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 category like this:

49. Are you male or female?

- \boxtimes Male \square Female
- > Be sure to read <u>all</u> the answer choices given before marking a box with an 'X.'
- You are sometimes told to answer some questions in this survey only when you have answered a previous question. When this happens, you will see an *italicized* instruction like the one below:

If you answered "Yes" to questions 31 or 32 above (that you have arthritis), answer the next question.

All information that would permit identification of any person who completes this survey will be kept strictly confidential. This information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without your permission.

If you have any questions or want to know more about the study, please call [vendor name] at [toll-free number].

OMB 0938-0701 Version 02-1

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Medicare Health Outcomes Survey

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



2. Compared to one year ago, how would you rate your health in general now?

Much better	Somewhat	About the	Somewhat	Much worse
now than one	better now than	same as one	worse now than	now than
year ago	one year ago	year ago	one year ago	one year ago
1	2	3	4	5

3. The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

ACTIVITIES	Yes, limited a lot	Yes, limited a little	No, not limited at all
 a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports 	1	2	3
 b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf 	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

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 your physical health?**

	Yes	No
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Were limited in the kind of work or other activities	1	2
d. Had difficulty performing the work or other activities (<i>for example</i> , it took extra effort)	1	2

5. 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)?

	Yes	No
 Cut down on the amount of time you spent on work or other activities 	1	2
b. Accomplished less than you would like	1	2
c. Didn't do work or other activities as carefully as usual	1	2

6. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
1	2	3	4	5

7. How much **bodily** pain have you had during the **past 4 weeks**?

None	Very mild	Mild	Moderate	Severe	Very severe
1	2	3	4	5	6

8. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?



9. 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.

How much of the time during the past 4 weeks	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
a. did you feel full of pep?	1	2	3	4	5	6
b. have you been a very nervous person?	1	2	3	4	5	6
c. have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. have you felt calm and peaceful?	1	2	3	4	5	6
e. did you have a lot of energy?	1	2	3	4	5	6
f. have you felt downhearted and blue?	1	2	3	4	5	6
g. did you feel worn out?	1	2	3	4	5	6
h. have you been a happy person?	1	2	3	4	5	6
i. did you feel tired?	1	2	3	4	5	6

10. 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.)?

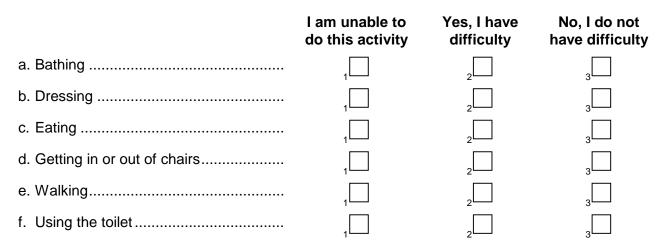
All of	Most of	Some of	A little of	None of
the time	the time	the time	the time	the time
1	2	3	4	5

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

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.

12. Because of a health or physical problem, do you have any difficulty doing the following activities? (Please mark one response for each activity.)



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

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

_____ **days** (If no days, please enter "0" days.)

14. 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?

_____ days (If no days, please enter "0" days.)

15. 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?

_____ days (If no days, please enter "0" days.)

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

16. During the past 4 weeks, how often have you had any of the following problems?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Chest pain or pressure when you exercise	1	2	3	4	5
b. Chest pain or pressure when resting	1	2	3	4	5

17. During the **past 4 weeks**, how often have you felt short of breath under the following conditions?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. When lying down flat	1	2	3	4	5
b. When sitting or resting	1	2	3	4	5
c. When walking less than one block	1	2	3	4	5
d. When climbing one flight of stairs	1	2	3	4	5

18. During the **past 4 weeks**, how much of the time have you had any of the following problems with your legs and feet? (Mark one response for each item)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Numbness or loss of feeling in your feet	1	2	3	4	5
 b. Tingling or burning sensation in your feet especially at night 	1	2	3	4	5
c. Decreased ability to feel hot or cold with your feet	1	2	3	4	5
d. Sores or wounds on your feet that did not heal	1	2	3	4	5

19a. Have you ever had paralysis or weakness on one side of the body?

Yes, I have it	Yes, but it went away	No
1	2	3

19b. Have you ever lost the ability to talk?

