

# **Home Health Care CAHPS® Survey**

## **Protocols and Guidelines Manual**

**Version 17.0**

**January 2025**



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## COMMUNICATIONS AND TECHNICAL SUPPORT FOR THE HOME HEALTH CARE CAHPS SURVEY

Home health agencies and survey vendors may use the following resources to obtain information or technical support with any aspect of the Home Health Care CAHPS (HHCAHPS) Survey.

- For general information, important news, updates, and all materials to support implementation of the HHCAHPS Survey:

<https://homehealthcahps.org>

- For technical assistance, contact the HHCAHPS Survey Coordination Team as noted below.

By e-mail: [hcahps@rti.org](mailto:hcahps@rti.org)

By telephone: (866) 354-0985

- Home health agencies (HHAs) and HHCAHPS Survey vendors must provide the HHA's name and six-digit CMS Certification Number (CCN) when contacting the HHCAHPS Survey Coordination Team by e-mail or telephone for technical assistance.

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## LIST OF ABBREVIATIONS AND ACRONYMS

### HOME HEALTH CARE CAHPS SURVEY PROTOCOLS AND GUIDELINES MANUAL

Abbreviation/ Acronym	Term/Phrase
AAPOR	American Association for Public Opinion Research
ADL	Activities of Daily Living
AHRQ	Agency for Healthcare Research and Quality
APU	Annual Payment Update
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CATI	Computer-assisted telephone interview
CCN	CMS Certification Number (formerly known as the Medicare Provider Number)
CMS	Centers for Medicare & Medicaid Services
DC	Discharge Assessment (OASIS Assessment)
DHHS	Department of Health and Human Services
DNR	Discrepancy Notification Report
DSRS	Disproportionate stratified random sampling
ERF	Exceptions Request Form
ESRD	End-stage renal disease
FAQ	Frequently Asked Questions (a list of frequently asked questions and suggested responses)
FU	Follow-up Assessment (OASIS follow-up assessment)
HHHA	Home health agency
HHCAHPS	Home Health Care CAHPS Survey
HH PPS	Home Health Prospective Payment System
HMO	Health Maintenance Organization
HIPAA	Health Insurance Portability and Accountability Act
ICD-10	International Classification of Diseases, 10th Revision
IRB	Institutional Review Board
MA	Medicare Advantage
MRN	Medical Record Number or Medicare Remittance Notice
NCOA	National Change of Address
NPI	National Provider ID Number
NQF	National Quality Forum
OASIS	Outcome and Assessment Information Set
OMB	Office of Management and Budget
PDC	Provider Data Catalog
PER	Participation Exemption Request

<b>Abbreviation/ Acronym</b>	<b>Term/Phrase</b>
PHI	Protected health information
PII	Personally identifiable information
PSRS	Proportionate stratified random sampling
QAP	Quality Assurance Plan
RAT-STATS	Regional Advanced Techniques Staff Statistics Program
ROC	Resumption of Care (OASIS Assessment)
SAS	Statistical Analysis System
SID	Sample identification (number)
SOC	Start of Care (OASIS Assessment)
SRS	Simple random sampling
XML	Extensible Markup Language

# HOME HEALTH CARE CAHPS SURVEY PROTOCOLS AND GUIDELINES MANUAL TABLE OF CONTENTS

<b><i>Communications and Technical Support for the Home Health Care CAHPS Survey</i></b>	<b><i>i</i></b>
<b><i>List of Abbreviations and Acronyms Home Health Care CAHPS Survey Protocols and Guidelines Manual</i></b>	<b><i>iii</i></b>
<b><i>I. Overview of the Contents of the Protocol and Guidelines Manual</i></b>	<b><i>1</i></b>
Overview	1
Section-by-Section Contents of the <i>Home Health Care CAHPS Survey Protocols and Guidelines Manual</i>	1
<b><i>II. Introduction and Background</i></b>	<b><i>5</i></b>
Overview of CAHPS Survey	5
The HHCAHPS Quality Initiative	5
Development of the HHCAHPS Survey	5
Mode Experiment	6
National Quality Forum Review	7
Office of Management and Budget and Public Comment Process	7
HHCAHPS Survey Instrument	7
HHCAHPS Survey Data Collection and Public Reporting	8
Sources of Information About the HHCAHPS Survey	9
<b><i>III. Home Health Care CAHPS Survey Participation Requirements</i></b>	<b><i>13</i></b>
Overview	13
Roles and Responsibilities	13
Survey Vendor Participation Requirements	19
Survey Vendor Eligibility and Minimum Business Requirements	20
<b><i>IV. Home Health Care CAHPS Survey Sampling Procedures</i></b>	<b><i>31</i></b>
Overview	31
Documenting Sampling Processes for Vendor Oversight	31
Step 1: Obtain a Monthly Patient Information File From Each Home Health Agency Client	32
Step 2: Examine the Monthly Patient Information File for Completeness	41
Step 3: Identify Eligible Patients and Construct a Sampling Frame	42
Step 4: Determine a Sampling Rate and Select a Sample for Each HHA	42
Step 5: Verify or Update Sample Contact Information	50
Step 6: Assign Unique Sample Identification Numbers	51
Step 7: Finalize the Monthly Sample File and Initiate Data Collection Activities	52
Sampling Issues for Quality Assurance	52

# HOME HEALTH CARE CAHPS SURVEY PROTOCOLS AND GUIDELINES MANUAL TABLE OF CONTENTS

<b><i>V. Mail-Only Administration Procedures</i></b>	<b>59</b>
Overview	59
Data Collection Schedule	59
Production of Questionnaires, Letters, and Envelopes	60
Survey Mailing Requirements	65
Data Receipt and Data Entry Requirements	67
Staff Training	69
Mail-Only Quality Control Guidelines	70
<b><i>VI. Telephone-Only Administration Procedures</i></b>	<b>73</b>
Overview	73
Data Collection Schedule	73
Telephone Instrument and Systems Requirements	74
Telephone Interviewing Requirements	77
Telephone Interviewer Training	81
Distressed Respondent Procedures	82
Telephone Data Processing Procedures	83
Telephone-Only Quality Control Guidelines	83
<b><i>VII. Mail with Telephone Follow-Up (Mixed-Mode) Survey Administration Procedures</i></b>	<b>87</b>
Overview	87
Data Collection Schedule	87
Production of Questionnaires, Letters, and Envelopes	88
Survey Mailing Requirements	93
Data Receipt and Data Entry Requirements	95
Staff Training	97
Telephone Instrument and Systems Requirements	98
Telephone Interviewing Requirements	101
Telephone Interviewer Training	105
Distressed Respondent Procedures	106
Telephone Data Processing Procedures	107
Mixed-Mode Quality Control Guidelines	107
<b><i>VIII. Confidentiality and Data Security</i></b>	<b>111</b>
Overview	111
Safeguarding Patient Data	111
Obtain Confidentiality Agreements	113
Ensure Electronic and Physical Data Security	113
Provide HHCAHPS Response Data to Client HHAs	114



**HOME HEALTH CARE CAHPS SURVEY  
PROTOCOLS AND GUIDELINES MANUAL  
TABLE OF CONTENTS**

<b><i>IX. Data Processing and Coding</i></b>	<b><i>117</i></b>
Overview	117
Data Processing Decision Rules and Coding Guidelines	117
Survey Disposition Codes	121
Handling Blank Questionnaires	125
Coding Proxy Surveys and Interviews	125
Definition of a Completed Survey	126
Computing the Response Rate	127
Quality Control Guidelines	127
<b><i>X. Website and File Submissions</i></b>	<b><i>131</i></b>
Overview	131
The HHCAHPS Survey Website	131
HHA Survey Vendor Authorization	136
Submitting HHCAHPS Survey XML Data Files to the Data Center	138
XML Data File Specifications for Data Submissions	139
XML Survey Data File Submission Procedures	147
Data Submission Quality Control Guidelines	149
<b><i>XI. Home Health Care CAHPS Survey Website Reports</i></b>	<b><i>153</i></b>
Overview	153
Reports for Survey Vendors	153
Reports for Home Health Agencies	155
<b><i>XII. Oversight Activities</i></b>	<b><i>157</i></b>
Overview	157
Quality Assurance Plan	157
Data Review	158
Communication Between Survey Vendors and the Coordination Team	159
Site Visits to Survey Vendors	159
Corrective Action Plans	161
<b><i>XIII. Public Reporting</i></b>	<b><i>163</i></b>
Overview	163
Measures That Are Reported	163
Adjustment and Reporting of Results	164
Star Ratings	165
Agency Preview Reports	165
Public Reporting Periods	165

**HOME HEALTH CARE CAHPS SURVEY  
PROTOCOLS AND GUIDELINES MANUAL  
TABLE OF CONTENTS**

<b><i>XIV. Exceptions Request Process and Discrepancy Notification Report</i></b>	<b><i>167</i></b>
Overview	167
Exceptions Request Process	167
Discrepancy Notification Report	169

**HOME HEALTH CARE CAHPS SURVEY  
PROTOCOLS AND GUIDELINES MANUAL  
TABLE OF CONTENTS**

*Appendix A: Vendor Application Form*

*Appendix B: Sample File Layout—Home Health Care CAHPS Survey*

*Appendix C: English: Mail Survey Cover Letters, Regular and Scannable  
Questionnaires, Telephone Interview Script, Proxy Interview Script*

*Appendix D: Spanish: Mail Survey Cover Letters, Regular and Scannable  
Questionnaires, Telephone Interview Script, Proxy Interview Script*

*Appendix E: Chinese—Simplified: Mail Survey Cover Letters, Regular and  
Scannable Questionnaires*

*Appendix F: Chinese—Traditional: Mail Survey Cover Letters, Regular and  
Scannable Questionnaires*

*Appendix G: Russian: Mail Survey Cover Letters, Regular and Scannable  
Questionnaires, Telephone Interview Script, Proxy Interview Script*

*Appendix H: Vietnamese: Mail Survey Cover Letters, Regular and Scannable  
Questionnaires, Telephone Interview Script, Proxy Interview Script*

*Appendix I: Armenian: Mail Survey Cover Letters, Regular and Scannable  
Questionnaires*

*Appendix J: OMB Paperwork Reduction Act Language in English, Spanish,  
Chinese, Russian, Vietnamese, and Armenian Languages*

*Appendix K: Supplemental Questions in English, Spanish, Chinese, Russian,  
Vietnamese, and Armenian Languages*

*Appendix L: FAQs for Telephone Interviewers*

*Appendix M: General Guidelines for Telephone Interviewers*

*Appendix N: XML Data File Layout for Standard Header Record*

*Appendix O: XML Data File Layout for Disproportionate Stratified Random  
Sampling*

*Appendix P: Model Quality Assurance Plan*

*Appendix Q: Exceptions Request Form*

*Appendix R: Discrepancy Notification Report*

# HOME HEALTH CARE CAHPS SURVEY PROTOCOLS AND GUIDELINES MANUAL TABLE OF CONTENTS

## ***Exhibits***

9.1	When to Assign the Proxy Flag	126
9.2	Steps for Determining Whether a Questionnaire Meets Completeness Criteria	126
9.3	How Response Rates Are Calculated	127
10.1	HHCAHPS Survey Website Navigation Menu	131
10.2	Quick Links on the HHCAHPS Survey Website	133
10.3	Links Under the HHCAHPS Survey Site Navigation Menu	134
10.4	Payer Source Data Elements	144
10.5	Link to Data Submission Tool	148

## ***Tables***

3.1	Minimum Business Requirements for HHCAHPS Survey Vendors	21
4.1	Information Needed From HHAs for Each Medicare or Medicaid Patient Served During Sample Month	35
4.2	Response Rates Obtained by Mode During the HHCAHPS 2025 Annual Payment Update Participation Period	44
4.3	Sampling Common Misconceptions and Problems with Proper Implementation	53
5.1	Mail-Only Administration Schedule and Protocol	59
6.1	Prescribed Order of Activities and Timing for an All-Telephone HHCAHPS Survey	73
7.1	Tasks and Schedule of Activities for Mail With Telephone Follow-Up	87
9.1	HHCAHPS Survey Disposition Codes	122
9.2	Handling Blank Mail Survey Questionnaires	125
13.1	Crosswalk of Composite Measures and Global Ratings to Medicare’s Care Compare Website Text	164
13.2	Public Reporting for the Home Health Care CAHPS Survey	166

# **I. OVERVIEW OF THE CONTENTS** **OF THE PROTOCOL AND GUIDELINES MANUAL**

## **Overview**

The *Home Health Care CAHPS Survey Protocols and Guidelines Manual* has been developed by the Centers for Medicare & Medicaid Services (CMS) to provide guidance and standard protocols for conducting the Home Health Care CAHPS<sup>®1</sup> Survey. The Home Health Care CAHPS Survey, also referred to as HHCAHPS, is part of a family of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instruments developed by the Agency for Healthcare Research and Quality (AHRQ) in conjunction with CMS. This section provides survey vendors and home health agencies (HHAs) with a top-level view of the contents of this manual. Each section is briefly described below, along with an explanation of the contents of the appendices.

## **Section-by-Section Contents of the *Home Health Care CAHPS Survey Protocols and Guidelines Manual***

### **Introduction and Overview**

*Chapter II* provides information about the purpose of the HHCAHPS Survey and history of the HHCAHPS Survey initiative, including a discussion of the instrument development, field test and mode experiment activities. It also includes information about the public reporting timeline and sources for more information about the HHCAHPS Survey.

### **HHCAHPS Survey Participation Requirements**

*Chapter III* describes the roles and responsibilities of CMS, the HHCAHPS Survey Coordination Team, HHAs, and approved survey vendors on the national implementation of the HHCAHPS Survey. It also includes information on the vendor rules of participation and business requirements for becoming an approved survey vendor. Information about how to communicate with and obtain technical assistance from the HHCAHPS Survey Coordination Team is also provided in this chapter.

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<sup>1</sup> CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. Government agency.

## Sampling Procedures

Information on the sampling process, requirements for developing the sample frame, and selection of a sample of patients for the HHCAHPS Survey is provided in *Chapter IV*.

## Mail-Only Administration Procedures

*Chapter V* contains the protocols and guidelines for administering the HHCAHPS Survey as a *mail-only* survey. The data collection schedule, production and mailing requirements, data receipt and processing requirements, and quality control and data storage guidelines associated with conducting a mail-only mode survey are covered in detail.

## Telephone-Only Administration Procedures

Procedures and guidelines for administering the HHCAHPS Survey as a *telephone-only* survey are provided in *Chapter VI*. The data collection schedule, the electronic data collection and tracking system requirements, telephone interviewing requirements, and quality control and data storage guidelines associated with conducting a telephone-only mode survey are covered in detail.

## Mixed-Mode Administration Procedures

*Chapter VII* contains the protocols and guidelines for administering the HHCAHPS Survey as a *mixed-mode* survey—that is, mail survey with telephone follow-up of nonrespondents. The data collection schedule, production and mailing requirements, electronic data collection and tracking system requirements, telephone interviewing requirements, data receipt and processing requirements, and quality control and data storage guidelines for conducting a mixed-mode survey are covered in detail.

## Confidentiality and Data Security

*Chapter VIII describes* the requirements and guidelines for protecting the identity of sample members included in the survey sample, safeguarding confidentiality of respondent data, and ensuring data security.

## Data Processing and Coding

Data processing procedures, including the assignment of a unique sample identification number to each sampled case, decision rules for assigning survey disposition codes, and the definition of a completed survey are described in *Chapter IX*.

## Website and File Submissions

*Chapter X* provides an overview of the purpose and functions of the HHCAHPS Survey website and a summary description of how to prepare and submit data files following HHCAHPS Survey data file preparation and submission guidelines. More detailed information about the HHCAHPS

Survey website and the data submission process, including screenshots of the data submission tool and instructions for data submission, is included in the *Home Health Care CAHPS Survey Website User and Data Submission Manual, Version 13.0*.

## **HHCAHPS Survey Website Reports**

*Chapter XI* provides an overview of the reports available to vendors and HHAs through the HHCAHPS Survey website. The reports are described briefly, with an emphasis on the intended audience for each report and how the reports should be used.

## **Oversight Activities**

*Chapter XII* provides information about the quality assurance activities that the HHCAHPS Survey Coordination Team and CMS use to ensure the successful administration of the HHCAHPS Survey by survey vendors. The chapter begins with a discussion of the vendor Quality Assurance Plan and reviews the various activities that the Coordination Team will conduct to ensure compliance with HHCAHPS Survey protocols and guidelines.

## **Public Reporting**

*Chapter XIII* presents an overview of the public reporting of HHCAHPS Survey results, including the information that is publicly reported.

## **Exceptions Request Process and Discrepancy Notification Report**

*Chapter XIV* describes the process to be used to request an exception to the HHCAHPS Survey protocols, including guidelines for submitting an online Exceptions Request Form. This section also covers the process for alerting the HHCAHPS Survey Coordination Team of an unplanned discrepancy in data collection procedures, including guidelines for submitting an online Discrepancy Notification Report.

## **Appendices**

The appendices contain copies of the HHCAHPS Survey questionnaire, mail survey cover letters, the required Office of Management and Budget disclosure language, and the HHCAHPS Survey supplemental questions—in English, Spanish, Simplified and Traditional Chinese, Russian, Vietnamese, and Armenian. Telephone interview scripts are provided in all of the aforementioned languages except Chinese and Armenian. Also included are general guidelines for telephone interviewer training and monitoring, a list of frequently asked questions and answers for telephone interviewers, XML data file layout and data file specifications, the Vendor Application Form, and the Exceptions Request and Discrepancy Notification Forms.

**The *HHCAHPS Survey Protocols and Guidelines Manual***

An electronic file of the *HHCAHPS Survey Protocols and Guidelines Manual* and its appendices are provided on the project website at <https://homehealthcahps.org> in both Microsoft Word and .pdf formats.



## **II. INTRODUCTION AND BACKGROUND**

### **Overview of CAHPS Survey**

The Centers for Medicare & Medicaid Services (CMS) has partnered with the Agency for Healthcare Research and Quality (AHRQ), another agency within the United States Department of Health and Human Services, to develop surveys measuring patient perspectives of care. Beginning in 1995 as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) initiative, AHRQ and its CAHPS grantees began to develop survey and reporting products focusing on health plans. Since 1995, the initiative has expanded to cover a range of surveys of health care services at multiple levels of the delivery system, including patients receiving care from both ambulatory and institutional settings. The intent of the CAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on patient care. CAHPS is meant to complement the data that providers collect to support improvements in internal customer services and quality-related activities.

### **The HHCAHPS Quality Initiative**

In November 2002, the Quality Initiative was launched to ensure quality health care for all Americans through accountability and public disclosure. The initiative aims to (a) empower consumers with quality-of-care information to help them make more informed decisions about their health care, and (b) stimulate and support providers and clinicians to improve the quality of health care. The Quality Initiative was launched nationally in November 2002 for nursing homes (the Nursing Home Quality Initiative) and expanded in 2003 to the nation's home health care agencies (the Home Health Quality Initiative) and hospitals (the Hospital Quality Initiative).<sup>2</sup> Consumers can view the home health measures on Medicare's Care Compare website at [www.medicare.gov/care-compare/](http://www.medicare.gov/care-compare/).

### **Development of the HHCAHPS Survey**

In addition to providing information about clinical measures to consumers and to the public, the Home Health Quality Initiative seeks to provide information to consumers about patients' perception of the care they receive from Medicare-certified home health agencies (HHAs). To

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<sup>2</sup> Centers for Medicare & Medicaid Services. *Home Health Care Quality Initiative Overview*. Baltimore, MD. March 21, 2003. Available online at <https://www.cms.hhs.gov/HomeHealthQualityInits/>.

that end, CMS partnered with AHRQ to develop a standard instrument, called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, or the HHCAHPS Survey. On September 25, 2006, AHRQ published a call for measures in the *Federal Register* and initiated an exhaustive review of existing literature in the area. AHRQ developed a draft of the HHCAHPS Survey to measure the experiences of those receiving home health care with the following three goals in mind:

- To produce comparable data on patients' perspectives on care that allow objective and meaningful comparisons between HHAs on domains that are important to consumers;
- To create incentives for agencies to improve their quality of care through public reporting of survey results; and
- To enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment.

AHRQ conducted several rounds of cognitive testing with a sample of home health patients in 2007. In 2008, AHRQ conducted a field test with a sample of current and recently discharged patients from 34 HHAs to test the psychometric properties of the survey and to finalize its contents. The final HHCAHPS Survey questionnaire includes the two types of questions contained on all CAHPS instruments—those dealing with reports of specific experiences and those asking for opinions and ratings.

## Mode Experiment

The primary focus of the HHCAHPS Survey field test was to assess the draft survey instrument. In addition to the field test, CMS conducted a mode experiment in 2009 to test the effect on survey responses of using three data collection modes: mail only, telephone only, and mixed mode (mail with telephone follow-up of nonrespondents). CMS also used data from the mode experiment to determine whether and to what extent characteristics of patients participating in the HHCAHPS Survey statistically affect survey results. Statistical models were developed to adjust or control for these patient characteristics once the survey results were publicly reported. Data from the mode experiment were also analyzed to detect potential nonresponse bias; the results of these analyses determined whether applicable nonresponse statistical adjustments must be made on the HHCAHPS Survey data.

In 2022, CMS conducted another mode experiment, to test a shorter survey instrument and the use of a web-based mode of survey administration. CMS will release results of the 2022 mode experiment, including any proposed updates to the survey instrument content, administration modes and procedures, and mode adjustments, as they become available.

## National Quality Forum Review

CMS submitted the final HHCAHPS Survey instrument to the National Quality Forum (NQF) for review and endorsement in October 2008. The NQF is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. The NQF has broad participation from all parts of the health care system, including national, state, regional, and local groups representing consumers, public and private purchasers, employers, health care professionals, provider organizations, health plans, accrediting bodies, labor unions, supporting industries, and organizations involved in health care research or quality improvement.<sup>3</sup> The HHCAHPS Survey was endorsed by NQF on March 31, 2009, and reendorsed on March 4, 2015. The survey was recommended for reendorsement in September 2019.

## Office of Management and Budget and Public Comment Process

CMS received approval of the HHCAHPS Survey from the United States Office of Management and Budget (OMB) in July 2009. The current OMB renewal approval of HHCAHPS was granted on July 13, 2023, under OMB Control Number 0938-1066. The expiration date for this OMB number is July 31, 2026.

## HHCAHPS Survey Instrument

The HHCAHPS Survey instrument contains 34 items that cover topics such as access to care, communications, and interactions with the agency and with agency staff. There are two global items: one asks the patient to rate the care provided by the HHA, and the second asks the patient about his or her willingness to recommend the HHA to family and friends. The survey also contains items that ask for self-reported health status and basic demographic information (race/ethnicity, education attainment level, language spoken in the home, etc.).

The HHCAHPS Survey is currently available in English, Spanish, Simplified and Traditional Chinese, Russian, Vietnamese, and Armenian. A version is provided for both mail and telephone survey administration in each language except for Chinese and Armenian. The Chinese-language and Armenian-language versions of the instrument can only be administered by mail. HHAs and their survey vendors are not permitted to translate the HHCAHPS Survey into any other languages. However, CMS will provide additional translations of the survey over time. Please check the HHCAHPS Survey website, <https://homehealthcahps.org>, for announcements about additional translations.

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<sup>3</sup> From the National Quality Forum's website at <https://www.qualityforum.org/Home.aspx>, July 2008.

## HHCAHPS Survey Data Collection and Public Reporting

The HHCAHPS Survey is being conducted by multiple survey vendors under contract with Medicare-certified HHAs. Survey vendors interested in administering the HHCAHPS Survey must complete and submit an application, complete HHCAHPS Survey Introductory training, complete a Training Certification Form, complete an electronic consent form, and participate in annual Update Trainings sponsored by CMS. Survey vendors cannot collect and submit data to CMS until they receive approval to conduct the survey.

Starting in October 2009, HHAs were invited to participate voluntarily in the HHCAHPS Survey. The Final Rule for the Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year 2010 published in the *Federal Register* on November 10, 2009 (*Federal Register/Vol. 74, No. 216/Tuesday November 10, 2009/ Pages 58099–58104*) required all Medicare-certified HHAs that served 60 or more patients between April 1, 2009, and March 31, 2010, who met survey eligibility criteria to conduct a dry run of the HHCAHPS Survey for at least 1 month in the third calendar year (CY) quarter (July, August, and September) in 2010, with ongoing monthly participation starting in October 2010. To receive the annual payment update (APU)<sup>4</sup> each year, Medicare-certified HHAs that are not eligible for an exemption must administer the HHCAHPS Survey on an ongoing (monthly) basis beginning with the April sample month.

Medicare-certified HHAs who meet survey eligibility criteria during a specified 12-month period but that serve 59 or fewer patients may request an exemption from participating in the HHCAHPS Survey. These agencies must count the number of patients who meet survey eligibility criteria that they served during each annual specified 12-month period and report the count to CMS by completing a Participation Exemption Request (PER) form available on the HHCAHPS Survey website at <https://homehealthcahps.org>. Public reporting of HHCAHPS Survey results includes four rolling quarters of data, with survey vendors submitting data on behalf of their HHAs for each quarter using the data submission tool function on the HHCAHPS Survey website (<https://homehealthcahps.org>). The data submitted are reviewed, cleaned, scored, and adjusted by the HHCAHPS Survey Coordination Team. Survey results are compiled for each HHA; a “preview” report containing the results is made available to each HHA for review before the results are publicly reported on Medicare’s Care Compare on [www.medicare.gov/care-compare/](http://www.medicare.gov/care-compare/).

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<sup>4</sup> The APU is an annual payment increase adjustment that agencies receive when they have met CMS’s quality reporting requirements.

## Sources of Information About the HHCAHPS Survey

More information about the HHCAHPS Survey and home health care is available at the two websites described below.

### The HHCAHPS Survey Website (<https://homehealthcahps.org>)

The HHCAHPS Survey Coordination Team maintains a website, which is available at <https://homehealthcahps.org> and hereafter in this chapter referred to as the HHCAHPS website or simply as the website. This website provides general information about the HHCAHPS Survey, contains the protocols and materials needed for survey implementation, and is one of the main vehicles for communicating information about the survey to HHAs and survey vendors. The website has both public and private, secure pages.

The public access pages contain the following:

- General information about the HHCAHPS Survey;
- Announcements about updates or changes in the survey protocols or materials and participation requirements;
- Requirements for becoming an HHCAHPS Survey vendor;
- Data collection materials, protocols, and guidelines for administration of the HHCAHPS Survey;
- A list of approved HHCAHPS Survey vendors;
- Quality Assurance Plan requirements;
- Data submission requirements; and
- Information about how to obtain technical assistance.

The *HHCAHPS Survey Protocols and Guidelines Manual* is updated annually to reflect changes to participation requirements and changes in survey protocols, materials, and procedures; however, CMS and the Coordination Team use the HHCAHPS website to disseminate important interim updates and news about the HHCAHPS Survey, including information related to participation requirements, updates and changes to survey protocols or survey materials, information about upcoming events (e.g., data submission deadlines, vendor training), and public reporting. Announcements posted on the HHCAHPS Survey website may clarify or supersede existing protocols.

It is critically important that survey vendors and HHAs check the HHCAHPS Survey website frequently for updates. To view announcements, go to the website at <https://homehealthcahps.org> and view the most recent announcements at the bottom of the home page or access archived announcements by selecting the “Announcements” link under the “General Information” menu. The announcements are listed in chronological order, with the most recent announcement listed first.

The secure or restricted-access sections of the HHCAHPS Survey website are accessible only to HHCAHPS Survey vendors and HHAs that have registered for and been provided credentials to access the links on the private side of the website. After successfully logging in, users will see a personalized Dashboard. The links provided on the private side of the website will enable HHAs to:

- Authorize a survey vendor to submit HHCAHPS Survey data on their behalf, switch vendors, or view the agency’s authorization history;
- View data submission reports for data submitted by their respective survey vendors;
- “Preview” their HHCAHPS Survey results before the results are publicly reported; and
- Grant access to additional HHA users.

Additional secured links on the HHCAHPS Survey website are accessible to survey vendors who have been given access credentials. These private secured links allow survey vendors to:

- View the current list of HHAs that have authorized the vendor to submit data on their behalf;
- Access the HHCAHPS Survey data submission tool and reports containing information about submitted data;
- Notify the HHCAHPS Survey Coordination Team of planned and unplanned deviations from standard protocols via online forms; and
- Submit their Quality Assurance Plan (QAP) for review.

More detailed information about the HHCAHPS Survey website is included in **Chapter XI** of this manual and in the *Home Health Care CAHPS Survey Website User and Data Submissions Manual, Version 13.0* located on the HHCAHPS Survey website, under the Data Submission Resources menu.

### **The Medicare Website** (<https://www.medicare.gov/care-compare/>)

This website is maintained by CMS and contains information on the services Medicare provides. Of particular interest to HHCAHPS Survey users is Medicare’s Care Compare site, which

provides information to the public on various quality measures. Viewers can obtain comparative information about HHAs by state, ZIP code, and county.

This website also displays clinical measures compiled from the Outcome and Assessment Information Set (OASIS) about home health care and the results from the HHCAHPS Survey. HHCAHPS Survey results are based on survey response data from the four quarters for which HHCAHPS Survey data are available and are “refreshed” or updated each calendar year quarter.

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### **III. HOME HEALTH CARE CAHPS SURVEY PARTICIPATION REQUIREMENTS**

#### **Overview**

This chapter describes participation requirements for the Home Health Care CAHPS (HHCAHPS) Survey, including the roles and responsibilities of the Centers for Medicare & Medicaid Services (CMS) and its HHCAHPS Survey Coordination Team, home health agencies (HHAs), and survey vendors that administer the HHCAHPS Survey for HHAs. This chapter also discusses the rules of participation and outlines the business requirements that survey vendors must meet to be approved to administer the HHCAHPS Survey. Information about obtaining technical assistance from the Coordination Team is also provided in this chapter.

#### **Roles and Responsibilities**

CMS is responsible for ensuring that the HHCAHPS Survey is administered using standardized survey protocols and data collection and processing methods. CMS works very closely with its HHCAHPS Survey Coordination Team to provide training, technical assistance, and oversight to approved survey vendors. Technical assistance is also provided to HHAs. HHAs are responsible for contracting with an approved survey vendor to conduct the HHCAHPS Survey on their behalf and for providing a monthly patient information file containing data about patients served. Survey vendors are responsible for conducting the HHCAHPS Survey on behalf of their client HHAs following the standard protocols and guidelines described in this manual.

