



Health Care Quality Performance (HCQP) Program

HOME HEALTH SUBCOMMITTEE

8:00-9:30 am, July 8, 2009

Quality Partners of Rhode Island

Goals/Objectives

- To begin planning for the next data patient satisfaction survey (Sept-Nov 2009), in part by obtaining the Subcommittee's input about using Medicare's new Home Health CAHPS (HH CAHPS) instrument

Attendees

- | | |
|-------------------------------|--------------------------|
| ✓ Rosa Baier (<i>Chair</i>) | ✓ Margaret Nugent |
| ✓ Jeanne Brockway | ✓ Lou Paolino |
| ✓ Kerry Demers | ✓ Colleen Rose |
| ✓ Alan Tavares | ✓ Sheila Turner |
| ✓ Karen Mercer | ✓ Samara Viner-Brown, MS |
| ✓ Barbara Novak | |

Time

Topic/Notes

- | | |
|--------|--|
| 8:00am | <p>Welcome & Meeting Objective <i>Rosa Baier, MPH (Chair)</i></p> <ul style="list-style-type: none"> – Rosa opened the meeting and welcomed meeting participants to the reconvened Subcommittee meeting. This is the first meeting since RI agencies collected satisfaction data in Fall 2007 and publicly reported it in early 2008. Notably, RI was the first state to report home health patient satisfaction. – The meeting objective is to begin planning for the next data patient satisfaction survey (Sept-Nov 2009), in part by obtaining the Subcommittee's input about using Medicare's new Home Health CAHPS (HH CAHPS) instrument. – For those who are new to the process: <ul style="list-style-type: none"> • The Subcommittee is open to all interested participants and meeting notices are posted on the state's Open Meetings site: http://www.sec.state.ri.us/etowncrier/ • The Subcommittee makes recommendations about how HEALTH reports home health agency data— which measures are reported, including how the data are collected, and what the report format looks like. • Policy decisions based are made by the program's Steering Committee, which has 19 voting members and is chaired by Dr. David Gifford, Director of HEALTH. Steering Committee meetings are also open to the public. – With questions, please contact Rosa (rbaier@riqio.sdps.org) or Sam Viner-Brown, Chief of the Center for Health Data and Analysis (samara.viner-brown@health.ri.gov). |
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| Time | Topic/Notes | | | | | | | | | | | | |
|--|---|-----------------|---------------------|---------------------|---------------|--|-----------------------|-------------------------|-------------------------|---|----|---|----|
| 8:10am | <p>Patient Satisfaction Data Collection <i>Samara Viner-Brown, MS</i> <i>Rosa Baier, MPH</i></p> <ul style="list-style-type: none"> - After agencies collected satisfaction data in Fall 2007, the Subcommittee recommended (and the Steering Committee approved): <ul style="list-style-type: none"> • Surveying every 2 years, and • Continued use of Press Ganey as the agencies' satisfaction survey vendor. - (Some agencies had expressed concern with Press Ganey's service, so HEALTH surveyed all agencies to ask for input: 16 agencies recommended staying with Press Ganey and six recommended switching. The Steering Committee endorsed staying with Press Ganey, but working with them to better support RI agencies.) - At that time, a single vendor was necessary because all RI home health agencies were required to use the same, validated questions, and survey instruments are proprietary. Using a single vendor also gave RI a competitive advantage to negotiate the lowest possible cost. The Subcommittee may decide to change its recommendation now, since vendors are switching to HH CAHPS (see below). - The next survey period is September to November 2009, which is why the Subcommittee is reconvening now to discuss and plan for the process. | | | | | | | | | | | | |
| 9:15am | <p>HH CAHPS <i>Rosa Baier, MPH</i></p> <ul style="list-style-type: none"> - Rosa shared information on Medicare's new HH CAHPS instrument (see handout), which was developed to measure and report patient experience/satisfaction. - HH CAHPS has gone through a rigorous development and testing phase, which included the development of several measures for public reporting. The following measures were endorsed by the National Quality Forum (NQF): <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>Measure:</u></th> <th style="text-align: right; border-bottom: 1px solid black;"><u>Question(s):</u></th> </tr> </thead> <tbody> <tr> <td>1. Care of patients</td> <td style="text-align: right;">9, 16, 19, 24</td> </tr> <tr> <td>2. Communications between providers and patients</td> <td style="text-align: right;">2, 15, 17, 18, 22, 23</td> </tr> <tr> <td>3. Specific care issues</td> <td style="text-align: right;">3, 4, 5, 10, 12, 13, 14</td> </tr> <tr> <td>4. Care from the agency's home health providers</td> <td style="text-align: right;">20</td> </tr> <tr> <td>5. Recommend this agency to friends or family</td> <td style="text-align: right;">25</td> </tr> </tbody> </table> <ul style="list-style-type: none"> - Based on the latest available information (which is subject to change), vendors plan to begin using HH CAHPS in Summer/Fall 2009 and Medicare will mandate its use in 2010, and begin publicly reported these measures then. There are also indications that the results will be tied to Medicare's pay for performance initiatives. - For more information about HH CAHPS, please see: <ul style="list-style-type: none"> • AHRQ: https://www.cahps.ahrq.gov/content/products/HH/PROD_HH_Intro.asp • HH CAHPS: https://homehealthcahps.org/ • Press Ganey: http://www.pressganey.com/cs/news_and_notes/hhcahps - Press Ganey released an April 22nd memo and FAQ for RI agencies (see handout). It is committed to supporting the RI agencies through a seamless transition from its tool to HH CAHPS, and can advise us on incorporating 'custom' questions, as need be. However, with the vendors' switch to a single survey instrument (HH CAHPS), the Subcommittee may recommend that agencies be allowed to use different vendors. | <u>Measure:</u> | <u>Question(s):</u> | 1. Care of patients | 9, 16, 19, 24 | 2. Communications between providers and patients | 2, 15, 17, 18, 22, 23 | 3. Specific care issues | 3, 4, 5, 10, 12, 13, 14 | 4. Care from the agency's home health providers | 20 | 5. Recommend this agency to friends or family | 25 |
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| 9:15am | <p>Discussion <i>Rosa Baier, MPH</i></p> <ul style="list-style-type: none"> - Do we want to use HH CAHPS in September? If so: <ul style="list-style-type: none"> • Do we want to customize it (add questions), as we've done in the past? • Do we want to use a single vendor, Press Ganey, or multiple vendors? <ul style="list-style-type: none"> ○ Using different vendors could facilitate continuity throughout the year for agencies that use another vendor (not Press Ganey) on an ongoing basis. ○ There may be cost saving in using the same vendor (collective bargaining). ○ Using more than 1-2 vendors may limit HEALTH's ability to track survey compliance and follow-up with agencies to prevent state citations. • How do we want to proceed with non-Medicare agencies? - Recommendations: <ul style="list-style-type: none"> • Stratification: <ul style="list-style-type: none"> ○ Split Medicare and non-Medicare certified agencies ○ Label Medicare agencies "skilled care" or "home health services"; label non-Medicare agencies "long-term care in the home" or "personal care services" • Medicare certified agencies: <ul style="list-style-type: none"> ○ Switch to HH CAHPS instrument in September, provided that Medicare has begun voluntary implementation by then. If not: <ul style="list-style-type: none"> • Revisit use of Press Ganey's tool, or • Consider pushing back the survey period (depending on Medicare's revised timeline). ○ Inform/confirm recommendation to switch by obtaining agency feedback via an emailed survey ○ Consider using different vendors (Press Ganey or Fazzi), but obtain information from both vendors about costs, opportunity for bargaining ○ Use the HH CAHPS instrument as-is to start, and revisit the addition of customized questions at a later date • Non-Medicare certified agencies: <ul style="list-style-type: none"> ○ Continue to use Press Ganey ○ Work with Press Ganey to refine their "non-skilled" survey instrument • All agencies: <ul style="list-style-type: none"> ○ Explore ways to increase response rates (e.g., second-wave mailings) ○ Ensure that HEALTH follows up appropriately to prevent gaming ○ Obtain refresher instructions from vendor (Press Ganey or Fazzi) - Action items: <ul style="list-style-type: none"> • Share suggestions for the non-skilled tool and process (Lou) • Identify venue to obtain other non-skilled agencies' input on tool & process (Sam) • Confirm HH CAHPS details with Press Ganey (Rosa) • Speak with Karen Voll about Lou's concerns (Rosa and Sam) • Identify pricing options with Press Ganey and Fazzi (Rosa) • Develop and disseminate a Medicare agency survey (Rosa and Sam) |

