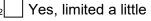


- 2. The following items are about activities you might do during a typical day. Does **your** health <u>now</u> limit you in these activities? If so, how much?
 - a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, or walking at a brisk pace

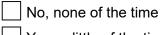
1		Yes,	limited	а	lot
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2	Yes,	limited	а	little
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- No, not limited at all
- b. Climbing **several** flights of stairs
 - Yes, limited a lot

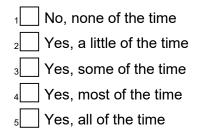


- No, not limited at all
- 3. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?
 - a. Accomplished less than you would like as a result of your physical health?



- Yes, a little of the time
- ___ Yes, some of the time
- Yes, most of the time
- S Yes, all of the time

b. Were limited in the **kind** of work or other activities **as a result of your physical health?**



- 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

1		No,	none	of	the	time
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2	Yes,	а	little	of	the	time
4	100,	~	nuo	<u> </u>		

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
 - Yes, a little of the time
 - Yes, some of the time
 - Yes, most of the time
 - 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.

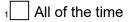
- 6. How much of the time during the past 4 weeks:
 - a. Have you felt calm and peaceful?

All of the time

- Most of the time
- Some of the time

A little of the time

- None of the time
- b. Did you have a lot of energy?



Most of the time

- Some of the time
- A little of the time
- None of the time

- c. Have you felt downhearted and sad?
 - All of the time Most 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.)?
 - All of the time Most of the time Some of the time A little of the time
 - None of the time

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.

- 8. Because of a health or physical problem, do you have any difficulty doing the following activities **without help from another person**?
 - a. Bathing

2

- ___ No, I do not have difficulty
- Yes, I have difficulty
- ³ 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

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- 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
 - ² Yes, I have difficulty
 - $_{3}$ 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

- 9. Are you able to walk briskly for 20 minutes without stopping to rest?
 - Without any difficulty
 With a little difficulty
 With some difficulty
 With much difficulty
 Unable to do
- 10. Are you able to climb up 5 flights of stairs?
 - 5 Without any difficulty
 - 4 With a little difficulty
 - ³ With some difficulty
 - With much difficulty
 - Unable to do
- 11. Does your health now limit you in bending, kneeling, or stooping?
 - 5 Not at all 4 Very little 3 Somewhat
 - 2 Quite a lot
 - 1 Cannot do
- 12. Does your health now limit you in doing moderate activities, such as moving a table, pushing a vacuum cleaner, or walking at a brisk pace?
 - 5 Not at all
 4 Very little
 3 Somewhat
 2 Quite a lot
 1 Cannot do

- 13. Does your health now limit you in doing heavy work around the house like moving heavy furniture?
 - 5 Not at all
 4 Very little
 3 Somewhat
 2 Quite a lot
 - Cannot do

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

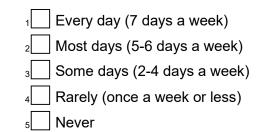
- 14. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
 - 1 Yes 2 No
- 15. Are you deaf or do you have serious difficulty hearing, even with a hearing aid?
 - 1 Yes 2 No
- 16. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?



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



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



Has a doctor ever told you that you had:

- 19. Hypertension or high blood pressure
 - 1 Yes 2 No
- 20. Angina pectoris or coronary artery disease

1	Yes
2	No

- 21. Emphysema, or asthma, or COPD (chronic obstructive pulmonary disease)
 - Yes No
- 22. Diabetes, high blood sugar, or sugar in the urine
 - 1 Yes 2 No
- 23. Depression
 - 1 Yes 2 No
- 24. Any cancer (other than skin cancer)
 - 1 Yes 2 No

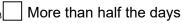
25. In the **past 7 days,** how much did pain interfere with your day to day activities?



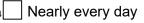
26. In the **past 7 days**, how often did pain keep you from socializing with others?



- 27. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
 - a. Feeling nervous, anxious or on edge
 - Not at all
 - Several days



- Nearly every day
- b. Not being able to stop or control worrying
 - Not at all
 - Several days
 - More than half the days



- c. Little interest or pleasure in doing things
 - Not at all
 - Several days
 - More than half the days
 - Nearly every day

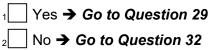
d. Feeling down, depressed, or hopeless

Not	at	all

Several days

More than half the days

- Nearly every day
- 28. Many people experience leakage of urine, also called urinary incontinence. In the **past six months**, have you experienced leaking of urine?



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

1	A lot
2] Somewhat
3] Not at all

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



31. 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?



32. 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.

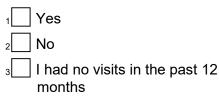
Yes → Go to Question 33
No → Go to Question 33

I had no visits in the past 12 months **→** *Go to Question 34*

33. 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.

1	Yes
2	No

34. 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?