The roles and responsibilities of each of these participating organizations are described below.

#### **Roles and Responsibilities of CMS and the HHCAHPS Survey Coordination Team**

CMS and the HHCAHPS Survey Coordination Team are responsible for the following activities on the HHCAHPS Survey:

- Disseminate information about HHCAHPS Survey administration;
- Train survey vendors on HHCAHPS Survey protocols and requirements;
- Monitor data integrity of HHCAHPS Survey administration to ensure the quality and comparability of the data;

- Provide technical assistance to HHAs and approved HHCAHPS Survey vendors via a toll-free telephone number and e-mail;
- Conduct oversight and quality assurance of survey vendors;
- Receive and conduct final processing of HHCAHPS Survey data submitted by approved survey vendors;
- Calculate and adjust HHCAHPS Survey data for mode and patient-mix effects prior to publicly reporting survey results; and
- Generate preview reports containing HHCAHPS Survey results for participating HHAs to review prior to public reporting.

### Home Health Agencies' Roles and Responsibilities

It is the responsibility of Medicare-certified HHAs to participate every month in the HHCAHPS Survey to obtain the annual payment update (APU) from CMS. The majority of HHAs are eligible to participate; however, some may be exempted from participation for a given APU period. The only two scenarios under which a Medicare-certified HHA can be exempted from participation in the HHCAHPS Survey are described below:

- If an HHA received Medicare certification from CMS after the cutoff date for a given APU period, it is considered too new to participate in the upcoming APU. This is a one-time exemption only, and HHAs do not need to apply for it. Medicare Certification eligibility cutoff dates and the period that each APU covers are provided in the *Home Health Prospective Payment System (HH PPS) Final Rule* for each calendar year. As of the date of this version of the *Protocols and Guidelines Manual*, the most recently published Rule is the Home Health Prospective Payment System (HH PPS) Final Rule for Calendar Year 2025, which was published in the *Federal Register* on November 7, 2024. A link to the Final Rule is available on the HHCAHPS website.
- If an HHA was certified before the cutoff date specified in the HH PPS Rule, that HHA may only receive an exemption if it served 59 or fewer survey-eligible patients during the 12-month period that the APU covers. To request an exemption, an HHA must submit a Participation Exemption Request (PER) form for that APU period through the HHCAHPS website. HHAs must submit a PER for every APU year that they believe they qualify for and wish to seek an exemption from participating in the HHCAHPS Survey.

Each APU has an associated reference count period and participation period that runs from April of one year to March of the following year. The reference count period (which HHAs should use to determine eligibility for the APU) is the year *prior to* the current APU participation period. More information on participation requirements for the APU is available on the HHCAHPS

website at the following link:

[https://homehealthcahps.org/Portals/0/Docs/HHAResponsibilities\\_and\\_FAQs\\_List.pdf](https://homehealthcahps.org/Portals/0/Docs/HHAResponsibilities_and_FAQs_List.pdf)

If an HHA is eligible to participate, it must:

- Contract with an approved HHCAHPS Survey vendor to conduct its survey;
- Authorize the contracted survey vendor to collect and submit HHCAHPS Survey data to the HHCAHPS Survey Data Center on the agency's behalf;
- Work with its approved vendor to determine a date each month by which the vendor will need the monthly patient information file for sampling and fielding the survey;
- By the agreed-upon date each month, compile and deliver to the survey vendor a complete and accurate list of patients (i.e., the monthly patient information file) and information that will enable the vendor to administer the survey;
- Use a secure method to transmit monthly patient information files to the survey vendor, ensuring that data are **encrypted** prior to sending to the vendor;
- Review data submission reports on the HHCAHPS Survey website to confirm that its survey vendor has submitted data on time;
- Review HHCAHPS Survey results prior to public reporting;
- Avoid influencing patients in any way about how to answer the HHCAHPS Survey; for example, HHAs may not hand out any information to patients about how to answer the survey (please refer to the section in this chapter titled Communications with Patients About the HHCAHPS Survey); and
- Understand the APUs, including key date ranges and deadline dates; again, information about APU periods and Medicare Certification eligibility cutoff dates is provided in the *Home Health Prospective Payment System (HH PPS) Final Rule* for each calendar year.

### **Communications With Patients About the HHCAHPS Survey**

Because home health patients may be sicker and more vulnerable than other patient populations and they receive care from the home health provider in their homes, they may be more susceptible to actions that may influence their responses to the HHCAHPS Survey. Any information or communication about the survey from HHAs may introduce bias to the survey. It is acceptable for HHAs to inform patients during their next scheduled assessment that they may be asked to respond to a patient experience survey as long as all patients are notified in this way. An official HHCAHPS fact sheet is available in English and Spanish on the HHCAHPS website,

for this purpose. The fact sheet is available through a link in the Information for HHAs box on the Home page. A direct link to the fact sheet and guidance for using it is here:

<https://homehealthcahps.org/For-HHAs/HHCAHPS-Fact-Sheet>.

Participating agencies are strongly encouraged to include the HHCAHPS fact sheet in the initial patient information packet so that patients are aware of the survey and its importance, and CMS recommends that HHCAHPS Survey vendors discuss with their client agencies using this fact sheet to help improve patient participation in the survey. Agencies are permitted to personalize the fact sheet with the agency name, vendor's name, agency's logo, and vendor's or CMS logo.

It is **not** acceptable, however, for an HHA to do the following:

- Mail or e-mail information to patients in advance alerting them about the survey, other than the information provided to all patients;
- Provide a copy of the HHCAHPS Survey questionnaire or cover letters to the patients;
- Include words or phrases verbatim from the HHCAHPS Survey in its marketing or promotional materials (CMS is encouraging HHAs not to use text from HHCAHPS questions in their marketing and promotional materials);
- Attempt to influence their patients' answers to the HHCAHPS Survey questions;
- Tell the patients that the agency hopes or expects that its patients will give it the best or highest rating or to respond in a certain way to the survey questions;
- Offer incentives of any kind to the patients for participating (or not) in the survey;
- Help the patient answer the survey questions, even if the patient asks for the home care provider's help;
- Ask patients why they gave a certain response or rating to any of the HHCAHPS Survey questions; and
- Include any messages or materials promoting the HHA or the services it provides in survey materials, including but not limited to mail survey cover letters and questionnaires and telephone interview scripts.

HHAs should never ask their patients if they would like to be included in the survey. All patients selected to participate in the HHCAHPS Survey must be able to decide on their own whether they wish to participate and will be provided an opportunity to do so as part of the survey process.

### ***Administering HHCAHPS in Conjunction With Other Surveys***

Some HHAs may wish to conduct other patient surveys to support internal quality improvement activities. A “survey,” for purposes of this project, is defined as a formal, HHCAHPS-like, patient experience or satisfaction survey. A formal survey, regardless of the data collection mode employed, is one in which the primary goal is to ask standardized questions of a sample of the HHA’s patient population. Contacting patients to assess their care at any time or calling a patient to check on services received are both considered to be routine patient contacts, not surveys.

To ensure that valid data are collected on the HHCAHPS Survey, and that the data collected represent patients’ perspectives of the home health care they receive, HHAs should use the following guidelines when administering other surveys in conjunction with HHCAHPS:

- For each sample month, the HHCAHPS Survey *sample* must be selected prior to selecting the samples for any other HHA survey.
- In other surveys that an HHA conducts, the agency can include questions that ask for more in-depth information about HHCAHPS issues but should not repeat the HHCAHPS questions or include questions that are very similar.
- HHAs may not ask their patients why they gave a certain response or rating to any of the HHCAHPS Survey questions.

The following are some examples of the types of questions that should not be included in any other surveys the agency conducts:

- “Did the home health agency office answer all of your questions?” (This question is similar to Q22 in the HHCAHPS Survey.)
- “On a scale of 0 to 10, how would you rate the home health care you received?” (This question is the same as Q20 in the HHCAHPS Survey.)
- “Would you recommend this agency to your family or friends?” and “Would you recommend our services or call us in the future?” (These questions are similar to Q25 in the HHCAHPS Survey.)
- “Was our staff friendly, professional, and courteous?” (This question is similar to Q19 in the HHCAHPS Survey.)

Guidelines for selecting the HHCAHPS Survey sample in conjunction with other surveys are provided in ***Chapter IV*** of this manual.

## Survey Vendor Roles and Responsibilities

The list below provides a synopsis of the roles and responsibilities of survey vendors on the HHCAHPS Survey.

- Complete the Vendor Application Form, which is available on the HHCAHPS Survey website after a vendor's HHCAHPS Survey Administrator/Project Manager registers for user credentials;
- Complete the electronic consent form available through the vendor HHCAHPS Survey Administrator/Project Manager's personalized Dashboard on the HHCAHPS website;
- Successfully complete the self-paced Introduction to the HHCAHPS Survey training, available on the HHCAHPS website (<https://homehealthcahps.org/Training/Training-Materials>) and all subsequent Update Webinar Trainings;
- The survey vendor's designated HHCAHPS Survey Administrator/Project Manager must also complete a Training Certification Form after reviewing the self-paced Introduction to the HHCAHPS Survey training;
- Ensure that all survey vendor staff who work on the HHCAHPS Survey are trained and follow the standard HHCAHPS Survey protocols and guidelines;
- Follow the participation requirements listed in the online Vendor Application Form and also repeated in the following chapters in this manual;
- Work with appropriate HHA staff to create monthly patient information files, including data elements needed and file format specifications, and decide on a date each month by which the HHA must provide each monthly patient information file;
- Receive and perform checks of the monthly patient information files provided by HHAs to ensure that they include the entire eligible population and all required data elements;
- Sample patients, following the sampling protocols described in this manual in **Chapter IV**;
- Administer the HHCAHPS Survey in accordance with the protocols specified in **Chapters V-VII** of this manual and oversee the quality of work performed by staff and any subcontractors, if applicable;
- Verify that each client HHA has authorized the vendor to submit data on the agency's behalf;
- Prepare and submit data files to the HHCAHPS Survey Data Center following the guidelines specified in **Chapters IX and X** of this manual and in the *Home Health Care CAHPS Survey Website User and Data Submission Manual, Version 13.0*; and

- Review all data submission reports for client agencies to ensure that data have been successfully uploaded and received.

## Survey Vendor Participation Requirements

Survey organizations interested in becoming an approved survey vendor for the HHCAHPS Survey must agree to the following requirements of participation, as specified in the online Vendor Application Form (*Appendix A*) and noted below.

- The vendor's staff member designated as the HHCAHPS Survey Administrator/Project Manager must complete the self-paced Introduction to the HHCAHPS Survey Training and attend any subsequent Update Webinar Trainings. It is strongly advised that the vendor's sampling and data managers also complete the self-paced Introductory Training and attend the Update Webinar Trainings. The survey vendor's designated HHCAHPS Survey Administrator/Project Manager must complete a training certification exam, also referred to as a Training Certification Form, after reviewing the Introductory Training. All Update Training sessions will be conducted via webinar and require that the survey vendor register in advance for and attend the session.
- Review this manual and follow the protocols and procedures described during survey administration. This manual is the main resource for survey vendors to use in implementing all stages of the HHCAHPS Survey—from sampling and data collection to file development and submission. Vendors are expected to refer to this manual frequently and adhere to all protocols contained within it. Protocol and policy updates will be posted on the HHCAHPS Survey website, so vendors are expected to check the website frequently for such notifications.
- Check the HHCAHPS website frequently to review announcements and protocol updates, and review and respond as appropriate to emails from the HHCAHPS Survey Coordination Team (emails will be from [hcahps@rti.org](mailto:hcahps@rti.org)).
- Develop and submit a Quality Assurance Plan (QAP), following guidelines described in *Chapter XII* of this manual and the model QAP provided in *Appendix P*. Survey vendors must complete and submit a QAP within 6 weeks after the vendor's first quarterly HHCAHPS Survey data submission. The QAP must be updated at least annually or as needed whenever changes are made to key personnel, survey modes being administered, or protocols. The QAP must include the following elements:
  - Organizational background and staff experience;
  - Work plan;

- Sampling protocols and quality assurance procedures;
  - Survey administration protocols and quality assurance procedures;
  - Data security, confidentiality, and privacy protocols; and
  - Copies of the survey instrument (questionnaire and/or computer-assisted telephone interviewing [CATI] script) and cover letters in English and Spanish (if applicable).
- Participate and cooperate in all oversight activities conducted by the HHCAHPS Survey Coordination Team, including but not limited to conference calls and site visits, as deemed necessary. Additionally, the Coordination Team may request teleconference calls with vendors to review sampling protocols, file submissions, or any other aspect of the data collection process. Documentation and requirements that vendors are expected to follow in light of these oversight activities are described in the online Vendor Application Form (*Appendix A*) and in *Chapter XII* of this manual.
  - Review and agree to the participation requirements listed in the online Vendor Application Form and described in the bullets above. Vendors who fail to adhere to or comply with the participation requirements risk losing their status as an approved HHCAHPS Survey vendor.

## Survey Vendor Eligibility and Minimum Business Requirements

CMS believes that an independent third-party survey vendor will be better able to solicit unbiased responses to the HHCAHPS Survey than HHAs; therefore, CMS requires that HHAs contract with an independent, CMS-approved HHCAHPS Survey vendor to administer the HHCAHPS Survey on their behalf. Survey vendors must have proven experience in conducting their desired mode(s): mail-only, telephone-only, and/or mixed-mode surveys.

## Survey Vendor Eligibility

According to the *Home Health Prospective Payment System Update Final Rule* for Calendar Year 2011, any organization that owns, operates, or provides staffing for an HHA is not permitted to administer its own HHCAHPS Survey or administer the survey on behalf of any other HHAs.

The following types of organizations will not be eligible to administer the HHCAHPS Survey (as an approved HHCAHPS Survey vendor):

- Organizations or divisions within organizations that own or operate an HHA or provide home health services, even if the division is run as a separate entity to the HHA;



- Organizations that provide telehealth, monitoring of home health patients, or teleprompting services for HHAs; and
- Organizations that provide staffing to HHAs for providing care to home health patients, whether personal care aides or skilled services staff.

## Minimum Business Requirements

Survey vendors seeking approval as an HHCAHPS Survey vendor must have the capability and capacity to collect and process all survey-related data for the survey administration mode(s) they intend to use on the HHCAHPS Survey following standardized procedures and guidelines. If the vendor does not have all required capabilities for the mode(s) in which it is applying, to be considered for approval, it must formally contract with a subcontractor that meets the requirements needed for CMS approval. The business requirements that survey vendors must meet are described in **Table 3.1**.

The HHCAHPS minimum business requirements (MBRs) described within this document are applicable to survey organizations at the time of application. The vendor must continue to meet these MBRs after an initial application is submitted up to and any point after approval is granted by the Centers for Medicare & Medicaid Services (CMS).

**Table 3.1**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
<b>Relevant Organizational Experience</b>	
Number of Years in Business at Time of Application	<ul style="list-style-type: none"> <li>• Minimum of 3 years.</li> </ul>

(continued)

**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
Number of Years Conducting Surveys as an Organization at Time of Application	<ul style="list-style-type: none"> <li>Minimum of 2 years conducting surveys of individuals. (Requirement applies to vendors and subcontractors.) If staff within the vendor organization have relevant experience obtained while in the employment of a different organization, that experience may not be counted toward this 2-year minimum.</li> <li>Minimum of 2 years conducting surveys using mode of administration the vendor is applying for. (Requirement applies to vendors and subcontractors.)</li> <li>For purposes of HHCAHPS, a “survey of individuals” is defined as the collection of data from individuals selected by statistical sampling methods and the data collected are used for statistical purposes. Polling questions, focus groups, cognitive interviews, surveys of fewer than 600 individuals, surveys that did not involve statistical sampling methods, Internet or web-based surveys, and interactive voice recognition surveys will not satisfy the “survey of individuals” requirement.</li> <li>Establishment and institution surveys do not meet this requirement.</li> <li>CMS reserves the right to request a past performance evaluation from the vendor or CAHPS contractor.</li> </ul>
HHCAHPS-Specific Organizational Requirements	<ul style="list-style-type: none"> <li>Any organization that owns, operates, or provides staffing for a home health agency (HHA) will <u>not</u> be permitted to administer its own HHCAHPS Survey or administer the survey on behalf of any other HHAs. The following types of organizations are not eligible to administer the HHCAHPS Survey (as an approved HHCAHPS survey vendor): <ul style="list-style-type: none"> <li>organizations or divisions within organizations that own or operate an HHA or provide home health services, even if the division is run as a separate entity to the HHA;</li> <li>organizations that provide telehealth, monitoring of home health patients, or teleprompting services for HHAs; and</li> <li>organizations that provide staffing to HHAs for providing care to home health patients, whether personal care aides or skilled services staff.</li> </ul> </li> </ul>
Requirements to Reapply	<ul style="list-style-type: none"> <li>Vendors that do not have any HHA clients after 2 years from the date of their interim approval will have their approval rescinded. If the vendor wants to maintain their approved vendor status, they must reapply.</li> </ul>

(continued)

**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
<b>Work With RTI International</b>	
Organization Information	<ul style="list-style-type: none"> <li>• RTI International serves as the HHCAHPS Survey Coordination Team. In this role, RTI provides oversight to CMS-approved HHCAHPS Survey vendors. To avoid a potential conflict of interest, vendors must not have any existing or future work with RTI while actively implementing and submitting data for the HHCAHPS Survey.</li> <li>• Vendors must disclose any existing or future contracts with RTI that fall under the specifications in the bullet above.</li> <li>• CMS reserves the right to request additional information or documentation of the vendor's work with RTI.</li> </ul>
<b>Survey Capability and Capacity</b>	
Personnel	<p>Vendors must currently have adequate staffing, including at least two individuals who will serve in the designated HHCAHPS roles listed below:</p> <ul style="list-style-type: none"> <li>• HHCAHPS Survey Administrator/Project Manager with relevant survey and management experience. This person must be different from the Sampling Manager.</li> <li>• Sampling Manager with experience with sample frame development and sample selection experience, including experience implementing different sampling methods (e.g., simple random sampling, proportionate stratified random sampling, and disproportionate stratified random sampling).</li> <li>• Computer Programmer with experience receiving encrypted data files in different formats/software packages electronically from an external organization; processing survey data needed for survey administration and survey response data; preparing data files for electronic submission; and submitting data files to an external organization.</li> </ul>

(continued)

**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
Facilities and Systems	<p>Vendors must currently have the following facilities and systems:</p> <ul style="list-style-type: none"> <li>• A secure commercial work environment.</li> <li>• Meet all local commercial code requirements.</li> <li>• Physical facilities, electronic equipment and software to: <ul style="list-style-type: none"> <li>◦ receive sample files from participating agencies;</li> <li>◦ process and store all data collection materials;</li> <li>◦ conduct survey implementation (e.g., scanners, printers, computer-assisted telephone interview [CATI] or alternative electronic data collection system, live monitoring of interviewers, data entry system);</li> <li>◦ electronic survey management system to track fielded surveys throughout the data collection period;</li> <li>◦ call center or telephone bank facilities for telephone survey implementation; and</li> <li>◦ upload HHCAHPS data to the Data Center.</li> </ul> </li> <li>• Vendors must conduct all HHCAHPS business operations within the continental United States. This requirement applies to all staff and subcontractors.</li> </ul>
Working with Other Organizations	<ul style="list-style-type: none"> <li>• To ensure compliance with all HHCAHPS protocols, a vendor that works with other organizations (as a subcontractor, partner, or prime through collaboration, merger or acquisition) must disclose and describe the details of this working relationship to the HHCAHPS Survey Coordination Team.</li> </ul>

(continued)

**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
Security Policies	<p>Vendors and all subcontractors must implement systems and security policies which protect the security of personally identifiable information (PII) and Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act. This includes sample data and survey data. Vendors will be required to submit security policies and maintain confidentiality agreement forms for all vendor and subcontractor staff. Submissions must describe in sufficient detail policies and procedures for:</p> <ul style="list-style-type: none"> <li>• Authorizing and de-authorizing individuals to access PII/PHI and survey data (including background checks, training, and signed agreements).</li> <li>• Preventing unauthorized individuals from accessing PII/PHI and survey data in physical format (including key card/locked access and locked file cabinets).</li> <li>• Preventing unauthorized individuals from accessing data in electronic format (including password protections, firewalls, data encryption software, personnel access limitation procedures, and virus and spyware protection).</li> <li>• Safeguarding PII/PHI and survey data in physical format against loss or destruction (including fire and building safety codes).</li> <li>• Safeguarding PII/PHI and survey data in electronic format against loss or destruction (e.g., offsite daily backups).</li> <li>• Establishing a disaster recovery plan for survey data in the event of a disaster.</li> <li>• Destruction of PII/PHI and survey data when specified.</li> </ul>
Statistical Sampling Process	<p>Vendors must demonstrate prior experience and currently have adequate staffing and software to enable them to:</p> <ul style="list-style-type: none"> <li>• Conduct surveys where a sample of individuals (as defined above) is selected, using simple random sampling, proportionate stratified random sampling, or disproportionate stratified random sampling.</li> <li>• Construct a sample frame that includes all patients who meet survey eligibility.</li> <li>• Work with individual agencies to obtain patient data for sampling (i.e., must be able to accept data electronically).</li> </ul>

(continued)

**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
Mail-only Survey Administration	<p>Vendors must demonstrate prior experience and currently have adequate staffing, commercial facilities, equipment, and software to enable them to:</p> <ul style="list-style-type: none"> <li>• Assign a random, unique, de-identified identification number to each sampled patient.</li> <li>• Obtain and verify addresses of sampled patients.</li> <li>• Print according to HHCAHPS formatting guidelines for professional-quality survey questionnaires (containing single-coded questions, code-all-that apply questions) and materials.</li> <li>• Merge and print sample patient name and address and the name of the HHA on personalized mail survey cover letters and print unique sample identification on the survey questionnaire.</li> <li>• Assemble and mail survey materials.</li> <li>• Track fielded surveys throughout the protocol.</li> <li>• Receive and process (key entry or scanning) completed questionnaires.</li> <li>• Track and identify nonrespondents for follow-up mailing.</li> <li>• Provide a toll-free customer support line to receive and address telephone calls from sample members within 48 hours for all languages offered by the vendor.</li> <li>• Assign final status codes in accordance with HHCAHPS coding requirements to reflect the results of attempt(s) to obtain a completed interview with each sampled patient.</li> </ul>

(continued)

**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
Telephone-only Survey Administration	<p>Vendors must demonstrate prior experience and currently have adequate staffing, commercial facilities, equipment and software to enable them to:</p> <ul style="list-style-type: none"> <li>• Assign a random, unique, de-identified identification number to each sampled patient.</li> <li>• Obtain and verify telephone numbers of sampled patients.</li> <li>• Develop computer programs for electronically administering the survey (for CATI).</li> <li>• Collect data using CATI or alternative electronic system that allows seamless administration of single-coded questions, code-all-that-apply questions.</li> <li>• Track fielded surveys throughout the protocol.</li> <li>• Schedule callbacks to nonrespondents at varying times of the day and week.</li> <li>• Provide a toll-free customer support line to receive and address telephone calls from sample members within 48 hours for all languages offered by the vendor.</li> <li>• Assign final status codes in accordance with HHCAHPS coding guidelines to reflect the results of attempt(s) to obtain a completed interview with each sampled patient.</li> <li>• Conduct monitoring of interviewers.</li> </ul>
Mixed-Mode (Mail with Telephone Follow-Up) Survey Administration	<p>Vendors must demonstrate prior experience and currently have adequate staffing, commercial facilities, equipment, and software to enable them to:</p> <ul style="list-style-type: none"> <li>• Adhere to all mail-only and telephone-only survey administration requirements (described above).</li> <li>• Track sampled patients via an electronic tracking system from mail survey through telephone follow-up activities.</li> </ul>

(continued)

**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
Data Processing and File Submission	<p>Vendors must demonstrate prior experience and currently have adequate staffing, facilities, equipment and software to enable them to:</p> <ul style="list-style-type: none"> <li>• Scan, key, or process responses to single coded questions, code-all-that-apply questions from completed surveys.</li> <li>• Develop data files and edit and clean data according to standard protocols.</li> <li>• Follow all data cleaning and data submission rules, including verifying that data files are de-identified and contain no duplicate patient records.</li> <li>• Export data from the electronic data collection system to an XML template and confirm that the data were exported correctly and that the XML files are formatted correctly and contain the correct data headers and data records.</li> <li>• Submit data electronically in the specified format (XML) via the HHCAHPS secured website.</li> <li>• Work with the Coordination Team to resolve data problems and data submission problems.</li> </ul>
<b>Adherence to All Protocols, Specifications, and Training Session Requirements</b>	
Survey Training	<ul style="list-style-type: none"> <li>• Complete the self-administered Introduction to the HHCAHPS Survey Training and participate in any subsequent HHCAHPS Vendor Update Training sessions. At a minimum, the Survey Administrator/Project Manager must attend these trainings.</li> <li>• Ensure that appropriate subcontractor staff members with significant roles or who are in receipt of patient identifying data participate in all vendor training sessions.</li> <li>• The Survey Administrator/Project Manager must complete a post-training certification exercise, also referred to as a <i>Training Certification Form</i>, after completing the Introduction to the HHCAHPS Survey Training.</li> </ul>
Administer the Survey According to All Survey Specifications	<ul style="list-style-type: none"> <li>• Review and follow all procedures described in the <i>Home Health Care CAHPS Survey Protocols and Guidelines Manual</i> that are applicable to the selected survey data collection mode(s).</li> </ul>

(continued)



**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
<b>Adherence to Quality Assurance Guidelines and Participation in QA Activities</b>	
Quality Control Procedures	<p>Vendors must demonstrate prior experience and currently have adequate staffing, facilities, equipment, and software to enable them to:</p> <ul style="list-style-type: none"> <li>• Incorporate well-documented quality control procedures (as applicable) for: <ul style="list-style-type: none"> <li>◦ in-house training of staff involved in survey operations;</li> <li>◦ receipt and processing of monthly patient information files, sample frame construction and sample selection;</li> <li>◦ printing, assembling, mailing, and recording receipt of survey questionnaires;</li> <li>◦ telephone administration of survey, including live monitoring capabilities;</li> <li>◦ coding and editing of survey data and survey-related materials;</li> <li>◦ scanning or keying in survey data;</li> <li>◦ preparation of final person-level data files for submission; and</li> <li>◦ all other functions and processes that affect the administration of the HHCAHPS Survey.</li> </ul> </li> </ul>
Participation in QA Activities	<ul style="list-style-type: none"> <li>• Participate in any conference calls and site visits requested by the Coordination Team as part of overall quality monitoring activities. Site visits will be conducted with all approved vendors.</li> <li>• Provide documentation as requested for site visits and conference calls, including but not limited to staff training records, telephone interviewer monitoring records, and file construction documentation.</li> </ul>
<b>Subcontractor Requirements</b>	
Subcontractor	<p>Any survey vendor using a subcontractor in any capacity on the HHCAHPS Survey is required to complete the relevant sections of the Vendor Application Form (<b>Appendix A</b> of the <i>HHCAHPS Survey Protocols and Guidelines Manual</i>) about each of its subcontractors. Information requested on the Vendor Application Form about subcontractor capabilities is similar to that requested for vendors.</p> <p>Details must be provided about the capabilities and capacity of the subcontractor to handle mail survey, telephone survey, and mixed-mode survey activities. Further, specific information must also be provided about the subcontractor's quality assurance practices, data security policies, and facilities and systems. Please see the vendor application for more details.</p>

(continued)

**Table 3.1 (continued)**  
**Minimum Business Requirements for HHCAHPS Survey Vendors**

Criteria	Requirement
<b>Documentation Requirements</b>	
Documentation	<p>Vendors must demonstrate prior experience and currently have adequate staffing, commercial facilities, equipment and software to enable them to:</p> <ul style="list-style-type: none"> <li>• keep electronic or hardcopy files of individuals trained, and training dates;</li> <li>• maintain electronic or hardcopy records of interviewers monitored (for telephone administration);</li> <li>• maintain electronic or hardcopy records of mailing dates;</li> <li>• maintain other documentation necessary to allow the HHCAHPS Coordination Team to review procedures implemented during a site visit; and</li> <li>• maintain documentation of actions required (and taken) as a result of any decisions made during site visits by the Coordination Team.</li> </ul>
<b>Additional Requirements</b>	
Additional	<p>CMS and the Coordination Team reserve the right to request additional information from applicant organizations. Information requested may include the following:</p> <ul style="list-style-type: none"> <li>• Taxpayer Identification Number;</li> <li>• website address;</li> <li>• photographs of applicant organization's facilities and systems;</li> <li>• resumes of key staff; and</li> <li>• additional descriptions of processes, including treatment of confidential data, control or tracking systems, quality assurance practices, and XML file construction.</li> </ul>

## **IV. HOME HEALTH CARE CAHPS SURVEY**

### **SAMPLING PROCEDURES**

#### **Overview**

This chapter describes the procedures survey vendors should use to request a file of patients from the home health agency (HHA), identify patients eligible for the survey, construct a sampling frame, and select a patient sample each month. The sampling procedures described in this chapter were developed to ensure standardized administration of the HHCAHPS Survey by all survey vendors and to ensure comparability of the data and survey results that are publicly reported. These sections are organized in the general chronological order in which the corresponding tasks will take place.

Step 1: Obtain a monthly patient information file each month from each client HHA.

Step 2: Examine the patient file for completeness and work with the HHA to obtain missing data. Process and check the file for duplicate information.

Step 3: Identify eligible patients and construct a sample frame.

Step 4: Determine a sampling rate and select the sample for each HHA.

Step 5: Verify or update patient contact information.

Step 6: Assign a unique sample identification (SID) number to each sample member.

Step 7: Finalize the monthly sample file and initiate data collection activities.

#### **Documenting Sampling Processes for Vendor Oversight**

Vendors should document all of their sampling processes for survey oversight purposes, since the HHCAHPS Survey Coordination Team will check each vendor's sampling procedures and documentation during oversight telephone calls or visits, including documentation of all sampling quality control checks conducted by vendor staff.