| Time | Topic/Notes |
|--------|--|
| 9:15am | <p data-bbox="342 144 1437 178">Action Items & Next Steps</p> <p data-bbox="342 178 1437 212"><i>Rosa Baier, MPH</i></p> <ul data-bbox="342 212 1437 573" style="list-style-type: none"><li data-bbox="342 212 1437 279">– See above action items.<li data-bbox="342 279 1437 388">– Next meeting: Sam and Rosa will schedule recurring Subcommittee meetings through August, to prepare for the anticipated September survey period, and will send “Save the Date” emails as soon as the dates are confirmed.<li data-bbox="342 388 1437 573">– Note: The Subcommittee’s recommendations will be brought to the Steering Committee for discussion and endorsement. The next Steering Committee meeting is scheduled for July 20, 2009, but is likely to be postponed due to vacation schedules. The date will be posted on the state’s Open Meetings site: http://www.sec.state.ri.us/etowncrier/ |



Memo

To: Home Health Subcommittee
From: Karen H. Voll, Primary Consultant, Home Health
CC: Rhode Island Department of Health
Date: 4/22/2009
Re: Home Health CAHPS ("HH CAHPS") Survey Instrument

HH CAHPS Schedule

CMS is not mandating use of the HH CAHPS questions this year, but is offering potential voluntary participation in the HH CAHPS survey process. If CMS has initiated the HH CAHPS voluntary participation process prior to or at the start of your survey process, we can offer you an integrated survey- your current PG questions and the HH CAHPS questions. This integrated survey will allow you to gather HH CAHPS question responses while maintaining your benchmarking for PG questions.

