Medicare Health Outcomes Survey Instructions

This survey asks about you and your health. Answer each question, thinking about yourself. 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.

Sample Questions:

➢ Answer the questions by putting an ‘X’ in the box next to the appropriate answer like this:

   58. What is your sex?
   1 Male
   2 Female

➢ Be sure to read all 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 question 36 above (that you have had cancer),

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].

© 2013 by the National Committee for Quality Assurance (NCQA). This survey instrument may not be reproduced or transmitted in any form, electronic or mechanical, without the express written permission of NCQA. All rights reserved.

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      Very good          Good       Fair       Poor
   □□□□□□□□□□

2. 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
   a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
   □□□□
   b. Climbing several flights of stairs
   □□□□

3. 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?

   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

   a. Accomplished less than you would like
   □□□□□
   b. Were limited in the kind of work or other activities
   □□□□□

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)?

   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

   a. Accomplished less than you would like
   □□□□□
   b. Didn't do work or other activities as carefully as usual
   □□□□□

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

   Not at all
   A little bit
   Moderately
   Quite a bit
   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? .............................................

   b. Did you have a lot of energy? ......

   c. Have you felt downhearted and blue? .............................................

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.)?

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

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

   Much better Slightly better About the same Slightly worse 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?

   Much better Slightly better About the same Slightly worse 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?

<table>
<thead>
<tr>
<th>Activity</th>
<th>No, I do not have difficulty</th>
<th>Yes, I have difficulty</th>
<th>I am unable to do this activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Bathing</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Dressing</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Eating</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. Getting in or out of chairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. Walking</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. Using the toilet</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

11. Because of a health or physical problem, do you have any difficulty doing the following activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>No, I do not have difficulty</th>
<th>Yes, I have difficulty</th>
<th>I don't do this activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Preparing meals</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Managing money</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Taking medication as prescribed</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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.

   days

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.

   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” days.

   days
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 1  No 2

16. Are you deaf or do you have serious difficulty hearing? .................
    Yes 1  No 2

17. **Because of a physical, mental, or emotional condition**, do you have serious difficulty concentrating, remembering or making decisions?........
    Yes 1  No 2

18. Do you have serious difficulty walking or climbing stairs? ..............
    Yes 1  No 2

19. Do you have difficulty dressing or bathing? ...................................
    Yes 1  No 2

20. **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 1  No 2

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

<table>
<thead>
<tr>
<th>Every day (7 days a week)</th>
<th>Most days (5-6 days a week)</th>
<th>Some days (2-4 days a week)</th>
<th>Rarely (once a week or less)</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes 1  No 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has a doctor ever told you that you had:

22. Hypertension or high blood pressure ..................................................
    Yes 1  No 2

23. Angina pectoris or coronary artery disease ..........................................
    Yes 1  No 2

24. Congestive heart failure ..................................................................
    Yes 1  No 2

25. A myocardial infarction or heart attack .............................................
    Yes 1  No 2

26. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat.....................................................
    Yes 1  No 2

27. A stroke ..........................................................................................
    Yes 1  No 2

28. Emphysema, or asthma, or COPD (chronic obstructive pulmonary disease)..........................................................................
    Yes 1  No 2

29. Crohn’s disease, ulcerative colitis, or inflammatory bowel disease ....................................................................................... 1 2

30. Arthritis of the hip or knee ................................................................
    Yes 1  No 2

31. Arthritis of the hand or wrist .............................................................
    Yes 1  No 2
Has a doctor ever told you that you had:

32. Osteoporosis, sometimes called thin or brittle bones ........................................ 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. Depression ........................................................................................................ 1 □ 2 □
36. Any cancer (other than skin cancer) ............................................................... 1 □ 2 □

If you answered "yes" to question 36 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 □
   e. Other cancer (other than skin cancer) ................................................... 1 □ 2 □

38. In the past 7 days, how much did pain interfere with your day to day activities?
   Not at all  A little bit  Somewhat  Quite a bit  Very much
   1 □ 2 □ 3 □ 4 □ 5 □

39. In the past 7 days, how often did pain keep you from socializing with others?
   Never  Rarely  Sometimes  Often  Always
   1 □ 2 □ 3 □ 4 □ 5 □