## Step 1: Obtain a Monthly Patient Information File From Each Home Health Agency Client

### Monthly Patient Information Files

HHAs administering the HHCAHPS Survey must submit a monthly patient information file to their contracted HHCAHPS Survey vendor. Survey vendors must work with each client HHA to (1) obtain all required data elements for every eligible patient served during the sample month and (2) ensure that their client HHA provides these data by an agreed-upon date each month. Survey vendors should request from each of their client HHAs a file, referred to as a monthly patient information file, containing specific information about all patients served at any time during the sample month, including those who were discharged during the sample month. The monthly HHA files must contain information that is at both the *agency* level and the *patient* level. This file should also include patients served by all branches in all states falling under the same CMS Certification Number (CCN).

### Patient Eligibility Requirements

HHAs should **include** in the files submitted to survey vendors all patients who meet the HHCAHPS Survey eligibility criteria (criteria with an asterisk (\*) are explained more fully in paragraphs that follow):

- Patients who are at least 18 years of age by the end of the sample month;
- Patients whose home care was paid for by Medicare or Medicaid. This includes patients who are enrolled in Medicare fee-for-service plans and those enrolled in Medicare Advantage (MA) plans or Medicaid managed care health plans.
- Patients who had at least one home health visit for skilled nursing care, physical therapy, occupational therapy, or speech therapy during the sample month\*;
- Patients who had at least two home health visits for skilled nursing care, physical therapy, occupational therapy, or speech therapy during the lookback period (includes the sample month and the preceding month)\*;
- Patients who are not deceased;
- Patients who are not currently receiving hospice care; and
- Patients who received home visits for services other than routine maternity care in the sample month.\*

HHAs should **exclude** from the file any patient who meets one of these criteria:

- Patients who received home visits ONLY for routine maternity care in the sample month\*;
- Patients who have harmed or endangered the health or well-being of a home health provider or *attempted* to harm or endanger the health or well-being of a home health provider\*;
- State-regulated patients\*; and
- Patients who requested that the HHA not release their name and contact information to anyone other than agency personnel, hereafter referred to in this manual as “no publicity” patients.\*

The next few paragraphs provide more information about selected eligibility criteria.

**Skilled Visits.** For purposes of this survey, the basis for determination of a skilled visit is the classification of the agency employee who visited the patient and not the reason for the home health visit, with the exception of patients who are receiving only routine maternity care or those who are discharged to hospice care. For a visit to be considered a “skilled visit” the agency employee must be classified as one of the following: registered nurse (RN), licensed practical nurse (LPN), physical therapist, physical therapist assistant, occupational therapist, occupational therapist assistant, speech therapist, or speech therapist assistant. Skilled visits do not include visits made by any category of social worker, home health or personal care aide, or nursing aide.

**Lookback Period.** The lookback period is defined as the sample month and the month immediately preceding the sample month. Patients must have had at least one skilled home care visit during the sample month and at least two skilled visits during the “lookback” period.

**Routine Maternity Care.** Note that patients who receive home health care only for routine maternity care are not eligible to be included in the survey. For purposes of this survey, routine maternity care is receiving a few visits for a normal delivery and would include, but is not limited to, assistance in breastfeeding and other educational services.

**Endangering Home Health Providers.** CMS will permit HHAs to exclude from the monthly patient information files information about patients who have harmed or endangered the health or well-being of a home health provider or attempted to harm or endanger the health or well-being of a home health provider. For an HHA to use this exclusion criterion, the agency must document the reason for the exclusion and provide the reason to the HHCAHPS Survey vendor when the monthly patient information file is submitted to the vendor. The vendor will be requested to provide the reason for the exclusion during HHCAHPS oversight visits.

**State-Regulated Patients.** Some states have regulations and laws governing the release of patient information for patients with specific illnesses or conditions, and for other special patient

populations, including patients with HIV/AIDS. It is the HHA's responsibility to identify any applicable state laws and regulations and exclude state-regulated patients from the survey as required by law or regulation.

**No Publicity Patients.** HHAs should also exclude information about no publicity patients from the monthly patient information files. These are patients who have requested that their agency not release their identity to anyone outside the agency, which typically occurs at the start of care.

### Removing Non-Eligible Patients From Monthly Files

Some HHAs may want to provide their contracted survey vendor with a monthly patient information file that contains information only about patients who meet the survey eligibility criteria. If the HHA is making the exclusions, it is the vendor's responsibility to make sure that the HHA understands and correctly applies the patient eligibility criteria. And, the survey vendor must still examine the file for completeness and to make sure that all patients on the file meet all of the eligibility criteria.

Other HHAs may opt to provide a file containing information about all patients served during the sample month so that the vendor can make the exclusions. If the survey vendor is making the exclusions, it is the survey vendor's responsibility to stress to its HHA clients that **all patients** must be represented in the file the HHA submits. The HHA **must** provide the vendor with sufficient information for the vendor to identify and exclude patients who do not meet eligibility requirements. And, even if the survey vendor is making the exclusions, the HHA must still exclude from the file information about harmful/dangerous, state-regulated, or no publicity patients.

### Information Needed From Each HHA at the Agency Level

HHAs are required to submit several agency-level data elements, including the HHA's "Provider Name," "Provider Number" (CCN), "National Provider Number" (NPI), the "Sample Month," "Sample Year," and the "Number of Patients Served." The "Number Of Patients Served" is the total number of patients the HHA served during the sample month. This total should include patients who had at least one visit for skilled care at any point during the sample month, regardless of whether they are eligible for the HHCAHPS Survey. In other words, this number should include both patients who are eligible for the survey and those who are not.

### Information Needed From HHAs for Each Patient Served

HHAs are required to provide all of the information shown in **Table 4.1** for each patient they served during the sample month *except* harmful/dangerous, state-regulated, or no publicity patients. The information that the HHA provides will be used by the survey vendor to survey sampled patients and will be used by the HHCAHPS Survey Coordination Team for data analysis. Further explanation of some of the elements listed in the table is provided in **Table 4.1**.

**Table 4.1**  
**Information Needed From HHAs for Each Medicare or Medicaid Patient Served During Sample Month**

Data Element Required	Reason Needed
Patient's full name (First Name, Middle Initial, and Last Name as separate fields)	Survey administration
Patient Sex	Survey administration and analysis
Patient's date of birth (MMDDYYYY)	Survey eligibility and quality assurance
Mailing address (Patient Mailing Address 1, Patient Mailing Address 2, Address City, Address State, and Address Zip Code as separate data fields)	Survey administration
Patient's telephone number including area code	Survey administration
Medical Record Number (Patient's HHA medical record number)	Survey quality assurance
Number of skilled home health visits in sample month	Survey eligibility and quality assurance
Number of skilled home health visits in lookback period	Survey eligibility and quality assurance
Payer(s) (Medicare, Medicaid, private health insurance, and/or other)	Survey eligibility and analysis
Source of admission (prior inpatient or community setting)	Survey analysis
HMO indicator	Survey analysis
Whether dually eligible for Medicare and Medicaid	Survey analysis
Primary diagnosis (ICD-10-CM for underlying condition)	Survey analysis
Other diagnosis	Survey analysis
Care related to surgical discharge indicator	Survey analysis
Whether patient has end-stage renal disease (ESRD)	Survey analysis
ADL levels (5-items) OR	Survey analysis
Number of ADLs for which patient is not independent (0–5)	Survey analysis

Many of the data elements from *Table 4.1* that the HHA will include on the monthly patient files are on the patient's Outcome and Assessment Information Set (OASIS) Assessment. The data elements needed may be found on the OASIS Start of Care (SOC) assessment, in the Resumption of Care (ROC) assessment, the Follow-up (FU) assessment, or the Discharge (DC) assessment. The HHA should provide the data for the activities of daily living (ADLs) from the most recent OASIS assessment.

### Explanation of Some of the Data Elements Required From HHAs

- Patient's date of birth. Patients must be 18 years of age by the end of the sample month in which they are sampled to be eligible for participation in the HHCAHPS Survey.

- Vendors should ensure that their client HHAs include each patient's mailing address, even if a telephone survey is planned for that HHA. For client HHAs planning telephone surveys, the mailing address for each patient is needed so that the vendor can obtain or verify the sample patient's telephone number. The HHA provides the initial contact information; however, survey vendors are strongly encouraged to use address verification or telephone number lookup services to obtain updated contact information.
- The patient's medical record number is the unique identifier that the HHA assigns to the patient that allows the HHA to track and document the care provided to the patient. This number, along with other data elements, will allow the vendor to keep track of whether each patient has been recently sampled.
- Number of skilled home health visits in the sample month should include only visits for skilled nursing care, physical therapy, occupational therapy, and speech therapy. The patient must have had at least one skilled care visit during the sample month.
- Number of skilled visits in the lookback period. The lookback period is the sample month and the month immediately preceding the sample month. The patient must have had at least one skilled care visit during the sample month and two such visits during the lookback period.

For example, if a patient had only one skilled visit for the sample month of February, they must have at least one skilled visit in January to meet the two-visit requirement. If the patient had two skilled visits in the sample month or one in each month, the requirement of having two such visits during the lookback period has been met. If the patient did not have any skilled visits during the sample month but two during the lookback period, the patient is not eligible to be included in the survey because they did not have at least one skilled visit during the sample month.

Vendors should make sure that they are defining the lookback period correctly in all communications with their HHA clients, including in written specifications for providing the monthly patient information files and in marketing materials. The lookback period must be defined in terms of months, not days. Use of terms such as "previous 60 days" or "60-day lookback period" is not correct because some lookback periods contain more than 60 days while the lookback period for the March sample month will contain fewer than 60 days.

Note that HHCAHPS Survey vendors must include on the XML data file submitted to the HHCAHPS Survey Data Center the number of skilled visits the patient had in the lookback period that is provided on the monthly patient information file submitted by the HHA. This means that the survey vendor cannot calculate the number of visits in the lookback period for a patient by adding the number of skilled visits reported for the current sample month with the number of visits included on the monthly patient information file submitted by the HHA



for the preceding sample month. However, if an HHA or its IT vendor provides the dates of all visits in the lookback period instead of the total number of visits, it is acceptable for the vendor to calculate the total number of visits in the lookback period. Note that this is the only reason that a vendor should calculate the number of lookback visits.

If the HHA does not include the number of lookback period visits on the monthly patient information file, the survey vendor should contact the HHA to obtain the number of visits in the lookback period. If the HHA cannot provide the number of skilled visits the patient had in the lookback period, the vendor should include the patient on the sample frame if the patient had at least one skilled visit in the sample month. If the HHA cannot provide the number of visits in the lookback period, the vendor should enter “M” (for Missing) for the lookback data element for this patient on the XML data file submitted to the Data Center.

- Source of admission is the place of residence or medical care setting from which the patient was admitted. The equivalent data element in OASIS may be used as the response.

If the HHA did not receive any information about the source of admission or regarding an inpatient stay prior to the patient being admitted for home health care, the HHA should indicate that the patient was admitted from the “community.” The term “community setting” refers to facilities that do not provide medical care, thus facilities such as hospitals, skilled nursing facilities, and nursing homes are not considered “community.” The code “community” is used if the patient was admitted from a private residence, an independent living facility, or an assisted living facility. Also, the HHA should report the source of admission as “community” if the patient was referred for home health care by a physician but lives in a private residence, an independent living facility, or an assisted living facility.

Also note that the HHA can provide multiple sources of admission; the survey vendor should include all sources of admission on the XML data files submitted to the HHCAHPS Survey Data Center. If the admission source is missing from the HHA’s monthly file, the vendor should enter the missing code on the XML data file that will be submitted to the HHCAHPS Survey Data Center.

- Payment source. Enter the source(s) of payment for the patient’s home health care. Note that multiple sources may apply. The HHA should provide the vendor with all applicable sources of payment for the care. The survey vendor, in turn, should include all sources of payment for the patient’s care on the XML data files that are submitted to the Data Center.

The source of payment is Item M0150 on the OASIS Start of Care assessment. If the payment source is missing for a patient, the survey vendor must enter the missing code for this data element for the patient on the XML data file submitted to the Data Center.

If the HHA does not include the source of payment on the monthly patient information file, the vendor should contact the HHA to obtain the source of payment. If the HHA cannot provide the source of payment, the vendor should assume that the patient’s care is covered by

Medicare or Medicaid and include the patient on the sampling frame if the patient meets all other survey eligibility criteria.

- The HMO Indicator is an indication of whether the patient is enrolled in a health maintenance organization (HMO), which coordinates patient care and has a network of providers to which patients can go for care. This indicator should be coded “yes” if the patient is enrolled in a Medicare Advantage plan or a Medicaid managed care plan.
- Primary Diagnosis is the ICD-10-CM code for the underlying reason for the home health care such as the principal diagnosis if the patient was admitted from a hospital. The source of diagnosis codes may be the plan of care, OASIS assessment, record of hospital stay, or other record documenting the patient admission.

HHAs should provide ICD-10 codes as the primary diagnosis. Z-codes as the primary diagnosis, while not preferred, are allowed and will be accepted. External cause codes (ICD-10-CM codes beginning with V, W, X, or Y) are not allowed as the primary diagnosis but are allowed for the other diagnoses.

- Other Diagnoses are comorbid conditions that are relevant for the care of the patient. The relevant comorbidities are ICD-10-CM diagnosis codes. The sources may be the same as for the primary diagnosis. HHAs can provide up to five other diagnoses for each patient included on the XML data file. ICD-10-CM codes beginning with V, W, X, or Y will be accepted, but they are not accepted for the primary diagnosis data element.
- ESRD indicator. ESRD is an indicator of whether the patient has End-Stage Renal Disease. This indicator should be coded “yes” if any of the following diagnosis codes are present: I12.0, I13.11, I13.2, N18.6, Z91.15, or Z99.2.
- Activities of Daily Living. Note that HHAs can provide on the monthly patient information file that they submit to the survey vendor **either** the *code* for each of the five individual ADL data elements **or** the *total count of ADLs* for which the patient is not fully independent, the “ADL Deficits” XML data element. The HHA should report the five individual ADL codes as taken from the list in the patient’s OASIS assessment. They are Ability to Dress Upper Body (M1810), Ability to Dress Lower Body (M1820), Bathing (M1830), Toilet Transferring (M1840), and Transferring (M1850). When reporting these ADL codes, the HHA must use the most current code on file for those data elements.

If the HHA provides the OASIS values for the five individual ADL data elements on its file, the vendor should enter the code provided for each of the five ADLs that were assessed for that patient on the XML data file it submits to the Data Center. The only acceptable range of codes for each of the five ADL Deficits is 0-5 and M (missing).

If the HHA provides the total count of ADL data elements (“ADL Deficits”), that count would be the total number of the five ADL data elements **not** coded as a “0” as taken from

OASIS. Note that if an HHA submits a value for the ADL deficits total count data element that exceeds 5, vendors should recode this data element to 5.

HHCAHPS Survey vendors must enter on the XML data file that they submit to the Data Center the same information that is provided by the HHA. That is, the vendor should provide in its XML data file the five individual ADL counts, or the total count of ADL deficits, or both if provided by the HHA. Survey vendors are not allowed to calculate the total count of ADLs for which the sample patient is not fully independent.

### **Option to Submit Separate Files to Vendor**

If an HHA cannot provide all of the patient information needed in time for the vendor to select the sample and field the survey within 21 days after the sample month ends, the HHA should submit two separate files. The first file should be submitted as soon as possible after the sample month ends, and should include all data elements that the vendor will need to determine whether patients on the file are eligible for the survey and for fielding the survey. This includes the following data elements:

- Patient contact information (name, address, and phone number);
- The patient's date of birth and sex;
- The number of skilled visits the patient had in the sample month;
- The number of skilled visits the patient had during the lookback period; and
- The payer source data element.

The HHA should submit all of the other data elements (Medical Record Number, HMO indicator, diagnoses, admission source, ADLs, surgical discharge, end-stage renal disease, and Medicare/Medicaid dual eligibility indicators) in a second or appended file, which should be submitted to the vendor no later than 6 weeks after the sample month ends.

Although HHCAHPS Survey vendors are urged to make a good faith effort to obtain accurate payer source information for each patient from their client HHAs, in some instances the HHA may not provide all data elements needed for the survey. If the HHA cannot provide the missing information when the vendor follows up with the HHA or cannot provide it in time for the sample to be selected and the survey initiated within 21 days after the sample month ends, the vendor should consider the patient eligible, include him or her on the sampling frame, and include that patient in the survey if they are sampled. More information about the data elements that the survey vendor should include on XML data files submitted to the Data Center and how those data elements should be coded is provided in *Chapters IX and X*.

Note that vendors must select the sample for each HHA at one point in time; that is, vendors cannot select two separate samples for the same month. If an HHA submits a second file with additional patients, and data collection has already begun for that sample month, the vendor must not select a second sample but should report this situation via a Discrepancy Notification Report (DNR), with a count of the number of additional eligible patients that were not included.

### **Surveying Non-Medicare and/or Non-Medicaid Patients**

Only patients whose care is paid for by either Medicare or Medicaid are eligible to be included in the HHCAHPS Survey. However, HHAs may want to survey their non-Medicare and/or non-Medicaid patients. If this is the case, the HHA should include information about non-Medicare and non-Medicaid patients on the patient information files that are submitted to the survey vendor. Survey vendors, however, should not include data collected from non-Medicare and non-Medicaid patients on the XML data files submitted to the Data Center.

### **Protocol for No Eligible Patients Served in the Sample Month**

If the HHA did not provide home care to *any* patients or did not serve any patients who met survey eligibility criteria during the sample month, the HHA must still submit a monthly patient information file or an e-mail notification to its HHCAHPS Survey vendor indicating that no survey-eligible patients were served during that sample month. Survey vendors must retain the monthly patient information file or e-mail notification provided for a minimum of 18 months, as this information is subject to review during HHCAHPS site visits.

If none of the patients on the monthly patient information file are eligible for the HHCAHPS Survey or the HHA sent an e-mail notification that no survey-eligible patients were served during a particular sample month, the vendor must still prepare and submit an XML data file for that sample month. The vendor must indicate on the file that there were 0 eligible cases in the number eligible data element (“Eligible Patients”) and enter all other information required in the Header Record Section of the XML data file (refer to **Chapter X** in this manual for more information about XML data file preparation and submission). If the vendor does not submit a 0 eligible file in this case, CMS and the Coordination Team will view the HHA as having “missed” a sample month and may be considered as being noncompliant with HHCAHPS Survey participation requirements.

### **Protocol for Administering Other Surveys in Conjunction With the HHCAHPS Survey**

Some HHAs may wish to administer other surveys of their patients. Because of the promise of confidentiality stated in the HHCAHPS Survey cover letters, and the nature of care that this population receives (ongoing from their provider), survey vendors are not permitted to share with their HHA clients the identities of patients who are sampled for HHCAHPS.

The following guidelines should be used if the HHA is planning to administer other surveys in conjunction with the HHCAHPS Survey and will be using its HHCAHPS Survey vendor to conduct the other survey(s).

- If an HHA will be fielding other survey(s) of its patients, it must provide a file of all eligible patients to its survey vendor. The vendor will select the sample for HHCAHPS for the sample month first, prior to selecting a sample for any other survey(s).
- Patients who were not randomly selected into the HHCAHPS Survey sample for the sample month may be eligible for the other survey(s) that the HHA conducts in that month.

For HHAs that are self-administering other surveys in addition to participating in HHCAHPS, the HHA will need to select a sample of patients for the other surveys with the understanding that some patients may be sampled for both the HHCAHPS and the other surveys.

It is up to the HHA to evaluate—based on the size, frequency, and purpose of the other survey(s) it conducts—whether to potentially sample its patients more than once or engage the services of their HHCAHPS Survey vendor to ensure that patients sampled for the HHCAHPS are not also sampled for their other surveys. HHAs should also note that conducting additional surveys with the same patient population as HHCAHPS may lower HHCAHPS Survey response rates because of respondent survey fatigue.

## **Step 2: Examine the Monthly Patient Information File for Completeness**

Survey vendors should examine each monthly patient information file provided by their client HHAs to ensure that information they need for determining survey eligibility for all patients on the file has been provided. If patient information needed for sample selection and/or data collection is missing, the vendor should work with the HHA to obtain the missing data.

Survey vendors should also check each monthly patient information file received to make sure that it does not include “duplicate” information—that is, to make sure that a patient does not appear more than once on the file. Note that vendors are required to retain the original monthly patient information files submitted by their client HHAs for possible audits by the HHCAHPS Survey Coordination Team; therefore, if the monthly patient information file is used as the basis for constructing the sampling frame, the vendor should make a copy of the monthly patient information file submitted and “de-duplicate” the file using the copy of the monthly patient information file.

When checking the monthly patient information files to identify duplicate patients (i.e., patients who may have been listed on the file more than once), it is important for vendors to note that HHAs do NOT always assign the same MRN to a patient if a patient is discharged from home

care and receives home care at some later point in time. For this reason, vendors should use the MRN and other patient information data elements to identify duplicate patients in the monthly patient information file.

After receiving a list or file with information needed for sampling, the survey vendor will then identify all patients eligible for participation in the HHCAHPS Survey from the file of patients served or discharged, creating the sample frame, making certain to have a different staff member conduct a quality control (QC) check for this process.

### **Step 3: Identify Eligible Patients and Construct a Sampling Frame**

After receiving the file of all patients served or discharged from their HHA, vendors must identify all patients eligible for participation in the HHCAHPS Survey.

The sample frame that the vendor constructs for each HHA must include all patients the HHA served during the sample month who meet all of the eligibility criteria provided previously in Step 1, and who also have not been included in the sample during any month in the current quarter or during the 5 months prior to the sample month.

To reduce respondent burden, home health patients who meet survey eligibility criteria can only be sampled once in a 6-month period. Therefore, the survey vendor must also exclude from the sample frame patients who were included in the HHCAHPS Survey sample during the 5 months prior to the sample month.

An example of a vendor sample frame file layout is included in *Appendix B*. For purposes of audit and quality assurance, survey vendors must keep the monthly patient information files submitted by all HHAs for 18 months. The survey vendor must also keep the sampling frame created for each sample month for 18 months. Vendors must also record and retain documentation showing the reasons patients were *excluded from the sample frame created for each HHA for each sample month, and provide documentation of all staff QC checks that were completed during the sampling process*. This documentation will be subject to review by the HHCAHPS Survey Coordination Team during site visits.

### **Step 4: Determine a Sampling Rate and Select a Sample for Each HHA**

Survey vendors must determine a sampling rate and use that rate to ensure that an even distribution of patients is sampled over a 12-month period. Vendors will need to have a good estimate of the size of the sample frame before they can determine a sampling rate. The typical frame size will depend on the number of patients served by the client HHA, the proportion of short- and long-stay patients, and the rate at which the sample exclusions (listed above) apply to the list of patients the HHA provides to the survey vendor.

For HHAs with patients having a relatively short period of home health care service (such as a month or less), there will be a proportionally large sample frame from month to month as new patients are accepted by the HHA. Vendors should expect that there will be variability in the number of patients the HHA serves and the number eligible for the survey because these characteristics vary over time. In some cases, there could be seasonality to admissions, depending on the mix of patients served by different HHAs.

The first month that an HHA participates in the HHCAHPS Survey, the agency will have a larger number of patients eligible for the survey because none of the patients will have been sampled in the preceding sample months. Therefore, no patients will be ineligible to be sampled because they were sampled in a prior month. A sampling rate should, therefore, not be based on the frame for the first month that the HHA conducts the HHCAHPS Survey. Instead, the survey vendor should estimate a sampling rate as described below.

### **Estimating an Initial Sampling Rate**

To develop a sampling rate for an HHA, the vendor should work with the HHA prior to the first sample month that the HHA begins its participation in the HHCAHPS Survey to estimate the sample frame size for each of the preceding 3 to 6 months. The more months the survey vendor includes in this sampling rate analysis, the better the estimate of the sample frame size and its variability; any single month can be nonrepresentative of an HHA's patient size and mix, so considering a range of months will guard against estimating sampling rates that will yield a sampling frame that is either too large or too small. For each of the 3 to 6 months prior to the first sample month the HHA implements the HHCAHPS Survey, the HHA should provide the survey vendor with a file of potentially eligible patients who received home health care, including current and discharged patients. In addition, the HHA should provide all of the required data elements for every patient in the file, just as the HHA will be required to provide after it begins its participation in the HHCAHPS Survey implementation.

In looking at the sample frame information for the 3 to 6 months that precede the first sample month, the vendor should apply the same sample frame construction criteria for each month that it would apply for the first sample month. Note that in the first month's sample file, the rule that a patient cannot be sampled more than once in the current or the following quarter will not be a constraint. In the second month of the 3- to 6-month test period, all patients sampled in the first month will be excluded from the frame. Only new admissions and patients not sampled the previous sample month can be included on the sample frame for the second (and subsequent) month(s). Some very long-stay patients may reenter the frame in the sixth month. This number will be significant only if long-stay patients, such as many Medicaid patients, are a significant proportion of the HHA's patient mix. The proportion of short-stay patients—that is, those who receive care for 30 days or fewer—will be an important driver of the sample frame size.

## Estimating an Appropriate Sampling Rate Each Month

The target for the statistical precision of HHCAHPS Survey results that will be publicly reported is based on a reliability criterion. The reliability criterion target for the HHCAHPS Survey ratings and most of the composites is 0.8 or higher. For reasons of statistical precision, a target minimum of 300 completed HHCAHPS Surveys has been set for each HHA over each 12-month reporting period. This is equivalent to an average of 25 completed surveys per HHA per month.

The number of patients to be selected each month to yield a minimum of 300 completed surveys will ultimately be determined by trial and error by the vendor and will differ by HHA. The value of the sampling rate or fraction applied to a sample frame is not itself a target; it may be varied over time to achieve the target number of usable returned surveys. The sampling rate must be kept approximately the same for each month in each quarter. The sample for an HHA during the first sample month that the HHA participates in the HHCAHPS Survey will likely have an atypically high number of eligible patients; therefore, the vendor should adjust the rate for the first sample month to make the sample for that month about equal to subsequent sample months. The rate may be increased in subsequent months to achieve the target of 300 completed surveys, but should not be decreased simply to avoid exceeding 300 completed surveys for a particular year. A sample must be selected for each sample month. The rate may be adjusted if there is a sustained change in the size of the typical sample frame.

The mode of administration of the survey will be an important factor in determining sample size and response rates. **Table 4.2** shows response rates by mode from the HHCAHPS Survey for all sample months from Quarter 2 2023 through Quarter 1 2024, which corresponds to the calendar year 2025 annual payment update participation period.

**Table 4.2**  
**Response Rates Obtained by Mode During the HHCAHPS 2025 Annual Payment Update Participation Period**

Mode	Response Rate	Sample Size for 25 Responses/Month
Mail only	24.0%	104
Phone only	20.7%	121
Mixed	29.4%	85

Note: The sample sizes shown in the table above are for illustrative purposes only. Vendors should work with their HHAs to take into account expected response rates, eligibility, and number of patients served to determine an appropriate sampling rate.

The sample size estimates above were derived using the following formula:

$$\text{Sample size} = (\text{number of responses needed}) / (\text{response rate}) = 25 / (\text{response rate})$$

where the value used for the number of responses needed is 25. These sample size estimates have been rounded up to the nearest integer. Each vendor should use its experience on the HHCAHPS



and other surveys with home health patients or similar populations and work with its client HHA to determine the appropriate data collection mode and expected response rate to use as a guide for calculating quarterly sampling rates.

Developing and using a sampling rate based on the number of survey-eligible patients an HHA serves over a 3- to 6-month period and with an expected response rate works well for an HHA that serves more than 650 survey-eligible patients over a given 12-month period. Consider, for example, to obtain the sample sizes in **Table 4.2** above, during a 12-month period an HHA would need to have provided home care to as many as 1,248 survey-eligible patients for the mail-only mode, 1,452 patients for the phone-only mode, and 1,020 survey-eligible patients for the mixed mode. Some very small HHAs will not have a sufficient number of patients to yield 300 completed surveys over a 12-month period. In this case the “full census” of eligible patients should be surveyed. Surveying a full census means that the sampling rate would be such that over the course of a 12-month period the vendor would have sampled the same **number** of patients as the HHA would have served during a 12-month period. It does not mean that the vendor selects and samples all patients the HHA served during the sample month who meet survey eligibility criteria.

The survey vendor should determine a sampling rate for all agencies, including small agencies, and select the sample so that there is an even distribution of patients over a 12-month period. For some very small HHAs, in some sample months the number of survey-eligible patients served may be less than the number required by the sampling rate. In this case, it is acceptable to survey a census of the total number of survey-eligible patients served during that sample month.

Although the targeted number of completed surveys is 300 over a 12-month period, some HHAs may want to survey more of their patients. There is no upper limit to the number of patients who may be surveyed. However, for large HHAs, the vendor should still use a sampling rate and select a sample (rather than surveying all eligible patients each month) so that the sample is evenly distributed across a 12-month period.

### Selecting the HHA Sample

To select the sample for each HHA, survey vendors should use a random number generator that is generally accepted as having satisfied the criterion of randomness. The random numbers should be generated from the uniform distribution—each number having an equal probability of selection. Unacceptable random number generators are those that use pseudo-random number generators that repeat numbers after some specified period. An acceptable random number generator will repeat only after many billions of numbers are produced.

An important feature of the random number generator is the “seed” number used to start the cycle. The selection of the seed number should be such that it cannot be manipulated. An appropriate seed often used is the clock time as measured by the computer. This seed varies each

fraction of a second, but the value used is documented by the program and is part of the output that can be retained. The seed number must be known and retained as part of the documentation vendors keep so that the sampling process can be reproduced for HHCAHPS Survey Coordination Team site visits.

Survey vendors should use a reputable statistical program like SAS either to select a sample from a frame using its procedures for survey sample selection or to generate random numbers that can be correctly applied.

Another reputable program, which runs under Windows, is RAT-STATS, developed by the Department of Health and Human Service Inspector General's Office. Survey vendors can download this program and its comprehensive manual at no cost from <https://oig.hhs.gov/compliance/rat-stats/index.asp>. There are many sampling tools in the program. One module can simply produce a sample size,  $n$ , random integers between 1 and the frame size, and uses the computer clock to generate the seed, which is retained and reported.

Both SAS and RAT-STATS are examples of readily available, high-quality, rigorously tested tools for selecting samples randomly. Commonly available spreadsheet programs also have random number generators; however, do not use these random number generators when selecting monthly samples for the HHCAHPS Survey because they do not generate a report of the seed used. Note, however, that a spreadsheet is an acceptable way to present and manipulate the sample frame.

It is also critical that vendors document how the random start number was generated and how the sample frame was sorted during the sampling process.

The following are examples of ways to sort the sample frame for the HHCAHPS Survey.

