HOME HEALTH CARE CAHPS® SURVEY

2017

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 0938-1066 (Expires: TBD). The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing data sources, 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, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

SURVEY INSTRUCTIONS

- 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 ➔ **If Yes, go to Q1 on Page 1.**

☐ No

YOUR HOME HEALTH CARE

1. According to our records, you got care from the home health agency, **[AGENCY NAME]**. Is that right?

As you answer the questions in this survey, think only about your experience with this agency.

1 ☐ Yes

2 ☐ No ➔ **If No, please stop and return the survey in the envelope provided.**

2. When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?

1 ☐ Yes

2 ☐ No

3 ☐ Do not remember

3. When you first started getting home health care from this agency, did someone from the agency **talk with you** about how to set up your home so you can move around safely?

1 ☐ Yes

2 ☐ No

3 ☐ Do not remember

4. When you started getting home health care from this agency, did someone from the agency talk with you about all the **prescription and over-the-counter medicines** you were taking?

1 ☐ Yes

2 ☐ No

3 ☐ Do not remember

5. When you started getting home health care from this agency, did someone from the agency ask to **see** all the prescription and over-the-counter medicines you were taking?

1 ☐ Yes

2 ☐ No

3 ☐ Do not remember

YOUR CARE FROM HOME HEALTH PROVIDERS IN THE LAST 2 MONTHS

These next questions are about all the different staff from **[AGENCY NAME]** who gave you care in the last 2 months. Do not include care you got from staff from another home health care agency. Do not include care you got from family or friends.

6. In the last 2 months of care, was one of your home health providers from this agency a nurse?

1 ☐ Yes

2 ☐ No

7. In the last 2 months of care, was one of your home health providers from this agency a physical, occupational, or speech therapist?

1 ☐ Yes

2 ☐ No

8. In the last 2 months of care, was one of your home health providers from this agency a home health or personal care aide?

1 ☐ Yes

2 ☐ No

9. In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

5 ☐ I only had one provider in the last 2 months of care

10. In the last 2 months of care, did you and a home health provider from this agency talk about pain?

1 ☐ Yes

2 ☐ No

11. In the last 2 months of care, did you take any new prescription medicine or change any of the medicines you were taking?

1 ☐ Yes

2 ☐ No ➔ **If No, go to Q15.**

12. In the last 2 months of care, did home health providers from this agency talk with you about the **purpose** for taking your new or changed prescription medicines?

1 ☐ Yes

2 ☐ No

3 ☐ I did **not** take any new prescription medicines or change any medicines

13. In the last 2 months of care, did home health providers from this agency talk with you about **when** to take these medicines?

1 ☐ Yes

2 ☐ No

3 ☐ I did **not** take any new prescription medicines or change any medicines

14. In the last 2 months of care, did home health providers from this agency talk with you about the **side effects** of these medicines?

1 ☐ Yes

2 ☐ No

3 ☐ I did **not** take any new prescription medicines or change any medicines

15. In the last 2 months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

17. In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

18. In the last 2 months of care, how often did home health providers from this agency listen carefully to you?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

19. In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

20. We want to know your rating of your care from this agency's home health providers.

Using any number from 0 to 10, where 0 is the worst home health care possible and 10 is the best home health care possible, what number would you use to rate your care from this agency's home health providers?

☐ 0 Worst home health care possible

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

☐ 8

☐ 9

☐ 10 Best home health care possible

YOUR HOME HEALTH AGENCY

The next questions are about the office of **[AGENCY NAME]**.

21. In the last 2 months of care, did you contact this agency's **office** to get help or advice?

1 ☐ Yes

2 ☐ No ➔ **If No, go to Q24.**

22. In the last 2 months of care, when you contacted this agency's office did you get the help or advice you needed?

1 ☐ Yes

2 ☐ No ➔ **If No, go to Q24.**

3 ☐ I did **not** contact this agency

23. When you contacted this agency's office, how long did it take for you to get the help or advice you needed?

1 ☐ Same day

2 ☐ 1 to 5 days

3 ☐ 6 to 14 days

4 ☐ More than 14 days

5 ☐ I did **not** contact this agency

24. In the last 2 months of care, did you have any problems with the care you got through this agency?

1 ☐ Yes

2 ☐ No

25. Would you recommend this agency to your family or friends if they needed home health care?

1 ☐ Definitely no

2 ☐ Probably no

3 ☐ Probably yes

4 ☐ Definitely yes

About You

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

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

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

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

28. Do you live alone?

1 ☐ Yes
2 ☐ No

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 Hispanic or Latino/Latina?

1 ☐ Yes
2 ☐ No

31. What is your race? Please select 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 mainly speak at home?

1 ☐ English

2 ☐ Spanish

3 ☐ Some other language:

_____

(Please print.)

33. Did someone help you complete this survey?

1 ☐ Yes

2 ☐ No ➔ **If No, please return the completed survey in the postage-paid envelope.**

34. How did that person help you? Check all that apply.

1 ☐ Read the questions to me

2 ☐ Wrote down the answers I gave

3 ☐ Answered the questions for me

4 ☐ Translated the questions into my language

5 ☐ Helped in some other way:

_____

(Please print.)

6 ☐ No one helped me complete this survey

Thank you!

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

HOME HEALTH CARE CAHPS® SURVEY (ALTERNATIVE INSTRUCTIONS, SCANNABLE FORMS) 2017

SURVEY INSTRUCTIONS

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● Yes ➔ **If Yes, go to Q1 on Page 1.**

○ No

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○ Yes

○ No

○ Do not remember

3. When you first started getting home health care from this agency, did someone from the agency **talk with you** about how to set up your home so you can move around safely?

○ Yes

○ No

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○ Never

○ Sometimes

○ Usually

○ Always

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- ○ 0 Worst home health care possible
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
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- ○ 10 Best home health care possible

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- ○ Definitely no
- ○ Probably no
- ○ Probably yes
- ○ Definitely yes

ABOUT YOU

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- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

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

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- ○ No

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- ○ Helped in some other way:

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(Please print.)

- ○ No one helped me complete this survey

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