Patient Experience Survey[1]

SURVEY INSTRUCTIONS

- This survey should be completed by the patient indicated on the survey cover letter.
- You can ask a family member or friend for help with this survey or ask them to complete the survey for you.
- If you are a family member or friend helping with this survey or completing this survey for the patient indicated on the survey cover letter, please remember that all survey questions ask about the patient's experiences. Unless a question says otherwise, please do not consider your own experiences or information in the answers you provide.
- Use a dark colored pen to fill out the survey.

Place an X directly inside the square indicating a response, like in the sample below.

☐ Yes

☒ No

This survey uses the word "provider" throughout. When we say "provider", we mean a medical provider like a doctor or a nurse.

YOUR PROVIDER AND TEAM

1. **Our records show that you got care from the provider and team named below in the last 6 months.**

   Is that right?

   ☐ Yes

   ☐ No → **If No, [implement skip]**

The questions in this survey will refer to the provider named in Question 1 as "this provider and team." Please think of this provider and team as you answer the survey.

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[1] This is an abbreviated version of the beta field test data collection instrument, created for the public comment process. This version includes the items essential to the proposed quality measures. The version of the instrument used in the beta field test includes additional questions for analytic purposes; item numbers do not align across instrument versions.

YOUR CARE FROM THIS PROVIDER AND TEAM IN THE LAST 6 MONTHS

The following questions ask about the care you have received from this provider and team in the last 6 months.

2. In the last 6 months, have you ever had pain?

- ☐ Yes
- ☐ No → **If No, [implement skip]**

3. In the last 6 months, did you want help from this provider and team for this pain?

- ☐ Yes
- ☐ No → **If No, [implement skip]**

4. In the last 6 months, did you get as much help as you wanted for your pain from this provider and team?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

YOUR OVERALL EXPERIENCE WITH THIS PROVIDER AND TEAM

5. Thinking about your overall experience with this provider and team in the last 6 months, how true are the following statements?

I felt heard and understood by this provider and team.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

6. I trusted this provider and team.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

7. I felt comfortable asking this provider and team questions.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

8. I could tell this provider and team anything, even things I might not tell anyone else.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

9. I felt this provider and team put my best interests first when making recommendations about my care.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

10. I felt this provider and team always told me the truth about my health, even if there was bad news.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

11. I felt this provider and team saw me as a person, not just someone with a medical problem.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

12. I felt this provider and team knew what worried me most about my health.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

13. I felt this provider and team understood what is important to me in my life.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

14. I felt this provider and team would know what I would want done if I was unconscious or in a coma.

- ☐ Completely true
- ☐ Very true
- ☐ Somewhat true
- ☐ A little bit true
- ☐ Not at all true

ABOUT YOU (THE PATIENT)

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

- ☐ 8th grade or less
- ☐ Some high school but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

16. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

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

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

18. What language do you mainly speak at home?

- ☐ English
- ☐ Spanish
- ☐ Some other language (please print): ____________________________________

19. Did someone help you with this survey?

- ☐ Yes
- ☐ No → **If No, please return the completed survey in the pre-paid envelope.**

20. Who helped you complete this survey?

- ☐ Spouse or partner
- ☐ Child
- ☐ Sibling
- ☐ Parent
- ☐ Other family member or friend
- ☐ Paid caregiver
- ☐ Someone else (please print): ____

21. How did that person help you complete the survey? Check all that apply.

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way

22. For what reason did someone help you complete this survey? Check all that apply.

- ☐ Too sick
- ☐ Trouble with memory
- ☐ Trouble seeing or reading
- ☐ Hard of hearing
- ☐ Do not understand English
- ☐ Wanted someone else to complete the survey
- ☐ Patient is in a coma
- ☐ Patient has passed away
- ☐ Some other reason (please print): ________________________________

23. How familiar is the person who helped you complete the survey with your condition and care?

- ☐ Completely
- ☐ Very
- ☐ Somewhat
- ☐ A little
- ☐ Not at all

24. How often does the person who helped you complete the survey also help you make decisions about your medical treatment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

25. Does the person who helped you complete this survey also provide or help you with any of the following? Check all that apply.

- ☐ Companionship (talking, reading, keeping company) or supervision
- ☐ Transportation (driving to doctor appointment, driving for errands)
- ☐ Homemaking (shopping, cleaning, preparing meals)
- ☐ Personal care assistance (feeding, bathing, toileting, dressing, grooming)
- ☐ Healthcare assistance (help with medications, wound care)
- ☐ Financial assistance (paying bills, managing budget)
- ☐ Other activities (please print): ____

Thank you for completing this survey.

Please return the completed survey in the provided pre-paid envelope.