### **Method 1**

Sort the sample frame of  $N$  eligible patients by any documented method.

- Generate the  $N$  random numbers.
- Assign the random numbers in the order generated to each element in the frame.
- Re-sort the elements as ordered by the random numbers (either ascending or descending, but document which is used).
- Select the first  $n$ , the sample size required for the mode used.

In this way, the initial sort of the data does not affect the result, although a standard sort order should always be used so that it does not appear that a frame has been altered. This method requires generating as many random numbers as there are patients on the frame.

### **Method 2**

If the random number generator is able to produce integers from a range of values, given that  $N$  is the size of the sample frame of eligible patients, we can use the following steps to select our sample.

- Generate  $n$  distinct random integers whose values range from 1 to  $N$ , where  $n$  is the sample size required for the mode used.
- Select the element of the frame that corresponds to the random number generated. For example, if the random number 10 is generated then select the 10th element on the frame for the sample.
- Continue selection of elements according to the random numbers generated until all  $n$  distinct elements have been selected.

The steps for selecting the sample can be summarized as follows:

1. Using 300 as the target number of responses and an estimate of a final response rate, calculate the target sample for a year and 1/12 of that per month. An effective response rate of 30 percent, for example, would yield an annual sample of 1,000 ( $300/.3$ ), which is a target of 84 per month.
2. Acquire from each HHA a test frame for at least 3 months prior to the start of the actual survey. This should be a census of patients each month and should contain the information about each patient to determine whether they meet survey eligibility requirements.
3. Apply exclusions for each month—that is, remove from the sample frame all patients who do not meet the survey eligibility criteria. Because the first month will not have any people excluded for reasons of prior sampling, the frame for that month will be larger than that for the subsequent months.
4. Using the second and third months as typical of what the frame size will be, determine whether the sample required in Step 1 above will require sampling the entire frame each month or what the typical sampling rate would be. Remember that the first month may be different from subsequent months.

5. Simulate creation of random numbers to reach the target number of completed surveys over the 12-month period, that is, 300 surveys. The proportion sampled from quarter 1 to quarter 2 to quarter 3 may vary to meet the target number. We recommend that the sampling rate not be varied within a quarter to accommodate short-term random variation. The first month will generally be sampled at a lower rate than subsequent months. In practice, adjustments may be needed over time to reach the annual goal of the lesser of (a) 300 over each of the rolling four quarters, yielding about 300 completed surveys over 12 months; or (b) a full census of eligible patients. Remember in this case a “**full census**” does not mean surveying every eligible patient each sample month, but using a sampling rate that, during a 12-month period, would yield the same number of sampled patients as the expected number of survey-eligible patients the HHA would serve over a 12-month period.

### Sampling With Other Than Simple Random Sampling

The method of sampling described above is simple random sampling (SRS), which is a standard method of sampling. Two other sampling methods may be used to sample patients for the HHCAHPS Survey—proportionate stratified random sampling (PSRS) and disproportionate stratified random sampling (DSRS). HHAs may opt to use PSRS and DSRS sampling methods if there is a way to divide their patient population into logical units (referred to as strata), the units are large enough, and there is a logical reason for doing so. The strata created may represent patients cared for by different branches of an HHA or geographic divisions, for example. **For each month that stratification is used, the minimum number of eligible patients allowable in a stratum frame is 10, and the same stratification must be used for all months in a quarter.**

#### *Proportionate Stratified Random Sampling*

In PSRS, the same sampling rate must be applied to each stratum included in the sample. A stratum is defined as a subset of the total sample frame. For the HHCAHPS Survey, an HHA with multiple branches may want to select a sample for each branch. In this example, each branch location would be considered a stratum.

HHAs may want to use PSRS for the following reasons:

- The HHA would like to keep track of samples and results from the HHCAHPS Survey for each stratum; or
- The HHA may want to designate other aggregates of operating units for tracking, while using the same sampling rate for each.

When using PSRS for units of an HHA (under the same CCN), the strata created must be large enough to support the same sampling rate in each stratum. All the patients in the HHA may be

sampled as one unit, or a separate sample may be made of each branch. Under PSRS the sampling rate would be the same for each branch and the samples combined.

For example, if an HHA had 200 patients to sample, divided into three strata consisting of 100, 50, and 50 patients, respectively, a sample of 90 would be drawn at about a 45 percent rate (90/200). A sample of 45 would be drawn from the large stratum because the large stratum used in this example should have half of the sampled patients. The selection would be  $.45 \times 50 = 23$  for the other strata. With a lower limit of 10 for a stratum size, small strata might have to be combined for a PSRS to be used in practice. The statistical precision of survey results at the stratum level may not be very good unless the stratum sample size is about the size of the overall sample requirements. The total sample size must also be taken into account when considering stratification options.

### ***Disproportionate Stratified Random Sampling***

DSRS is another appropriate sampling option if an HHA wishes to achieve statistically precise numbers for operating subunits (e.g., branches). To achieve as good a level of precision for the separate units as required for the HHA as a whole, each unit would have to have a sample size as large as if it were a separate HHA. In this case, the sampling rate may be different for each stratum. To allow the separate strata to be recombined to represent the HHA as a whole the sampling rate for each stratum must be reported in the data submitted to the HHCAHPS Survey Coordination Team. This will permit appropriate weighting of the respondents in computing results. Different sampling rates in strata with particularly high or low ratings could otherwise distort the ratings.

If an HHA chooses to use DSRS, its survey vendor must do the following:

- Complete and submit an Exceptions Request Form—the process for identifying the different strata must be provided on the Exceptions Request Form;
- Use the same name for each stratum in each month in the quarter;
- Make sure that each stratum has a minimum of 10 patients eligible to be included in the survey during the sample month; and
- Provide to the HHCAHPS Survey Data Center additional information about each stratum, including the following:
  - The name of the stratum;
  - The total number of patients sampled in each stratum during the sample month;
  - The total number of patients on the file submitted by the HHA for that stratum;

- The number of patients in the stratum who were eligible for the survey during the sample month; and
- The total number of patients sampled during each sample month.

An example of the use of DSRS is as follows. The ABC Best Care Agency selects a sample each month, creating three distinct strata—one each for Branch A, Branch B, and Branch C.

- The survey vendor first uses data from 3 or more preceding months prior to the HHA beginning its participation in the HHCAHPS Survey to determine a sampling rate for each of the three strata.
- Assume that the target for each stratum is the same as for the HHA as a whole, that 25 is the target number of responses, and that the expected response rate is 50 percent. The sample size required is 50 for the HHA as a whole. Therefore, to get the same precision for each stratum the sample size would be 50 for each of the three strata in this example.
- Assume that Branch A has 120 eligible patients, Branch B has 100, and Branch C has 40 (these are the numbers that would be reported on the XML template for DSRS sampling).
- Based on these numbers, the number sampled is 50 for Branch A, 50 for Branch B, and 40 for Branch C. Because Branch C only had 40 patients, the sample for it would be a census.
- When analyzing the data, the HHCAHPS Survey analysts will use the sampling rates in the weighting calculation when the strata are combined at the HHA level as follows:
  - Branch A,  $50/120 = 41.6\%$ .
  - Branch B,  $50/100 = 50.0\%$ .
  - Branch C,  $40/40 = 100.0\%$ .

Note that the survey vendor will report the number of patients eligible for the survey and the number sampled to the HHCAHPS Survey Data Center for use in computing weights for the HHA when the data are combined. Patients in Branch A had a lower probability of selection than those in Branch B and C, and that will be accounted for when the data from sample members in the strata are combined. Survey vendors should keep in mind that a minimum of 10 eligible patients must be in each stratum for DSRS sampling to be used.

## Step 5: Verify or Update Sample Contact Information

We strongly recommend that survey vendors send all HHA-provided patient mailing addresses through an outside address service, such as the National Change of Address (NCOA) or a similar

service, to confirm or update patient contact information. In addition, vendors conducting either a telephone-only or mixed-mode data collection are urged to send the most updated mailing addresses through a telephone number–provider service to attempt to obtain an updated telephone number. Performing these quality control activities prior to the start of data collection will result in fewer surveys returned as undeliverable and fewer unproductive telephone call attempts.

Note that vendors may not share the identities of sampled patients with their HHA clients, so if a vendor asks for updated information, it must ask for **all** of the patients in the file for the relevant sample month. Asking for missing information on all patients preserves the anonymity of patients who were selected for the sample. Because patients received skilled care in their homes, the HHA should have an address at which that care is provided. Similarly, for surveys being administered by telephone or mixed mode, in most cases an HHA will have the patient’s telephone number to schedule or confirm the provider’s home care visits.

Vendors should also note that even if an address or telephone number cannot be obtained for a patient, the patient is still eligible for inclusion on the sample frame (and in the survey if sampled) if they meet all other survey eligibility criteria. And, patients with missing or foreign mailing addresses are also considered eligible for the survey.

## **Step 6: Assign Unique Sample Identification Numbers**

Survey vendors are responsible for assigning a unique **numeric or alphanumeric** sample identification (SID) number to every sample member selected into each monthly sample. Vendors should use the SID to track efforts to complete the survey with each sample member throughout the data collection period. When creating and assigning SID numbers to sampled cases, follow the guidelines listed below.

- The SID number assigned to a sample member cannot contain any combination of letters or numbers that could link the SID with a particular sample member or a particular HHA. For example, no part of the sample member’s name, address, date of birth, telephone number, Social Security number, or dates of home health care visits or an HHA CMS Certification Number (CCN) can be included in the unique SID created and assigned to the sample member.
- The SID can be a numeric or alphanumeric data element; however, it must have a minimum length of 6 and a maximum length of 16 characters.
- Vendors must not reuse the same SID numbers—that is, once a SID number is assigned, it should never be assigned again for any sampled patient. Vendors must assign new SID numbers to the new set of patients sampled each month.

- If the same patient is sampled more than once in a calendar year or across multiple calendar years, the vendor must assign a new SID number to that patient each time they are sampled.

## Step 7: Finalize the Monthly Sample File and Initiate Data Collection Activities

Although HHCAHPS Survey data will be analyzed on a quarterly basis, sample frame construction, sample selection, and data collection are conducted monthly. Survey vendors must initiate the survey for each monthly sample within 3 weeks (21 days) after the end of the sample month. As soon as the sampling activities described above have been completed, data collection for the sample month should begin.

All data collection for each monthly sample must be completed within 6 weeks (42 days) after data collection begins. For mail-only and mixed-mode surveys, data collection for a monthly sample must end 6 weeks after the first questionnaire is mailed. For telephone-only surveys, data collection must end 6 weeks following the first telephone attempt.

CMS recognizes that on rare occasions an HHA may have a situation that prevents it from providing the monthly patient information in time for the vendor to initiate the survey within 21 days after the sample month ends; therefore, the vendor can initiate the survey within 26 days after the sample month ends. However, the survey vendor must submit a Discrepancy Notification Report, described in *Chapter XIV* of this manual, for each HHA for which the survey is initiated from the 22nd through the 26th day after the sample month ends.

If the survey cannot be initiated within 26 days after the sample month ends because of a natural disaster (earthquake, tornado, etc.), snow or severe weather emergencies, fires, extreme computer problems, or for some other reason, CMS may allow a survey vendor to initiate the survey more than 26 days after the sample month ends. The HHA's survey vendor, however, must request (via e-mail to [hhcahps@rti.org](mailto:hhcahps@rti.org)) and obtain approval from CMS before initiating the survey more than 26 days after the sample month ends.

## Sampling Issues for Quality Assurance

Since the national implementation of the HHCAHPS Survey began in October 2009, CMS and the HHCAHPS Survey Coordination Team have observed some common misconceptions and problems with the sampling process. For quality assurance purposes, we have listed common misconceptions, paired with the proper implementation method that survey vendors should use to avoid these issues during the sampling process.



**Table 4.3**  
**Sampling Common Misconceptions and Problems with Proper Implementation**

Number	Misconception	Correct Implementation
<b>Patient Eligibility Criteria</b>		
1	Patients with missing, incomplete or foreign mailing addresses or telephone numbers were considered as ineligible for the HHCAHPS Survey.	Patients with missing, incomplete or foreign mailing addresses or telephone numbers <i>are eligible</i> to be included in the HHCAHPS Survey if they meet all other survey eligibility criteria. HHCAHPS Survey vendors should keep in mind that home health care patients receive care in their homes; therefore, the HHA must have an address at which the home care is provided. Survey vendors should follow up with the HHA to obtain an address if the address is missing or incomplete. We also recommend that survey vendors use address or telephone-lookup services to confirm or obtain sample patients' mailing address or telephone number.
2	It is acceptable for vendors to share the identities of sampled patients with their HHA client(s).	Vendors may not share the identities of sampled patients with their HHA clients. Patients' identities must be protected because of the promise of confidentiality made to patients in the HHCAHPS cover letter, introductory telephone script, and the fact that patients who received care from an HHA may still be receiving care from that agency. However, if patients indicate via their response to the "Consent to Share Responses" question in the survey that it is acceptable for the vendor to link their responses with their name, the vendor can share that patient's identity with the HHA.
3	If two or more home health patients are in the same household, only one patient in the household or at the same address is eligible to participate in the HHCAHPS Survey.	This is not an eligibility criterion for HHCAHPS.
4	If the HHA did not serve any patients who met survey eligibility criteria, the HHA does not need to submit a sample file to its HHCAHPS Survey vendor for that sample month or notify them in any way.	To be compliant with HHCAHPS Survey participation requirements, all Medicare-certified HHAs participating in the HHCAHPS Survey must submit a monthly patient information file to their survey vendors for each sample month or send an email notification if no survey-eligible patients were served in a particular sample month. The survey vendor must, in turn, submit an XML data file to the HHCAHPS Survey Data Center for each corresponding sample month. Otherwise, the HHA will be considered to have "missed" a month of survey participation and may be deemed noncompliant with HHCAHPS Survey participation requirements.

(continued)

**Table 4.3 (continued)**  
**Sampling Common Misconceptions and Problems with Proper Implementation**

Number	Misconception	Correct Implementation
<b>Patient Eligibility Criteria (continued)</b>		
5	The HHCAHPS Survey vendor should treat patients as ineligible for the survey if the source of payment is missing.	If the source of payment is missing on the monthly patient information file, the vendor should recontact the HHA to obtain the source of payment. If the HHA cannot provide the source of payment, the vendor should consider the patient as eligible for the survey if they meet all other survey eligibility criteria.
6	If a patient's payer source includes private pay <u>in combination with</u> Medicare and/or Medicaid, the patient is not eligible for the HHCAHPS Survey.	A patient whose source of payment is private pay in addition to Medicare and/or Medicaid is eligible for the HHCAHPS Survey (if they meet the other eligibility criteria). The presence of Medicare and/or Medicaid as the source of payment determines if the patient meets the payer source eligibility requirement. On the other hand, a patient whose source of payment is only private pay would not be eligible for the HHCAHPS Survey.
7	Vendors should remove patients from the number of eligible patients entered on the XML data file if those patients were identified as deceased or reported during data collection that they did not receive care from the HHA.	The number of eligible patients data element on the XML data file must reflect the number of eligible patients at the time of sampling (i.e., who were included on the monthly patient information file and must include patients who were later identified as ineligible for the survey during the data collection period). Do not take these ineligible patients out of the total number eligible count.
<b>Skilled Visits and Lookback Period</b>		
8	The lookback period is defined as a 60-day lookback period.	The lookback period is the sample month and the month that immediately precedes the sample month. The lookback period is defined in terms of months, not days. HHCAHPS Survey vendors should make sure that their HHA clients understand the definition of the lookback period, and not refer to it as a "60-day" lookback period.

(continued)

**Table 4.3 (continued)**  
**Sampling Common Misconceptions and Problems with Proper Implementation**

Number	Misconception	Correct Implementation
<b>Skilled Visits and Lookback Period (continued)</b>		
9	An HHCAHPS Survey vendor can calculate and use the total number of skilled visits a patient had in the lookback period, rather than use the number of skilled visits reported by the HHA.	It is not acceptable for a vendor to calculate the number of skilled visits in the lookback period. HHCAHPS Survey vendors are required to use the number of skilled visits included on the monthly patient information file submitted by the HHA. However, if an HHA or its IT vendor provides the dates of all visits in the lookback period instead of the total number of visits, it is acceptable for the vendor to calculate the total number of visits in the lookback period. If the number of skilled visits the patient had during the lookback period is missing, the vendor should follow up with the HHA to retrieve the missing information. If the HHA cannot provide the total number of visits in the lookback period, then the vendor should consider the patient as eligible if they meet all other survey eligibility criteria.
<b>Sampling Procedures and Documentation Requirements</b>		
10	It is acceptable for a survey vendor to use only the patient's medical record number to identify patients who may have been listed more than once on a monthly patient information file or to identify patients who have been sampled in the last 5 months.	HHCAHPS Survey vendors are urged to use more than one data element to identify patients for whom duplicate information is provided on the monthly patient information file and to identify patients who have been sampled in the last 5 months. Using the medical record number together with at least one other data element, including patient name, date of birth, telephone number, or address will ensure that the correct patient is identified. Vendors may choose to perform the de-duplication process in multiple steps. However, the MRN should never be applied as the sole data element in any of the steps; that is, it should always be combined with another patient data element.
11	A SID number can be assigned more than once.	Once a SID number is assigned, it must never be used again. If a patient is sampled more than once, a new SID number must be assigned to that patient each time they are sampled. During the sampling process, all vendors should check the sample file to make sure that the same SID number is not assigned to two different patients and that the SID has not been assigned in a preceding sample month.
12	An HHCAHPS Survey vendor can conduct a census survey of all eligible patients during the first sample month that an HHA administers the HHCAHPS Survey; therefore, the survey vendor does not have to conduct the survey for the next 5 months unless the HHA has served new patients in those 5 months.	As described in this chapter, HHCAHPS Survey vendors must select and survey a sample of patients each sample month, including for very small HHAs. Using a sampling rate and selecting a sample of patients each sample month will ensure that an even distribution of patients is surveyed across a 12-month period.

(continued)

**Table 4.3 (continued)**  
**Sampling Common Misconceptions and Problems with Proper Implementation**

Number	Misconception	Correct Implementation
<b>Sampling Procedures and Documentation Requirements (continued)</b>		
13	The sampling rate should be adjusted each month.	The sampling rate should remain constant during a quarter. If there is a huge difference in the number of patients served in a month within a quarter, the HHCAHPS Survey vendor should follow up with the HHA to make sure that the information on the file is correct and determine the reason for the difference.
14	Vendors do not need to retain documentation of seed number or random numbers used.	Documentation of the seed number and the random number generation and application process is a critical component of the HHCAHPS sampling protocols, so that samples can be replicated for review during HHCAHPS site visits.
15	Vendors do not need to retain documentation of ineligible sample members.	Vendors must retain a separate file or list of each patient deemed ineligible and the reason that the patient did not meet the eligibility criteria. This information allows someone other than the person who selected the sample to conduct quality control of the sample, as a second person can easily check to make sure that the right patients were excluded. This information is also subject to review during site visits.
<b>Processing Patient Administrative Data</b>		
16	Vendors can use the ADL deficit count for individual ADLs to calculate and include on the XML data file the total ADL deficit count.	It is not acceptable for vendors to calculate and include on the XML data file the total number of ADL deficits. A vendor must report the same ADL information that the HHA provides on the monthly patient information file. If the HHA provides both a total ADL deficit count and the number of deficits for each individual ADL, the vendor must include both on the XML data file.
17	Vendors should enter a value of 0 (zero) on the XML data file for the ADL deficit count if the HHA does not provide either the total ADL count or the number of deficits for each individual ADL.	If an HHA does not provide the number of ADL deficits in the monthly patient information file, vendors must code the value on the XML as "M" for missing, rather than zero. If the ADL for which the value is missing is incorrectly coded as 0, it will incorrectly indicate that the sample patient was fully independent for that ADL.
18	Vendors can calculate the patient's age as of the beginning of the sample month.	Vendors need to compute the patient's age as of the end of the sample month in which the patient is being considered for eligibility. Some vendors were using other variations in how age was being computed (such as the date the sample was being processed or date patient received the home health visit). Vendors should check their age algorithm to ensure that the patient's age is being computed properly.

(continued)

**Table 4.3 (continued)**  
**Sampling Common Misconceptions and Problems with Proper Implementation**

<b>Number</b>	<b>Misconception</b>	<b>Correct Implementation</b>
<b>Processing Patient Administrative Data (continued)</b>		
19	If an HHA changes/switches vendors, the current HHCAHPS Survey vendor must provide a file containing patient information about all patients sampled in the preceding sample months so that the new vendor can exclude those patients from the sample frame.	Vendors are not required to provide the new vendor with a file containing information about patients sampled in the last 5 months.
<b>Sampling Quality Control Procedures</b>		
20	It is acceptable for HHAs not to provide all of the patient information required for administering the survey and for data analysis.	HHAs vary in the completeness of the patient information that they include on the monthly patient information files they submit to their HHCAHPS Survey vendor. HHAs are encouraged to provide complete information for all patients included on each monthly patient information file. Providing as much patient data as possible will increase the potential for an HHA's patients' characteristics to contribute to the calculation of the patient-mix adjustment factors that will be used in calculating an HHA's adjusted HHCAHPS Survey scores that will be publicly reported.
21	Vendors who have automated the receipt and processing of monthly patient information files and the sample selection process do not need to implement any quality control procedures, since the programs and algorithms used for these processes were fully tested after they were developed.	All vendors must have in place and implement quality control procedures on the entire sampling process, including receipt and processing of the monthly patient information files and sample selection for each sample month for each HHA client, including vendors who use automated systems or procedures for sampling.
22	It is acceptable for vendors to use the same staff who conduct the sampling process to also conduct quality control checks of the sample.	The quality control of each sample file should be performed by someone other than the person who performed each task associated with the sample selection process. Vendors are also encouraged to apply appropriate quality control checks on and test all of the computer programs and systems the vendor uses to receive and process monthly files.

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## **V. MAIL-ONLY ADMINISTRATION PROCEDURES**

### **Overview**

This chapter describes the requirements and guidelines for implementing the mail-only mode of survey administration for the HHCAHPS Survey. The chapter begins with a discussion of the mail survey protocol and schedule, followed by a discussion of the requirements for producing all mailing materials, including questionnaires, cover letters, and envelopes. Guidelines on how the questionnaire packages should be mailed and data processing guidelines, including optical scanning and data entry, are provided in this chapter. This chapter also provides suggestions for incorporating quality control activities into the mail-only mode of survey administration. Note that in most cases in this and subsequent chapters of this manual, patients included in the sample are referred to as “sample members,” “sample patients,” or “sampled cases.”

### **Data Collection Schedule**

Data collection for each sample member must be initiated no later than 3 weeks (21 days) after the close of the sample month. The timing of a mail-only administration process is shown in *Table 5.1*.

**Table 5.1**  
**Mail-Only Administration Schedule and Protocol**

<b>Activity</b>	<b>Timing</b>
Mail initial questionnaire with cover letter to sample members	No later than 3 weeks (21 days) after the close of the sample month
Mail second questionnaire with cover letter to all sample members who do not respond to first questionnaire mailing	Approximately 3 weeks (21 days) after the first questionnaire is mailed
Complete data collection	Six weeks (42 days) after the first questionnaire is mailed
Submit XML data files to the HHCAHPS Survey Data Center via the HHCAHPS Survey website	See the quarterly data submission deadlines on the HHCAHPS Survey website

If the 21st day of the month falls on a weekend or holiday, vendors should make every attempt to begin the survey on the business day prior to that weekend or holiday. However, it is acceptable to mail the questionnaire on the first business day following the weekend or holiday if necessary.

As indicated in *Chapter IV*, HHCAHPS Survey vendors must make a concerted effort to initiate the survey for each sample month within 21 days after the sample month ends. If for some reason

the survey cannot be initiated within 21 days after the sample month ends, the vendor can initiate the survey within 26 days after the sample month ends. Vendors must complete and submit a Discrepancy Notification Report if the survey is initiated within 26 days after the sample month closes. If the survey cannot be initiated within 26 days after the close of the sample month, CMS may allow the survey to be initiated more than 26 days after the sample month ended. However, survey vendors must submit a request via email (to [hhcahps@rti.org](mailto:hhcahps@rti.org)) for approval from CMS to initiate the survey more than 26 days after the sample month ends.

As noted in **Table 5.1**, data collection must be closed 6 weeks (42 calendar days) after the first questionnaire is mailed. Questionnaires returned after the 6-week data collection period has ended should be considered nonresponses and coded as such. Note as well that the deadline for quarterly data submission is constant. This deadline will not shift later even if the vendor starts data collection late.

## Production of Questionnaires, Letters, and Envelopes

The requirements for producing all materials needed for the mail-only survey packets are described below. Note that the mail survey version of the instrument is available in English, Spanish, Simplified and Traditional Chinese, Russian, Vietnamese, and Armenian. All of these versions of the survey materials are available on the HHCAHPS Survey website at <https://homehealthcahps.org>.

Copies of the mail survey instrument and mail survey cover letters are also included in the appendices to this manual:

- Mail survey cover letters, questionnaire and questionnaire in scannable format in English, *Appendix C*;
- Mail survey cover letters, questionnaire and questionnaire in scannable format in Spanish, *Appendix D*;
- Mail survey cover letters, questionnaire and questionnaire in scannable format in Simplified Chinese, *Appendix E*;
- Mail survey cover letters, questionnaire and questionnaire in scannable format in Traditional Chinese, *Appendix F*;
- Mail survey cover letters, questionnaire and questionnaire in scannable format in Russian, *Appendix G*;
- Mail survey cover letters, questionnaire and questionnaire in scannable format in Vietnamese, *Appendix H*;



- Mail survey cover letters, questionnaire and questionnaire in scannable format in Armenian, *Appendix I*; and
- OMB Disclosure Notice in English, Spanish, Simplified and Traditional Chinese, Russian, Vietnamese, and Armenian in *Appendix J*.

## Home Health Care CAHPS Survey Questionnaire

The HHCAHPS Survey mail mode questionnaire contains 34 questions. The survey can be administered as a standalone survey or can be combined with agency-specific questions. Questions 1 to 25 are considered the “core” questions and must be placed at the beginning of the questionnaire. Questions 26 to 34 are the “About You” questions and must be administered as a unit, although they may be placed either before or after any specific or supplemental questions that the home health agency (HHA) plans to add to the HHCAHPS Survey, if any. If no agency-specific questions are to be added to the HHCAHPS Survey questionnaire, the “About You” questions should follow the “core” questions. In addition, 10 CAHPS supplemental questions are available for HHAs (and vendors) to use, if an HHA desires, in *Appendix K*. An HHA can choose to use one or more of these supplemental questions; they do not need to be administered as a group. The HHCAHPS Survey questionnaire and supplemental questions are available on the HHCAHPS Survey website at <https://homehealthcahps.org>.

The following are formatting and content requirements and recommendations for the HHCAHPS Survey questionnaire. Survey vendors cannot deviate from questionnaire requirements.

### HHCAHPS Survey Questionnaire Requirements

- Every questionnaire must begin with the “core” HHCAHPS Survey questions.
- HHAs may add their own or the HHCAHPS Survey supplemental questions or open-ended questions, following the guidelines (listed below) about adding supplemental questions.
- The “About You” questions must be administered as a unit (i.e., they must be kept together and may not be split into multiple questions and placed throughout the questionnaire) but may be placed before or after any agency-specific questions.
- No changes in wording or order are allowed to either the HHCAHPS Survey questions or to the response (answer) choices.
- Questions and associated responses choices may not be split across pages.
- Vendors must be consistent throughout the questionnaire in formatting response options either vertically or horizontally. If a vendor elects to list the response options vertically, this must be done for every question in the questionnaire. Vendors may not format some response options vertically and some horizontally.

- A unique, randomly generated sample identification (SID) number must be assigned and appear on at least the first page of the survey, for tracking purposes. Additional identifiers are permitted; however, the sample member's name or other identifying information must not be printed anywhere on the survey.
- Only CMS-approved translations of the instrument are permitted; however, if agencies choose to add their own supplemental questions, vendors will be responsible for translating these questions if needed.
- The HHA name or logo should appear on the survey or the cover letter but cannot appear on the envelopes (for privacy), unless vendors submit an Exceptions Request Form indicating that they have the agency's approval to display the name or logo on the envelope and the agency believes there are no HIPAA risks.
- Survey vendors cannot include any promotional messages or materials, including indications that either the HHA or the survey vendor has been approved by the Better Business Bureau, on the HHCAHPS cover letter, questionnaire, or outgoing or incoming mailing envelopes.
- The vendor's name and mailing address must be printed at the bottom of the last page of the HHCAHPS Survey questionnaire in case the respondent does not use the enclosed business reply envelope.
- No matrix formatting of the questions is allowed. Matrix formatting means formatting a set of questions as a table, with responses listed across the top of a page and individual questions listed in a column on the left.
- Font size should be no smaller than size 10.
- The Office of Management and Budget (OMB) number and expiration date shown in *Appendix J* must be printed on the questionnaire cover, separately from the OMB disclosure notice. If there is no cover, then the OMB number and expiration date must be printed on the first page of the questionnaire.
- The OMB disclosure notice, which includes the OMB expiration date (see *Appendix J*), must be printed either on the questionnaire or in the cover letter.

### ***Recommendations for Printing the HHCAHPS Survey Questionnaire***

- Vendors should use best survey practices when formatting the instrument, such as maximizing the use of white space and using simple fonts like Arial.
- Use a two-column format.

- Use a font size of 12 or larger.
- If data entry keying is being used as the data entry method, small coding numbers next to the response choices may be used.

### ***Adding Supplemental Questions to the HHCAHPS Survey***

The Agency for Healthcare Research and Quality (AHRQ) developed 10 supplemental questions about home health care, which are included in *Appendix K* and available on the HHCAHPS Survey website (<https://homehealthcahps.org>); HHAs may wish to use these questions or add their own agency-specific questions to the HHCAHPS Survey questionnaire. In addition, one supplemental question must be included in the mail survey questionnaire if the HHA wishes to view the survey responses linked to respondents' name and other identifying information. The survey question, referred to as the Consent to Share Responses, must be printed in the mail survey questionnaire, and the respondent must mark the "Yes" response option for the vendor to provide the HHA with the respondent's answers linked to the respondent's name and identifying information. The Consent to Share Responses question is available in all six languages on the HHCAHPS Survey website.

