

**SURVEY OF HEALTHCARE  
EXPERIENCES OF PATIENTS  
RECENTLY DISCHARGED INPATIENT 2007**

**In order for the VA to carry out its mission to provide the best possible medical care and services to all veterans, it is extremely important that you complete and return this questionnaire. Your answers will help ensure that all veterans receive the high quality care they have earned and so richly deserve.**

**We want to remind you that all information is strictly anonymous. It will not be shared with your doctor or affect your VA care.**

**Please read each question and fill in the circle that best describes your experience. Use blue or black ink pen, or pencil. Please be sure to read all pages of this booklet**

**The Paperwork Reduction Act of 1995:** This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this survey will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. Customer satisfaction surveys are used to gauge customer perceptions of VA services as well as customer expectations and desires. The results of this survey will lead to improvements in the quality of service delivery by helping to shape the direction and focus of specific programs and services. Disclosure of information involves release of statistical data and other non-identifying data for the improvement of services within the VA healthcare system and associated administrative purposes. Submission of this form is voluntary and failure to respond will have no impact on benefits to which you may be entitled.

**SURVEY INSTRUCTIONS**

- ◆ You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- ◆ Answer all the questions by checking the box to the left of your answer.
- ◆ You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

- Yes  
 No    ➔ *If No, Go to Question 1 on Page 1*

*You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.*

*Please note: Questions 1-22 in this survey are part of a national initiative to measure the quality of care in hospitals.*

**Please answer the questions in this survey about your stay at the hospital named on the cover. Do not include any other hospital stay in your answers.**

**YOUR CARE FROM NURSES**

1. **During this hospital stay, how often did nurses treat you with courtesy and respect?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
2. **During this hospital stay, how often did nurses listen carefully to you?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
3. **During this hospital stay, how often did nurses explain things in a way you could understand?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
4. **During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always  
<sup>5</sup>  I never pressed the call button

**YOUR CARE FROM DOCTORS**

5. **During this hospital stay, how often did doctors treat you with courtesy and respect?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always

6. **During this hospital stay, how often did doctors listen carefully to you?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
7. **During this hospital stay, how often did doctors explain things in a way you could understand?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always

**THE HOSPITAL ENVIRONMENT**

8. **During this hospital stay, how often were your room and bathroom kept clean?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always
9. **During this hospital stay, how often was the area around your room quiet at night?**
- <sup>1</sup>  Never  
<sup>2</sup>  Sometimes  
<sup>3</sup>  Usually  
<sup>4</sup>  Always

**YOUR EXPERIENCES IN THIS HOSPITAL**

10. **During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?**
- <sup>1</sup>  Yes  
<sup>2</sup>  No ➔ If No, Go to Question 12
11. **How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?**

- Never  
 Sometimes  
 Usually  
 Always

**12. During this hospital stay, did you need medicine for pain?**

- Yes  
 No → If No, Go to Question 15

**13. During this hospital stay, how often was your pain well controlled?**

- Never  
 Sometimes  
 Usually  
 Always

**14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?**

- Never  
 Sometimes  
 Usually  
 Always

**15. During this hospital stay, were you given any medicine that you had not taken before?**

- Yes  
 No → If No, Go to Question 18

**16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?**

- Never  
 Sometimes  
 Usually  
 Always

**17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?**

- Never  
 Sometimes  
 Usually  
 Always

#### WHEN YOU LEFT THE HOSPITAL

**18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?**

- Own home  
 Someone else's home  
 Another health facility → If Another, Go to Question 21

**19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?**

- Yes  
 No

**20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?**

- Yes  
 No

**OVERALL RATING OF HOSPITAL**

Please answer the following questions about your stay at the hospital named on the cover. Do not include any other hospital stays in your answer.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

- 0 Worst hospital possible  
 1  
 2  
 3  
 4  
 5  
 6  
 7  
 8  
 9  
 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?

- Definitely no  
 Probably no  
 Probably yes  
 Definitely yes

23. Was personal information about you treated in a confidential manner?

- Never  
 Sometimes  
 Usually  
 Always

24. During this hospital stay, how often did nurses show respect for what you had to say?

- Never  
 Sometimes  
 Usually  
 Always

25. During this hospital stay, did you feel nurses really cared about you as a person?

- Never  
 Sometimes  
 Usually  
 Always

26. During this hospital stay, how often did doctors show respect for what you had to say?

- Never  
 Sometimes  
 Usually  
 Always

27. During this hospital stay, how often did you feel doctors really cared about you as a person?

- Never  
 Sometimes  
 Usually  
 Always

28. During this hospital stay, were providers willing to talk to your family or friends about your health or treatment?

- Yes  
 No

29. During this hospital stay, how often did you have a hard time speaking with or understanding your doctors or other health providers because you spoke different languages?

