



**Medicare
Health Outcomes
Survey 2003**

HEDIS 2003

HEALTH PLAN EMPLOYER DATA & INFORMATION SET

NCQA

Measuring the Quality of America's Health Care

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

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.

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

49. Are you male or female?

Male 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 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].

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Medicare Health Outcomes Survey

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

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5

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

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Lifting or carrying groceries	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Climbing several flights of stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Climbing one flight of stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Bending, kneeling, or stooping	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g. Walking more than a mile	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
h. Walking several blocks	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
i. Walking one block	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
j. Bathing or dressing yourself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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 <input type="checkbox"/>	2 <input type="checkbox"/>
b. Accomplished less than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c. Were limited in the kind of work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d. Had difficulty performing the work or other activities (for example, it took extra effort).....	1 <input type="checkbox"/>	2 <input type="checkbox"/>

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
a. Cut down on the amount of time you spent on work or other activities.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b. Accomplished less than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c. Didn't do work or other activities as carefully as usual.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>

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 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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

None	Very mild	Mild	Moderate	Severe	Very severe
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

8. 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 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
b. have you been a very nervous person?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
c. have you felt so down in the dumps that nothing could cheer you up?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
d. have you felt calm and peaceful?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
e. did you have a lot of energy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
f. have you felt downhearted and blue?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
g. did you feel worn out?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
h. have you been a happy person?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
i. did you feel tired?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

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 the time	Most of the time	Some of the time	A little of the time	None of the time
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. I am as healthy as anybody I know	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. I expect my health to get worse	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. My health is excellent.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>