Guidance for adding supplemental questions and the Consent to Share Responses question is as follows:

- All supplemental questions must be placed **after** the "core" questions. Supplemental questions may be placed either before or after the "About You" questions.
- We strongly recommend that agencies and vendors avoid sensitive questions or lengthy additions, because these will likely reduce expected response.
- Supplemental questions do not need to be approved by or reported to CMS. However, survey vendors should review the appropriateness of supplemental questions added to the HHCAHPS Survey and share any concerns they have directly with the HHA or the HHCAHPS Survey Coordination Team. Survey vendors must not include responses to the supplemental questions on the XML files that will be submitted to the HHCAHPS Survey Data Center.
- HHAs cannot add questions that repeat any of the survey items in the "core" HHCAHPS Survey verbatim, even if the response scale is different.
- Supplemental questions cannot be used with the intention of marketing or promoting services provided by the HHA or any other organization.
- Supplemental questions cannot ask sample patients to identify other individuals who may need home health care services because of privacy and confidentiality issues they raise if

personally identifiable information (PII) were shared with the HHA without that person's knowledge and permission.

- The HHCAHPS Survey supplemental questions are available in English, Spanish, Simplified and Traditional Chinese, Russian, Vietnamese, and Armenian. Vendors are responsible for translating non-CAHPS supplemental questions added to the questionnaire; however, only CMS-approved translations may be used for HHCAHPS Survey questions.
- The Consent to Share Responses question, available on the HHCAHPS Survey website, must be added to all questionnaires where an HHA requests that the survey vendor provide the survey responses linked to a sample member's name and other identifying information. This question is typically placed at the end of the questionnaire, as the last question.

### **Mail Survey Cover Letters (First and Second Questionnaire Mailings)**

The cover letters are provided in the appendices with the survey instruments (see *Appendices C–I*), and on the HHCAHPS website. Vendors that choose to modify the existing cover letters or develop their own cover letters must submit an Exceptions Request Form for CMS approval. All cover letters must meet the following requirements:

#### ***Requirements for Cover Letters***

- Cover letters must be personalized with the name and address of the sample member.
- Cover letters must be separate from the questionnaire, so that no PII is returned with the questionnaire when the respondent sends it back to the vendor.
- The OMB disclosure notice (see *Appendix J*) must be printed *either* on the questionnaire or in the cover letter.
- Vendors may not offer sample members the opportunity to complete the survey over the telephone if a mail-only mode is being implemented.

The following elements must be included in the cover letters for both the initial and follow-up questionnaire mailings:

- Language describing the purpose of the survey;
- Language stating that if help is needed, the sample member should ask a family member or friend for help to complete the survey rather than HHA personnel;
- A statement that participation is voluntary;
- The HHA name (or logo);

- A text box stating, “We care about your home health care experience” in the initial mail questionnaire cover letter;
- A text box stating, “We care about your care experiences” in the follow-up mail questionnaire cover letter; and
- A toll-free customer support telephone number, which will be staffed by the survey vendor.

Vendors that wish to deviate from these cover letter requirements must submit an Exceptions Request Form for CMS’s consideration.

### ***Recommendations for Cover Letters***

- Survey vendors offering a Spanish, Simplified and Traditional Chinese, Russian, Vietnamese, or Armenian version of the questionnaire may add language to the English cover letter indicating that a version of the questionnaire is available in those languages, or vice versa.
- We recommend that the signature of an appropriate official from the HHA be printed on each cover letter.

### **Mail Survey Mailing Envelopes**

Vendors are responsible for supplying both the outgoing envelopes for the questionnaire mailings and business reply envelopes that sample members will use to return their completed surveys. A postage-paid business reply envelope must be included with each questionnaire mailing, pre-addressed to the survey vendor.

### **Survey Mailing Requirements**

Mailing requirements and recommendations for the HHCAHPS Survey questionnaire mailings are described below. Vendors are expected to follow these requirements to maximize response rates and ensure consistency in how the mail-only mode of administration is implemented.

#### **Mail Survey Mailing Requirements**

- Each questionnaire mailing must contain a personalized cover letter, questionnaire, and postage-paid business reply envelope.
- The first questionnaire package must be mailed to all sampled cases, regardless of whether the mailing address is determined to be complete.
- Mailings must follow the schedule specified for the mail-only mode of administration in **Table 5.1**—the first questionnaire package must be mailed no later than 3 weeks after the close of the sample month; the second questionnaire to sample members who do not respond

to the first questionnaire mailing must be mailed approximately 3 weeks after the first questionnaire mailing.

- Data collection must end 6 weeks after the first questionnaire has been mailed.
- The use of incentives—monetary or nonmonetary—is not permitted.
- The use of proxy respondents is permitted. Vendors must adhere to the requirements listed below regarding proxies:
  - Other individuals may assist the sample member in reading the survey, marking response options, translating the survey, or answering questions for the sample member. However, the sample member should be advised in the letter not to ask for help with completing the survey from home health aides or other agency personnel.
  - Proxy respondents are NOT permitted for deceased sampled members.
  - An employee of a group home may serve as a proxy respondent for a sample patient who lives in the group home and who is physically or mentally incapable of responding to the survey. However, the vendor should ensure that the patient is physically or mentally incapable of responding for him- or herself, the proxy respondent is an employee of the group home and not the HHA, and the proxy respondent is knowledgeable about the sample patient's home health care. Provided these conditions are met, employees of the group home may serve as a proxy for the sample patient.
- Sample members with foreign addresses are considered eligible to participate in the HHCAHPS Survey if they meet all other eligibility criteria. Vendors should contact the HHA for the address where the home care was provided, but if no such address can be provided, vendors must mail to the foreign address.
- If the sample member's address is missing or incomplete, the vendor must follow up with the HHA to obtain the address. Because home health patients receive skilled care in their homes, the HHA must have an address at which the care is delivered. If the HHA cannot provide an address and the patient is sampled, the vendor should treat the patient as eligible and assign the applicable final disposition code to the case.

## Recommendations

- We recommend that vendors verify mailing addresses obtained from the agencies using commercial address update services, such as the National Change of Address (NCOA) or the U.S. Postal Service Zip+4 software.

- We recommend that vendors attempt to identify a new or updated address using commercial address vendors or the Internet for any mail returned as undeliverable in time to include the sample member in the follow-up questionnaire mailing.
- We recommend that questionnaires be sent with either first-class postage or indicia, to ensure timely delivery and maximize response rates.
- We recommend that vendors “seed” each mailing. Seeding means including the name and address of designated vendor staff in each mailing file to assess the completeness of the questionnaire package and timeliness of package delivery.

## Data Receipt and Data Entry Requirements

The following guidelines are provided for receiving and tracking returned questionnaires and entering the data using either data entry or optical scanning.

### Data Receipt Requirements

- The date the questionnaire was received from each sample member must be entered into the data record created for each case on the XML data file.
- Questionnaires should be visually reviewed prior to scanning for notes or comments. Vendors should have more than one person who can code or review comments and attach notes for proper disposition code assignment.
- Completed questionnaires received should be logged into the tracking system in a timely manner to ensure that sample members who respond to the first mailing are excluded from the second questionnaire mailing.
- If two questionnaires are received from the same sample member, vendors should keep and use the questionnaire that has the more complete data, regardless of which questionnaire is received first. If the two questionnaires received contain the same amount of data (are equally complete), the vendor should retain and use the first one received.
- If a completed questionnaire is returned and the vendor learns that a sampled patient is deceased and the questionnaire was completed by someone else, it is not acceptable to scan a questionnaire for that patient, even if it was completed by a proxy respondent. If the vendor learns that a sample patient is deceased (via a telephone call from a relative or friend or through a note or comment marked on the completed questionnaire), the vendor should not process (scan) data from the questionnaire, but instead assign the applicable final disposition code to the case to indicate that the sample member is deceased.

- A final HHCAHPS Survey status code (see *Table 9.1* in *Chapter IX*) must be assigned to each case.

## Optical Scanning Requirements

- The scanning program should not permit scanning of duplicate questionnaires.
- The scanning program should not permit out-of-range or invalid responses.
- A sample of questionnaires (minimum of 10%) should be rescanned and compared with the original as a quality control measure. Any discrepancies should be reconciled by a supervisor.
- The survey responses marked in a sample of questionnaires (minimum of 10%) should be compared to the entries scanned for that case to make sure that the scanning program scanned the marked responses correctly.
- If a response mark falls between two answer choices but is clearly closer to one answer choice than to another, select the response that is closest to the marked response.
- If two responses are checked for the same question, select the one that appears darkest. If it is not possible to make a determination, leave the response blank and code as “missing” rather than guessing.
- If a mark is between two answer choices but is not clearly closer to one answer choice, code as “missing.”
- If a response is missing, leave the response blank and code as “missing.”
- The decision on whether to key the responses to open-ended survey items, specifically, the “Some other language” (response option 3) in Q32 and the “Helped in some other way” (response option 5) in Q34, is up to each individual HHA. Vendors will not be required to key and include responses to open-ended survey items on the XML data files submitted to the HHCAHPS Survey Data Center. CMS, however, encourages survey vendors to review the open-ended entries so that they can provide feedback to the Coordination Team about adding additional preprinted response options to these survey items if needed.
- If the vendor includes the Consent to Share Responses question in the mail survey questionnaire, we recommend that the vendor scan the response to that question. However, responses to the Consent to Share Responses question will not be included on the XML data files submitted to the Data Center.



## Data Entry Requirements

- The key entry process should not permit keying of duplicate questionnaires.
- The key entry program should not permit out-of-range or invalid responses.
- All questionnaires should be 100% rekeyed for quality control purposes. That is, for every questionnaire, a different keyer should rekey the questionnaire to ensure that all entries are accurate. If any discrepancies are observed, a supervisor should resolve the discrepancy and ensure that the correct value is keyed.
- If a response mark falls between two answer choices but is clearly closer to one answer choice than to another, select the answer choice that is closest to the marked response.
- If two responses are checked for the same question, select the one that appears darkest. If it is not possible to make a determination, leave the response blank and code as “missing” rather than guessing.
- If a mark is between two answer choices but is not clearly closer to one answer choice, code as “missing.”
- If a response is missing, leave the response blank and code as “missing.”
- The decision on whether to key the responses to open-ended survey items, specifically, the “Some other language” (response option 3) in Q32 and the “Helped in some other way” (response option 5) in Q34, is up to each individual HHA. Vendors will not be required to key and include responses to open-ended survey items on the XML data files submitted to the HHCAHPS Survey Data Center. CMS, however, encourages survey vendors to review the open-ended entries so that they can provide feedback to the Coordination Team about adding additional preprinted response options to these survey items if needed.
- If the vendor includes the Consent to Share Responses question in the mail survey questionnaire, we recommend that the vendor key the response to that question. However, responses to the Consent to Share Responses question will not be included on the XML data files submitted to the Data Center.

## Staff Training

All staff involved in the mail survey implementation, including support staff, must be thoroughly trained on the survey specifications and protocols. A copy of relevant chapters of this manual should be made available to all staff as needed. In particular, staff involved in questionnaire assembly and mailout, data receipt, and data entry must be trained on:

- Use of relevant equipment (case management systems for entering questionnaire receipts, scanning equipment, data entry programs);
- HHCAHPS Survey protocol specific to their role (for example, contents of questionnaire package, how to document or enter returned questionnaires into the tracking system);
- Decision rules and coding guidelines for returned questionnaires (see *Chapter IX*); and
- Proper handling of hardcopy and electronic data, including data storage requirements and adhering to HIPAA regulations (see *Chapter VIII*).

Staff involved in providing customer support via the toll-free telephone number should also be trained on the accurate responses to commonly asked questions, how to respond to questions when customer support does not know the answer, and the rights of survey respondents. If the HHCAHPS Survey is being offered in a language other than English, customer support staff should also be able to handle questions via the toll-free telephone number in that language. Telephone interviewer training requirements are described in more detail in *Chapter VI* of this manual. Please refer to that chapter for more information on training customer support staff.

## Mail-Only Quality Control Guidelines

The following steps are required or recommended as a means of incorporating quality control into the mail-only survey administration procedures. Quality control checks should be conducted by a different staff person than the one who completed the task. Some of these are mentioned earlier in the chapter.

### Required

- Check a minimum of 10% of all printed materials to ensure the quality of the printing—that is, make sure that there is no smearing, misaligned pages, duplicate pages, or stray marks on pages.
- Check a minimum of 10% of all outgoing questionnaire packages to ensure that all package contents are included and that the same unique SID number appears on both the cover letter and the questionnaire.
- For vendors that use optical scanning, a sample of questionnaires (minimum of 10%) should be rescanned and compared with the original as a quality control measure. This serves as a quality control measure that the scanning program is capturing the hardcopy questionnaire responses correctly. Any discrepancies should be reconciled by a supervisor.
- For vendors that use manual data entry, all questionnaires should be 100% rekeyed for quality control purposes. That is, for every questionnaire, a different keyer should rekey the

questionnaire to ensure that all entries are accurate. If any discrepancies are observed, a supervisor should resolve the discrepancy and ensure that the correct value is retained.

## **Recommended**

- Verify that sample members' mailing addresses provided by the HHA are correct by using commercial address update services, such as NCOA or the U.S. Postal Service Zip+4 software. Note that cases with incomplete mailing addresses must remain in the sample.
- "Seed" each mailing. That is, include the name and address of designated vendor staff in each mailing file to assess the completeness of the questionnaire package and timeliness of package delivery.
- Before submitting data to the HHCAHPS Data Center, we highly recommend that vendors do the following:
  - Review a sample of cases comparing responses coded on the hardcopy questionnaire to the response codes that appear on the XML data file. This quality control step will ensure that the responses included in the XML data files accurately reflect the sample patients' responses to the survey questions.
  - Review a sample of cases with a noncomplete final code (i.e., cases with a final disposition other than 110 or 310) against the original source of information that resulted in the case being finalized. This could include reviewing vendor's toll-free telephone number call-in tracker, handwritten notes on mail survey, white mail, etc.
- Vendors are urged to develop a way to measure error rates for their data receipt staff (in terms of recognizing marginal notes and passing these on to someone for review), for data entry or scanning operators, and for coders. Vendors should then work with their staff to minimize error rates. The Coordination Team will request information about data receipt and processing error rates during site visits to survey vendors.

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## **VI. TELEPHONE-ONLY ADMINISTRATION PROCEDURES**

### **Overview**

This chapter describes the requirements and guidelines for implementing the telephone-only mode of survey administration for the HHCAHPS Survey. The chapter begins with a discussion of the telephone-only data collection schedule, followed by a discussion of the requirements for producing all telephone interviewing materials and systems. It includes guidelines on how the telephone interview should be developed and administered, including general interviewing guidelines and frequently asked questions that interviewers may encounter. This chapter also provides suggestions for data processing procedures and incorporating quality control activities into the telephone-only mode of survey administration.

### **Data Collection Schedule**

If the HHCAHPS Survey is being administered as a telephone-only survey, data collection for each sample member must be initiated no later than 3 weeks (21 days) after the close of the sample month.

*Table 6.1* shows the prescribed order of activities and timing for an all-telephone HHCAHPS Survey.

**Table 6.1**  
**Prescribed Order of Activities and Timing for an All-Telephone HHCAHPS Survey**

<b>Activity</b>	<b>Timing</b>
Begin telephone contact with sample members	No later than 3 weeks (21 days) after the close of the sample month
Complete telephone data collection	Six weeks (42 days) after initial telephone contact begins
Submit XML data files to the HHCAHPS Survey Data Center via the HHCAHPS Survey website	See quarterly data submission deadlines on the HHCAHPS Survey website

If the 21st day of the month falls on a weekend or holiday, vendors should make every attempt to begin the survey on the business day prior to that weekend or holiday. However, it is acceptable to begin telephone calls on the first business day following the weekend or holiday if necessary.

As indicated in *Chapter IV*, HHCAHPS Survey vendors must make a concerted effort to initiate the survey for each sample month within 21 days after the sample month ends. If for some reason the survey cannot be initiated within 21 days after the sample month ends, the vendor can initiate

the survey within 26 days after the sample month ends. The vendors must complete and submit a Discrepancy Notification Report if the survey is initiated within 26 days after the sample month closes. If the survey cannot be initiated within 26 days after the close of the sample month, CMS may allow the survey to be initiated more than 26 days after the sample month ended. However, survey vendors must submit a request via email (to [hhcahps@rti.org](mailto:hhcahps@rti.org)) for approval from CMS to initiate the survey more than 26 days after the sample month ends.

As noted in **Table 6.1**, data collection must be closed 42 calendar days after the telephone survey begins. Note as well that the deadline for data submission is constant. This deadline will not shift later if the vendor starts data collection late.

## Telephone Instrument and Systems Requirements

The following paragraphs describe the requirements for producing all materials and systems needed for the telephone-only survey. The telephone script for interviews with sampled patients and the telephone script for interviews with proxy respondents in English, Spanish, Russian, and Vietnamese in both Microsoft Word and PDF formats are available on the HHCAHPS Survey website at <https://homehealthcahps.org>. Note that although Chinese-language and Armenian-language versions of the mail survey instrument are available, the HHCAHPS Survey cannot be administered in Chinese or Armenian by telephone.

Copies of the telephone interview script and the script for use with proxy respondents can also be found in **Appendix C** (English), **Appendix D** (Spanish), **Appendix G** (Russian), and **Appendix H** (Vietnamese). A list of questions that are frequently asked by sample members and suggested answers to those questions are included in **Appendix L**. Some general guidelines for telephone interviewer training and monitoring are provided in **Appendix M**.

Specific requirements and guidelines associated with the telephone survey administration are discussed below.

## Telephone Interviewing Systems

An electronic telephone interviewing system means that the interviewer reads from and enters responses into a computer program. Using an electronic system encourages standardized interviewing and monitoring of interviewers. Survey vendors using the telephone-only survey mode must use an electronic system to administer the HHCAHPS Survey. ***Paper-and-pencil administration is not permitted for telephone surveys.*** To ensure that sample members are called at different times of the day and across multiple days of the week, vendors must also have a survey management system. Ideally, the electronic system will be linked to the survey management system so that cases can be tracked, appointments set and called back at appropriate times, and pending and final case status easily accessed for any case.

There are two additional requirements as follows:

- Predictive or automatic dialers are permitted, as long as they are compliant with Federal Trade Commission and Federal Communications Commission regulations, and as long as respondents can easily interact with a live interviewer. For more information about Federal Trade Commission and Federal Communications Commission regulations, please visit <https://www.ftc.gov/> and <https://www.fcc.gov/>.
- Indication of cell phone is needed for phone-only and mixed-mode surveys. FCC regulations prohibit predictive-dialing of cell phone numbers. Therefore, cell phone numbers need to be identified in advance to allow the vendor to treat cell phone numbers in a way that complies with FCC regulations. Vendors are advised to familiarize themselves with all applicable state and federal laws. If the home health agency (HHA) is unable to advise the survey vendor as to which telephone numbers provided are cell phone numbers, it is the vendor's responsibility to obtain from an external source an up-to-date list of cell phone numbers and land line numbers which have been ported to cell phone. The external source must be compared to the phone numbers of the sampled patients to identify any phone numbers which are cell phones. Vendors must do this for each monthly sample.

### Telephone Interview Script

Survey vendors are provided with standardized telephone scripts in *Appendix C* (English), *Appendix D* (Spanish), *Appendix G* (Russian), and *Appendix H* (Vietnamese). These scripts include the introductory screens, in addition to the survey questions. The survey can be administered as a standalone survey or can be combined with agency-specific questions.

Note that the HHCAHPS telephone interview script contains only 32 questions and the mail survey contains 34 questions, because the mail survey questionnaire contains questions that ask if anyone helped the sample member to complete the survey (Questions 33 and 34). These two questions are not applicable if the survey is administered by telephone. However, the survey vendor must indicate on the XML data file submitted to the HHCAHPS Survey Data Center whether the phone interview was completed by a proxy respondent.

Programming requirements for the HHCAHPS Survey telephone interview are listed below:

- The “core” HHCAHPS Survey questions (Questions 1 to 25) must be administered first and in the order in which they appear—vendors cannot change the ordering of these “core” questions.
- No changes in wording or order are allowed for either the HHCAHPS Survey questions or to the response choices.

- HHAs may add their own or the HHCAHPS Survey supplemental questions (*Appendix K*), following the guidance below about adding supplemental questions.
- The “About You” questions (Questions 26 to 32) must be administered as a unit, but may come before or after any HHA-specific questions. If the HHA does not plan to add supplemental questions to the questionnaire, the questions in the “About You” section should follow the core set of questions.
- Only CMS-approved translations of the HHCAHPS Survey interview are permitted, although if agencies choose to add supplemental questions, vendors are responsible for translating these questions.
- A proxy telephone interview script is provided in English, Spanish, Russian, and Vietnamese in *Appendices C (English), D (Spanish), G (Russian), and H (Vietnamese)*. Vendors are required to administer this script when conducting proxy interviews; therefore, this script must be programmed for electronic administration in each language the vendor offers.
- Once the XML data files are submitted to the HHCAHPS Survey Data Center, survey vendors must indicate whether the interview was completed by a proxy respondent; therefore, the electronic interview should be programmed to indicate whether the interview was completed by the sample member or a proxy respondent.

## Adding Supplemental Questions

The Agency for Healthcare Research and Quality (AHRQ) developed 10 supplemental questions about home health care, which are included in *Appendix K* and available on the HHCAHPS Survey website (<https://homehealthcahps.org>); HHAs may wish to use these questions or add their own agency-specific questions to the HHCAHPS Survey questionnaire. In addition, one supplemental question must be included in the questionnaire if the HHA wishes to view the survey responses linked to the respondents’ name and other identifying information. The survey question, referred to as the Consent to Share Responses, must be included in the telephone survey questionnaire and the respondent must answer “Yes” to this question for the vendor to link the respondent’s answers with his or her name and/or other identifying information. The Consent to Share Responses question is available in all six languages on the HHCAHPS Survey website.

Guidance for adding the HHCAHPS Survey supplemental questions and the Consent to Share Responses question is as follows:

- All supplemental questions must be placed **after** the “core” questions. Supplemental questions may be placed either before or after the “About You” questions.



- We strongly recommend that agencies/vendors avoid sensitive questions or lengthy additions, because these will likely reduce expected response.
- Supplemental questions do not need to be approved by or reported to CMS. However, survey vendors should review the appropriateness of supplemental questions added to the HHCAHPS Survey and share any concerns they have directly with the HHA or the HHCAHPS Survey Coordination Team. Supplemental question responses will not be reported to CMS.
- HHAs cannot add questions that repeat any of the survey items in the HHCAHPS Survey instrument, even if the response scale is different.
- Supplemental questions cannot be used with the intention of marketing or promoting services provided by the HHA or any other organization.
- Supplemental questions cannot ask sample patients to identify other individuals who may need home health care services because of privacy and confidentiality issues they raise if personally identifiable information (PII) were shared with the HHA without that person's knowledge and permission.
- Vendors are responsible for translating any non-CAHPS supplemental questions; only CMS-approved translations may be used for HHCAHPS Survey questions, however.
- The Consent to Share Responses question, available on the HHCAHPS Survey website, must be added to all questionnaires if the HHA requests that the survey vendor provide survey responses linked to the respondent's name and other identifying information. This question is typically placed at the end of the interview.

## Telephone Interviewing Requirements

Telephone interviewing requirements and recommendations for the HHCAHPS Survey interview are described below. Vendors are expected to follow these requirements to maximize response rates and to ensure consistency in how the telephone-only mode of administration is implemented.

### Telephone Contact

- Vendors must attempt to contact every patient in the sample. Vendors are required to make five telephone contact attempts for each sampled case, unless the sample member refuses or the vendor learns that the sample member is ineligible to participate in the survey.
- A telephone contact attempt is defined as one of the following:
  - the telephone rings six times with no answer or an answering machine is reached;

- the interviewer reaches a household member and is told that the sample member is not available to take the call;
  - the interviewer reaches the sample member and is asked to schedule a call-back at a later date; or
  - the interviewer gets a busy signal on each of three consecutive phone call attempts, spaced at least 20 minutes apart.
- Vendors may make more than one phone call in one 7-day period but cannot make all five attempts in one 7-day period. Vendors should keep in mind that some home health patients may be sicker than some other patient populations and may be hospitalized when some of the initial calls are made. Scheduling calls to take place over a longer period of time could reach patients who may be unavailable the first week of the data collection period.
  - Phone calls must be made at different times of the day (i.e., morning, afternoon, and evening) and different days of the week throughout the data collection period.
  - Contact with a sample member may be continued after five attempts if the fifth attempt results in a scheduled appointment with the sample member, as long as the appointment is within the data collection period.
  - Interviewers **may not** leave voicemail messages on answering machines **or** leave messages with household members.
  - Interviewers may tell the person who answers the phone that they would like to speak to the sample member about their experiences with home health care at the named agency **ONLY IF** the person on the phone volunteers they are the sample member's next of kin (which CMS defines as the sample member's partner, child, parent, sibling, grandchild, or power of attorney). Otherwise, interviewers can only say they would like to speak to the sample member "about a health care study." The interviewer may say they would like to talk to the proxy about the sample member's experiences with home health care they received from the named agency. **IMPORTANT:** These are the only circumstances in which a vendor can share this additional information.
  - Vendors must maintain a phone call log that keeps track of the date and time phone calls were made for each sample member.
  - If the vendor finds out that a sample member is ineligible for the HHCAHPS Survey, the vendor must immediately stop further contact attempts with that sample member.

- Telephone survey data collection for each monthly sample must begin no later than 3 weeks from the close of the sample month and must be completed within 6 weeks from the initial telephone attempt.
- The use of incentives—monetary or nonmonetary—is not permitted.
- The use of proxy respondents is permitted. Vendors must adhere to the requirements listed below regarding proxies:
  - Other individuals may assist the sample member in answering questions or answer questions on the sample member’s behalf, as long as the sample member is physically or mentally incapable of completing an interview.
  - Proxy respondents may not be used for sample members who simply “do not want” to participate.
  - The sample member should be advised not to ask for help from HHA personnel, nor should interviewers conduct proxy interviews with HHA personnel.
  - Proxy responses are NOT permitted for deceased sample members.
  - An employee of a group home may serve as a proxy respondent for a sample patient who lives in the group home. However, the vendor should ensure that the patient is physically or mentally incapable of responding for him- or herself, the proxy respondent is an employee of the group home and not the HHA, and the proxy respondent is knowledgeable about the sample patient’s home health care.
- If a respondent begins the interview but cannot complete it during the call for a reason other than a refusal, the vendor should follow up with the respondent to complete the entire interview. The interviewer should follow up even if the respondent answered enough questions in the interview for the case to pass the completeness criteria (as discussed in **Chapter IX**). It is especially important to complete the questions in the “About You” section of the questionnaire, because data from some of those questions will be used in patient-mix adjustment.
- The vendor must be able to offer the interview in any of the approved languages (English, Spanish, Russian, or Vietnamese) for which an HHA has contracted, even if the language is different from the language that the HHA believes the sample member will require. That is, the vendor must be able to easily switch to accommodate a respondent’s language preference. For example, if the initial contact is in English but the respondent prefers to conduct the interview in Spanish, the vendor must be able to switch to Spanish.

- Sample members are still eligible even if they have missing, incomplete, or foreign phone numbers. The vendor should contact the HHA to obtain the telephone number for the address where home care was delivered. If the HHA cannot provide this number, the vendor should attempt to obtain a telephone number for the sample patient from other sources (directory assistance, Internet directories, etc.). If the vendor still cannot obtain a telephone number, the vendor should code the case as code “340—wrong, disconnected, no telephone number.”
- If a respondent decides after they have answered some of the questions in the telephone interview that they do not wish to participate in the survey any longer, the vendor should code the case as a refusal. The vendor should not use the partial data that were obtained before the interview ended. This protocol applies even if the respondent answered enough questions in the interview for the case to pass the completeness criteria. Note that this situation is different from the respondent saying that they do not wish to continue an interview. If the respondent breaks off the interview but does not state that they do not wish to participate in the survey, the data may be used. In this case, the vendor should code the case as a 120 – Completed Telephone Interview if the case passes the completeness criteria; otherwise, it should be coded as a 310 – Breakoff.

### **Contacting Difficult-to-Reach Sample Members**

- Although not required, we strongly recommend that survey vendors verify telephone numbers obtained from the HHA, using a commercial address/telephone database service or directory assistance.
- We recommend that vendors attempt to identify a new or updated telephone number for any sample member whose telephone number is no longer in service when called and for any sample members who have moved so that the sample members can be contacted prior to the end of the data collection period.
- If the sample member’s telephone number is incorrect, the interviewer may ask the person who answers the phone for the sample member’s phone number.
- If the sample member is temporarily ill, on vacation, or unavailable during initial contact, the interviewer should attempt to recontact the sample member before the data collection period ends. If the sample member cannot be reached before the data collection period ends, code the case as 350 – No Response After Maximum Attempts.
- If the sample member does not speak the language(s) that the vendor is administering for that agency, the interviewer should thank the sample member for his or her time, end the interview, and code the case as 230 – Ineligible: Language Barrier.

- If a sample member is physically or mentally incapable of responding by telephone, a family member or friend can serve as a proxy respondent. Under no circumstances should an interviewer use a home health provider or aide from an HHA as a proxy respondent.
- For sample members who are living in institutions (nursing homes, assisted living, etc.), HHCAHPS Survey vendors should contact the HHA to obtain a direct-dial telephone number. Because health care is delivered in the patient's home, the HHA should have a direct-dial number for the patient to reach him or her to arrange and schedule home care. If the HHA cannot provide a direct-dial telephone number for the sample patient, try to obtain the sample member's telephone number using other sources, such as a telephone number lookup service, directory assistance, or Internet telephone survey directories. If vendors cannot obtain a telephone number for the sample patient, they should assign a disposition code of 340—Wrong, Disconnected, or No Telephone Number to the case.

## Telephone Interviewer Training

Vendors must provide training to all telephone interviewing and customer support staff prior to starting telephone survey data collection activities. Telephone interviewer and customer support staff training must include the following:

- Teaching interviewers how to establish rapport with the respondent;
- Teaching interviewers the content and purpose of the interview so that they can effectively communicate this information to the sampled patients;
- Teaching interviewers to administer the interview in a standardized format, which includes reading the questions as they are worded, not providing the respondent with additional information that is not scripted, maintaining a professional manner, and adhering to all quality control standards;
- Teaching interviewers how to administer the proxy script;
- Teaching interviewers how to use effective neutral probing techniques;
- Teaching interviewers to use the FAQs document (see *Appendix L*) so that they can answer questions in a standardized format; and
- Teaching multilingual customer support staff how to handle questions in English and the other language(s) in which the survey is being offered.