Yes, I have lost it	Yes, but it returned	No
1	2	3

		Yes	No
20.	Can you see well enough to read newspaper print (with your glasses or contacts if that's how you see best)?	1	2
21.	Can you hear most of the things people say (with a hearing aid if that's how you hear best)?	1	2
22.	Do you have difficulty controlling urination?	1	2
Has	a doctor ever told you that you had:	Yes	No
23.	Hypertension or high blood pressure	1	2
24.	Angina pectoris or coronary artery disease	1	2
25.	Congestive heart failure	1	2
26.	A myocardial infarction or heart attack	1	2
27.	Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat	1	2
28.	A stroke	1	2
29.	Emphysema, or asthma, or COPD (Chronic Obstructive Pulmonary Disease)	1	2
30.	Crohn's disease, ulcerative colitis, or inflammatory bowel disease	1	2
31.	Arthritis of the hip or knee	1	2
32.	Arthritis of the hand or wrist	1	2
33.	Sciatica (pain or numbness that travels down your leg to below your knee)	1	2
34.	Diabetes, high blood sugar, or sugar in the urine	1	2
35.	Any cancer (other than skin cancer)	1	2

If you answered "yes" to questions 31 or 32 above (that you have arthritis),

36. During the **past 4 weeks**, how would you describe the arthritis pain you usually had? (Mark one answer.)

None	Very Mild	Mild	Moderate	Severe
1	2	3	4	5

If you answered "yes" to question 35 above (that you have had cancer),

37. Are you currently under treatment for:

	Yes	No
a. Colon or rectal cancer	1	2
b. Lung cancer	1	2
c. Breast cancer	1	2
d. Prostate cancer	1	2

38. In the **past 4 weeks**, how often has low back pain interfered with your usual daily activities (work, school or housework)?

	All of the time	Most of the time	Some of the time	A little the tim	-	None of the time
	1	2	3	4		5
					Yes	No
39.	In the past year , hav felt sad, blue or depr in things that you usu	essed; or when yo	ou lost interest or pl	leasure	1	2
40.	In the past year , hav time?				1	2
41.	Have you ever had 2 depressed or sad mo				1	2

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

1	Excellent
2	Very good
3	Good
4	Fair
5	Poor

43. Do you now smoke every day, some days, or not at all?

1	Every day
2	Some days
3	Not at all
4	Don't know

44. Many people experience problems with urinary incontinence, the leakage of urine. In the **last six months**, have you accidentally leaked urine?

1	Yes	→Go to Question 45
2	No	→Go to Question 48

45. How much of a problem, if any, was the urine leakage for you?

A big problem	→Go to Question 46
A small problem	→Go to Question 46
Not a problem	→Go to Question 48

46. In the **last six months**, have you talked with a doctor or other health provider about your current urine leakage problem?



No

→Go to Question 47



1L

→Go to Question 48

I did not see a doctor or other health provider in the last six months **>Go to Question 48**

47. There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. In the **last six months**, have you received these or any other treatments for your current urine leakage problem?

1	Yes
2	No

48. In what **year** were you born? Please provide your **year of birth** only. For example, if your date of birth is January 1, 1935, please answer "1935."

		i i

49. Are you male or female?

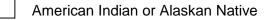


Female

50. Are you of Hispanic or Spanish family background?

1	Yes
2	No

51. How would you describe your race?







Black or African American

White

- Another race or multiracial
- 52. What is your current marital status?

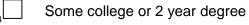


- 53. What is the highest grade or level of school that you have completed?
 - 1 2 3 4 5

8th grade or less

Some high school, but did not graduate

High school graduate or GED



- 4 year college graduate
- More than a 4 year college degree
- 54. Is the house or apartment you currently live in:

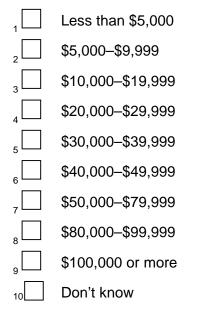


Owned or being bought by you

- Owned or being bought by someone in your family other than you
- Rented for money
- Not owned and one in which you live without payment of rent
- None of the above
- 55. Who completed this survey form?
 - Person to whom survey was addressed →Go to Question 57
 - 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
- 56. What is the name of the person who completed this survey form? Please print clearly.

First Name													
												1	1
Middle Name													
Last Name													

57. 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.*

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays 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, S3-02-01, Baltimore, Maryland 21244-1850."

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