As of this date, 4/21/2009, the actual deployment timeline and protocols for the voluntary use of HH CAHPS have been discussed, but not finalized. The deployment of this process is contingent on a number of factors including but not limited to CMS's OMB (Office of Management and Budget) approval, modality testing and outcomes and vendor education and certification. We plan to become a certified HH CAHPS vendor to insure we are prepared to offer this service to our clients on day one of the voluntary participation stage.

In addition, we are developing HH CAHPS specific improvement consulting to insure our clients the maximum benefit of their partnership with Press Ganey. We are waiting on CMS to announce firm dates for scheduling/completion of the deployment process and will keep you updated as these steps are finalized. If CMS has not announced the start of voluntary HH CAHPS participation prior to the onset of your survey process, we recommend using the current Press Ganey survey.

Switching to HH CAHPS

Press Ganey has an entire department dedicated to ensuring a smooth transition to the HH CAHPS instrument, and plans to offer an integrated survey to ensure that you continue to receive the benefits of Press Ganey benchmarking and other beneficial report instruments.

While planning ahead as much as possible, Press Ganey is waiting for final survey instrument before moving ahead with HH CAHPS training. Once the questions have been finalized, we will offer an implementation and educational process designed to insure as smooth a transition as possible. This will include an educational binder, Webinar conferences, and other tools.

What HH CAHPS Means for Rhode Island

The Rhode Island Department of Health's (HEALTH's) mandatory survey process is scheduled for September to November 2009 (approximately Labor Day through Thanksgiving). By then, Press Ganey will have completed a HH CAHPS pilot test (currently underway) and have several months' experience with the new survey instrument.

We look forward to a smooth transition into HH CAHPS. If you have any other questions regarding HH CAHPS, please feel free to contact me:

- Karen H. Voll, Primary Consultant, Home Health: 888-773-7742, ext. 326 or kvoll@pressganey.com

Note: The Rhode Island Department of Health's mandatory survey process differs from the proposed HH CAHPS survey process. Based on information available to date, the HH CAHPS process may require surveying throughout the year on a regular basis. This may affect the Home Health Subcommittee's recommendations for public reporting. If you have questions about public reporting specifically, please contact:

- Rosa Baier , Chair of the Home Health Subcommittee: 401-528-3205 or rbaier@riqio.sdps.org
- Samara Viner-Brown, Project Director: 401-222-5122 or samara.viner-brown@health.ri.gov



Frequently Asked Questions on HH-CAHPS
<http://www.pressganey.com/cs/hhcahps/faqs>

Q: What is CAHPS?

A: CAHPS originally stood for Consumer Assessment of Health Plan Survey. The original CAHPS tool was developed by AHRQ (Agency for Healthcare Research and Quality) and is used by health plans to understand their members' perception of their quality of health care. The CAHPS team has expanded the number of survey tools within the suite of surveys developed by AHRQ. The CAHPS acronym has been changed to denote Consumer Assessment of Healthcare Providers and Systems. The family of surveys now includes tools for different types of facility care (e.g., HCAHPS or Hospital CAHPS, NH CAHPS or Nursing Home CAHPS) and ambulatory settings (e.g., CG-CAHPS or Clinician and Group CAHPS).

The Home Health Care CAHPS (HH-CAHPS), a standardized tool to measure home health patient perceptions of their care, is currently under development.

AHRQ's CAHPS resource page: <https://www.cahps.ahrq.gov/default.asp>

Q: What is HH-CAHPS?

A: HH-CAHPS refers to Home Health Care CAHPS®, a tool being designed to assess patient perceptions of care provided by Medicare certified home health care agencies. The tool is designed for adult patients who currently receive home health care or who have been recently discharged from home health care. The patient population includes those who received skilled care (not related to pregnancy), regardless of payor type.

Q: Who initiated the development of HH-CAHPS?

A: CMS initiated the development of the tool and requested that AHRQ develop the survey as a measure of quality for the Home Health Care arena.

Q: Who is developing HH-CAHPS?

A: The CAHPS team within AHRQ is developing the CAHPS tool. The HH-CAHPS tool has been tested and submitted to the National Quality Forum (NQF) for approval. The final version of the survey has not yet been released to the public.

Q: What is the status of the HH-CAHPS instrument?

A: The HH-CAHPS draft survey has been tested and submitted to NQF for review. A panel of experts will review the survey and process. The full membership of NQF will then vote on the proposed survey.

Q: Will HH-CAHPS be linked to payment?

A: The Centers for Medicare & Medicaid Services (CMS) has indicated that voluntary national implementation of Home Health CAHPS would begin in calendar year 2009. In the past they have also mentioned the possibility of including this survey as part of the pay for reporting requirements for home health agencies in CY 2010.