Survey vendors should also provide telephone survey supervisors with an understanding of effective quality control procedures to monitor and supervise interviewers.

Vendors must conduct an interviewer certification process of some kind—either oral, written, or both—for each interviewer and customer service staff member prior to permitting that person to make or take calls on the HHCAHPS Survey. The certification should be designed to assess the interviewer’s level of knowledge and comfort with the HHCAHPS Survey instrument and ability to respond to sample members’ questions about the survey. Documentation of training and certification of all telephone interviewers and customer support staff and outcomes will be subject to review during oversight visits by the HHCAHPS Survey Coordination Team.

## Distressed Respondent Procedures

It is critically important that survey vendors to develop a “distressed respondent protocol,” to be incorporated into all interviewer and help desk training. Handling distressed respondent situations requires balancing keeping PII and private health information (PHI) confidential and helping a person who needs assistance. For survey research organizations, best interviewing practices recommend having a distressed respondent protocol in place for handling distressed respondents, which balances the respondent’s right to confidentiality and privacy and providing assistance, if the situation indicates that the respondent’s health and safety are in jeopardy.

Each approved HHCAHPS Survey vendor is expected to have procedures in place for handling distressed respondent situations and to follow those procedures. CMS and the HHCAHPS Survey Coordination Team cannot provide guidelines on how to evaluate or handle distressed respondents. However, survey vendors are urged to consult with their organization’s Committee for the Protection of Human Subjects Institutional Review Board (IRB) for guidance. In addition, professional associations for researchers, such as the American Association of Public Opinion Researchers (AAPOR), may be able to provide guidance regarding this issue. The following is an excerpt from AAPOR’s website that lists resources for the protection of human subjects. More information about protection of human subjects is available at AAPOR’s website at <https://www.aapor.org/>.<sup>5</sup>

- The Belmont Report (guidelines and recommendations that gave rise to current federal regulations)
- Federal Regulations Regarding Protection of Human Research Subjects (45 CFR 46) (also known as the Common Rule)
- Federal Office for Human Research Protections (OHRP)

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<sup>5</sup> The American Association of Public Opinion Researchers website at <https://www.aapor.org/Standards-Ethics/Institutional-Review-Boards/>, 2014.

- NIH Human Participant Investigator Training (although the site appears to be for cancer researchers, it is the site for the general investigator training used by many institutions)
- University of Minnesota Web-Based Instruction on Informed Consent

## Telephone Data Processing Procedures

The following guidelines are provided for ensuring that the telephone interview data are properly processed and managed.

### Telephone Data Processing Requirements

- A unique sample identification (SID) number must be assigned to each sample case and included in the case management system and on the final XML data file for each sample member.
- Vendors must enter the date of the interview with each respondent in the survey management system or in the interview data.
- Vendors must be able to link each telephone interview to their survey management system, so that appropriate data elements, such as the language in which the survey was conducted, can be pulled into the final XML data file.
- Vendors must de-identify all telephone interview data when the data are transferred into the final XML data file for delivery. Identifiable data include respondent names and contact information.
- Vendors must assign a final HHCAHPS Survey status or disposition code to each case (see *Chapter IX* for a list of these codes) and include a final disposition code for each sampled case in the final XML data file. It is up to the vendor to develop and use a set of pending disposition codes to track actions on a case before it is finalized appropriately—pending disposition codes are not specified in the HHCAHPS Survey protocol.

### Telephone-Only Quality Control Guidelines

The following activities are methods to incorporate quality control into the telephone-only survey administration procedures. Quality control checks should be conducted by a different staff person than the one who completed the task.

### Requirements for Telephone Protocol

- HHCAHPS requires that survey vendors thoroughly test the electronic telephone interviewing system before beginning the HHCAHPS Survey. Testing will vary from system to system, but includes at a minimum comparing each screen to the telephone script (in *Appendices C, D, G, and H*) to verify that the questions and response options are faithful to

the script, checking each question to ensure that the answers input match the data exported, and checking that a respondent is automatically routed to the next appropriate question.

- Vendors are required to keep written documentation that all telephone interviewing and customer support staff have been properly trained prior to interviewing. Copies of interviewer certification exam scores should be retained as well. Documentation should be maintained for any retraining required and will be subject to review during oversight visits.
- Vendors must establish and communicate clear telephone interviewing quality control guidelines for their staff to follow. These guidelines should be used to conduct the monitoring and feedback process, and should include clear explanations of the consequences of not following protocols, including actions such as removal from the project or termination of employment.
- Vendors are required to silently monitor a minimum of 10% of all telephone interviews to ensure that correct administration procedures are being followed. Vendor must be able to conduct live monitoring for regular survey operations and site visits.
- There are federal and state laws and regulations relating to the monitoring/recording of telephone calls. In certain states, consent must be obtained from **every party** or conversation if it involves more than two people (“two-party consent”). When calling sample members who reside in these states, survey vendors should not begin either monitoring or recording the telephone calls until *after* the interviewer has read the following statement: “This call may be monitored or recorded for quality improvement purposes.”<sup>6</sup>
- Vendors are responsible for identifying and adhering to federal and state laws and regulations in the states in which they will be administering the HHCAHPS Survey.

### Recommendations for Telephone Protocol

- Although not required, we recommend that vendors conduct regular Quality Circle meetings with telephone interviewing and customer support staff to obtain feedback on issues related to telephone survey administration or handling inbound calls.
- Monitoring staff or supervisors should provide performance feedback to interviewers as soon as possible after the monitoring session has been completed.

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<sup>6</sup> The following states currently require two-party or all-party consent when telephone calls are monitored or audiotaped: California, Connecticut, Delaware, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, New Hampshire, Pennsylvania, Vermont, and Washington.



- Supervisory staff monitoring telephone interviewers should use the computer-assisted telephone interviewing (CATI) or alternative electronic system to observe the interviewer conducting the interview while listening to the audio of the call at the same time.
- Interviewers should be given the opportunity to correct deficiencies in their administration through additional practice or retraining; however, interviewers who receive consistently poor monitoring scores should be removed from the project.
- Vendors should conduct periodic reviews of their XML data files by comparing at least 50 completed telephone interview responses directly from their CATI system to the values output in the XML data file. Doing this monthly review will ensure that the responses are being accurately captured and output to the XML data file.
- Review a sample of cases with a noncomplete final code (i.e., cases with a final disposition other than 120 or 310) against the original source of information that resulted in the case being finalized. This could include reviewing telephone interviewer call notes, vendor's toll-free telephone number call-in tracker, etc.

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## **VII. MAIL WITH TELEPHONE FOLLOW-UP (MIXED-MODE)**

### **SURVEY ADMINISTRATION PROCEDURES**

#### **Overview**

This chapter describes the requirements and guidelines for implementing a mixed-mode survey administration for the HHCAHPS Survey. For the HHCAHPS Survey, “mixed mode” is defined as a mail survey followed by a telephone survey of nonrespondents. Vendors are not permitted to conduct mixed-mode surveys where the mail and telephone modes are offered in two different languages.

This chapter begins with a discussion of the data collection schedule that should be followed when a mixed-mode design is used. The mail survey protocols are described next, followed by a discussion of the protocols for implementing the telephone follow-up of nonrespondents. The chapter ends with quality control guidelines that should be implemented throughout the mixed-mode data collection process.

#### **Data Collection Schedule**

Survey vendors using mail with telephone follow-up of nonrespondents must initiate the mail survey for each monthly sample no later than 3 weeks (21 days) after the close of the sample month. **Table 7.1** shows the basic tasks and timing of activities when conducting the HHCAHPS Survey using a mixed-mode survey administration.

**Table 7.1**  
**Tasks and Schedule of Activities for Mail With Telephone Follow-Up**

<b>Activity</b>	<b>Timing</b>
Mail questionnaire with cover letter to sample members	No later than 3 weeks (21 days) after the close of the sample month
Initiate telephone follow-up contact for all mail survey nonrespondents	Approximately 3 weeks (21 days) after the questionnaire is mailed
Complete data collection	Six weeks (42 days) after the questionnaire is mailed
Submit XML data files to the HHCAHPS Survey Data Center via the HHCAHPS Survey website	See quarterly data submission deadlines on the HHCAHPS Survey website

If the 21st day of the month falls on a weekend or holiday, vendors should make every attempt to begin the survey on the business day prior to that weekend or holiday. However, it is acceptable

to mail the questionnaires on the first business day following the weekend or holiday if necessary.

As indicated in **Chapter IV**, HHCAHPS Survey vendors must make a concerted effort to initiate the survey for each sample month within 21 days after the sample month ends. If for some reason the survey cannot be initiated within 21 days after the sample month ends, the vendor can initiate the survey within 26 days after the sample month ends. The vendors must complete and submit a Discrepancy Notification Report if the survey is initiated within 26 days after the sample month ends. If the survey cannot be initiated within 26 days after the close of the sample month, CMS may allow the survey to be initiated more than 26 days after the sample month ended. However, survey vendors must submit a request via email (to [hhcahps@rti.org](mailto:hhcahps@rti.org)) for approval from CMS to initiate the survey more than 26 days after the sample month ends.

As noted in **Table 7.1**, data collection must be closed 42 calendar days after the questionnaire is mailed. Note as well that the deadline for data submission is constant. This deadline will not shift later if the vendor starts data collection late.

As explained in **Chapter IX**, all cases that ***are not finalized*** as a result of the mail survey component of mixed-mode administration must be assigned for telephone follow-up, including both cases that are returned blank and undeliverable mail. This means that unless the case was a complete, refusal, or the patient was determined to be ineligible for the survey during the mail survey data collection phase of the survey, survey vendors should follow up with the patient by telephone.

All telephone contact should be initiated and completed within the specified 3-week period noted above in **Table 7.1**. Questionnaires may be received through the mail after the case has been referred for telephone follow-up. If these questionnaires arrived *before* the 6-week data collection period ended, they should be processed and telephone efforts with this case should be stopped. If these questionnaires arrived *after* the 6-week data collection period ended, they should be considered nonresponses and coded as such.

## **Production of Questionnaires, Letters, and Envelopes**

Vendors conducting mixed mode surveys must administer the survey using the same language in both components (mail and telephone) (e.g., English mail survey must be administered with English telephone follow-up; Spanish mail survey with Spanish telephone follow-up). For this reason, the mixed-mode design cannot be used in conjunction with the Chinese or Armenian versions of the mail questionnaire, because there is no corresponding HHCAHPS-approved telephone interview in these languages.

The requirements for producing all materials needed for the mail survey packets are described below. All versions of these survey materials in the approved languages (English, Spanish,

Russian, and Vietnamese) are available on the HHCAHPS Survey website at <https://homehealthcahps.org> and as appendices to this manual:

- Mail survey cover letters, questionnaire, and questionnaire in scannable format in English, *Appendix C*;
- Mail survey cover letters, questionnaire, and questionnaire in scannable format in Spanish, *Appendix D*;
- Mail survey cover letters, questionnaire, and questionnaire in scannable format in Russian, *Appendix G*;
- Mail survey cover letters, questionnaire, and questionnaire in scannable format in Vietnamese, *Appendix H*; and
- OMB Disclosure Notice in English, Spanish, Russian, and Vietnamese in *Appendix J*.

Specific requirements and guidelines associated with the questionnaire and cover letter are discussed below. In addition, general guidelines for the production of envelopes to be used with the mailing are provided.

## HHCAHPS Survey Questionnaires

The HHCAHPS Survey questionnaire used in the mail mode contains 34 questions. The survey can be administered as a standalone survey or can be combined with agency-specific questions. Questions 1 to 25 are considered the “core” questions and must be placed at the beginning of the questionnaire. Questions 26 to 34 are the “About You” questions and must be administered as a unit, although they may be placed either before or after any agency-specific supplemental questions that the home health agency (HHA) plans to add to the HHCAHPS Survey, if any. If no agency-specific questions are to be added, the “About You” questions should follow the “core” questions. In addition, 10 HHCAHPS supplemental questions are available for HHAs (and vendors) to use, if an HHA desires, in *Appendix K*. An HHA can choose to use one or more of these supplemental questions; they do not need to be administered as a group. The HHCAHPS Survey questionnaire and supplemental questions are available on the HHCAHPS Survey website at <https://homehealthcahps.org>.

## HHCAHPS Survey Questionnaire Requirements

The following are formatting and content requirements and recommendations for the HHCAHPS Survey questionnaire. Note that survey vendors cannot deviate from questionnaire requirements.

- Every questionnaire must begin with the “core” HHCAHPS Survey questions.
- HHAs may add their own or the HHCAHPS Survey supplemental questions, following the guidelines listed below about adding supplemental questions.

- The “About You” questions must be administered as a unit (i.e., they must be kept together and may not be split into multiple questions and placed throughout the questionnaire) but may be placed before or after any agency-specific questions.
- No changes in wording or order are allowed to either the HHCAHPS Survey questions or to the response (answer) choices.
- Questions and associated response choices may not be split across pages.
- Vendors must be consistent throughout the questionnaire in formatting response options either vertically or horizontally. If a vendor elects to list the response options vertically, this must be done for every question in the questionnaire. Vendors may not format some response options vertically and some horizontally.
- A unique, randomly generated sample identification (SID) number must be assigned and appear on at least the first page of the survey, for tracking purposes. Additional identifiers are permitted; however, the sample member’s name or other identifying information must not be printed anywhere on the survey.
- Only CMS-approved translations of the instrument are permitted, although if agencies choose to add supplemental questions, vendors will be responsible for translating these questions if needed.
- The HHA name or logo should appear on the survey or the cover letter but cannot appear on the envelopes (for privacy), unless vendors submit an Exceptions Request Form indicating that they have the agency’s approval to display the name or logo on the envelope and the agency believes there are no HIPAA risks.
- Survey vendors cannot include any promotional messages or materials, including indications that either the HHA or the survey vendor has been approved by the Better Business Bureau, on the HHCAHPS cover letter, questionnaire, or outgoing or incoming mailing envelopes.
- The vendor’s name and mailing address must be printed at the bottom of the last page of the survey questionnaire, in case the respondent does not use the enclosed business reply envelope.
- No matrix formatting of the questions is allowed. Matrix formatting means formatting a set of questions as a table, with responses listed across the top of a page and individual questions listed in a column on the left.
- Font size should be no smaller than size 10.
- The Office of Management and Budget (OMB) number and expiration date shown in *Appendix J* must be printed on the questionnaire cover, separately from the OMB disclosure

notice. If there is no cover, then the OMB number and expiration date must be printed on the first page of the questionnaire.

- The OMB disclosure notice, which includes the OMB expiration date (see *Appendix J*), must be printed on either the questionnaire or in the cover letter.

### ***Recommendations for Printing the HHCAHPS Survey Questionnaire***

- Vendors should use best survey practices when formatting the instrument, such as maximizing the use of white space and using simple fonts like Arial.
- Use a two-column format.
- Use a font size of 12 or larger.
- If data entry keying is being used as the data entry method, small coding numbers next to the response choices may be used.

### ***Adding Supplemental Questions to the HHCAHPS Survey***

The Agency for Healthcare Research and Quality (AHRQ) developed 10 supplemental questions about home health care, which are included in *Appendix K* and available on the HHCAHPS Survey website (<https://homehealthcahps.org>); HHAs may wish to use these questions or add their own agency-specific questions to the HHCAHPS Survey questionnaire. In addition, one supplemental question must be used if an HHA wishes to request of respondents that their responses may be shared with the HHA. This question is referred to as the “Consent to Share Responses” question and is available in all six languages on the HHCAHPS Survey website. However, no Chinese or Armenian translations of these items are approved for mixed-mode administration because there are no telephone interviews permitted for these languages.

Guidance for adding supplemental questions and the Consent to Share Responses question is as follows:

- All supplemental questions must be placed **after** the “core” questions. Supplemental questions may be placed either before or after the “About You” questions.
- We strongly recommend that agencies and vendors avoid sensitive questions or lengthy additions, because these will likely reduce expected response.
- Supplemental questions do not need to be approved by or reported to CMS. However, survey vendors should review the appropriateness of supplemental questions added to the HHCAHPS Survey and share any concerns they have directly with the HHA or the HHCAHPS Survey Coordination Team. Survey vendors must not include responses to the

supplemental questions on the XML data files that will be submitted to the HHCAHPS Survey Data Center.

- HHAs cannot add questions that repeat any of the survey items in the “core” HHCAHPS Survey verbatim, even if the response scale is different.
- Supplemental questions cannot be used with the intention of marketing or promoting services provided by the HHA or any other organization.
- Supplemental questions cannot ask sample patients to identify other individuals who may need home health care services because of privacy and confidentiality issues they raise if personally identifiable information (PII) were shared with the HHA without that person’s knowledge and permission.
- Vendors are responsible for translating supplemental questions added to the questionnaire; however, only CMS-approved translations may be used for HHCAHPS Survey questions.
- The Consent to Share Responses question, available on the HHCAHPS Survey website, must be added to all questionnaires where an HHA requests that the vendor provide survey responses linked to the respondent’s name and other identifying information. This question is typically placed at the end of the questionnaire, as the last question.

### **Mail Survey Cover Letter**

Cover letters in English, Spanish, Russian, and Vietnamese are provided in the appendices to this manual (see *Appendices C, D, G, and H*) and on the HHCAHPS website. Vendors who choose to modify the existing letters or develop their own cover letter must submit an Exceptions Request Form for CMS approval. All cover letters must meet the following requirements.

#### ***Requirements for Cover Letter***

- Cover letters must be personalized with the name and address of the sample member.
- Cover letters must be separate from the questionnaire so that no PII is returned with the questionnaire when the respondent sends it back to the vendor.
- The OMB disclosure notice (see *Appendix J*) must be printed *either* on the questionnaire *or* in the cover letter.
- Vendors may not offer sample members the opportunity to complete the survey over the telephone while the mail survey protocol is being implemented—telephone interviews may only be conducted as part of the nonresponse follow-up.



The following elements must be included in the cover letter:

- Language indicating the purpose of the survey;
- Language requesting the sample member ask a family member or friend to help complete the survey rather than HHA personnel, if help is needed;
- A statement that participation is voluntary;
- The HHA name (or logo);
- A text box stating, “We care about your home health care experience;” and
- A toll-free customer support telephone number, which will be staffed by the survey vendor.

Vendors that wish to deviate from these cover letter requirements must submit an Exceptions Request Form for CMS’s consideration.

### ***Recommendations for Cover Letter***

- Vendors offering a Spanish, Russian, or Vietnamese version of the questionnaire may add language to the English cover letter indicating that a version of the questionnaire is available in Spanish, Russian, or Vietnamese, or vice versa.
- We recommend that the signature of an appropriate official from the HHA be printed on each cover letter.

## **Mail Survey Mailing Envelope Requirements**

Vendors are required to supply both the outgoing envelopes for the questionnaire mailings and business reply envelopes that sample members will use to return their completed surveys. A postage-paid business reply envelope must be included with each questionnaire mailing, pre-addressed to the survey vendor.

## **Survey Mailing Requirements**

Mailing requirements and recommendations for the HHCAHPS Survey questionnaire mailing are described below. Vendors are expected to follow these requirements to maximize response rates and ensure consistency in how the mail survey portion of the mixed-mode administration is implemented.

### **Survey Mailing Requirements**

- A specific requirement for mail survey envelopes is that a postage-paid business reply envelope must be included with each questionnaire mailing, pre-addressed to the vendor.

- The questionnaire must be mailed to all sampled cases, regardless of whether the mailing address appears to be complete.
- The mailing must follow the schedule specified for the mixed mode of administration in *Table 7.1*—the questionnaire must be mailed within 3 weeks after the close of the sample month.
- The use of incentives—monetary or nonmonetary—is not permitted.
- Data collection must end 6 weeks after the questionnaire has been mailed.
- The use of proxy respondents is permitted. Vendors must adhere to the requirements listed below regarding proxies:
  - Other individuals may assist the sample member in reading the survey, marking response options, translating the survey, or answering questions for the sample member. However, the sample member should be advised in the letter not to ask home health care providers or agency personnel to help them complete the survey.
  - Proxy respondents are NOT permitted for deceased sample members.
  - An employee of a group home may serve as a proxy respondent for a sample patient who lives in the group home and who is physically or mentally incapable of responding to the survey. However, the vendor should ensure that the patient is physically or mentally incapable of responding for him- or herself, the proxy respondent is an employee of the group home and not the HHA, and the proxy respondent is knowledgeable about the sample patient's home health care. Provided these conditions are met, employees of the group home may serve as a proxy for the sample patient.
- Sample members with foreign addresses are considered eligible to participate in the HHCAHPS Survey if they meet all other eligibility criteria. Vendors should contact the HHA for the address where the home care was provided, but if no such address can be provided, vendors must mail to the foreign address.
- If the sample member's address is missing or incomplete, the vendor must follow up with the HHA to obtain the address. Because home health patients receive skilled care in their homes, the HHA must have an address at which the care is delivered. If the HHA cannot provide an address and the patient is sampled, the vendor should treat the patient as eligible and assign the applicable final disposition code to the case.

## Survey Mailing Recommendations

- We recommend that vendors verify mailing addresses obtained from the agencies, using commercial address update services, such as the National Change of Address (NCOA) or the U.S. Postal Service Zip+4 software.
- We recommend that vendors “seed” the mailing. Seeding means including the name and address of designated vendor staff in each mailing file to assess completeness of questionnaire package and timeliness of package delivery.
- We recommend that questionnaires be sent with either first-class postage or indicia, to ensure timely delivery and maximize response rates.

## Data Receipt and Data Entry Requirements

The following guidelines are provided for receiving and tracking returned questionnaires and entering the data, using either data entry or optical scanning.

### Data Receipt Requirements

- The date the questionnaire was received from each sample member must be entered into the data record created for each case on the XML data file.
- Questionnaires should be visually reviewed prior to scanning for notes and comments. Vendors should have more than one person who can code or review comments and attached notes for proper disposition code assignment.
- Questionnaires should be logged into the tracking system in a timely manner to ensure that they are taken out of the cases being rolled over to the telephone follow-up activity.
- If a completed questionnaire is received from the sample member after telephone follow-up begins and a telephone interview with that sample member has already been completed, retain the questionnaire or interview with the more complete data. If both surveys are equally complete, the vendor should use the first one received or completed.
- If a completed survey questionnaire is returned and the vendor learns that a sampled patient is deceased and the questionnaire was completed by someone else, it is not acceptable to scan a questionnaire for that patient, even if it was completed by a proxy respondent. If the vendor learns that a sample patient is deceased (via a telephone call from a relative or friend or through a note or comment marked on the completed questionnaire), the vendor should not process (scan) data from the questionnaire, but instead assign the applicable final disposition code to the case to indicate that the sample member is deceased.

- A final HHCAHPS Survey status code (see the list in *Table 9.1* in *Chapter IX*) must be assigned to each case.

## **Optical Scanning Requirements**

- The scanning program should not permit scanning of duplicate questionnaires.
- The scanning program should not permit out-of-range or invalid responses.
- A sample of questionnaires (minimum of 10%) should be rescanned and compared with the original as a quality control measure. Any discrepancies should be reconciled by a supervisor.
- The survey responses marked in a sample of questionnaires (minimum of 10%) should be compared to the entries scanned for that case to make sure that the scanning program scanned the marked responses correctly.
- If a response mark falls between two answer choices but is clearly closer to one answer choice than to another, select the response that is closest to the marked response.
- If two responses are checked for the same question, select the one that appears darkest. If it is not possible to make a determination, leave the response blank and code as “missing” rather than guessing.
- If a mark is between two answer choices but is not clearly closer to one answer choice, code as “missing.”
- If a response is missing, leave the response blank and code as “missing.”
- The decision on whether to key the responses to open-ended survey items, specifically the “Some other language” (response option 3) in Q32 and the “Helped in some other way” (response option 5) in Q34, is up to each individual HHA. Vendors will not be required to key and include responses to open-ended survey items on the XML data files submitted to the HHCAHPS Survey Data Center. CMS, however, encourages survey vendors to review the open-ended entries so that they can provide feedback to the Coordination Team about adding additional preprinted response options to these survey items if needed.
- If the vendor includes the Consent to Share Responses question in the mail survey questionnaire, we recommend that the vendor scan the response to that question. However, responses to the Consent to Share Responses question will not be included on the XML data files submitted to the Data Center.

## Data Entry Requirements

- The key entry process should not permit keying of duplicate questionnaires.
- The key entry program should not permit out-of-range or invalid responses.
- All questionnaires should be 100% rekeyed for quality control purposes. That is, for every questionnaire, a different keyer should rekey the questionnaire to ensure that all entries are accurate. If any discrepancies are observed, a supervisor should resolve the discrepancy and ensure that the correct value is keyed.
- If a response mark falls between two answer choices but is clearly closer to one answer choice than to another, select the answer choice that is closest to the marked response.
- If two responses are marked for the same question, select the one that appears darkest. If it is not possible to make a determination, leave the response blank and code as “missing” rather than guessing.
- If a mark is between two answer choices but is not clearly closer to one answer choice, code as “missing.”
- If a response is missing, leave the response blank and code as “missing.”
- The decision on whether to key the responses to open-ended survey items, specifically the “Some other language” (response option 3) in Q32 and the “Helped in some other way” (response option 5) in Q34, is up to each individual HHA. Vendors will not be required to key and include responses to open-ended survey items on the XML data files submitted to the Data Center. CMS, however, encourages survey vendors to review the open-ended entries so that they can provide feedback to the Coordination Team about adding additional preprinted response options to these survey items if needed.
- If the vendor includes the Consent to Share Responses question in the mail survey questionnaire, we recommend that the vendor key the response to that question. However, responses to the Consent to Share Responses question will not be included on the XML data files submitted to the Data Center.

## Staff Training

All staff involved in the mail survey implementation, including support staff, must be thoroughly trained on the survey specifications and protocols. A copy of relevant chapters of this manual should be made available to all staff as needed.

In particular, staff involved in questionnaire assembly and mailout, data receipt, and data entry must be trained on:

- Use of relevant equipment (case management systems for entering questionnaire receipts, scanning equipment, data entry programs);
- The HHCAHPS Survey protocol specific to their role (for example, contents of questionnaire package, how to document or enter returned questionnaires into the tracking system);
- Decision rules and coding guidelines for returned questionnaires (see *Chapter IX*); and
- Proper handling of hardcopy and electronic data, including data storage requirements and adhering to HIPAA regulations (see *Chapter VIII*).

Staff involved in providing customer support via the toll-free telephone number should also be trained on the accurate responses to common respondent questions, how to respond to questions when customer support does not know the answer, and the rights of survey respondents. If the HHCAHPS Survey is being offered in a language other than English, customer support staff should also be able to handle questions via the toll-free telephone number in that language. Telephone interviewer training requirements are described in more detail in *Chapter VI*. Please refer to that chapter for more information on training customer support staff.

## **Telephone Instrument and Systems Requirements**

The following paragraphs describe the requirements for producing all materials and systems needed for the telephone survey. The telephone script for interviews with sampled patients and the script for telephone interviews with proxy respondents in English, Spanish, Russian, and Vietnamese are available on the HHCAHPS Survey website at <https://homehealthcahps.org>.

Copies of the telephone interview script and the script for use with proxy respondents can also be found in *Appendix C* (English), *Appendix D* (Spanish), *Appendix G* (Russian), and *Appendix H* (Vietnamese). A list of frequently asked interview questions is included in *Appendix L*. Some general guidelines for telephone interviewer training and monitoring are provided in *Appendix M*.

Specific requirements and guidelines associated with the telephone interview administration are discussed below.

## **Telephone Interviewing Systems**

In electronic interviewing systems, the interviewer reads from and enters responses into a computer program. Using an electronic interviewing system or some other type of electronic data collection system encourages standardized interviewing and monitoring of interviewers. The

HHCAHPS Survey mixed-mode administration requires that vendors use an electronic interviewing system to administer the follow-up telephone HHCAHPS Survey. ***Paper-and-pencil administration for telephone mode of the HHCAHPS Survey is not permitted.*** To ensure that sample members are called at different times of the day and across multiple days of the week, vendors must also have a survey management system. Ideally, the electronic interviewing system will be linked to the survey management system so that cases can be tracked, appointments set and called back at appropriate times, and pending and final case status easily accessed for any case.

There are two additional requirements as follows:

- Predictive or automatic dialers are permitted, as long as they are compliant with Federal Trade Commission and Federal Communications Commission regulations, and as long as respondents can easily interact with a live interviewer. For more information about Federal Trade Commission and Federal Communications Commission regulations, please visit <https://www.ftc.gov/> and <https://www.fcc.gov/>.
- Indication of cell phone is needed for phone-only and mixed-mode surveys. FCC regulations prohibit predictive-dialing of cell phone numbers. Therefore, cell phone numbers need to be identified in advance to allow the vendor to treat cell phone numbers in a way that complies with FCC regulations. Vendors are advised to familiarize themselves with all applicable state and federal laws. If the home health agency is unable to advise the survey vendor as to which telephone numbers provided are cell phone numbers, it is the vendor's responsibility to obtain from an external source an up-to-date list of cell phone numbers and landline numbers which have been ported to cell phone. The external source must be compared to the phone numbers of the sampled patients to identify any phone numbers which are cell phones. Vendors must do this for each monthly sample.

## Telephone Interview Script

Survey vendors are provided with standardized telephone scripts in ***Appendix C*** (English), ***Appendix D*** (Spanish), ***Appendix G*** (Russian), and ***Appendix H*** (Vietnamese). These scripts include the introductory screens, in addition to the survey questions. The survey script (and telephone interview) contains 32 questions. Questions 1 to 25 are considered the “core” HHCAHPS Survey questions and must be placed at the beginning of the interview. Questions 26 to 32 are the “About You” HHCAHPS Survey questions. Note that the HHCAHPS telephone interview does not include questions 33 and 34 of the mail survey because these questions ask whether someone helped the respondent complete the questionnaire and how that person helped—these are not applicable if the survey is being administered by telephone. However, the survey vendor must indicate on the XML data file submitted to the HHCAHPS Survey Data Center whether the phone interview was completed by the sample member or a proxy respondent.

The “About You” questions must be administered as a unit, although they may be placed either before or after supplemental questions that the HHA plans to add to the questionnaire, if any. If the HHA does not plan to add supplemental questions to the questionnaire, the questions in the “About You” section should follow the “core” set of questions.