- Never  
 Sometimes  
 Usually  
 Always

**30. During your most recent hospital stay, did providers at this hospital give you complete and accurate information about:**

	Yes	No	Does Not Apply
a) Tests?	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>
b) Choices for your care?	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>
c) Treatment?	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>
d) Plan for your care?	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>
e) Medications?	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>
f) Follow-up care?	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>
g) Side effects of medications	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>

**31. If you could have free care outside the VA, would you choose to be hospitalized here again?**

- <sup>1</sup> Definitely would not
- <sup>2</sup> Probably would not
- <sup>3</sup> Probably would
- <sup>4</sup> Definitely would

**32. During this hospital stay, how often did health care providers seem informed and up-to-date about the care you got from other providers at the hospital?**

- <sup>1</sup> Never
- <sup>2</sup> Sometimes
- <sup>3</sup> Usually
- <sup>4</sup> Always

**33. Were there times when you were confused because different providers told you different things?**

- <sup>1</sup> Yes, Always
- <sup>2</sup> Yes, Sometimes
- <sup>3</sup> No

**34. Did you know who to ask when you had questions about your health care?**

- <sup>1</sup> Yes, Always
- <sup>2</sup> Yes, Sometimes
- <sup>3</sup> No

**35. During this hospital stay, when there was more than one choice for your treatment or health care, did providers ask which choice you thought was best for you?**

- <sup>1</sup> Yes
- <sup>2</sup> No

**36. During this hospital stay, did providers talk with you about the pros and cons of each choice for your treatment or health care?**

- <sup>1</sup> Yes
- <sup>2</sup> No

**37. Did someone on the hospital staff tell you what activities you could do after you got home?**

- <sup>1</sup> Yes
- <sup>2</sup> No

**38. Did you know who to contact if you needed medical advice or help right away, after you went home?**

- <sup>1</sup> Yes
- <sup>2</sup> No

**39. Did you have a complaint about how you were treated (medically or personally) during your last hospitalization?**

- <sup>1</sup> Yes
- <sup>2</sup> No →Go to Question 45

**40. If you reported this complaint to someone at the VA location where you received your care, to whom did you report this complaint?**

- <sup>1</sup> Treatment Team  
 <sup>2</sup> Other VA Staff  
 <sup>3</sup> Patient Advocate  
 <sup>4</sup> Did not report the complaint to a VA employee

**41. If you did not report this complaint, what was the most important reason you did not report it? (Please mark only one)**

- <sup>1</sup> I didn't know where to complain  
 <sup>2</sup> I was afraid of what would happen if I did complain  
 <sup>3</sup> I thought complaining wouldn't do any good  
 <sup>4</sup> I wasn't sure I had the right to complain  
 <sup>5</sup> Other

**42. If you had a complaint, how easy was it for you to find someone to hear your complaint?**

- <sup>1</sup> Very easy  
 <sup>2</sup> Easy  
 <sup>3</sup> Difficult  
 <sup>4</sup> Very difficult  
 <sup>5</sup> Not Applicable

**43. If you spoke with someone at the VA location about a complaint, how satisfied were you with the way your complaint was handled?**

- <sup>1</sup> Very satisfied  
 <sup>2</sup> Satisfied  
 <sup>3</sup> Dissatisfied  
 <sup>4</sup> Very dissatisfied  
 <sup>5</sup> Not Applicable

**44. How long did it take for the VA hospital to resolve your complaint?**

- <sup>1</sup> Same day  
 <sup>2</sup> 2-7 days  
 <sup>3</sup> 8-14 days  
 <sup>4</sup> 15-21 days  
 <sup>5</sup> More than 21 days  
 <sup>6</sup> Complaint is not resolved

### SPIRITUAL NEEDS

**Please tell us whether each of the following statements describes you and how your spiritual needs were met during this hospital stay.**