Q: What concept areas are included in the draft of HH-CAHPS?

A: There are several broad areas of patient care represented on the survey including: patient experience with home health staff, patient experience with agency office, patient ratings of service quality and demographics. Contact your Press Ganey Consultant to receive a copy of the draft version of the survey.

Q: Which patients will be eligible for the survey?

A: We believe that the criteria for eligibility will include:

- Patients over the age of 18
- Patients that have received at least two skilled nurse visits in the past 60 days
- Patients not currently receiving hospice care
- Patients that did not have maternity as the primary reason for home health care based on the data you provide

Q: What is Press Ganey's involvement in the development of HH-CAHPS?

A: Press Ganey responded to AHRQ's initial call for measures for the HH-CAHPS tool in the fall of 2006 and has provided additional research-based information regarding measuring patient perceptions of home health care. Press Ganey has also provided comments on the draft version of the survey through the Federal Register comment submission process.

Q: What is the timeline for the development of HH-CAHPS?

A: Training for vendors is expected to occur in 2009 followed by a period of voluntary national implementation

- September 2006: Call for Measures
- February 2007: Technical Advisory Panel review
- Spring 2008: Pilot Testing
- 2008: Submission to the National Quality Forum
- Early Summer 2009: Vendor Training (anticipated)
- Summer 2009: CMS National Implementation (anticipated)
- 2010: CMS link of HH-CAHPS to Pay for Reporting (anticipated)

Q: Can home health agencies conduct the survey?

A: Home health agencies that would like to participate in voluntary implementation of the Home Health CAHPS survey must use an approved vendor. Agencies will not be permitted to conduct their own Home Health CAHPS surveys.

Q: What should you expect from an HH-CAHPS vendor:

A: We are prepared to help your agency:

- Fulfill expected requirements:
 - Determine eligible patient populations
 - Conduct a random sample
 - Track the survey and monitor returns
 - Submit data on your behalf
- Provide you with improvement resources
 - Actionable results and data
 - Dedicated Consultant
 - Solutions Starters
 - Webinars and white papers

CAHPS[®] Home Health Care Survey

Version: Adult (Mail)

Language: English



File name: HH_Adult_Eng.doc
Last updated: April 23, 2009

Instructions for Front Cover

- Replace the cover of this document with your own front cover. Include a user-friendly title and your own logo.
- Include this text regarding the confidentiality of survey responses:

Your Privacy is Protected. All information that would let someone identify you or your family will be kept private. {VENDOR NAME} will not share your personal information with anyone without your OK. Your responses to this survey are also completely **confidential**. You may notice a number on the cover of the survey. This number is used **only** to let us know if you returned your survey so we don't have to send you reminders.

Your Participation is Voluntary. You may choose to answer this survey or not. If you choose not to, this will not affect the health care you get.

What To Do When You're Done. Once you complete the survey, place it in the envelope that was provided, seal the envelope, and return the envelope to [INSERT VENDOR ADDRESS].

If you want to know more about this study, please call XXX-XXX-XXXX.

Instructions for Format of Questionnaire

Proper formatting of a questionnaire improves response rates, the ease of completion, and the accuracy of responses. The CAHPS team's recommendations include the following:

- If feasible, insert blank pages as needed so that the survey instructions (see next page) and the first page of questions start on the right-hand side of the questionnaire booklet.
- Maximize readability by using two columns, serif fonts for the questions, and ample white space.
- Number the pages of your document, but remove the headers and footers inserted to help sponsors and vendors distinguish among questionnaire versions.

Note: There are no instructional documents to support users of the CAHPS Home Health Care Survey. For general guidance on formatting, administering, and analyzing results of this survey, you may want to consult the documentation provided in the **CAHPS Health Plan Survey and Reporting Kit**:

<https://www.cahps.ahrq.gov/cahpskit/Healthplan/HPChooseQx2.asp>

Survey Instructions

Answer each question by marking 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 #1 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?

¹ Yes
² No → **If No, please stop and return the survey in the envelope provided.**

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

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 #15**

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
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- Provide you with improvement resources
 - Actionable results and data
 - Dedicated Consultant
 - Solutions Starters
 - Webinars and white papers

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 #24**

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 #24**
- 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 yes
- ² Probably yes
- ³ Probably no
- ⁴ Definitely no

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.**

If a section or question does not apply to you, please SKIP to the next section or question.

F. OTHER RATINGS (...continued)

| | | | | | |
|--|------|------|------|------|------|
| | very | | | | very |
| | poor | poor | fair | good | good |
| | 1 | 2 | 3 | 4 | 5 |

- 4. Staff concern to keep your family informed about your treatment, condition or progress (if you wanted them informed).....
- 5. Likelihood of your recommending our home care services to others.....
- 6. Overall quality of the agency.....