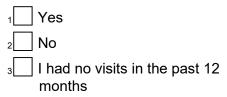


35. Did you fall in the past 12 months?



- 36. In the **past 12 months,** have you had a problem with balance or walking?
 - 1 Yes 2 No

- 37. 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.



38. During the <u>past month</u>, 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.)



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



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



41. How tall are you without shoes on, in feet and inches? Please fill in both feet and inches, for example: 5 feet 00 inches, or 5 feet 04 inches (if 1/2 inch, please round up).



Your access to transportation, food, and housing can impact your health.

The following questions are about whether you have reliable transportation for medical appointments. This can mean access to a vehicle, public transportation, someone to drive you, or another way to get to appointments.

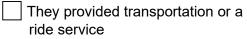
42. In the past 12 months, how often did you <u>struggle with having reliable transportation</u> <u>for medical appointments</u>?

1	Never
2	Rarely
3	Sometimes
4	Often
5	Always

43. In the past 12 months, did someone from your Medicare Advantage plan <u>or</u> doctor's office <u>ask you</u> if you had reliable transportation for medical appointments?

1	Yes
2	No

44. In the past 12 months, did someone from your Medicare Advantage plan <u>or</u> doctor's office <u>help you</u> get reliable transportation for medical appointments? **Please select all that apply.**



They gave me information or referred me to someone that could help

3		I	did	not	get	help
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45. Do you currently have reliable transportation for medical appointments?



The following questions are about **whether you have enough food to eat.** This can mean not eating as much as you should because there is not enough money for food.

46. In the past 12 months, how often did you struggle with having enough food to eat?

1 Never
2 Rarely
3 Sometimes
4 Often
5 Always

47. In the past 12 months, did someone from your Medicare Advantage plan <u>or</u> doctor's office <u>ask you</u> if you had enough food to eat?

1	Yes
2	No

- 48. In the past 12 months, did someone from your Medicare Advantage plan <u>or</u> doctor's office <u>help you</u> get enough food to eat? **Please select all that apply.**
 - I received a healthy food benefit card from my Medicare Advantage plan
 - ² They connected me with a food pantry
 - They helped me sign up for assistance like Meals on Wheels or the Supplemental Nutrition Assistance Program (SNAP)
 - They gave me information or referred me to someone that could help
 - I did not get help
- 49. Do you have enough food to eat this month?



The following questions are about **whether you have a steady place to live.** This can mean having a consistent place to stay, and <u>not</u> having to stay with others temporarily, stay in a hotel, or stay in a shelter.

50. In the past 12 months, how often did you struggle with having a steady place to



51. In the past 12 months, did someone from your Medicare Advantage plan <u>or</u> doctor's office <u>ask you</u> if you had a steady place to live?

1	Yes
2	No

- 52. In the past 12 months, did someone from your Medicare Advantage plan <u>or</u> doctor's office <u>help you</u> get a steady place to live? **Please select all that apply.**
 - They helped me find housing or shelter
 - 2 They gave me information or referred me to someone that could help
 - ³ I did not get help
- 53. Do you currently have a steady place to live?



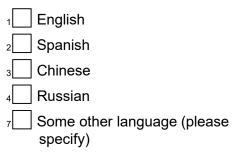
NOTE: If you need assistance, please contact your Medicare Advantage plan or doctor's office to ask about your options. 54. Are you male or female?



- 55. Are you of Hispanic, Latino/a or Spanish origin? (One or more categories may be selected)
 - No, not of Hispanic, Latino/a, or Spanish origin
 - Yes, Mexican, Mexican American, Chicano/a
 - Yes, Puerto Rican
 - Yes, Cuban
 - Yes, another Hispanic, Latino/a, or Spanish origin
- 56. What is your race? (One or more categories may be selected)

⁰³ American Indian or Alaska Native				
16 Asian – If YES:				
₀₄ Asian Indian				
05 Chinese				
06 Filipino				
07 Japanese				
08 Korean				
09 Vietnamese				
10 Other Asian				
₀₂ Black or African American				
15 Native Hawaiian or Other Pacific Islander – If YES:				
11 Native Hawaiian				
12 Guamanian or Chamorro				
13 Samoan				
14 Other Pacific Islander				
01 White				

57. What language do you **<u>mainly</u>** speak at home?



58. What is your current marital status?



59. What is the highest grade or level of school that you have completed?

1		8 th	grade	or	less
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2

3

- Some high school, but did not graduate
- ___ High school graduate or GED
- Some college or 2-year degree
- ⁵ 4-year college graduate
- 6 More than a 4-year college degree

YOU HAVE COMPLETED THE SURVEY.

PLEASE RETURN IT IN THE ENCLOSED PREPAID ENVELOPE. THANK YOU.

Centers for Medicare & Medicaid Services c/o Survey Processing [Insert Survey Vendor Return Address Here]