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2007 Hospital Patient Satisfaction Survey

Dear Member,

You have been selected from the membership of your BlueCross BlueShield of Illinois (BCBSIL) health plan to participate in our Hospital Patient Satisfaction Survey.

Your participation in this survey is very valuable to us. Responses will be used to help us identify areas of opportunity regarding service and patient care provided to our members. Your response will not impact your benefits. **Your individual responses will not be reported.** All results will be reported at an overall level by hospital. Please return the completed survey in the enclosed postage paid envelope within 5 business days of receipt.

Please note: If this survey is addressed to a person who is unable to complete the survey, such as a child or person too ill to respond, we ask that you fill out the survey with or for this person, indicating "Relative" or "Other" in the appropriate space provided at the beginning of the survey.

If you have any questions or concerns regarding this survey, please contact the Blue Cross and Blue Shield of Illinois Quality Improvement Department at (312) 653-3465.

Thank you in advance for your time.

Sincerely,
Blue Cross and Blue Shield of Illinois
Quality Improvement Department

We are particularly interested in your experience regarding your stay in the hospital listed below:

Discharge Date **Hospital Name**

Who is completing this survey? ☐ Patient ☐ Relative ☐ Other

HOSPITAL STAY

	Excellent	Very Good	Good	Fair	Poor
1. Please rate the following:					
a. Your involvement with decision making about your care	☐	☐	☐	☐	☐
b. Education that you were given about your medical condition	☐	☐	☐	☐	☐
2. How would you rate the communication between you and your physician(s)?	☐	☐	☐	☐	☐
3. How would you rate the communication between you and the nursing staff?	☐	☐	☐	☐	☐
4. How would you rate the skill of the nursing staff?	☐	☐	☐	☐	☐

MEDICATIONS

5. Did you receive any medication(s) while in the hospital? ☐ Yes ☐ No (If No, Skip to Question 6)

- Did doctors, nurses or other hospital staff ask if you were allergic to any medicine? ☐ Yes ☐ No

	Excellent	Very Good	Good	Fair	Poor
• If yes, please rate the education you received about the medication(s).	☐	☐	☐	☐	☐

	Always	Usually	Sometimes	Rarely	Never
• How frequently did the hospital staff verify your identity (for example: look at your wristband, ask you for your name, etc.) before giving you medication?	☐	☐	☐	☐	☐

6. Did you receive any pain medication(s)? ☐ Yes ☐ No (If No, Skip to Question 7)

- If yes, were your expectations for pain control met? ☐ Yes ☐ No

Please complete both sides of this survey. Thank you.

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DIAGNOSTIC TESTING/SURGICAL PROCEDURES

7. Did you have any diagnostic tests, such as an x-ray, blood test, or treadmill test, during your hospital stay? ☐ Yes ☐ No (If No, Skip to Question 8)

- If yes, please rate the explanation that you received about what would happen during your tests. Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐
- How frequently did the hospital staff verify your identity before drawing blood or doing other tests (for example: look at your wristband, ask for your name, ask for your date of birth, etc.)? Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐

8. Did you have a surgical procedure performed while in the hospital? ☐ Yes ☐ No (If No, Skip to Question 9)

   a. If yes, please rate the education you received about the purpose and risks of your surgery. Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

   b. Did the doctor or other health care staff explain the risks, benefits and alternatives of the procedure to you? ☐ Yes ☐ No (If No, Skip to Question 9)

   - If yes, were you asked to summarize in your own words what was explained to you? ☐ Yes ☐ No ☐ Not Sure ☐ Does Not Apply
   - Were any audiovisual aids (for example: books, brochures, videos, computer, audio tapes, etc.) used to explain the procedure to you? ☐ Yes ☐ No ☐ Not Sure ☐ Does Not Apply

9. Were there any delays in having diagnostic tests or procedures during your hospital stay? ☐ Yes ☐ No (If No, Skip to Question 10)

- If yes, did this delay lengthen your hospital stay by one day or longer? ☐ Yes ☐ No

DISCHARGE PLANNING

10. Before you left the hospital, were you given:

   a. A complete list of medications? ☐ Yes ☐ No

   b. Information about any new medications prescribed? ☐ Yes ☐ No ☐ Does Not Apply

   c. Instructions for a follow-up visit with your physician? ☐ Yes ☐ No

   d. Written instructions for care after discharge? ☐ Yes ☐ No (If No, Skip to Question 11, below)
   If yes:

   - Rate your understanding of the written instructions. Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐
   - After you left the hospital, were the instructions clear enough to follow? ☐ Yes ☐ No

11. Were you discharged from the hospital on a special diet (fluid restriction, diabetic, low sodium, etc)? ☐ Yes ☐ No (If No, Skip to Question 12, below)

- If yes, was the diet explained to you in a way that you could understand? ☐ Yes ☐ No

ADVICE TO QUIT SMOKING

12. Do you smoke every day, some days, or not at all? Every day ☐ Some days ☐ Not at all ☐

13. During this hospital admission were you advised to quit smoking by a doctor or other health provider? ☐ Yes ☐ No

OVERALL

14. Overall, how would you rate the quality of care you received in the hospital during your stay? Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

15. Would you return to this hospital for care in the future? Definitely Yes ☐ Probably Yes ☐ Probably Not ☐ Definitely Not ☐

16. How likely would you be to recommend this hospital to a friend or relative? Definitely recommend ☐ Probably recommend ☐ Probably not recommend ☐ Definitely not recommend ☐

Thank you for taking the time to complete this survey.

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