Attachment B.

Medicare Health Outcomes Survey Questionnaire (English)

HOS 3.1

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.

>	below.	questions by putting an 'X' in the box next to the appropriate answer like the example
	Are you mal	e or female?
	1	Male
	2	Female
>	Be sure to r	ead all 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 35
	2	No → Go to Question 36
All information that would permit identification of any person who completes this survey is		

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. 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 (Expires: XX/XX/XXXX)

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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: Excellent	 b. Were limited in the kind of work or other activities as a result of your physical health?
² Very good	No, none of the time
₃ Good	Yes, a little of the time
₄ Fair	$_{3}$ Yes, some of the time
Poor	Yes, most of the time
J.	$_{5}$ Yes, all of the time
 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? Moderate activities, such as moving a table, pushing a vacuum cleaner, 	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)?
bowling, or playing golf	 a. Accomplished less than you would like as a result of any emotional problems
Yes, limited a lot	No, none of the time
Yes, limited a little	Yes, a little of the time
No, not limited at all	Yes, some of the time
b. Climbing several flights of stairs	Yes, most of the time
Yes, limited a lot	Yes, all of the time
Yes, limited a little	h Didult de week er ether eet vities ee
No, not limited at all	 b. Didn't do work or other activities as carefully as usual as a result of any emotional problems
3. During the past 4 weeks , have you had	No, none of the time
any of the following problems with your work or other regular daily activities as a	Yes, a little of the time
result of your physical health?	\int_{3}^{2} Yes, some of the time
a. Accomplished less than you would like	Yes, most of the time
as a result of your physical health?	$_{\scriptscriptstyle 5}$ Yes, all of the time
No, none of the time	5. During the past 4 weeks, how much did
Yes, a little of the time	pain interfere with your normal work
yes, some of the time	(including both work outside the home and housework)?
Yes, most of the time	Not at all
₅ Yes, all of the time	A little bit
	₃ Moderately
	Quite a bit
	Extremely

These questions are about how you feel and 7. During the past 4 weeks, how much of the how things have been with you during the time has your physical health or past 4 weeks. For each question, please give emotional problems interfered with your the one answer that comes closest to the way social activities (like visiting with friends, you have been feeling. relatives, etc.)? 6. How much of the time during the past 4 All of the time weeks: Most of the time a. Have you felt calm and peaceful? Some of the time All of the time A little of the time Most of the time None of the time A good bit of the time Some of the time Now, we'd like to ask you some questions A little of the time about how your health may have changed. None of the time 8. Compared to one year ago, how would you rate your physical health in general now? b. Did you have a lot of energy? Much better All of the time Slightly better Most of the time About the same A good bit of the time Slightly worse Some of the time Much worse A little of the time None of the time 9. Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed, or irritable) c. Have you felt downhearted in general now? and blue? Much better All of the time Slightly better Most of the time About the same A good bit of the time Slightly worse Some of the time Much worse A little of the time None of the time

