Medicare Health Outcomes Survey—Modified (HOS-M) Questionnaire (English)

2023

Medicare Health Outcomes Survey – Modified Instructions

This survey asks about your health, feelings, and ability to do daily activities. Please take the time to complete this survey. Your answers are very important to us. If you need help to complete this survey, a family member or a friend may fill out the survey about <u>your</u> health. If a family member or a friend is NOT available, please ask your nurse or other health professional to help.

- 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 may find some of the questions to be personal. It is important that you answer EVERY question on this survey. However, you do not have to answer a question if you do not want to. If you are unsure of the answer to a question or unsure the question applies to you, just choose the BEST available answer.
- **Please complete the survey within two weeks and return it in the enclosed postage-paid envelope.**

<u>IF YOU ARE FILLING OUT THIS SURVEY FOR SOMEONE ELSE</u>

Please answer every question the way you believe best describes that person's health, feelings, and ability to do daily activities. Answer each question the way you think the person you are helping would answer about him or herself.

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 **0938-0701**. 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 (Expires: 05/31/2025)

Medicare Health Outcomes Survey—Modified

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

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

2. How much difficulty, if any, do you have lifting or carrying objects as heavy as 10 pounds, such as a sack of potatoes?

No difficulty at all	A little difficulty	Some difficulty	A lot of difficulty	Not able to do it
1☐	2☐	3☐	4☐	5☐

3. How much difficulty, if any, do you have walking a quarter of a mile—that is about 2 or 3 blocks?

No difficulty at all	A little difficulty	Some difficulty	A lot of difficulty	Not able to do it
1☐	2☐	3☐	4☐	5☐

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

	No, I do not have difficulty	Yes, I have difficulty	I am unable to do this activity
a. Bathing	1☐	2☐	3☐
b. Dressing	1☐	2☐	3☐
c. Eating	1☐	2☐	3☐
d. Getting in or out of chairs	1☐	2☐	3☐
e. Walking	1☐	2☐	3☐
f. Using the toilet	1☐	2☐	3☐

5. Do you receive **help from another person** with any of these activities?

	Yes, I receive help	No, I do not receive help	I do not do this activity
a. Bathing	1☐	2☐	3☐
b. Dressing	1☐	2☐	3☐
c. Eating	1☐	2☐	3☐
d. Getting in or out of chairs	1☐	2☐	3☐
e. Walking	1☐	2☐	3☐
f. Using the toilet	1☐	2☐	3☐

6. 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. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1☐	2☐	3☐
b. Climbing **several** flights of stairs	1☐	2☐	3☐

7. **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**? (If you are not able to do work or regular daily activities, please answer 'yes, all of the time' to both questions).

	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	1☐	2☐	3☐	4☐	5☐
b. Were limited in the **kind** of work or other activities	1☐	2☐	3☐	4☐	5☐

8. **During the past 4 weeks,** have you had any of the following problems with your regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (If you are not able to do work or regular daily activities, please answer 'yes, all of the time' to both questions.)

	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	1☐	2☐	3☐	4☐	5☐
b. Didn't do work or other activities as **carefully** as usual	1☐	2☐	3☐	4☐	5☐

9. **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
1☐	2☐	3☐	4☐	5☐

These questions are about how you feel and how things have been with you **during the past four weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

10. 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. have you felt **calm and peaceful**?	1☐	2☐	3☐	4☐	5☐	6☐
b. did you have **a lot of energy**?	1☐	2☐	3☐	4☐	5☐	6☐
c. have you felt **downhearted and blue**?	1☐	2☐	3☐	4☐	5☐	6☐

11. **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**
1☐	2☐	3☐	4☐	5☐

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

12. **Compared to <u>one year ago</u>,** how would you rate your **physical health** in general **now**?

Much better	**Slightly better**	**About the same**	**Slightly worse**	**Much worse**
1☐	2☐	3☐	4☐	5☐

13. **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**
1☐	2☐	3☐	4☐	5☐

14. Do you experience memory loss that interferes with daily activities?

1☐ Yes

2☐ No

15. How often, if ever, do you have difficulty controlling urination (bladder accidents)?

Never	Less than once a week	Once a week or more often	Daily	Catheter
1☐	2☐	3☐	4☐	5☐

16. Who completed this survey form?

1☐ Medicare Participant ➔ ***STOP HERE***

2☐ Family member, relative, or friend of Medicare Participant ➔ ***Go to Question 17***

3☐ Nurse or other health professional ➔ ***Go to Question 17***

17. What was the reason you filled out this survey for someone else? (Please answer **ALL** that apply.)

1☐ Physical problems

2☐ Memory loss or mental problems

3☐ Unable to speak or read English

4☐ Person not available

5☐ Other

18. How did you help complete this survey? (Please answer **ALL** that apply.)

1☐ Read the questions to the person

2☐ Wrote down the person's answers

3☐ Answered the questions based on my experience with the person

4☐ Used medical records to fill out the survey

5☐ Translated the survey questions

6☐ Other

FOR PROFESSIONAL STAFF (CAREGIVERS) ONLY

19. Which of the following **best describes** your position? (Please choose **one** answer.)

1☐ Home Health Aide, Personal Care Attendant, or Certified Nursing Assistant

2☐ Nurse (RN, LPN, or NP)

3☐ Social Worker or Case Manager

4☐ Adult Foster Care/Adult Day Care/Assisted Living/Residential Care Staff

5☐ Interpreter

6☐ Other

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]