Comments (describe good or bad experience): _____

QUESTIONS ABOUT THE PATIENT OR CLIENT

[write in answer or fill in circle (for example: ●) as appropriate]

- 1. Do you live alone?..... Yes No
- 2. Your sex: Male Female
- 3. Your age in years:

| | | |
|--|--|--|
| | | |
|--|--|--|

 years
- 4. Compared to others of similar age, how would you rate your current state of health? (Choose one only.)

| | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| very | | | | very |
| poor | poor | fair | good | good |
| <input type="radio"/> |
- 5. Are you Hispanic or Latino?
 Yes, Hispanic or Latino
 No, not Hispanic or Latino
- 6. What is your race?
 American Indian
 Asian
 Black or African American
 Native Hawaiian or Pacific Islander
 White

If you want the agency to know who you are, please print your name below. If you are a family member or friend, it would be helpful to know the name of the patient or client for whom you are filling out this survey. (Do NOT print any names below if you wish their answers and/or yours remain confidential.)

Your Name: (optional) _____

Patient or Client's Name: (optional) _____

If you would like the agency to contact you to follow up with your concerns, please write your telephone number here:

Telephone Number: _____

Best time(s) of day or night to call: _____

Do you have urgent concerns about your care? Call your home care agency directly.



HOME CARE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed postage paid envelope.

All questions in this survey refer to the patient or client, and should be answered from the patient or client's point of view.

BACKGROUND QUESTIONS [fill in circle (for example: ●) as appropriate]

- 1. Who is filling out this survey?
 patient or client
 family member for patient or client
 friend for patient or client
 other interested party for patient or client
- 2. Is this your first use of our services? Yes No
- 3. How long have you been using our services this time?
 1-14 days 61 days-1 year
 15-30 days more than 1 year
 31-60 days
- 4. Where were you staying when the arrangements for our services were made?
 Home (Private Residence)
 Hospital
 Nursing Home or Rehab. Facility
 Assisted Living
- 5. Are we still providing services to you, or have you been discharged from our care?
 I am still receiving services
 I have been discharged

INSTRUCTIONS: Please rate the services you received from our agency.

Fill in the circle that best describes your experience. If a section or question does not apply to you, SKIP to the next section or question. Space is provided after each section for you to comment on good or bad things that may have happened to you. Please answer questions from the point of view of the patient or client.

Please use black or blue ink to fill in the circle completely.
 Example: ●

A. ARRANGING YOUR HOME CARE

| | | | | | |
|--|------|------|------|------|------|
| | very | | | | very |
| | poor | poor | fair | good | good |
| | 1 | 2 | 3 | 4 | 5 |

- 1. How well the initial plan of care or treatment met your needs.....
- 2. How easy it was to schedule visits for the days and times you wanted
- 3. Helpfulness of the person who made the initial arrangements for your services

Comments (describe good or bad experience): _____



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If a section or question does not apply to you, please SKIP to the next section or question.

B. DEALING WITH THE OFFICE

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|----------------|-----------|-----------|-----------|----------------|
|--|----------------|-----------|-----------|-----------|----------------|

1. Helpfulness of the person who answered the phone.....
2. How well the office dealt with your problems and complaints.....
3. How easy it was to get the visit schedule changed.....
4. How well the office handled your request to change caregivers.....
5. How well the office handled emergencies.....
6. How well billing and cost questions were handled.....
7. How well calls were handled after hours

Comments (describe good or bad experience): _____

C. NURSES

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|----------------|-----------|-----------|-----------|----------------|
|--|----------------|-----------|-----------|-----------|----------------|

1. Friendliness of the nurses who visited you.....
2. Nurses' concern for your privacy.....
3. Nurses' concern for your comfort while treating or caring for you.....
4. Technical skill of the nurses in caring for you.....
5. Amount of attention the nurses paid to your own ideas about your care.....
6. How well the nurses taught you to care for yourself.....
7. Nurses' concern to contact you if he or she could not make it, or would be coming late.....
8. Nurses' sensitivity to the personal difficulties and inconvenience that may be caused by your health problem.....
9. Nurses' explanation concerning proper use of medications.....

Comments (describe good or bad experience): _____

**D. HOME HEALTH AIDES (NON-NURSE)
(persons who provide personal care such as bathing or dressing)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|----------------|-----------|-----------|-----------|----------------|
|--|----------------|-----------|-----------|-----------|----------------|

1. Friendliness of the aides who visited you.....
2. Aides' concern for your privacy.....
3. Aides' concern for your comfort while treating or caring for you.....
4. Technical skill of the aides in caring for you.....
5. Amount of attention the aides paid to your own ideas about your care.....

Comments (describe good or bad experience): _____

If a section or question does not apply to you, please SKIP to the next section or question.

**D. HOME HEALTH AIDES (NON-NURSE) (...continued)
(persons who provide personal care such as bathing or dressing)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|----------------|-----------|-----------|-----------|----------------|
|--|----------------|-----------|-----------|-----------|----------------|

6. Aides' concern to contact you if he or she could not make it, or would be coming late.....
7. Aides' sensitivity to the personal difficulties and inconvenience that may be caused by your health problem.....