40. In the past 7 days, how would you rate your pain on average?
   No pain
   Worst imaginable pain
   1 2 3 4 5 6 7 8 9 10
   01 □ 02 □ 03 □ 04 □ 05 □ 06 □ 07 □ 08 □ 09 □ 10 □

41. 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 .......................................... 1 □ 2 □
   b. Feeling down, depressed or hopeless .............................................. 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 past 6 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?
   1. A big problem  ➔ Go to Question 46
   2. A small problem  ➔ Go to Question 46
   3. Not a problem  ➔ Go to Question 48

46. Have you talked with your current doctor or other health provider about your urine leakage problem?
   1. Yes
   2. No

47. There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem?
   1. Yes
   2. No

48. 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 49
   2. No  ➔ Go to Question 49
   3. I had no visits in the past 12 months  ➔ Go to Question 50
49. 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

50. 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

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

   1. Yes
   2. No

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

   1. Yes
   2. No

53. 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.
   - Check your blood pressure lying or standing.
   - Suggest that you do an exercise or physical therapy program.
   - Suggest a vision or hearing testing.

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

54. Have you ever had a **bone density test** to check for **osteoporosis**, sometimes thought of as “brittle bones”? This test may have been done to your back, hip, wrist, heel or finger.

   1. Yes
   2. No

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

   [ ] [ ] lbs.
56. How tall are you without shoes on in feet (ft.) and inches (in.)? Please remember to fill in both feet and inches (for example, 5 ft. 00 in.) If 1/2 in., please round up.

[ ] ft. [ ] in.

57. In what year were you born? Please provide your year of birth only.

[ ] [ ] [ ] [ ]

58. What is your sex?

[ ] Male
[ ] Female

59. Are you 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

60. What is your race? (One or more categories may be selected)

[ ] White
[ ] Black or African American
[ ] American Indian or Alaska Native
[ ] Asian Indian
[ ] Chinese
[ ] Filipino
[ ] Japanese
[ ] Korean
[ ] Vietnamese
[ ] Other Asian
[ ] Native Hawaiian
[ ] Guamanian or Chamorro
[ ] Samoan
[ ] Other Pacific Islander

61. How well do you speak English?

[ ] Very well
[ ] Well
[ ] Not well
[ ] Not at all

62. What is your current marital status?

[ ] Married
[ ] Divorced
[ ] Separated
[ ] Widowed
[ ] Never married
63. What is the highest grade or level of school that you have completed?
   1. 8th grade or less
   2. Some high school, but did not graduate
   3. High school graduate or GED
   4. Some college or 2 year degree
   5. 4 year college graduate
   6. More than a 4 year college degree

64. Do you live alone or with others? (One or more categories may be selected)
   1. Alone
   2. With spouse/significant other
   3. With children/other relatives
   4. With non-relatives
   5. With paid caregiver

65. Where do you live?
   1. Independent house, apartment, condominium or mobile home ➔ Go to Question 66
   2. Assisted living apartment or board and care home ➔ Go to Question 66
   3. Nursing home ➔ Go to Question 69
   4. Other ➔ Go to Question 69

66. Is the house or apartment you currently live in:
   1. Owned or being bought by you
   2. Owned or being bought by someone in your family other than you
   3. Rented for money
   4. Not owned and one in which you live without payment of rent
   5. None of the above

67. Do you currently provide care for someone else in your home?
   1. Yes ➔ Go to Question 68
   2. No ➔ Go to Question 69
68. During the past week, how many days did you provide at least some care?

1. No care provided in the last week
2. 1 or 2 days
3. 3 or 4 days
4. 5 or 6 days
5. 7 days (every day)

69. Do you have difficulty getting to places you need to go (either by driving or by getting a ride)?

1. Always or almost always
2. Sometimes
3. Almost never or never

70. Who completed this survey form?

1. Person to whom survey was addressed ➔ Go to Question 72
2. Family member or relative of person to whom the survey was addressed
3. Friend of person to whom the survey was addressed
4. Professional caregiver of person to whom the survey was addressed

71. What is the name of the person who completed this survey form? Please print clearly.

First Name

Last Name

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

01. Less than $5,000
02. $5,000–$9,999
03. $10,000–$19,999
04. $20,000–$29,999
05. $30,000–$39,999
06. $40,000–$49,999
07. $50,000–$79,999
08. $80,000–$99,999
09. $100,000 or more
10. Don't know

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 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."

Insert Vendor Contact Information Here