Programming requirements for the HHCAHPS Survey telephone follow-up interview are listed below:

- The “core” HHCAHPS Survey questions must be administered first and in the order in which they appear.
- No changes in wording or order are allowed for either the “core” questions or answer choices.
- Agencies may add their own or HHCAHPS Survey supplemental questions (in *Appendix K*), following the guidance below about adding supplemental questions.
- The “About You” questions must be administered as a unit, but may come before or after any agency-specific questions.
- Only CMS-approved translations of the HHCAHPS Survey interview are permitted, although if agencies choose to add supplemental questions, vendors are responsible for translating these questions.
- A proxy telephone interview script is provided in English, Spanish, Russian, and Vietnamese in *Appendices C* (in English), *D* (in Spanish), *G* (in Russian), and *H* (in Vietnamese) and on the HHCAHPS website. Vendors are required to administer this script when conducting proxy interviews; therefore, vendors must program the script for electronic administration for each language the vendor offers.
- On the XML data files submitted to the Data Center, vendors must indicate whether the interview was completed by a proxy respondent; therefore, the electronic interview should be programmed to indicate whether the interview was completed by the sample member or a proxy respondent.

### **Adding Supplemental Questions**

- Agencies/Vendors may add their own or the HHCAHPS supplemental questions to the telephone interview.
- All supplemental questions must be placed **after** the “core” questions. Supplemental questions may be placed either before or after the “About You” questions.



- It is strongly recommended that agencies and vendors avoid sensitive questions or lengthy additions, because these will likely reduce expected response.
- Supplemental questions do not need to be approved by or reported to CMS. However, survey vendors should review the appropriateness of supplemental questions added to the HHCAHPS Survey and share any concerns they have directly with the HHA or the HHCAHPS Survey Coordination Team.
- HHAs cannot add questions that repeat any of the survey items in the “core” HHCAHPS Survey verbatim, even if the response scale is different.
- Supplemental questions cannot be used with the intention of marketing or promoting services provided by the HHA or any other organization.
- Supplemental questions cannot ask sample patients to identify other individuals who may need home health care services because of privacy and confidentiality issues they raise if personally identifiable information (PII) were shared with the HHA without that person’s knowledge and permission.
- Vendors are responsible for translating any non-CAHPS supplemental questions; only CMS-approved translations may be used for HHCAHPS Survey questions, however.
- As noted above in the section on the mail survey questionnaire, one supplemental question must be used if an HHA wishes to request of respondents that their responses may be shared with the HHA. This question is referred to as the “Consent to Share Responses” question and is available in all six languages on the HHCAHPS Survey website. It is typically placed at the end of the interview.

## Telephone Interviewing Requirements

Telephone interviewing requirements and recommendations for the HHCAHPS Survey interview are described below. Vendors are expected to follow these requirements to maximize response rates and ensure consistency in how the telephone follow-up is implemented in the mixed mode of administration.

### Telephone Contact

- Vendors must attempt to contact every sample member included in the sample. Vendors are required to make five contact attempts for each nonrespondent to the mail survey, unless the sample member refuses or the vendor learns that the sample member is ineligible for the survey.

- A telephone contact attempt is defined as one of the following:
  - the telephone rings six times with no answer or an answering machine is reached;
  - the interviewer reaches a household member and is told that the sample member is not available to take the call;
  - the interviewer reaches the sample member and is asked to schedule a call-back at a later date; or
  - the interviewer gets a busy signal on each of three consecutive phone call attempts, spaced at least 20 minutes apart.
- Vendors may make more than one phone call in one 7-day period but cannot make all five attempts in one 7-day period. Vendors should keep in mind that some home health patients may be sicker than some other patient populations, and may be hospitalized when some of the initial calls are made. Scheduling calls to take place over a longer period of time may reach patients who may be unavailable the first week of the data collection period.
- Phone calls must be made at different times of the day (i.e., morning, afternoon, and evening) and different days of the week throughout the data collection period.
- Contact with a sample member may be continued after five attempts if the fifth attempt results in a scheduled appointment with the sample member, as long as the appointment is within the data collection period.
- Interviewers **may not** leave voicemail messages on answering machines **or** leave messages with household members.
- Interviewers may tell the person who answers the phone that they would like to speak to the sample member about their experiences with home health care at the named agency **ONLY IF** the person on the phone volunteers they are the sample member's next of kin (which CMS defines as the sample member's partner, child, parent, sibling, grandchild, or power of attorney). Otherwise, interviewers can only say they would like to speak to the sample member "about a health care study." The interviewer may say they would like to talk to the proxy about the sample member's experiences with home health care they received from the named agency. **IMPORTANT:** These are the only circumstances in which a vendor can share this additional information.
- Vendors must maintain a phone call log that keeps track of the date and time phone calls were made for each sample member.

- If the vendor finds out that a sample member is ineligible for the HHCAHPS Survey, the vendor must immediately stop further contact attempts with that sample member.
- Telephone interviewing must follow the schedule specified for the mixed mode of administration, with the first phone contact initiated approximately 3 weeks after the questionnaire is mailed and all phone contacts ending 3 weeks after phone contact begins.
- The use of incentives—monetary or nonmonetary—is not permitted in the telephone follow-up portion of the mixed-mode survey administration.
- The use of proxy respondents is permitted. Vendors must adhere to the requirements listed below regarding proxies:
  - Other individuals may assist the sample member in answering questions or answer questions on the sample member’s behalf as long as the sample member is physically or mentally incapable of completing an interview.
  - Proxy respondents may not be used for sample members who simply “do not want” to participate.
  - the sample member should be advised not to ask for help from HHA providers or home health aides, nor should interviewers conduct proxy interviews with HHA personnel.
  - Proxy responses are NOT permitted for deceased sample members.
  - An employee of a group home may serve as a proxy respondent for a sample patient who lives in the group home. However, the vendor should ensure that the patient is physically or mentally incapable of responding for him- or herself, the proxy respondent is an employee of the group home and not the HHA, and the proxy respondent is knowledgeable about the sample patient’s home health care.
- If a respondent begins the interview but cannot complete it during the call for a reason other than a refusal, the vendor should follow up with the respondent to complete the entire interview. This follow-up should be done even if the respondent answered enough questions in the interview for the case to pass the completeness criteria (as discussed in **Chapter IX**). It is especially important to complete the questions in the “About You” section of the questionnaire, because data from some of those questions will be used in patient-mix adjustment.
- The vendor must be able to offer the interview in any of the approved languages (English, Spanish, Russian, or Vietnamese) for which an HHA has contracted, even if the language is different from the language that the HHA believes the sample member will require. That is, the vendor must be able to easily switch to accommodate a respondent’s language preference.

For example, if the initial contact is in English but the respondent prefers to conduct the interview in Spanish, the vendor must be able to switch to Spanish.

- Sample members are still eligible even if they have missing, incomplete, or foreign phone numbers. The vendor should contact the HHA to obtain the telephone number for the address where home care was delivered. If the HHA cannot provide this number, the vendor should attempt to obtain a telephone number for the sample patient from other sources (directory assistance, Internet directories, etc.). If the vendor still cannot obtain a telephone number, the vendor should code the case as code 340 – Wrong, Disconnected, or No Telephone Number.
- If a respondent decides after they have answered some of the questions in the telephone interview that he or she does not wish to participate in the survey any longer, the vendor should code the case as a refusal. The vendor should not use the partial data that were obtained before the interview was ended. This protocol applies even if the respondent answered enough questions in the interview for the case to pass the completeness criteria. Note that this is different from the respondent saying that they do not wish to continue an interview. If the respondent breaks off the interview but does not state that they do not wish to participate in the survey, the data may be used. In this case, the vendor may code the case as a 120 – Completed Telephone Interview if the case passes the completeness criteria; otherwise, it should be coded as a 310 – Breakoff.

### **Contacting Difficult-to-Reach Sample Members**

- Although not required, we strongly recommend that survey vendors verify telephone numbers obtained from the HHA, using a commercial address/telephone database service or directory assistance.
- We recommend that vendors attempt to identify a new or updated telephone number for any sample member whose telephone number is no longer in service when called and for sample patients who have moved so that the sample members can be contacted prior to the end of the data collection period.
- If the sample member's telephone number is incorrect, the interviewer may ask the person who answers the phone for the sample member's phone number.
- If the sample member is temporarily ill, on vacation, or unavailable during initial contact, the interviewer should attempt to recontact the sample member before the data collection period ends. If the sample member cannot be reached before the data collection period ends, code the case as 350 – No Response After Maximum Attempts.

- If the sample member does not speak the language(s) that the vendor is administering for that agency, the interviewer should thank the sample member for his or her time, end the interview, and code the case as 230 – Ineligible: Language Barrier.
- If a sample member is physically or mentally incapable of responding by telephone, a proxy interview may be conducted with a family member or friend. Under no circumstances should an interviewer conduct the interview with an HHA provider or home health aide.
- For sample members who are living in institutions (nursing homes, assisted living, etc.), vendors should contact the HHA to obtain a direct-dial telephone number for the patients who live in those facilities. Because health care is delivered in the patient's home, the HHA should have a direct-dial number for the patient to reach the patients to arrange and schedule home care. If the HHA cannot provide a direct-dial telephone number for the sample patient, try to obtain the sample member's telephone number using other sources, such as a telephone number lookup service, directory assistance, or Internet telephone survey directories. If vendors cannot obtain a telephone number for the sample patient, they should assign a disposition code of 340—Wrong, Disconnected, or No Telephone Number to the sample case.

## Telephone Interviewer Training

Vendors must provide training to all telephone interviewing and customer support staff prior to starting telephone survey data collection activities. The telephone interview training must include the following:

- How to establish rapport with the respondent;
- Information about the content and purpose of the interview so that they can effectively communicate this information to the sample members;
- How to administer the interview in a standardized format (reading the questions as they are worded, not providing the respondent with additional information that is not scripted, maintaining a professional manner, and adhering to all quality control standards);
- How to administer the script for use with proxy respondents;
- How to use effective neutral probing techniques;
- How to use the FAQs document (see *Appendix L*) so that they can answer questions in a standardized format;
- Information about HIPAA regulations and how to always comply with those regulations while working on HHCAHPS; and

- Teaching multilingual customer support staff how to handle questions in English and the other language(s) in which the survey is being offered.

Survey vendors should also provide telephone survey supervisors with an understanding of effective quality control procedures to monitor and supervise interviewers.

Vendors must conduct an interviewer certification process of some kind—either oral, written, or both—for each interviewer and customer service staff member prior to permitting that person to make or take calls on the HHCAHPS Survey. The certification should be designed to assess the interviewer’s level of knowledge and comfort with the HHCAHPS Survey instrument and ability to respond to sample members’ questions about the survey. Documentation of training and certification of all telephone interviewers and customer support staff and outcomes will be subject to review during oversight visits by the HHCAHPS Survey Coordination Team.

## **Distressed Respondent Procedures**

It is important that survey vendors to develop a “distressed respondent protocol,” to be incorporated into all interviewer and help desk training. Handling distressed respondent situations requires balancing keeping PII and private health information (PHI) confidential and helping a person who needs assistance. For survey research organizations, best interviewing practices recommend having a distressed respondent protocol in place for handling distressed respondents, which balances the respondent’s right to confidentiality and privacy and providing assistance, if the situation indicates that the respondent’s health and safety are in jeopardy.

Therefore, each approved HHCAHPS Survey vendor is expected to have procedures in place for handling distressed respondent situations and to follow those procedures. CMS and the HHCAHPS Survey Coordination Team cannot provide guidelines on how to evaluate or handle distressed respondents. However, survey vendors are urged to consult with their organization’s Committee for the Protection of Human Subjects Institutional Review Board (IRB) for guidance. In addition, professional associations for researchers, such as the American Association of Public Opinion Researchers (AAPOR), may be able to provide guidance regarding this issue. The following is an excerpt from AAPOR’s website that list resources for the protection of human subjects. More information about protection of human subjects is available at AAPOR’s website at <https://www.aapor.org/>.<sup>7</sup>

- The Belmont Report (guidelines and recommendations that gave rise to current federal regulations)

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<sup>7</sup> The American Association of Public Opinion Researchers website at <https://www.aapor.org/Standards-Ethics/Institutional-Review-Boards/>, July 2010.

- Federal Regulations Regarding Protection of Human Research Subjects (45 CFR 46) (also known as the Common Rule)
- Federal Office for Human Research Protections (OHRP)
- NIH Human Participant Investigator Training (although the site appears to be for cancer researchers, it is the site for the general investigator training used by many institutions)
- University of Minnesota Web-Based Instruction on Informed Consent

## Telephone Data Processing Procedures

The following guidelines are provided for ensuring that the telephone interview data are properly processed and managed.

### Telephone Data Processing Requirements

- A unique SID number must be assigned to each sampled case and included in the case management system and on the final XML data file for each sample member.
- Vendors must enter the date the interview was conducted with each respondent in the survey management system or in the interview data.
- Vendors must be able to link each telephone interview to their survey management system, so that appropriate data elements, such as the language in which the survey was conducted, can be pulled into the final XML data file.
- Vendors must de-identify all telephone interview data when the data are transferred into the final XML data file for delivery. Identifiable data include respondent name and contact information.
- Vendors must assign a final HHCAHPS Survey status or disposition code to each case (see *Chapter IX* for a list of these codes) and include a final disposition code for each sampled case in the final XML data file. It is up to the vendor to develop and use a set of pending disposition codes to track actions on a case before it is finalized appropriately—pending disposition codes are not specified in the HHCAHPS Survey protocol.

## Mixed-Mode Quality Control Guidelines

The following steps are required or recommended as a means of incorporating quality control into the mixed-mode survey administration procedures. Quality control checks should be conducted by a different staff person than the one who completed the task. Some of these are mentioned earlier in the chapter.

### **Mail Protocol (Required)**

- Check a minimum of 10% of all printed materials to ensure the quality of the printing—that is, make sure that there is no smearing, misaligned pages, duplicate pages, or stray marks on pages.
- Check a minimum of 10% of all outgoing questionnaire packages to ensure that all package contents are included and that the same unique SID number appears on both the cover letter and the questionnaire.
- For vendors that use optical scanning, a sample of questionnaires (minimum of 10%) should be rescanned and compared with the original as a quality control measure. This serves as a quality control measure that the scanning program is capturing hardcopy questionnaire responses correctly. Any discrepancies should be reconciled by a supervisor.
- For vendors that use manual data entry, all questionnaires should be 100% rekeyed for quality control purposes. That is, for every questionnaire, a different keyer should rekey the questionnaire to ensure that all entries are accurate. If any discrepancies are observed, a supervisor should resolve the discrepancy and ensure that the correct value is retained.

### **Mail Protocol (Recommended)**

- Verify that sample members' mailing addresses provided by the HHA are correct by using commercial address update services, such as the NCOA or the U.S. Postal Service Zip+4 software. Note that cases with incomplete mailing addresses must remain in the sample.
- “Seed” the mailing. That is, include the name and address of designated vendor staff in the mailing file to assess completeness of questionnaire package and timeliness of package delivery.
- Before submitting data to the HHCAHPS Data Center, we highly recommend that vendors do the following:
  - Review a sample of cases comparing responses coded on the hardcopy questionnaire to the response codes that appear on the XML file. This quality control step will ensure that the responses included in the XML data files accurately reflect the sample patients' responses to the survey questions.
  - Review a sample of cases with a noncomplete final code (i.e., cases with a final disposition other than 110 or 310) against the original source of information that resulted in the case being finalized. This could include reviewing vendor's toll-free telephone number call-in tracker, handwritten notes on mail survey, white mail, etc.



- Vendors are urged to develop a way to measure error rates for their data receipt staff (in terms of recognizing marginal notes and passing these on to someone for review), for data entry or scanning operators, and for coders. Vendors should then work with their staff to minimize error rates. The Coordination Team will request information about data receipt and processing error rates during site visits to survey vendors.

### Telephone Protocol (Required)

The following activities are methods to incorporate quality control into the survey administration procedures for the telephone follow-up portion of the mixed-mode survey administration. Quality control checks should be conducted by a different staff person than the one who completed the task.

- HHCAHPS requires that survey vendors thoroughly test the electronic telephone interviewing system before beginning the HHCAHPS Survey. Testing will vary from system to system, but includes at a minimum comparing each screen to the telephone script (in *Appendices C, D, G, and H*) to verify that the questions and response options are faithful to the script, checking each question to ensure that the answers input match the data exported, and checking that a respondent is automatically routed to the next appropriate question.
- Vendors are required to keep written documentation that all telephone interviewing and customer support staff have been properly trained prior to interviewing. Copies of interviewer certification exam scores should be retained as well. Documentation should be maintained for any retraining required and will be subject to review during oversight visits.
- Vendors must establish and communicate clear telephone interviewing quality control guidelines for their staff to follow. These guidelines should be used to conduct the monitoring and feedback process and should include clear explanations of the consequences of not following protocols, including actions such as removal from the project or termination of employment.
- Vendors are required to silently monitor a minimum of 10% of all telephone interviews to ensure that correct administration procedures are being followed. Vendors must be able to conduct live monitoring for regular survey operations and site visits.
- Interviewers should be given the opportunity to correct deficiencies in their administration through additional practice or retraining; however, interviewers who receive consistently poor monitoring scores should be removed from the project.
- There are federal and state laws and regulations relating to the monitoring/recording of telephone calls. In certain states, consent must be obtained from **every party** or conversation if it involves more than two people (“two-party consent”). When calling sample members

who reside in these states, survey vendors should not begin either monitoring or recording the telephone calls until *after* the interviewer has read the following statement: “This call may be monitored or recorded for quality improvement purposes.”<sup>8</sup>

- Vendors are responsible for identifying and adhering to federal and state laws and regulations in the states in which it will be administering the HHCAHPS Survey.

### **Telephone Protocol (Recommended)**

- Although not required, we recommend that vendors conduct regular Quality Circle meetings with telephone interviewing and customer support staff to obtain feedback on issues relating to telephone survey administration or handling inbound calls.
- Monitoring staff or supervisors should provide performance feedback to interviewers as soon as possible after the monitoring session has been completed.
- Supervisory staff monitoring telephone interviewers should use the computer-assisted telephone interviewing (CATI) or alternative electronic system to observe the interviewer conducting the interview while listening to the audio of the call at the same time.
- Vendors should conduct periodic reviews of their XML data files by comparing at least 50 completed telephone interview responses directly from their CATI system to the values output in the XML file. Doing this monthly review will ensure that the responses are being accurately captured and output to the XML data file.
- Review a sample of cases with a noncomplete final code (i.e., cases with a final disposition other than 120 or 310) against the original source of information that resulted in the case being finalized. This could include reviewing telephone interviewer call notes, vendor’s toll-free telephone number call-in tracker, etc.

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<sup>8</sup> The following states currently require two-party or all-party consent when telephone calls are monitored or audiotaped: California, Connecticut, Delaware, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, New Hampshire, Pennsylvania, Vermont, and Washington.

## **VIII. CONFIDENTIALITY AND DATA SECURITY**

### **Overview**

This chapter describes the requirements and guidelines for protecting the identity of survey sample members and their survey data, and ensuring data security. There is a discussion of how confidential data should be handled, the importance of establishing and maintaining physical and electronic data security, the importance of confidentiality agreements, and HHCAHPS protocols for providing and sharing de-identified and identified data.

### **Safeguarding Patient Data**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is legislation intended to protect private medical information and to improve the efficiency of the health care system. This law went into effect April 14, 2003.

The type of information protected under HIPAA is called “protected health information,” or PHI. PHI is defined as personally identifiable information (PII) that relates to a person’s past, present, or future health or medical treatment. If the health information is completely de-identified, it is no longer PHI and can be released. HIPAA also applies to electronic records, whether they are being stored or transmitted. All vendors approved to implement the HHCAHPS Survey must adhere to all HIPAA requirements. That is, vendors must safeguard any and all data collected from sample members as required by HIPAA. Vendors should, therefore, stress to their home health agency (HHA) clients the importance of sending the monthly patient information files in a manner which adheres to HIPAA guidelines, at a minimum encrypting the patient information files prior to sending them to their vendor.

*To safeguard patient data, vendors must adhere to the following requirements* when conducting the HHCAHPS Survey. Each requirement is discussed in more detail in the paragraphs that follow.

- Adhere to state regulations and laws protecting patients with specific conditions/illnesses
- Limit access to confidential data to authorized staff members
- Obtain confidentiality agreements
- Ensure security of electronic and physical data
- Develop procedures for identifying and handling breaches of confidential data

- Submit only de-identified XML data files to the HHCAHPS Survey Data Center
- Provide client HHAs HHCAHPS response data according to HHCAHPS protocols

### **Adhere to State Regulations and Laws Protecting Patients With Specific Conditions/Illnesses**

As indicated in *Chapter IV*, some states have additional regulations and laws governing the release of patient information for patients with specific illnesses or conditions, and for other special patient populations, including patients with HIV. It is the HHA's responsibility to identify any applicable state laws and regulations and exclude patients from their monthly patient information files as required by the law or regulation.

### **Limit Access to Confidential Data to Authorized Staff**

All identifying information associated with a patient should be considered private and must be securely protected. Vendors must take appropriate actions to safeguard all survey data obtained during the course of implementing the HHCAHPS Survey, including all hardcopy and electronic data obtained from HHAs and data provided by survey respondents.

When the sample frame information is received from an HHA, it will contain PHI and PII, such as the name and address or telephone number of the patient, and other information such as diagnoses or reason for the home health care. From the moment the vendor receives sample frame information, the data must be handled in a way to ensure that the patient information is kept confidential and that only authorized personnel have access to it.

Examples of ways to keep confidential data secure include storing the data electronically in password-protected locations and limiting the number of staff with access to the password. For confidential information that is obtained on hard copy, data should be kept in a locked room or file cabinet, with access restricted to authorized staff. Confidential data should not, under any circumstances, be removed from the survey vendor's place of business, either in electronic or hardcopy form, even by survey vendor staff. Confidential data should not be stored on laptop computers unless those laptops have data encryption software to protect the information should the laptop be lost or stolen.

Survey vendors should consider carefully who needs access to confidential HHCAHPS Survey data and then ensure that only those staff have access to the data. For example, the HHCAHPS Sampling Manager will need access to the agency sample frame to select the sample. However, information on the frame does not need to be included in every data file—although names and addresses need to be provided in the file used to create mail survey cover letters, other PHI does not have to be on that file.

Any staff who will be working with data about home health patients should sign a confidentiality agreement specific to the HHCAHPS Survey implementation, as described below.

## Obtain Confidentiality Agreements

Survey vendors are required to obtain a signed affidavit of confidentiality from all staff, including subcontractors, who will work on the HHCAHPS Survey implementation. This includes individuals who will be working as telephone interviewers or staffing the customer support line and individuals printing or assembling mail survey packets or working in data receipt or data entry positions. Copies of the signed agreements should be retained by the HHCAHPS Survey Administrator/Project Manager as documentation of compliance with this requirement, because vendors will be asked to provide this documentation during site visits by the HHCAHPS Survey Coordination Team.

## Ensure Electronic and Physical Data Security

Vendors should take the following measures to ensure physical and electronic data security:

- Paper copies of questionnaires or sample frame information must be stored in a secure location at the vendor's facility, such as a locked file cabinet or within a locked room, for 3 years. Paper copies of questionnaires do not need to be kept if electronic images of the questionnaires are being kept instead. *At no time should paper copies be removed from the vendor's premises, even temporarily.*
- Electronic data must be protected. Electronic security measures may include firewalls, restricted access levels, or password-protected access.
- Data stored electronically must be backed up nightly or more frequently to minimize data loss. Vendors must have a disaster recovery plan for the HHCAHPS data.
- Electronic images of paper questionnaires or keyed data, including computer-assisted telephone interview (CATI) or alternative electronic system data, should be retained for 3 years, also in a secure location at the vendor's facility.

## Develop Procedures for Identifying and Handling Breaches of Confidential Data

Survey vendors are required to develop protocols for identifying when there has been a breach of security with HHCAHPS Survey data, including when an unauthorized individual has gained access to confidential information and when an authorized individual has distributed confidential data in an unauthorized manner. Vendors must have a security incident response program in place to ensure that the appropriate actions are taken to contain identified security incidents, communicate to stakeholders, and remediate the incident. The vendor's plans must include, but

are not limited to, a system to notify the vendor's HHCAHPS Survey Administrator/Project Manager in a timely manner of a security breach, a means to detect the level of risk represented by the breach in security, and a means to take corrective action against the individual who created the breach and any persons affected by the breach, including sample members.

### **Submit Only De-Identified XML Data Files to the HHCAHPS Survey Data Center**

Although vendors will have access to confidential information about home health patients, none of the XML data files submitted to the HHCAHPS Survey Data Center may contain any confidential information (i.e., any information that would identify a sample member). All files submitted to the Data Center must contain de-identified data only. Therefore, only the unique patient sample identification (SID) numbers that the survey vendor assigns to each sample member should be included on the file for each data record. (There will be a data record for each patient sampled.)

### **Provide HHCAHPS Response Data to Client HHAs**

When providing response data to their client agencies, survey vendors must provide data that are de-identified. Survey vendors must be aware of the following requirements and exceptions.

#### ***"Core" Questions (Questions 1-25)***

Vendors are permitted to provide de-identified responses to the "core" HHCAHPS questions (Questions 1–25) without the patient's consent to share his or her survey responses.

#### ***"About You" Questions (Questions 26-32)***

Vendors can provide responses to "About You" questions (Questions 26–32) linked to a sample patient's name and other identifying information **only if** the sample patient gives his or her consent on the "Consent to Share Responses" question.

Since responses to Questions 26-32 may enable HHAs with small sample sizes to link survey responses to a specific patient, vendors may provide de-identified survey responses to the "About You" questions only by following one of the two methods described below.

The first method permits vendors to share responses to the "About You" questions if there are a minimum of 11 patients who have responded to each response option for a given question. For example, to report the results of Q31 (What is your race?) to an HHA client, at least 11 respondents must have answered each of the response options (American Indian or Alaska Native, Asian, Black or African American, etc.) for the vendor to report the responses for this question.

There are two questions in the “About You” section (Questions 33 and 34) that do not require this restriction. Questions 33 and 34 are proxy questions that collect information about who helped the sampled patient complete the mail survey and how they helped. Response data for these two survey items can be reported to client agency regardless of how many responses for each response option there are.

### ***Alternative Method for Providing De-Identified Response Data***

An acceptable alternative method for reporting de-identified “About You” response data is to combine two or more contiguous response options so that the combined responses meet the reporting requirement of 11 or more. Below is an example for how vendors can implement this alternative method with **Question 29** (What is the highest grade or level of school that you have completed?).

This HHA has 50 completed surveys in a month. The distribution of response categories for Q29 is as follows:

<b>Response Category</b>	<b>Number of Responses</b>
8th grade or less	4
Some high school	9
High school graduate	12
Some college	11
4-year graduate	8
More than 4-year degree	6

When following the first method, data for Q29 cannot be shared with the agency because one or more of the response categories has fewer than 11 responses.

However, using the alternative method, the vendor can combine Q29 response categories (with appropriate adjustments to the response categories for reporting purposes) to meet the reporting requirement of 11 or more responses per category, as shown in the table below.

<b>Response Category</b>	<b>Number of Responses</b>
Some high school or less	13
High school graduate	12
Some college	11
4-year grad or more	14

***Providing Identified Data***

Survey vendors can provide responses linked to a sample member's name and other identifying information **only if** the sample member gives his or her consent on the "Consent to Share Responses" question. This includes providing this sample member's responses to any "About You" questions that do not meet the threshold of 11 responses per response option that is required for reporting response data overall.

In the absence of this explicit consent, only de-identified response data can be provided. In this case, patient-level data cannot be shared with anyone outside of the vendor's organization, including client agencies.



## **IX. DATA PROCESSING AND CODING**

### **Overview**

This chapter describes decision rules related to processing and coding returned mail survey questionnaires, assignment of survey disposition codes, and quality control measures. This chapter also provides procedures for determining whether a returned survey meets the definition of a completed survey and information about how survey response rates are calculated.

### **Data Processing Decision Rules and Coding Guidelines**

Guidelines and procedures for handling ambiguous, missing, or inconsistent survey responses from returned mail questionnaires are provided below. These guidelines should be followed regardless of whether the vendor is using optical scanning or data entry to enter data from completed questionnaires.

### **Mail Surveys**

In mail surveys some respondents may choose not to answer particular questions, and others may not clearly mark their answer choices. Use the following rules to handle missing or ambiguous responses when processing completed questionnaires.

- If a response mark falls between two answer choices but is clearly closer to one answer choice than to another, select the response that is closest to the marked response.
- If two responses are marked for the same question, select the one that appears darkest. If it is not possible to make a determination, leave the response blank and code as “Missing” (code “M”) rather than guess.
- If a mark is between two answer choices but is not clearly closer to one answer choice, code as “Missing” (code “M”).
- The only survey items in the HHCAHPS Survey where two or more answers are acceptable are Questions 31 and 34, which ask the sample member to check all answer choices that are applicable to him or her. These questions instruct the respondent to “Please select one or more” (for Question 31) or to “Please check all that apply” (for Question 34). For both of these questions, enter responses for all of the categories that the respondent marked.
- If a response is missing, leave the response blank and code it as “Missing.”

## Coding Skip Patterns

Some of the questions included in the HHCAHPS Survey instrument are “screening” questions—that is, they are designed to determine whether one or more follow-up questions about the same topic are applicable to the respondent. The respondent is directed to the next applicable question by a “skip” instruction printed beside the answer choice that they mark.

In mail surveys, some respondents may answer the screening question but leave applicable follow-up questions blank. In other cases, some respondents will mark an answer to follow-up questions that are not applicable to them (based on the answer to the screening question). Yet in other cases, some respondents will answer both the screening and follow-up questions with responses that contradict each other. Use the following rules for completed questionnaires.

### ***Decision Rules for Coding Screening Questions (Qs. 1, 11, 21, 22, and 33\*)***

\*Please note: Question 33 is included in the mail survey only.