a. Bathing No, I do not have difficulty Yes, I have difficulty I am unable to do this activity No, I do not have difficulty Yes, I have difficulty Yes, I have difficulty No, I do not have difficulty No, I do not have difficulty Yes, I have difficulty Yes, I have difficulty Yes, I have difficulty Yes, I have difficulty No, I do not have difficu	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?	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 Yes, I have difficulty I don't do this activity
yes, I have difficulty The month have difficulty The month have difficulty	a. Bathing	h Managing manoy
Yes, I have difficulty I don't do this activity	' <u> </u>	
b. Dressing No, I do not have difficulty Yes, I have difficulty I am unable to do this activity No, I do not have difficulty Yes, I have difficulty No, I do not have difficulty Yes, I have difficulty I am unable to do this activity These next questions ask about your physica and mental health during the past 30 days. No, I do not have difficulty Yes, I have difficulty No, I do not have difficulty Yes, I have difficulty No, I do not have difficulty Yes, I have difficulty No, I do not have difficulty Yes, I have difficulty No, I do not have diffic		l '—
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c. Taking medication as prescribed No, I do not have difficulty Tes, I have difficulty I am unable to do this activity No, I do not have difficulty Yes, I have difficulty I am unable to do this activity These next questions ask about your physica and mental health during the past 30 days. 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? No, I do not have difficulty Yes, I have difficulty No, I do not have difficulty Walking No, I do not have difficulty Walking No, I do not have difficulty Walking No, I do not have difficulty Mo, I do not have difficulty No, I do not have difficulty Walking No, I do not have difficulty Walking 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? I am unable to do this activity So, I have difficulty and mental health not good? No, I do not have difficulty and mental health not good? No, I do not have difficulty and mental health not good? No, I do not have difficulty and mental health not good? No, I do not have difficulty and mental health not good? No, I do not have difficulty and 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.	b. Dressing	3 Lant do this activity
Yes, I have difficulty I don't do this activity I days. If no days, please enter "0" days. Your best estimate would be fine.		c. Taking medication as prescribed
c. Eating No, I do not have difficulty These next questions ask about your physical and mental health during the past 30 days. 1 am unable to do this activity d. Getting in or out of chairs No, I do not have difficulty Yes, I have difficulty Yes, I have difficulty 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 past 30 days 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. 14. No, I do not have difficulty These next questions ask about your physical and mental health, which includes physical illness and injury, for how many days. If no days, please enter "0" days. Your best estimate would be fine. 15. Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days. 16. Getting in or out of chairs Ways was your physical and mental health, which includes physical illness and injury, for how many days. If no days, please enter "0" days. Your best estimate would be fine.	<u>'</u>	No, I do not have difficulty
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 Yes, I have difficulty I am unable to 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 past 30 days 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. These next questions ask about your physical and mental health, which includes physical illness and injury, for how many days during the past 30 days. If no days, please enter "0" days. Your best estimate would be fine. These next questions ask about your physical and mental health, which includes physical illness and injury, for how many days during the past 30 days. If no days, please enter "0" days during the past 30 days was 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.	²	l '—
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d. Getting in or out of chairs No, I do not have difficulty Yes, I have difficulty a I am unable to do this activity e. Walking No, I do not have difficulty Yes, I have difficulty a I am unable to do this activity The image of the	₃ I am unable to do this activity	
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No, I do not have difficulty days. Your best estimate would be fine.	f. Using the toilet	
	No, I do not have difficulty	
,	Yes, I have difficulty	1
I am unable to do this activity	2	uays cays

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" days. Your best estimate would be fine. days	19. In the past month, how often did memory problems interfere with your daily activities? Levery day (7 days a week) Most days (5-6 days a week) Some days (2-4 days a week) Rarely (once a week or less) Never
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? Yes No	Has a doctor ever told you that you had: 20. Hypertension or high blood pressure Yes No 21. Angina pectoris or coronary artery
 16. Are you deaf or do you have serious difficulty hearing, even with a hearing aid? Yes No No 17. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? Yes No No 	disease Yes No 22. Congestive heart failure Yes No 23. A myocardial infarction or heart attack Yes No
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? Yes No	24. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat Yes No 25. A stroke Yes No

Has a doctor ever told you that you had:	c. Breast cancer
26. Emphysema, or asthma, or COPD (chronic obstructive pulmonary disease) 1 Yes 2 No 27. Crohn's disease, ulcerative colitis, or	Yes I No d. Prostate cancer Yes No
inflammatory bowel disease Yes No No 28. Osteoporosis, sometimes called thin or brittle bones	e. Other cancer (other than skin cancer) Yes No
Yes No 29. Diabetes, high blood sugar, or sugar in the urine Yes	33. In the past 7 days, how much did pain interfere with your day to day activities? Not at all A little bit Somewhat
2 No 30. Depression ✓ Yes	Quite a bit Substitute of the
No 31. Any cancer (other than skin cancer) Yes → Go to Question 32 No → Go to Question 33	34. In the past 7 days , how often did pain keep you from socializing with others? Never Rarely Sometimes
32. Are you <u>currently</u> under treatment for: a. Colon or rectal cancer Yes No b. Lung cancer Yes No No	Often 5 Always

