Attachment A

SUPPORTING STATEMENT – Part A:

National Implementation of the Hospital CAHPS Survey
CMS-10102

HCAHPS Survey Instrument (Mail) and Supporting Materials

HCAHPS Survey

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 <u>all</u> 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***

You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.
Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981

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

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with <u>courtesy and respect</u>?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

2. During this hospital stay, how often did nurses <u>listen carefully to you</u>?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

3. During this hospital stay, how often did nurses <u>explain things</u> in a way you could understand?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always
9☐ 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?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

6. During this hospital stay, how often did doctors listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

9. During this hospital stay, how often was the area around your room quiet at night?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ 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?

1 ☐ Yes
2 ☐ 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?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

1 ☐ Yes
2 ☐ No ➔ **If No, Go to Question 15**

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

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

[1] ☐ Yes
[2] ☐ 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?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

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

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ 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?

[1] ☐ Own home
[2] ☐ Someone else's home
[3] ☐ 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?

[1] ☐ Yes
[2] ☐ 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?

[1] ☐ Yes
[2] ☐ No

OVERALL RATING OF HOSPITAL

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

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] ☐ 0 Worst hospital possible
[1] ☐ 1
[2] ☐ 2
[3] ☐ 3
[4] ☐ 4
[5] ☐ 5
[6] ☐ 6
[7] ☐ 7
[8] ☐ 8
[9] ☐ 9
[10] ☐ 10 Best hospital possible

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

- [1] ☐ Definitely no
- [2] ☐ Probably no
- [3] ☐ Probably yes
- [4] ☐ Definitely yes

UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL

23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

- [1] ☐ Strongly disagree
- [2] ☐ Disagree
- [3] ☐ Agree
- [4] ☐ Strongly agree

24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

- [1] ☐ Strongly disagree
- [2] ☐ Disagree
- [3] ☐ Agree
- [4] ☐ Strongly agree

25. When I left the hospital, I clearly understood the purpose for taking each of my medications.

- [1] ☐ Strongly disagree
- [2] ☐ Disagree
- [3] ☐ Agree
- [4] ☐ Strongly agree
- [5] ☐ I was not given any medication when I left the hospital

ABOUT YOU

There are only a few remaining items left.

26. During this hospital stay, were you admitted to this hospital through the Emergency Room?

- [1] ☐ Yes
- [2] ☐ No

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

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

28. In general, how would you rate your overall mental or emotional health?

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

29. 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 4-year college degree

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

- [1] ☐ No, not Spanish/Hispanic/Latino
- [2] ☐ Yes, Puerto Rican
- [3] ☐ Yes, Mexican, Mexican American, Chicano
- [4] ☐ Yes, Cuban
- [5] ☐ Yes, other Spanish/Hispanic/Latino

31. What is your race? Please choose one or more.

- [1] ☐ White
- [2] ☐ Black or African American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or other Pacific Islander
- [5] ☐ American Indian or Alaska Native

32. What language do you <u>mainly</u> speak at home?

- [1] ☐ English
- [2] ☐ Spanish
- [3] ☐ Chinese
- [4] ☐ Russian
- [5] ☐ Vietnamese
- [6] ☐ Portuguese
- [9] ☐ Some other language (please print): _____

THANK YOU

Please return the completed survey in the postage-paid envelope.

[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

Sample Initial Cover Letter for the HCAHPS Survey

[HOSPITAL LETTERHEAD]

[SAMPLED PATIENT NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [SAMPLED PATIENT NAME]:

Our records show that you were recently a patient at [NAME OF HOSPITAL] and discharged on [DATE OF DISCHARGE]. Because you had a recent hospital stay, we are asking for your help. This survey is part of an ongoing national effort to understand how patients view their hospital experience. Hospital results will be publicly reported and made available on the Internet at www.medicare.gov/hospitalcompare. These results will help consumers make important choices about their hospital care, and will help hospitals improve the care they provide.

Questions 1-25 in the enclosed survey are part of a national initiative sponsored by the United States Department of Health and Human Services to measure the quality of care in hospitals. Your participation is voluntary and will not affect your health benefits.

We hope that you will take the time to complete the survey. Your participation is greatly appreciated. After you have completed the survey, please return it in the pre-paid envelope. Your answers may be shared with the hospital for purposes of quality improvement. [*OPTIONAL*: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.]

If you have any questions about the enclosed survey, please call the toll-free number 1-800-xxx-xxxx. Thank you for helping to improve health care for all consumers.

Sincerely,

[HOSPITAL ADMINISTRATOR]
[HOSPITAL NAME]

Note: The OMB Paperwork Reduction Act language must be included in the mailing. This language can be either on the front or back of the cover letter or questionnaire, but cannot be a separate mailing. The exact OMB Paperwork Reduction Act language is included in this appendix. Please refer to the Mail Only, and Mixed Mode sections, for specific letter guidelines.

Sample Follow-up Cover Letter for the HCAHPS Survey

[HOSPITAL LETTERHEAD]

[SAMPLED PATIENT NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [SAMPLED PATIENT NAME]:

Our records show that you were recently a patient at [NAME OF HOSPITAL] and discharged on [DATE OF DISCHARGE]. Approximately three weeks ago we sent you a survey regarding your hospitalization. If you have already returned the survey to us, please accept our thanks and disregard this letter. However, if you have not yet completed the survey, please take a few minutes and complete it now.

Because you had a recent hospital stay, we are asking for your help. This survey is part of an ongoing national effort to understand how patients view their hospital experience. Hospital results will be publicly reported and made available on the Internet at www.medicare.gov/hospitalcompare. These results will help consumers make important choices about their hospital care, and will help hospitals improve the care they provide.

Questions 1-25 in the enclosed survey are part of a national initiative sponsored by the United States Department of Health and Human Services to measure the quality of care in hospitals. Your participation is voluntary and will not affect your health benefits. Please take a few minutes and complete the enclosed survey. After you have completed the survey, please return it in the pre-paid envelope. Your answers may be shared with the hospital for purposes of quality improvement. [*OPTIONAL*: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.]

If you have any questions about the enclosed survey, please call the toll-free number 1-800-xxx-xxxx. Thank you again for helping to improve health care for all consumers.

Sincerely,

[HOSPITAL ADMINISTRATOR]
[HOSPITAL NAME]

Note: The OMB Paperwork Reduction Act language must be included in the mailing. This language can be either on the front or back of the cover letter or questionnaire, but cannot be a separate mailing. The exact OMB Paperwork Reduction Act language is included in this appendix. Please refer to the Mail Only, and Mixed Mode sections, for specific letter guidelines.

OMB Paperwork Reduction Act Language

The OMB Paperwork Reduction Act language must be included in the survey mailing. This language can be either on the front or back of the cover letter or questionnaire, but cannot be a separate mailing. The following is the language that must be used:

English Version

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0981. The time required to complete this information collected is estimated to average 8 minutes for questions 1-25 on the survey, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, C1-25-05, Baltimore, MD 21244-1850."