Comments (describe good or bad experience): _____

**E. THERAPIST AND OTHER PROFESSIONALS
(includes all those listed in Q. 1 below)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|----------------|-----------|-----------|-----------|----------------|
|--|----------------|-----------|-----------|-----------|----------------|

1. Rate the care you received from each type of therapist or professional below. (Skip any one that doesn't apply to you. If you received no such care at all, skip to Section G.)
 - a. Occupational Therapist.....
 - b. Physical Therapist.....
 - c. Speech Therapist.....
 - d. Social Worker.....
 - e. Dietician or Nutritionist.....
2. Now think about the therapists or professionals in the question above as a group. Overall, how would you rate (their):
 - a. Friendliness.....
 - b. Concern for your privacy.....
 - c. Concern for your comfort while treating or caring for you.....
 - d. Concern to contact you if he or she could not make it or would be coming late.....
 - e. Technical skill in caring for you.....
 - f. How well the therapists or professionals taught you to care for yourself.....

Comments (describe good or bad experience): _____

F. OTHER RATINGS

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|----------------|-----------|-----------|-----------|----------------|
|--|----------------|-----------|-----------|-----------|----------------|

1. How well your pain was controlled.....
2. Extent to which safety issues and precautions were explained to you...
3. Degree of involvement you and your family have had in planning your home care.....

Comments (describe good or bad experience): _____



Draft

this section continued on next page...

this section continued on next page...

HOME CARE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed postage paid envelope.

All questions in this survey refer to the patient or client, and should be answered from the patient or client's point of view.

BACKGROUND QUESTIONS [fill in circle (for example: ●) as appropriate]

- Who is filling out this survey?
 - patient or client
 - family member for patient or client
 - friend for patient or client
 - other interested party for patient or client
- Is this your first use of our services? Yes No
- How long have you been using our services this time?
 - 1-14 days 61 days-1 year
 - 15-30 days more than 1 year
 - 31-60 days
- Where were you staying when the arrangements for our services were made?
 - Home (Private Residence)
 - Hospital
 - Nursing Home or Rehab. Facility
 - Assisted Living
- Are we still providing services to you, or have you been discharged from our care?
 - I am still receiving services
 - I have been discharged

INSTRUCTIONS: Please rate the services you received from our agency.

Fill in the circle that best describes your experience. If a section or question does not apply to you, SKIP to the next section or question. Space is provided after each section for you to comment on good or bad things that may have happened to you. Please answer questions from the point of view of the patient or client.

Please use black or blue ink to fill in the circle completely.
Example: ●

A. ARRANGING YOUR HOME CARE

- | | very poor | poor | fair | good | very good |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | 1 | 2 | 3 | 4 | 5 |
| 1. How well the initial plan of care or treatment met your needs..... | <input type="radio"/> |
| 2. How easy it was to schedule visits for the days and times you wanted | <input type="radio"/> |
| 3. Helpfulness of the person who made the initial arrangements for your services | <input type="radio"/> |

Comments (describe good or bad experience): _____

If a section or question does not apply to you, please SKIP to the next section or question.

B. DEALING WITH THE OFFICE

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Helpfulness of the person who answered the phone..... | <input type="radio"/> |
| 2. How well the office dealt with your problems and complaints..... | <input type="radio"/> |
| 3. How easy it was to get the visit schedule changed..... | <input type="radio"/> |
| 4. How well the office handled your request to change caregivers..... | <input type="radio"/> |
| 5. How well the office handled emergencies..... | <input type="radio"/> |
| 6. How well billing and cost questions were handled..... | <input type="radio"/> |
| 7. How well calls were handled after hours..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

**C. HOME HEALTH AIDES (NON-NURSE)
(persons who provide personal care such as bathing or dressing)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Friendliness of the aides who visited you..... | <input type="radio"/> |
| 2. Aides' concern for your privacy..... | <input type="radio"/> |
| 3. Aides' concern for your comfort while treating or caring for you..... | <input type="radio"/> |
| 4. Technical skill of the aides in caring for you..... | <input type="radio"/> |
| 5. Amount of attention the aides paid to your own ideas about your care..... | <input type="radio"/> |
| 6. Aides' concern to contact you if he or she could not make it, or would be coming late..... | <input type="radio"/> |
| 7. Aides' sensitivity to the personal difficulties and inconvenience that may be caused by your health problem..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

**D. HOMEMAKERS-COMPANIONS
(persons who shop, cook, clean, or run errands for you)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Amount of attention the homemaker or companion paid to your ideas about your home..... | <input type="radio"/> |
| 2. Helpfulness of the homemaker or companion..... | <input type="radio"/> |
| 3. Homemaker or companion's respect for you and your property..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

If a section or question does not apply to you, please SKIP to the next section or question.