35. In the past 7 days , how would you rate your pain on average ?	37. In general, compared to other people your age, would you say that your health is:
_∞ No pain	Excellent
₀₁ 1	Very good
2	Good
3 3	Fair
☐ 4	Poor
5	5 1 001
05 6	
7	38. Many people experience leakage of urine, also called urinary incontinence. In the
07 8	past six months, have you experienced
9	leaking of urine?
10 Worst imaginable pain	Yes → Go to Question 39
10 Worst imaginable pain	No → Go to Question 42
36. 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 Not at all Several days More than half the days Not at all Several days Nearly every day b. Feeling down, depressed, or hopeless Not at all Several days More than half the days	39. During the past six months , how much did leaking of urine make you change your daily activities or interfere with your sleep? A lot Somewhat Not at all 40. Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine? Yes No
More than half the days Nearly every day	41. 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? Yes No

42. 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 43 No → Go to Question 43	 47. 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.
$_{3}$ I had no visits in the past 12	₁ Yes
months → Go to Question 44	No I had no visits in the past 12
43. In the past 12 months , did a doctor or other health provider advise you to start, increase or maintain your level of exercise	months
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	48. 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.)
from 10 to 20 minutes every day or to maintain your current exercise program.	Less than 5 hours 5 – 6 hours
Yes No	$\frac{2}{3}$ 7 – 8 hours $\frac{2}{4}$ 9 or more hours
44. 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? Yes I had no visits in the past 12	49. During the past month , how would you rate your overall sleep quality? Very Good Fairly Good Fairly Bad Very Bad
months	50. How much do you weigh in pounds (lbs.)?
45. Did you fall in the past 12 months?	lbs.
Yes No	51. 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
46. In the past 12 months , have you had a problem with balance or walking?	5 feet 04 inches (if 1/2 inch, please round up).
Yes No	feet inches

52.	Are you male or female?	55. What language do you mainly speak at
	₁ Male	home?
	Female	English
	2—	₂ Spanish
5 0	Ana very Hierania I etimo/a en Craniala	¸☐ Chinese
53.	Are you Hispanic, Latino/a or Spanish origin? (One or more categories may be	Russian
	selected)	Some other language (please
	No, not of Hispanic, Latino/a or	specify)
	Spanish origin	opeony)
	Yes, Mexican, Mexican American,	
	Chicano/a	56. What is your current marital status?
	Yes, Puerto Rican	
	₄∐ Yes, Cuban	Married
	Yes, another Hispanic, Latino/a or	Divorced
	Spanish origin	3 Separated
5 4	N/II / 1: 0 / 0	₄ Widowed
54.	What is your race? (One or more categories may be selected)	₅ Never married
	White	
	01	57. What is the highest grade or level of
	Description Black or African American	school that you have completed?
	O3 American Indian or Alaska Native	₁ 8 th grade or less
	₀₄ Asian Indian	Some high school, but did not
	Chinese	graduate
	Filipino	₃∐ High school graduate or GED
	Japanese	Some college or 2-year degree
	Korean	₅ 4-year college graduate
	08	6 More than a 4-year college degree
	og	
	Other Asian	58. Do you live alone or with others? (One or
	Native Hawaiian	more categories may be selected)
	Guamanian or Chamorro	Alone
	Samoan	With spouse/significant other
	Other Pacific Islander	With children/other relatives
	14—	With non-relatives
		₅ With paid caregiver

House, apartment, condominium or mobile home → Go to Question 60 Assisted living or board and care home → Go to Question 60 Nursing home → Go to Question 61 Other → Go to Question 61	62. Did someone help you complete this survey? If so, please fill in that person's name. DO NOT enter the name of the person to whom this survey was addressed. Please print clearly. First Name:
60. 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	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]
61. Who completed this survey form? Person to whom survey was addressed → End of Survey 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	