**45. My religious/spiritual needs are an important part of my overall care.**

- <sup>1</sup> Yes  
 <sup>2</sup> No  
 <sup>3</sup> Not applicable

**46. I was asked if I had any religious/spiritual needs during my stay?**

- <sup>1</sup> Yes  
 <sup>2</sup> No  
 <sup>3</sup> Not applicable

**47. My religious/spiritual needs were appropriately assessed and addressed?**

- <sup>1</sup> Yes  
 <sup>2</sup> No  
 <sup>3</sup> Not applicable

**48. Literature in keeping with my faith was offered to me?**

- <sup>1</sup> Yes  
 <sup>2</sup> No  
 <sup>3</sup> Not applicable

**ABOUT YOUR HEALTH**

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

a. **Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?**

- 1  Yes, Limited A Lot
- 2  Yes, Limited A Little
- 3  No, Not Limited At All

b. **Climbing several flights of stairs?**

- 1  Yes, Limited A Lot
- 2  Yes, Limited A Little
- 3  No, Not Limited At All

50. **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?**

a. **Accomplished less than you would like?**

- 1  No, none of the time
- 2  Yes, a little of the time
- 3  Yes, some of the time
- 4  Yes, most of the time
- 5  Yes, all of the time

b. **Were limited in the kind of work or other activities?**

- 1  No, none of the time
- 2  Yes, a little of the time
- 3  Yes, some of the time
- 4  Yes, most of the time
- 5  Yes, all of the time

51. **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) ?**

a. **Accomplished less than you would like**

- 1  No, none of the time
- 2  Yes, a little of the time
- 3  Yes, some of the time
- 4  Yes, most of the time
- 5  Yes, all of the time

b. **Didn't do work or other activities as carefully as usual**

- 1  No, none of the time
- 2  Yes, a little of the time
- 3  Yes, some of the time
- 4  Yes, most of the time
- 5  Yes, all of the time

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

- 1  Not at all
- 2  A little bit
- 3  Moderately
- 4  Quite a bit
- 5  Extremely

55. **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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



52. How much of the time during the past 4 weeks 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

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

- Much better  
 Somewhat better  
 About the same  
 Somewhat worse  
 Much worse

56. Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed or irritable) now?

- Much better  
 Somewhat better  
 About the same  
 Somewhat worse  
 Much worse

57. How much of the time during the past week, did you feel depressed?

- Rarely or none of the time (less than 1 day)  
 Some or a little of the time (1-2 days)  
 Occasionally or a moderate amount of the time (3-4 days)  
 Most or all of the time (5-7 days)

**58. In the past year, have you had 2 weeks or more when you felt sad, blue or depressed or when you lost interest or pleasure in things that you usually cared about or enjoyed?**

- Yes
- No

**59. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?**

- Yes
- No

**60. How would you rate the hospital building overall (e.g., attractiveness of facility appearance, quality of building maintenance and upkeep)?**

- Poor
- Fair
- Good
- Very good
- Excellent

**61. In terms of your satisfaction, how would you rate the convenience of the location of the facility?**

- Poor
- Fair
- Good
- Very good
- Excellent

**62. Your Room:**

	Poor	Fair	Good	Very Good	Excellent	Does Not Apply
a. Cleanliness of your room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Privacy of your room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Noise level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sense of safety and security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**63. Equipment and Facilities:**

	Poor	Fair	Good	Very Good	Excellent	Does Not Apply
a. Ease of finding your way around the hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Availability of parking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**64. Have you ever smoked cigarettes?**

- Yes, still smoking every day  
 Yes, still smoking some days  
 Yes, but no longer smoke at all  
 No, never smoked → Go to 72.

**65. If you used to smoke but no longer do so, about how long has it been since you last smoked cigarettes at all?**

- Less than 1 month  
 1-5 months  
 6-12 months  
 1-5 years  
 More than 5 years → Go to 72.

**66. In the past 12 months have you stopped smoking for 1 day or longer because you were trying to quit smoking?**

- Yes  
 No

**67. During the past 12 months has a VA doctor or other VA health care provider asked if you were interested in stopping smoking?**

- Yes  
 No → Go to 72.