E. OTHER RATINGS

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well your pain was controlled..... | <input type="radio"/> |
| 2. Extent to which safety issues and precautions were explained to you... | <input type="radio"/> |
| 3. Degree of involvement you and your family have had in planning your home care..... | <input type="radio"/> |
| 4. Staff concern to keep your family informed about your treatment, condition or progress (if you wanted them informed)..... | <input type="radio"/> |
| 5. Likelihood of your recommending our home care services to others..... | <input type="radio"/> |
| 6. Overall quality of the agency..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

QUESTIONS ABOUT THE PATIENT OR CLIENT

[write in answer or fill in circle (for example: ●) as appropriate]

- | | | | | | | | | | | | |
|---|--|-----------------------|-----------------------|-----------------------|-----------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|--|
| 1. Do you live alone?..... <input type="radio"/> Yes <input type="radio"/> No | 5. Are you Hispanic or Latino? <input type="radio"/> Yes, Hispanic or Latino <input type="radio"/> No, not Hispanic or Latino | | | | | | | | | | |
| 2. Your sex: <input type="radio"/> Male <input type="radio"/> Female | 6. What is your race? <input type="radio"/> American Indian <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian or Pacific Islander <input type="radio"/> White | | | | | | | | | | |
| 3. Your age in years: <input type="text"/> <input type="text"/> <input type="text"/> years | | | | | | | | | | | |
| 4. Compared to others of similar age, how would you rate your current state of health? (Choose one only.) <table border="0"> <tr> <td>very poor</td> <td>poor</td> <td>fair</td> <td>good</td> <td>very good</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> | very poor | poor | fair | good | very good | <input type="radio"/> | |
| very poor | poor | fair | good | very good | | | | | | | |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | | | | | | | |

If you want the agency to know who you are, please print your name below. If you are a family member or friend, it would be helpful to know the name of the patient or client for whom you are filling out this survey. (Do NOT print any names below if you wish their answers and/or yours remain confidential.)

Your Name: (optional) _____

Patient or Client's Name: (optional) _____

If you would like the agency to contact you to follow up with your concerns, please write your telephone number here:

Telephone Number: _____

Best time(s) of day or night to call: _____

Do you have urgent concerns about your care? Call your home care agency directly.

If a section or question does not apply to you, please SKIP to the next section or question.

G. OTHER RATINGS

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well your pain was controlled..... | <input type="radio"/> |
| 2. Extent to which safety issues and precautions were explained to you... | <input type="radio"/> |
| 3. Degree of involvement you and your family have had in planning your home care | <input type="radio"/> |
| 4. Staff concern to keep your family informed about your treatment, condition or progress (if you wanted them informed)..... | <input type="radio"/> |
| 5. Likelihood of your recommending our home care services to others..... | <input type="radio"/> |
| 6. Overall quality of the agency..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

QUESTIONS ABOUT THE PATIENT OR CLIENT

[write in answer or fill in circle (for example: ●) as appropriate]

| | |
|---|---|
| 1. Do you live alone?..... <input type="radio"/> Yes <input type="radio"/> No | 5. Are you Hispanic or Latino? |
| 2. Your sex: <input type="radio"/> Male <input type="radio"/> Female | <input type="radio"/> Yes, Hispanic or Latino |
| 3. Your age in years: <input type="text"/> <input type="text"/> <input type="text"/> years | <input type="radio"/> No, not Hispanic or Latino |
| 4. Compared to others of similar age, how would you rate your current state of health? (Choose one only.) | 6. What is your race? |
| very poor poor fair good very good | <input type="radio"/> American Indian |
| <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> | <input type="radio"/> Asian |
| | <input type="radio"/> Black or African American |
| | <input type="radio"/> Native Hawaiian or Pacific Islander |
| | <input type="radio"/> White |

If you want the agency to know who you are, please print your name below. If you are a family member or friend, it would be helpful to know the name of the patient or client for whom you are filling out this survey. (Do NOT print any names below if you wish their answers and/or yours remain confidential.)

Your Name: (optional) _____

Patient or Client's Name: (optional) _____

If you would like the agency to contact you to follow up with your concerns, please write your telephone number here:

Telephone Number: _____

Best time(s) of day or night to call: _____

Do you have urgent concerns about your care? Call your home care agency directly.



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HOME CARE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed postage paid envelope.

All questions in this survey refer to the patient or client, and should be answered from the patient or client's point of view.

BACKGROUND QUESTIONS [fill in circle (for example: ●) as appropriate]

| | |
|--|---|
| 1. Who is filling out this survey? <input type="radio"/> patient or client <input type="radio"/> family member for patient or client <input type="radio"/> friend for patient or client <input type="radio"/> other interested party for patient or client | 4. Where were you staying when the arrangements for our services were made? <input type="radio"/> Home (Private Residence) <input type="radio"/> Hospital <input type="radio"/> Nursing Home or Rehab. Facility <input type="radio"/> Assisted Living |
| 2. Is this your first use of our services? <input type="radio"/> Yes <input type="radio"/> No | 5. Are we still providing services to you, or have you been discharged from our care? <input type="radio"/> I am still receiving services <input type="radio"/> I have been discharged |
| 3. How long have you been using our services this time? <input type="radio"/> 1-14 days <input type="radio"/> 61 days-1 year <input type="radio"/> 15-30 days <input type="radio"/> more than 1 year <input type="radio"/> 31-60 days | |

INSTRUCTIONS: Please rate the services you received from our agency.

