Appendix P

Mail Survey Materials (English)

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Hospice Survey

Please answer the survey questions about the care the patient listed on the survey cover letter received from this hospice:

[NAME OF HOSPICE]

All of the questions in this survey will ask about experiences with this hospice.

If you want to know more about this survey, please call [TOLL FREE NUMBER]. All calls to this number are free.

OMB # 0938-1257
Expires November 30, 2027

Who Should Fill Out the Survey?

- The person in your household who knows the most about the hospice care received by the patient listed on the survey cover letter.

How to Fill Out the Survey

- Please use a dark colored pen.
- Please put an X inside the square by your answer, like this:

  ☐ Yes
  ☒ No

- At times you will be asked to skip some questions. When this happens you will see an arrow with a note that tells you where to go next, like this:

  ☒ Yes ➔ ***If Yes, Go to Question 1***
  ☐ No

You may notice a number on the survey. This number is used to let us know if you returned your survey so we do not have to send you reminders.

The Hospice Patient

1. How are you related to the patient listed on the survey cover letter?

- [1] ☐ My spouse or partner
- [2] ☐ My parent
- [3] ☐ My mother-in-law or father-in-law
- [4] ☐ My grandparent
- [5] ☐ My aunt or uncle
- [6] ☐ My sister or brother
- [7] ☐ My child
- [8] ☐ My friend
- [9] ☐ Other (please print): _____

2. For this survey, the phrase "family member" refers to the patient listed on the survey cover letter.

In what locations did your family member receive care from this hospice? Please choose one or more.

- [1] ☐ Home
- [2] ☐ Assisted living facility
- [3] ☐ Nursing home
- [4] ☐ Hospital
- [5] ☐ Hospice facility/hospice house
- [6] ☐ Other (please print): _____

Your Role

3. While your family member was in hospice care, how often did you take part in or oversee care for them?

- [1] ☐ Never ➔ **If Never, go to Question 32**
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

Your Family Member's Hospice Care

For the rest of the questions, please think only about your family member's experience with the hospice listed on the survey cover.

4. For this survey, the <u>hospice team</u> means all the nurses, doctors, social workers, chaplains and others who gave hospice care to your family member.

While your family member was in hospice care, did you need to contact anyone on the hospice team during evenings, weekends, or holidays for questions or help?

- [1] ☐ Yes
- [2] ☐ No ➔ **If No, go to Question 6**

5. How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?

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

6. How often did the hospice team let you know when they would arrive to care for your family member?

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

7. When you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?

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

8. How often did the hospice team explain things in a way that was easy to understand?

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

9. How often did the hospice team keep you informed about your family member's condition?

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

10. How often did the hospice team treat your family member with dignity and respect?

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

11. How often did you feel that the hospice team really cared about your family member?

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

12. Did the hospice team provide care that respected your family member's wishes?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

13. Did the hospice team make an effort to listen to the things that mattered most to you or your family member?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

14. Did you talk with the hospice team about any problems with your family member's hospice care?

1☐ Yes
2☐ No ➔ **If No, go to Question 16**

15. How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?

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

16. While your family member was in hospice care, did they have any pain?

1☐ Yes
2☐ No ➔ **If No, go to Question 18**

17. Did your family member get as much help with pain as they needed?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

18. While your family member was in hospice care, did they ever have trouble breathing or receive treatment for trouble breathing?

1☐ Yes
2☐ No ➔ **If No, go to Question 20**

19. How often did your family member get the help they needed for trouble breathing?

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

20. While your family member was in hospice care, did they ever have trouble with constipation?

1☐ Yes
2☐ No ➔ **If No, go to Question 22**

21. How often did your family member get the help they needed for trouble with constipation?

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

22. While your family member was in hospice care, did they show any feelings of anxiety or sadness?

1☐ Yes
2☐ No ➔ **If No, go to Question 24**

23. How often did your family member get the help they needed <u>from the hospice team</u> for feelings of anxiety or sadness?

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

Your Own Experience with Hospice

24. Hospice teams may teach you how to care for family members who need pain medicine, have trouble breathing, are restless or agitated, or have other care needs.

Did the hospice team teach you how to care for your family member?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No
4☐ I did not need this teaching

25. While your family member was in hospice care, how often did the hospice team listen carefully to you?

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

26. Did the hospice team give you as much information as you wanted about what to expect while your family member was dying?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

27. Support for religious, spiritual, or cultural beliefs may include talking, praying, quiet time, or respecting traditions.

While your family member was in hospice care, how much support for your religious, spiritual, or cultural beliefs did you get from the hospice team?

1☐ Too little
2☐ Right amount
3☐ Too much

28. While your family member was in hospice care, how much <u>emotional</u> support did you get from the hospice team?

1☐ Too little
2☐ Right amount
3☐ Too much

29. In the weeks <u>after</u> your family member died, how much emotional support did you get from the hospice team?

1☐ Too little
2☐ Right amount
3☐ Too much

Overall Rating of Hospice Care

30. Please answer the following questions about the hospice named on the survey cover. Do not include care from other hospices in your answers.

Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care?