**68. During the past 12 months were you treated for smoking within the VA?**

- Yes  
 No

**69. If you were treated for smoking, where did you receive the majority of your treatment?**

- VA primary care provider  
 VA mental health care provider  
 VA smoking cessation clinic or program  
 Other VA provider or program

**70. During the past 12 months what services were recommended or offered to you by VA providers or**

**VA treatment programs to help you stop smoking?**

**Mark all that apply.**

- Self-help materials  
 Nicotine replacement medication (patch, gum, nasal spray or inhaler)  
 Zyban, an antismoking medication (also called Bupropion or Welbutrin)  
 Individual counseling  
 Group counseling  
 Telephone counseling

**71. During the past 12 months which of the following services did you actually use to help you stop smoking?**

**Mark all that apply.**

- Self-help materials  
 Nicotine replacement medication (patch, gum, nasal spray or inhaler)  
 Zyban, an antismoking medication (also called Bupropion or Welbutrin)  
 Individual counseling  
 Group counseling  
 Telephone counseling

72. **How often did you have a drink containing alcohol in the past 12 months? Consider a "drink" to be a can or bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin or vodka).**

**Please mark only one.**

- <sup>1</sup>  Never →Go to 76  
<sup>2</sup>  Monthly or less  
<sup>3</sup>  2-4 times a month  
<sup>4</sup>  2-3 times a week  
<sup>5</sup>  4-5 times a week  
<sup>6</sup>  6 or more times a week

73. **How many drinks containing alcohol did you have on a typical day when you were drinking in the past 12 months?**

- <sup>1</sup>  0 drinks (Did not drink in the past 12 months) →Go to 76.  
<sup>2</sup>  1-2 drinks  
<sup>3</sup>  3-4 drinks  
<sup>4</sup>  5-6 drinks  
<sup>5</sup>  7-9 drinks  
<sup>6</sup>  10 or more drinks

74. **How often did you have 6 or more drinks on one occasion in the past 12 months?**

- <sup>1</sup>  Never  
<sup>2</sup>  Less than monthly  
<sup>3</sup>  Monthly  
<sup>4</sup>  Weekly  
<sup>5</sup>  Daily or almost daily

75. **In the past 12 months has a VA doctor or other VA health care provider advised you about your drinking (to drink less or not to drink alcohol)?**

- <sup>1</sup>  Yes  
<sup>2</sup>  No

### ABOUT YOU

**There are only a few remaining items left.**

76. **In general, how would you rate your overall health?**

- <sup>1</sup>  Excellent  
<sup>2</sup>  Very good  
<sup>3</sup>  Good  
<sup>4</sup>  Fair  
<sup>5</sup>  Poor

77. **What is the highest grade or level of school that you have completed?**

- <sup>1</sup>  8th grade or less  
<sup>2</sup>  Some high school, but did not graduate  
<sup>3</sup>  High school graduate or GED  
<sup>4</sup>  Some college or 2-year degree  
<sup>5</sup>  4-year college graduate  
<sup>6</sup>  More than 4-year college degree

78. **Are you of Spanish, Hispanic or Latino origin or descent?**

- <sup>1</sup>  No, not Spanish/Hispanic/Latino  
<sup>2</sup>  Yes, Puerto Rican  
<sup>3</sup>  Yes, Mexican, Mexican American, Chicano  
<sup>4</sup>  Yes, Cuban  
<sup>5</sup>  Yes, other Spanish/Hispanic/Latino

**79. What is your race? Please choose one or more.**

- <sup>1</sup> White
- <sup>2</sup> Black or African American
- <sup>3</sup> Asian
- <sup>4</sup> Native Hawaiian or other Pacific Islander
- <sup>5</sup> American Indian or Alaska Native

**80. What language do you mainly speak at home?**

- <sup>1</sup> English
- <sup>2</sup> Spanish
- <sup>8</sup> Some other language (please print): \_\_\_\_\_

**If you have a specific question or need help with your VA care, you may contact the VA:**

1. By telephone:
  - a. VA Benefits: 1-800-827-1000
  - b. Health Care Benefits: 1-877-222-8387
  - c. Telecommunications Device for the Deaf (TDD): 1-800-829-4833
2. Information on a broad range of veterans' benefits is available on our home page at **[www.va.gov](http://www.va.gov)**.
3. At your local VA medical center. Either contact the department that you think can help you or ask for the Patient Advocate.

**Your answers are important to help us improve VA care. Thank you for completing this questionnaire. Please place the completed questionnaire in the envelope we sent you. No stamp is required. Simply place the envelope in any mailbox and return the survey to:**

**OQP/SHEP Surveys  
C/OSynovate Corporation  
P.O. Box ???  
Chicago, IL Zip**