Fill in the circle that best describes your experience. If a section or question does not apply to you, SKIP to the next section or question.

Space is provided after each section for you to comment on good or bad things that may have happened to you. Please answer questions from the point of view of the patient or client.

Please use black or blue ink to fill in the circle completely.
Example: ●

A. ARRANGING YOUR HOME CARE

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well the initial plan of care or treatment met your needs..... | <input type="radio"/> |
| 2. How easy it was to schedule visits for the days and times you wanted | <input type="radio"/> |
| 3. Helpfulness of the person who made the initial arrangements for your services | <input type="radio"/> |

Comments (describe good or bad experience): _____

continued ...



If a section or question does not apply to you, please SKIP to the next section or question.

B. DEALING WITH THE OFFICE

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Helpfulness of the person who answered the phone..... | <input type="radio"/> |
| 2. How well the office dealt with your problems and complaints..... | <input type="radio"/> |
| 3. How easy it was to get the visit schedule changed..... | <input type="radio"/> |
| 4. How well the office handled your request to change caregivers..... | <input type="radio"/> |
| 5. How well the office handled emergencies..... | <input type="radio"/> |
| 6. How well billing and cost questions were handled..... | <input type="radio"/> |
| 7. How well calls were handled after hours..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

C. NURSES

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Friendliness of the nurses who visited you..... | <input type="radio"/> |
| 2. Nurses' concern for your privacy..... | <input type="radio"/> |
| 3. Nurses' concern for your comfort while treating or caring for you..... | <input type="radio"/> |
| 4. Technical skill of the nurses in caring for you..... | <input type="radio"/> |
| 5. Amount of attention the nurses paid to your own ideas about your care..... | <input type="radio"/> |
| 6. How well the nurses taught you to care for yourself..... | <input type="radio"/> |
| 7. Nurses' concern to contact you if he or she could not make it, or would be coming late..... | <input type="radio"/> |
| 8. Nurses' sensitivity to the personal difficulties and inconvenience that may be caused by your health problem..... | <input type="radio"/> |
| 9. Nurses' explanation concerning proper use of medications..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

**D. HOME HEALTH AIDES (NON-NURSE)
(persons who provide personal care such as bathing or dressing)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Friendliness of the aides who visited you..... | <input type="radio"/> |
| 2. Aides' concern for your privacy..... | <input type="radio"/> |
| 3. Aides' concern for your comfort while treating or caring for you..... | <input type="radio"/> |
| 4. Technical skill of the aides in caring for you..... | <input type="radio"/> |
| 5. Amount of attention the aides paid to your own ideas about your care..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

If a section or question does not apply to you, please SKIP to the next section or question.

**D. HOME HEALTH AIDES (NON-NURSE) (...continued)
(persons who provide personal care such as bathing or dressing)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 6. Aides' concern to contact you if he or she could not make it, or would be coming late..... | <input type="radio"/> |
| 7. Aides' sensitivity to the personal difficulties and inconvenience that may be caused by your health problem..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

**E. HOMEMAKERS-COMPANIONS
(persons who shop, cook, clean, or run errands for you)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Amount of attention the homemaker or companion paid to your ideas about your home..... | <input type="radio"/> |
| 2. Helpfulness of the homemaker or companion..... | <input type="radio"/> |
| 3. Homemaker or companion's respect for you and your property..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

**F. THERAPIST AND OTHER PROFESSIONALS
(includes all those listed in Q. 1 below)**

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Rate the care you received from each type of therapist or professional below. (Skip any one that doesn't apply to you. If you received no such care at all, skip to Section G.) | | | | | |
| a. Occupational Therapist..... | <input type="radio"/> |
| b. Physical Therapist..... | <input type="radio"/> |
| c. Speech Therapist..... | <input type="radio"/> |
| d. Social Worker..... | <input type="radio"/> |
| e. Dietician or Nutritionist..... | <input type="radio"/> |
| 2. Now think about the therapists or professionals in the question above <u>as a group</u> . Overall, how would you rate (their): | | | | | |
| a. Friendliness..... | <input type="radio"/> |
| b. Concern for your privacy..... | <input type="radio"/> |
| c. Concern for your comfort while treating or caring for you..... | <input type="radio"/> |
| d. Concern to contact you if he or she could not make it or would be coming late..... | <input type="radio"/> |
| e. Technical skill in caring for you..... | <input type="radio"/> |
| f. How well the therapists or professionals taught you to care for yourself..... | <input type="radio"/> |

Comments (describe good or bad experience): _____