0☐ 0 Worst hospice care possible
1☐ 1
2☐ 2
3☐ 3
4☐ 4
5☐ 5
6☐ 6
7☐ 7
8☐ 8
9☐ 9
10☐ 10 Best hospice care possible

31. Would you recommend this hospice to your friends and family?

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

About Your Family Member

32. What is the highest grade or level of school that <u>your family member</u> 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
- 7 ☐ Don't know

33. Was <u>your family member</u> of Hispanic, Latino, or Spanish origin or descent?

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

34. What was <u>your family member's</u> race? Please choose one or more.

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

About You

35. What is your age?

- 1 ☐ 18 to 24
- 2 ☐ 25 to 34
- 3 ☐ 35 to 44
- 4 ☐ 45 to 54
- 5 ☐ 55 to 64
- 6 ☐ 65 to 74
- 7 ☐ 75 to 84
- 8 ☐ 85 or older

36. Are you male or female?

- 1 ☐ Male
- 2 ☐ Female

37. 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

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

- 1 ☐ English
- 2 ☐ Spanish
- 3 ☐ Chinese
- 4 ☐ Russian
- 5 ☐ Portuguese
- 6 ☐ Vietnamese
- 7 ☐ Polish
- 8 ☐ Korean
- 9 ☐ Some other language (please print):

_____

THANK YOU

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

COMPANY
Attn: NAME
STREET
CITY, STATE ZIP

Hospice Survey

Alternative survey instructions for use with a scannable form that uses bubbles rather than boxes for answer choices.

Please answer the survey questions about the care the patient listed on the survey cover letter received from this hospice:

[NAME OF HOSPICE]

All of the questions in this survey will ask about experiences with this hospice.

If you want to know more about this survey, please call [TOLL FREE NUMBER]. All calls to this number are free.

OMB # 0938-1257
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Who Should Fill Out the Survey?

- The person in your household who knows the most about the hospice care received by the patient listed on the survey cover letter.

How to Fill Out the Survey

- Please use a dark colored pen.
- Answer all the questions by filling in the circle to the left of your answer, like this:
  - ● Yes
- At times you will be asked to skip some questions. When this happens you will see an arrow with a note that tells you where to go next, like this:
  - ● Yes ➔**If Yes, go to Question 1**
  - ○ No

You may notice a number on the survey. This number is used to let us know if you returned your survey so we do not have to send you reminders.

EXAMPLE

The Hospice Patient

1. How are you related to the patient listed on the survey cover letter?

- ○ My spouse or partner
- ○ My parent
- ○ My mother-in-law or father-in-law
- ○ My grandparent
- ○ My aunt or uncle
- ○ My sister or brother
- ○ My child
- ○ My friend
- ○ Other (please print)

  _____

2. For this survey, the phrase "family member" refers to the patient listed on the survey cover letter.

In what locations did your family member receive care from this hospice? Please choose one or more.

- ○ Home
- ○ Assisted living facility
- ○ Nursing home
- ○ Hospital
- ○ Hospice facility/hospice house
- ○ Other (please print)

  _____

Your Role

3. While your family member was in hospice care, how often did you take part in or oversee care for them?

- ○ Never ➔ **If Never, go to Question 32**
- ○ Sometimes
- ○ Usually
- ○ Always

Sample Initial Cover Letter for the CAHPS Hospice Survey

[HOSPICE OR VENDOR LETTERHEAD]

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

Dear [SAMPLED CAREGIVER NAME],

We realize this may be a hard time for you, and we're sorry for your recent loss. In this package is an important survey about the care patients get from [HOSPICE NAME]. You're getting this survey because you helped care for [DECEDENT NAME].

Please take a few moments to tell us how [HOSPICE NAME] cared for your loved one. Medicare uses your responses to this survey to improve hospice care and help others select a hospice.

We'd greatly appreciate your help with this survey. Please return your response in the enclosed pre-paid envelope. Your answers may be shared with the hospice for purposes of quality improvement. Your participation in this survey is voluntary.

For questions about the survey, please call [VENDOR NAME] toll-free at [TOLL FREE PHONE NUMBER]. If you'd like to see how your responses will be used, hospice ratings are posted online on Medicare's Care Compare website.

Again, we are very sorry for your loss.

Sincerely,

[HOSPICE ADMINISTRATOR]
[HOSPICE NAME]

Sample Follow-up Cover Letter for the CAHPS Hospice Survey

[HOSPICE OR VENDOR LETTERHEAD]

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

Dear [SAMPLED CAREGIVER NAME],

We realize this may be a hard time for you, and we're sorry for your recent loss. A few weeks ago, we sent you a survey asking for feedback about your experiences with [HOSPICE NAME]. **This is a friendly reminder that we're very interested in hearing from you.** We hope you'll help us learn how [HOSPICE NAME] cared for your loved one.

Your feedback helps improve hospice care and also helps others when selecting a hospice.

We are sending you the survey because you helped care for [DECEDENT NAME]. If you already returned the survey to us, thank you, and please disregard this letter.

We'd greatly appreciate your help with this survey. Please return your response in the enclosed pre-paid envelope. Your answers may be shared with the hospice for purposes of quality improvement. Your participation in this survey is voluntary.

For questions about the survey, please call [VENDOR NAME] toll-free at [TOLL FREE PHONE NUMBER]. If you'd like to see how your responses will be used, hospice ratings are posted online on Medicare's Care Compare website.

Thank you for taking the time to improve hospice care. Again, we are very sorry for your loss.

Sincerely,

[HOSPICE ADMINISTRATOR]
[HOSPICE NAME]

Reply-by Date (Optional)
The following two options are available for adding a reply-by date to the ***follow-up cover letter****.*

Placed above the salutation, such as:
Please reply by: [DATE (mm/dd/yyyy)].

In the second paragraph after the sentence, "If you already returned the survey to us, thank you, and please disregard this letter." An example of allowable reply-by text includes:
Please fill out the enclosed survey and mail it by [DATE (mm/dd/yyyy)] in the pre-paid envelope.

OMB Paperwork Reduction Act Language

The OMB Paperwork Reduction Act language must appear in the mailing, either on the cover letter or on the front or back of the questionnaire. In addition, the OMB control number must appear on the front page of the questionnaire. 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 0938-1257 (Expires November 30, 2027). The time required to complete this information collection is estimated to average 9 minutes for questions 1 – 31, the "About Your Family Member" questions and the "About You" questions 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."