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 ☒ Yes ➔***Go to Question 29***
  2 ☐ 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.

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 [survey vendor name] at [phone 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. This applies to both mandatory and voluntary collections of information. The OMB control number for this information collection is **0938-1464.** The time required to complete this information collection is estimated to average **15 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 0938-1464 (Expires: 3/31/2027)

Medicare Health Outcomes Survey

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

   1 ☐ Excellent
   2 ☐ Very good
   3 ☐ Good
   4 ☐ Fair
   5 ☐ Poor

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 a lot
      2 ☐ Yes, limited a little
      3 ☐ No, not limited at all

   b. Climbing **several** flights of stairs

      1 ☐ Yes, limited a lot
      2 ☐ Yes, limited a little
      3 ☐ 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?**

      1 ☐ No, none of the time
      2 ☐ Yes, a little of the time
      3 ☐ Yes, some of the time
      4 ☐ Yes, most of the time
      5 ☐ Yes, all of the time

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

      1 ☐ No, none of the time
      2 ☐ Yes, a little of the time
      3 ☐ Yes, some of the time
      4 ☐ Yes, most of the time
      5 ☐ 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**

      1 ☐ No, none of the time
      2 ☐ Yes, a little of the time
      3 ☐ Yes, some of the time
      4 ☐ Yes, most of the time
      5 ☐ Yes, all of the time

   b. Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems**

      1 ☐ No, none of the time
      2 ☐ Yes, a little of the time
      3 ☐ Yes, some of the time
      4 ☐ Yes, most of the time
      5 ☐ 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)?

   1 ☐ Not at all
   2 ☐ A little bit
   3 ☐ Moderately
   4 ☐ Quite a bit

5 ☐ Extremely

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?

1 ☐ All of the time
2 ☐ Most of the time
3 ☐ Some of the time
4 ☐ A little of the time
5 ☐ None of the time

b. Did you have a lot of energy?

1 ☐ All of the time
2 ☐ Most of the time
3 ☐ Some of the time
4 ☐ A little of the time
5 ☐ None of the time

c. Have you felt downhearted and sad?

1 ☐ All of the time
2 ☐ Most of the time 3 ☐ Some of the time
4 ☐ A little of the time
5 ☐ 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
☐ 4 A little of the time
☐ 5 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

1 No, I do not have difficulty
2 Yes, I have difficulty
3 I am unable to do this activity

b. Dressing

1 No, I do not have difficulty
2 Yes, I have difficulty
3 I am unable to do this activity

c. Eating

1 No, I do not have difficulty
2 Yes, I have difficulty
3 I am unable to do this activity

d. Getting in or out of chairs

1 No, I do not have difficulty
2 Yes, I have difficulty
3 I am unable to do this activity

e. Walking

1 No, I do not have difficulty
2 Yes, I have difficulty
3 I am unable to do this activity

f. Using the toilet

1 No, I do not have difficulty
2 Yes, I have difficulty
3 I am unable to do this activity

9. Are you able to walk briskly for 20 minutes without stopping to rest?

5 Without any difficulty
4 With a little difficulty
3 With some difficulty
2 With much difficulty
1 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
2 With much difficulty
1 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
1 ☐ 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?

1 Yes
2 No

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?

1 ☐ Yes
2 ☐ No

18. In the **<u>past month</u>**, 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)
5 ☐ Never

Has a doctor <u>ever</u> 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)

1 ☐ Yes
2 ☐ 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 **<u>past 7 days,</u>** how much did pain interfere with your day to day activities?

1 ☐ Not at all
2 ☐ A little bit
3 ☐ Somewhat
4 ☐ Quite a bit
5 ☐ Very much

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

1 Never

2 Rarely 3 Sometimes

4 Often

5 Always

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

☐ 1 Not at all

☐ 2 Several days

☐ 3 More than half the days

☐ 4 Nearly every day

b. Not being able to stop or control worrying

1☐ Not at all

2☐ Several days

3☐ More than half the days

4☐ Nearly every day

c. Little interest or pleasure in doing things

1☐ Not at all

2☐ Several days

3☐ More than half the days

4☐ Nearly every day

d. Feeling down, depressed, or hopeless

1☐ Not at all

2☐ Several days

3☐ More than half the days

4☐ 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?

1☐ Yes ➔ ***Go to Question 29***

2☐ No ➔ ***Go to Question 32***

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 **ever** talked with a doctor, nurse, or other health care provider about leaking of urine?

1☐ Yes

2☐ No

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?

1☐ Yes

2☐ No

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.

1☐ Yes ➔ ***Go to Question 33***

2☐ No ➔ ***Go to Question 33***

3☐ 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?

1 ☐ Yes
2 ☐ No
3 ☐ I had no visits in the past 12 months

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

1 ☐ Yes
2 ☐ No

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.

1 ☐ Yes
2 ☐ No
3 ☐ I had no visits in the past 12 months

38. In the **past 12 months**, has a doctor or other health professional provided advice about your diet or eating habits?

1 ☐ Yes
2 ☐ No
3 ☐ I had no visits in the past 12 months

39. In the **past 12 months**, has a doctor or other health professional provided advice about your alcohol use?

1 ☐ Yes
2 ☐ No
3 ☐ I had no visits in the past 12 months

40. 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.)

1 ☐ Less than 5 hours
2 ☐ 5 – 6 hours 3 ☐ 7 – 8 hours
4 ☐ 9 or more hours

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

☐ Very Good
☐ Fairly Good
☐ Fairly Bad
☐ Very Bad

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

☐☐☐ **lbs**
.

43 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).

☐ **feet** ☐☐ **inches**

44 What is your race or ethnicity? Please mark one or

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White

45 What language do you **mainly** speak at home?

☐ English
☐ Spanish
☐ Chinese
☐ Russian
☐ Some other language (please specify)

_____

46 What is your current marital status?

1 ☐ 3 ☐ Separated
1 ☐ 4 ☐ Widowed
2

☐ Never married

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

- 8th grade or less
- Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than a 4-year college degree

more.

YOU HAVE COMPLETED THE SURVEY.

THANK YOU.

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

Centers for Medicare & Medicaid Services c/o Survey Processing

[Insert Survey Vendor Return Address Here]

If you have questions about this survey, please contact the survey organization working with Medicare at [survey vendor phone number] or [survey vendor email].

☐
☐

1 Married

2 Divorced