- Key or scan the response provided by the respondent.
- If the screener question is left blank, code it as “Missing” (code “M”).
- If the answer to Q1 on the **mail survey** is “No,” which implies that the respondent is ineligible, but some or all of the rest of the questions in the survey have been answered, key or scan all responses given, including the “No” response to Q1. If the questionnaire meets the completeness criteria, code the questionnaire as 110 – Completed Mail Survey, regardless of the “No” response provided in Q1.
- If the answer to Q1 on the mail survey is missing, but some or all of the rest of the questions in the survey have been answered, key or scan all of the responses marked, including the “Missing” response to Q1. If the questionnaire meets the completeness criteria, code the questionnaire as 110 – Completed Mail Survey, regardless of the fact that no response was provided in Q1.
- If the answer to Q1 on the **telephone survey** is “No,” the code assigned should be 220 – **Ineligible: Does Not Meet Eligible Population Criteria**. These cases should **not** be assigned a partial interview or breakoff code, as answering “No” indicates that the sample member is not eligible.

### ***Decision Rules for Coding Follow-Up Questions (Qs. 12–14, 22, 23, and 34\*)***

\*Note: Question 34 is only included in the mail survey.

- Enter the response provided by the respondent whenever one is given, regardless of whether the response agrees with the screener question. For example, if the respondent answers “No”

to the screener question and then marks a response to the follow-up question(s) instead of skipping it, that is acceptable—the response must still be keyed or scanned.

- If the follow-up question is left blank (correctly) because the respondent answered the screener question as “No,” code the follow-up question as “Not Applicable,” (code “8”).
- If the follow-up question is left blank (incorrectly) because the respondent skipped it rather than answering it, enter “Missing” (code “M”) for the follow-up response.
- To summarize, when follow-up questions are appropriately skipped, the follow-up question response should be coded as “Not Applicable,” which is Code “8.” When follow-up questions are incorrectly answered, enter the response that the respondent provides.

### ***Decision Rules for Coding Survey Responses Marked Outside of the Response Box***

Although HHCAHPS Survey mail questionnaires use response bubbles or boxes, vendors may receive surveys where a response is marked outside the response box. CMS and the HHCAHPS Survey Coordination Team acknowledge that there are some instances where it is acceptable to consider a response “marked,” even if the response box itself is not marked. However, to minimize the opportunity for coding interpretation errors among vendors, CMS requests that all responses or response boxes that are not circled, checked, underlined, or in some other way *clearly designated by the respondent* (i.e., the respondent writes the **exact** wording of a response to the right of the response options) be coded as “Missing” (code “M”).

Although some text or marks to the right of the response options may seem to point to a particular response, many times the respondent’s intent is not clear. This opens the door to nonstandardized interpretations from vendor to vendor. To provide some visual guidance on what is expected, we have offered three examples below of when it is acceptable to code a response and two examples of when it is not acceptable to code a response.

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**When it is Acceptable to Code a Response**

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**Example 1:**

In this first example, the respondent has circled a response. The respondent's intention is clear.

13. In the last 2 months of care, did home health providers from this agency talk with you about **when** to take these medicines?
- ☐ Yes
  - ☒ No
  - ☐ I did **not** take any new prescription medicines or change any medicines

**Example 3:**

In this third example, the respondent has placed a check mark very close to a response. Again, the respondent's intention is clear.

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?
- ☐ Never
  - ☐ Sometimes
  - ☒ Usually ✓
  - ☐ Always

**Example 2:**

In this second example, the respondent has underlined a response. The respondent's intention is clear.

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?
- ☒ Yes
  - ☐ No
  - ☐ I did **not** take any new prescription medicines or change any medicines

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### When it is NOT Acceptable to Code a Response

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**Example 1:**

In this example, the respondent has placed a check mark to the right of the response boxes. It is not clear which response was intended.

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

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

**Example 2:**

In this example, the respondent has placed a check mark to the right of the response boxes. It is not clear which response was intended.

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

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

## Survey Disposition Codes

Vendors must follow all required HHCAHPS Survey disposition code assignment protocols. Survey disposition codes, also referred to as status codes, track the current status of a sampled case as it moves through the survey process. For example, a status code is used to designate that the first questionnaire has been mailed, and another status code is used to indicate that the questionnaire has been received. Status codes can be interim (meaning that they are expected to change as the case moves through the rest of the survey process) or final (meaning that no further action will be taken with that case).

This section provides a list and description of the *final* disposition codes that are to be used on the HHCAHPS Survey, for mail-only, telephone-only, and mixed-mode surveys. It is up to the vendor to designate interim status codes to use to track the pending status of a case. However, the vendor must select and assign the applicable code from the disposition codes shown in **Table 9.1** for each sampled case included on the XML data file submitted to the HHCAHPS Survey Data Center.

**Table 9.1**  
**HHCAHPS Survey Disposition Codes**

<b>Code</b>	<b>Description</b>
110	<p><b>Completed Mail Survey<sup>9</sup></b></p> <p>The respondent answered at least 50% of the questions based on the specific completeness criteria (provided later in this chapter). Assign this code for mail-only and mixed-mode cases if the sample member responded by mail.</p>
120	<p><b>Completed Phone Interview</b></p> <p>The respondent answered at least 50% of the questions based on the specific completeness criteria (provided later in this chapter). Assign this code for phone-only and mixed-mode cases if the interview was completed by phone.</p>
210	<p><b>Ineligible: Deceased</b></p> <p>Assign this code if the sample member is reported as deceased during the course of the data collection period.</p>
220	<p><b>Ineligible: Does Not Meet Eligible Population Criteria<sup>10</sup></b></p> <p>Assign this code if it is determined during the data collection period that the sample member does not meet all of the required eligibility criteria for being included in the survey sample. This includes the following:</p> <ul style="list-style-type: none"> <li>• The sample member is under age 18.</li> <li>• The sample member's home health care was not paid for by either Medicare or Medicaid.</li> <li>• The sample member reports that they do not have at least one skilled care visit by the named HHA during the sample month.</li> <li>• The sample member reports that the home health visits she received were for routine maternity care only.</li> <li>• It is reported that the sample member was discharged to hospice care during the sample month.</li> <li>• The sample member answers "No" to Q1 <u>and</u> no additional questions in the mail survey instrument are answered.</li> </ul> <p>A full listing of eligibility criteria is provided in <i>Chapter IV</i> of this manual.</p>
230	<p><b>Ineligible: Language Barrier</b></p> <p>Assign this code to sample members who do not speak any of the HHCAHPS Survey language(s) which the vendor is administering for that HHA. The language barrier code only applies to the sample member and should not be assigned until a determination is made that the sample member cannot speak the language(s) being administered.</p>
240	<p><b>Ineligible: Mentally or Physically Incapacitated/No Proxy Available</b></p> <p>Assign this code if it is determined that the sample member is unable to complete the survey because they are mentally or physically incapable <u>and</u> no proxy is available to complete the survey on his or her behalf. This includes sample members who are visually impaired (for mail surveys only) or hearing impaired (for telephone surveys only).</p>

(continued)

<sup>9</sup> Refers to the definition of a completed survey, which is discussed later in this chapter.

<sup>10</sup> See *Chapter IV* for eligibility rules for the HHCAHPS Survey.

**Table 9.1**  
**HHCAHPS Survey Disposition Codes (continued)**

<b>Code</b>	<b>Description</b>
310	<p><b>Break-Off</b></p> <p>Assign this code if the sample member completes some responses but not enough to meet the completeness criteria (provided later in this chapter).</p>
320	<p><b>Refusal</b></p> <p>Assign this code if the sample member indicates either in writing or verbally that they do not wish to participate in the survey.</p> <p>For mail-only mode, see <b>Table 9.2</b> of instances when a blank survey is returned and this code should be assigned.</p>
330	<p><b>Bad Address/Undeliverable Mail</b></p> <p><i>This code should be assigned only when using the mail-only mode.</i> It should be assigned if it is determined that the sample member's address is bad (e.g., the questionnaire is returned by the Post Office as undeliverable with no forwarding address).</p>
340	<p><b>Wrong, Disconnected, or No Telephone Number</b></p> <p><i>This code should be used in telephone-only or mixed-mode survey administration.</i> Because the telephone follow-up represents the last attempt to reach the sample member for mixed-mode survey administration, this code should be used even if it is determined that the mailing address is also bad.</p> <p>This code should be assigned if it is determined that the telephone number is bad (e.g., disconnected, no telephone number available, etc.).</p>
350	<p><b>No Response After Maximum Attempts</b></p> <p>This code can be used in all three approved data collection modes. It should be assigned when the contact information for the sample member is assumed to be viable, but the sample member does not respond to the survey/cannot be reached during the data collection period.</p> <p>This code should be assigned to completed surveys received after the data collection period for the sample month ends.</p> <p><u>Mail-Only Mode</u></p> <ul style="list-style-type: none"> <li>This code should be assigned if the sample member's address is viable but they do not respond to either the first or second questionnaire mailing during the data collection period. Assign this code only if work on the case has not resulted in a completed survey or other final disposition code.</li> <li>This code should be assigned if the initial questionnaire is returned blank and the second questionnaire is never returned. See <b>Table 9.2</b> below.</li> </ul> <p><u>Telephone-Only Mode</u></p> <ul style="list-style-type: none"> <li>This code should be assigned if it is determined that the telephone number is viable but the required number of telephone attempts (five) did not result in a completed interview or other final disposition code.</li> </ul>
350	<p><u>Mixed Mode</u></p> <ul style="list-style-type: none"> <li>This code should be assigned if it is determined that the telephone number is viable but the maximum number of contact attempts (i.e., the five telephone attempts) did not result in a completed survey or another final disposition code.</li> </ul>

### **Differentiating Between Disposition Codes 330 (Nonresponse: Bad Address), 340 (Bad/No Telephone Number), and 350 (No Response After Maximum Attempts)**

**Code 330: Nonresponse: Bad Address/Undeliverable Address** should be used for mail-only mode and assigned only if there is evidence that the patient's address is not viable. Evidence that the address is not viable includes the following:

- The HHA does not provide an address for the sample member and the vendor has attempted but failed to obtain an address;
- The questionnaire is returned as “undeliverable, no forwarding address”; and
- The questionnaire is returned as “address or addressee unknown” or some other reason the mail was not delivered.

The vendor is strongly encouraged to use an outside address update service prior to mailing questionnaires to ensure that the most accurate mailing address is used. Similarly, if a questionnaire is returned as undeliverable, the vendor is strongly encouraged to attempt to locate a new address prior to the second questionnaire mailing if possible.

**Code 340: Nonresponse: Wrong, Disconnected, or No Telephone Number** should be used for phone-only and mixed modes and assigned only if there is evidence that the sample member's telephone number is not viable. Evidence that the phone number is not viable includes the following:

- The HHA does not provide a telephone number for the sample member and the vendor has attempted and failed to obtain a telephone number;
- On calling, the telephone interviewer learns that the telephone number on file is disconnected, nonworking, or out of order, and no new telephone number is provided; and
- On calling, the telephone interviewer reaches a person and learns that the telephone number is the wrong number for the sample member and no new number is provided.

To ensure that the most accurate telephone number is used, the vendor is strongly encouraged to use an outside telephone number update service prior to initiating telephone contact. Similarly, if the vendor learns that a telephone number is not viable, the vendor is strongly encouraged to attempt to locate a new telephone number for the sample member prior to the end of the data collection period.

**Code 350: Nonresponse: No Response After Maximum Attempts** should be used for all three approved modes and assigned if there is evidence that the sample member's address or telephone



number is viable but the sample member has not responded after all questionnaire mailings or telephone attempts appropriate for the given mode have been implemented.

## Handling Blank Questionnaires

For the mail-only mode it is appropriate to send a second questionnaire to the sample member if the first questionnaire is returned blank, as long as it is mailed before the end of the data collection period. **Table 9.2** provides guidance on how to code mail surveys that are returned blank.

**Table 9.2**  
**Handling Blank Mail Survey Questionnaires**

If first questionnaire returned.....	If second questionnaire returned....	Assign code....
Blank	Blank	320—refusal
Not returned	Blank	320—refusal
Blank or Not returned	Not returned	350—maximum attempts

The procedures described above are for surveys that are returned blank, not for surveys that have been marked undeliverable because the United States Postal Service could not deliver the mail.

## Coding Proxy Surveys and Interviews

It is the vendor’s responsibility to flag and code all telephone interviews and returned hardcopy questionnaires completed with a proxy respondent as a “proxy” interview. For mail questionnaires, the vendor must assign a proxy flag to any case where the respondent indicated in Question 34 that the person helping him or her “answered the questions for me” (response option 3).

**Exhibit 9.1** shows when the proxy flag should be coded as “1,” “2,” or “M,” for surveys completed by mail mode and the mail portion of the mixed-mode data collection mode.

For telephone surveys, the proxy flag should be assigned (“1”) if the interview was completed by a proxy respondent or (“2”) if the interview was completed by the sample member. It is not acceptable to assign a proxy value of “M” for surveys completed by telephone.

**Exhibit 9.1**  
**When to Assign the Proxy Flag**

Value for Q33	Value for Q34 <help-answer>	Proxy Flag
1	1	1
2	1	1
M	1	1
1	M	2
2	M	2
M	M	M

## Definition of a Completed Survey

A survey is considered to be “complete” and should be assigned a survey disposition code of 110—Completed Mail Survey or 120—Completed Phone Interview if at least 50% of the questions applicable to all sample members (Questions 1–11, 15–21, and 24–25) are answered.

- Survey items that are part of skip patterns and the items in the “About You” section of the questionnaire (Questions 12–14, 22–23, and 26–34) should not be included in the calculation of percentage complete. Question 1 is included, however.
- Responses of “Don’t Know” and “Refuse” should be recoded to missing (“M”) and should not be counted as responses.
- Use the steps in *Exhibit 9.2* to determine whether a survey can be considered “complete.”

**Exhibit 9.2**  
**Steps for Determining Whether a Questionnaire Meets Completeness Criteria**

Sum the number of questions that have been answered by the respondent that are applicable to all patients. These include questions 1–11, 15–21, and 24–25.

$R = \text{total number of questions answered}$

Divide the total number of questions answered by 20, which is the total number of questions applicable to all patients, and then multiply by 100 to determine the percentage.

$\text{Percentage Complete} = (R / 20) \times 100$

If the Percentage Complete is greater than or equal to 50 percent, then assign the applicable survey completed disposition code (code 110 or 120) to indicate that the case meets the definition of a completed survey. Otherwise, assign the disposition code for breakoff (code 310) to the case.

## Computing the Response Rate

Survey vendors are not required to compute a response rate for each monthly sample. However, CMS will compute and report a response rate for each participating HHA when survey results are publicly reported. For a given public reporting period (i.e., the last four quarters of collected data), a response rate for each HHA will be calculated as described in *Exhibit 9.3*. The information below is provided for illustrative purposes only.

**Exhibit 9.3**  
**How Response Rates Are Calculated**

<p style="text-align: center;"><b>Response Rate =</b></p> $\frac{\text{Total Number of Completed Surveys}}{\text{Total Number of Surveys Fielded} - \text{Total Number of Ineligible Surveys}}$ <p>Total Number of Completed Surveys is the number of surveys assigned a final survey disposition code of 110 and 120.</p> <p>Total Number of Surveys Fielded is the total number of patients selected for the survey in the sample month. This includes all cases with a final survey disposition code of 110 through 350.</p> <p>Total Number of Ineligible Surveys is the number of sample cases assigned a final survey disposition code of 210, 220, 230, or 240. No other cases will be removed from the denominator.</p>
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## Quality Control Guidelines

Vendors are strongly encouraged to implement quality control measures for every aspect of mail and telephone data processing activities. Required and recommended quality control measures are described in detail in the mail, telephone, and mixed-mode survey administration chapters (*Chapters V, VI, and VII*) of this manual and are not repeated here. In this section, we focus on quality control measures associated with coding and data processing activities only. Quality control measures are listed by topic in the paragraphs that follow. Vendors should conduct additional quality control measures as warranted, based on their individual processes. All quality control checks should be conducted by a different person than the one who completed the task.

### Quality Control for Mail Survey Data Processing Activities

- Vendors should select and review a sample of cases coded by each coder to make sure that coding rules were followed correctly.
- Before submitting data to the HHCAHPS Data Center, we highly recommend that vendors do the following:

- Review a sample of cases (of at least 10%) comparing the responses recorded on the hardcopy questionnaires to the response codes that appear in the XML data file. This quality control step will ensure that the responses included in the XML data files accurately reflect the sample patients' responses to the survey questions.
- Review a sample of cases (at least 10%) with a noncomplete final code (i.e., cases with a final disposition other than 110—Completed Mail Survey or 310—Breakoff) against the original source of information that resulted in the case being finalized. This could include reviewing vendor's toll-free telephone number call-in tracker, handwritten notes on mail survey, white mail, etc.
- Vendors should develop a way to measure error rates of both their data receipt staff in terms of recognizing marginal notes and passing these on to someone for review and in terms of data entry or scanning verification. Vendors should work with their staff to minimize error rates. The HHCAHPS Survey Coordination Team will request information about data receipt and processing error rates during site visits to survey vendors.
- Vendors should calculate and review the response rates periodically for each of their client HHAs. If a sample was selected for an HHA but there is no response or a very low response rate, this could be an indicator that incoming mail was not processed, scanned/keyed data were not exported to the XML data file, or other problems occurred with the mail survey. In instances where the number of cases sampled was very small (e.g., 10 or fewer), it is possible that there were no completed or partially completed survey returned. For HHAs with larger sample sizes, no response from any of the sample members could be indicative of a data collection or data processing problem.

### Quality Control for Telephone Survey Data Processing Activities

- Vendors should conduct periodic reviews of their XML data files by comparing at least 50 completed telephone interview responses directly from their CATI system to the values output in the XML data files. Doing this review monthly will ensure that the responses are being accurately captured and output to the XML data file.
- Vendors should generate and review frequencies of cases at the various interim and final disposition codes for each HHA and perhaps by telephone interviewer. A higher-than-average percentage of cases coded as “Physically or Mentally Incapable, No proxy respondent available” could indicate that interviewers are not attempting to identify and conduct the interview with a proxy respondent. Similarly, a high percentage of cases coded as “not available” after maximum attempts could indicate that call attempts are not being scheduled appropriately.

- Vendors should calculate and review the response rates on a periodic basis for each of their client HHAs. If a sample was selected for an HHA but there is no response or a very low response rate, this could be an indication of a data collection or data processing problem. In cases where the number of cases sampled was very small (e.g., 10 or fewer), it is possible all sample members decided not to participate in the survey. For HHAs with larger sample sizes, it is highly unlikely that 100% of the sample cases will refuse to participate in the survey.

### Quality Control on XML Data Files

- Vendors should use the XML schema validation tool to conduct an initial quality control of their XML data file formatting. The XML Schema Validation Tool is available on the HHCAHPS website through a link in the “Data Submission” menu after logging in.
- Vendors should run frequencies of distributions on both the patient administrative data and the patient response data to look for outliers or anomalies, including missing values. By reviewing frequencies, vendors may be able to identify problems in the data they receive from HHAs, their own data file processing, or their XML coding operations.
  - Examples of frequencies that vendors could run include
    - race (are all respondents coded as Alaska Native, for example); and
    - age (is there a reasonable distribution of age categories across sample members, or do the ages lean heavily toward the very young or very old?).
- Vendors should periodically check their data processing programs to confirm that data elements on the XML data files are coded properly on the XML data file, including Activities of Daily Living (ADL) values. For example, codes of “0” on each of the ADL deficit data elements reflect an individual who has no deficits—unusual for an individual receiving home health care. If they see zeroes on the data files they receive from either HHAs or their software vendors, vendors must ensure that the HHAs and software vendors understand the difference between the use of “0” to designate an individual with no deficits and “M” for ADL deficit information that is completely missing.
- Vendors should make sure that a code is entered on the XML data file to indicate whether a proxy respondent was used, for all completed mail and telephone survey cases.
  - For surveys completed by mail, the “Yes” code (“1”) on the XML data file for the proxy indicator should be marked if the answer to Q34 in the completed mail survey is “Answered the questions for me.” The only time the “M” code for the proxy respondent indicator is acceptable on the XML data file is when a respondent to the mail survey did not answer Q33 or Q34.

- For surveys completed by telephone, mark the “Yes” indicator (code as “1”) on the XML data file if the interview was conducted with a proxy respondent.
- Vendors are responsible for running the completeness criteria on all completed surveys to ensure that they meet the completeness criteria described in this chapter. Vendors should assign either a completed interview code or a partial data/breakoff code based on whether the survey passes the completeness criteria.
- Vendors should conduct a final check of the disposition codes assigned to all sampled cases before submitting XML data files to the HHCAHPS Survey Data Center. If the vendor identifies a case assigned either an ineligible or non-interview final disposition code AND there are data included in the Patient Response Record section of the XML data file, the vendor should determine why code 110—Completed Mail Survey or 120—Completed Phone Interview was not assigned to the case. If it is determined that the case is indeed ineligible or was a non-interview, remove the survey response data from the XML data file.
- Vendors should select a random sample of cases on the XML data file and compare the variables in the Patient Administrative Data Record against the patient information that was provided by the HHA on the original monthly patient information file to make sure the information was exported to the XML data file correctly.

## **X. WEBSITE AND FILE SUBMISSIONS**

### **Overview**

This chapter introduces the HHCAHPS Survey website and discusses how HHAs and survey vendors access and use the private links on the website. It also covers the HHCAHPS Survey XML data file specifications and the steps involved in the XML data submission process.

### **The HHCAHPS Survey Website**

The HHCAHPS Survey website, available at <https://homehealthcahps.org>, is maintained by RTI International, which is assisting CMS with the national implementation of the HHCAHPS Survey. The website is the primary portal for communicating and updating information about the HHCAHPS Survey to HHAs and survey vendors. The website has both public and private (restricted-access) sections to ensure the security and privacy of selected interactions. Medicare-certified HHAs participating in the HHCAHPS Survey access private links on the HHCAHPS website to authorize their contracted survey vendor to submit HHCAHPS Survey data on their behalf, review their data submission reports, and view their HHCAHPS Survey results before the results are publicly reported. Survey vendors access specific links on the private side of the website to manage their user accounts, submit HHCAHPS Survey data to the Data Center and upload their Quality Assurance Plan (QAP).

On the public page, a link to a login allows authorized users (HHA and survey vendor users) access to the private sections of the website, where they can carry out administrative functions. Access to the private side is controlled through website-issued user identification and passwords. The public sections of the website contain important survey information for HHAs and survey vendors. *Exhibit 10.1* presents the main navigation menu that allow users to access different informational areas on the website.

**Exhibit 10.1**  
**HHCAHPS Survey Website Navigation Menu**

Home	General Information	Training	Forms for Vendors	Survey and Protocols	Data Submission	For HHAs
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Each link below the dark navigation menus provides direct access to a form or file that may be of use to HHAs or vendors. A brief description of the content available on the Home page, including information accessed via the website navigation menu, is presented below.

- The links under the “General Information” menu provide HHAs and survey vendors with participation news and requirements and archived public reporting files.
- HHCAHPS Survey training registration forms, agendas, and training slides are posted under the “Training” menu, while the “Forms for Vendors” menu includes many online forms survey vendors need to conduct survey operations for their client HHAs. The *Protocols and Guidelines Manual* and the complete set of HHCAHPS survey materials are located under the “Survey and Protocols” menu and are updated annually or as needed.
- Located under the “Data Submission” menu, the “Data Submission Resources” webpage contains documents and materials to support survey vendor data submission activities, including the *Home Health Care CAHPS Survey Website User and Data Submission Manual, Version 13.0* and XML data file layout guidance. The *Website User and Data Submission Manual* contains detailed information about the website and data submission process.
- The “For HHAs” menu contains documents and materials to support HHA participation activities, including the online registration form for HHAs to request credentials for accessing links in the private section of the website and the online Participation Exemption Request form. This is the form that Medicare-certified HHAs that qualify for an exemption from participating in the HHCAHPS Survey are required to complete and submit to request an exemption.
- A “Quick Links” box (shown in *Exhibit 10.2*) on the right side of the website Home page provides easy access to several important links.
- Recent announcements are located at the bottom of the Home page. CMS and the HHCAHPS Survey Coordination Team use the Announcements page to disseminate important updates about the HHCAHPS Survey, including information about new policies or changes in survey administration protocols and procedures and reminders of upcoming data submission deadlines.
- The “Information for HHAs” box, also on the right side of the Home page, contains important information for Medicare-certified HHAs, including the HHCAHPS Survey fact sheet, information about HHA participation requirements, eligibility for an exemption from participating in the HHCAHPS Survey, and instructions on steps that HHAs must take to participate in the HHCAHPS Survey.



**Exhibit 10.2**  
**Quick Links on the HHCAHPS Survey Website**



Public and private links contained under each of the main navigation menus are shown in *Exhibit 10.3*. Private links under the menus are only available once the HHA or vendor has logged into the private side of the website, with the menu labelled “HHA Dashboard” or “Vendor Dashboard” only appearing once a user has logged into the private side of the HHCAHPS website.

**Exhibit 10.3**  
**Links Under the HHCAHPS Survey Site Navigation Menu**

<b>HHA or Vendor Dashboard</b>	<b>General Information</b>	<b>Training</b>	<b>Forms for Vendors</b>	<b>Survey and Protocols</b>	<b>Data Submission</b>	<b>For HHAs</b>
This menu appears only on the private side of website	About HHCAHPS Survey	Registration Form	Vendor Registration	Protocols & Guidelines Manual	Data Submission Deadlines	Register for Login Credentials
	CTQR Newsletters	Training Materials	Minimum Business Requirements	Questionnaire	Data Submission Resources	Register CCNs (Private Link)
	Chartbook		Exceptions Request Form (Private link)	Supplemental Questions	Schema Validation Tool (Private link)	Participation Exemption Request Form
	Mode Experiment		Discrepancy Notification Report (Private link)	Consent to Share Responses	Data Submission Tool (Private link)	Manage Users (Private link)
	Vendor Application Process		Model Quality Assurance Plan	Survey Composites	Data Submission Reports (Private link)	Authorize a Vendor (Private link)
	Approved Survey Vendors		Submit Quality Assurance Plan (Private link)	Sample Letters		Data Submission Reports (Private link)
	Archived Publicly Reported Data		Survey Vendor Authorization Report (Private link)	Telephone Scripts		Survey Preview Report (Private Link)
	Calculating PR Measures		Manage Users (Private link)	FAQs for Interviewers		Understanding the Preview Report
	Contact Us / Other Links			OMB Disclosure Notice		
	Announcements					

The Dashboard menu provides users with links to key items on the website, depending on the type of user. For example, HHAs are given links to all of the documents required for the Registration and Vendor Authorization processes, including links to the Register CCNs and vendor authorization forms; a User Access console, showing administrative users within the organization; and a link to their data submission report. Survey vendors are provided with the status of key elements of the Vendor Approval Process—including the status of and links to their

Vendor Registration, Vendor Application Form, Consent Form, and overall approval status; links to both data submission reports and reports showing the HHAs that have authorized the; and a User Access console showing administrative users within the organization.

### HHA Access to the Website's Private Links

HHCAHPS Survey protocol require that HHAs designate a Survey Administrator, who will carry out protocol-required tasks on the private side of the HHCAHPS Survey website. The HHCAHPS Survey Administrator's role and responsibilities are listed below.

- Serve as the main point of contact with the HHCAHPS Survey Coordination Team;
- Designate at least one other individual within the organization as the backup Administrator;
- Add and manage additional administrative and non-administrator users on the Manage Users page; and
- Authorize their contracted HHCAHPS-approved survey vendor.

To register for Survey Administrator credentials to access the private links, HHAs should:

- Click on the "For HHAs" link on the HHCAHPS Survey website (<https://homehealthcahps.org>) and then click the "Register for Login Credentials" link.
- Enter the contact information in the form, along with a username and password.
- Click the "Submit" button.

After the designated Survey Administrator submits the online Register for Login Credentials Form, the HHCAHPS system will send a confirmation email.

Once a Survey Administrator has registered for user credentials, they then need to register the CCN(s) associated with the account. To do this, the user should log in, click on the "For HHAs" menu, and click on the "Register CCNs" link. After entering the CCN(s), the system will display a text box with **Survey Administrator Roles and Responsibilities**, with a checkbox for the user to acknowledge that they accept these. The user can then submit the Register CCNs form. We strongly recommend that the Survey Administrator designate a "Backup Administrator" once they are logged into the private side of the website. The backup HHCAHPS Survey Administrator will have all of the same permissions as the primary Administrator. Having a backup Administrator ensures continued system use if the primary Administrator is unavailable or terminates employment with the HHA. Survey Administrators can also add staff as administrative and non-administrator users. After a Survey Administrator registers an additional user, the HHCAHPS system will automatically send a credentials email to that user. **Non-**

*administrator users* will only be able to view survey reports on the private side of the website. They will not be able to carry out any of the administrative functions.

If the Survey Administrator for an HHA changes, the new Survey Administrator must contact the HHCAHPS Survey Coordination Team to have the previous Survey Administrator credentials deleted so they can then register for login credentials.

## HHCAHPS Survey Vendor Authorization

Each HHA must authorize a survey vendor on the HHCAHPS Survey website to submit data on its behalf *before* the survey vendor can successfully submit HHCAHPS Survey data for that HHA. To authorize a survey vendor, the HHA's Survey Administrator must log into the website and click on the "For HHAs" link. The dropdown box under this link will show the "Authorize a Vendor" link.

The online Authorize a Vendor form is set up to allow a Survey Administrator to authorize the vendor to submit data on behalf of multiple HHAs. If a Survey Administrator serves several HHAs they will be able to view vendor authorizations for all of the HHAs for which they have administrative user credentials, and they can authorize different survey vendors for each HHAs if desired.

HHCAHPS Survey Administrators are responsible for checking their vendor authorization status periodically to ensure that the vendor name, Start Date, and End Date (if applicable) are correct.

The online Authorize a Vendor form allows HHAs to perform the four functions described below. An automatic email will be sent to the HHA Survey Administrator confirming that the vendor has been authorized immediately after the authorization has been submitted.

**1. Authorize a vendor for an HHA for which a vendor has never been authorized.** The HHA that is just beginning to participate in the HHCAHPS Survey will need to follow the directions below to authorize its survey vendor for the first time. To authorize the vendor for one or more HHAs, the HHA should:

- Select "Select a vendor for an HHA for the first time" from the Select Action dropdown list;
- Select a vendor from the dropdown list;
- Select the Start Date, which is the first day of the calendar year quarter for which the vendor is being authorized to submit HHCAHPS Survey data;
- Select the HHA(s) (CCNs) to which the authorization applies; and
- Click the "Submit" button.

- 2. Change the Start Date or End Date for the current vendor.** The “Change the start/end date for an existing vendor authorization” action allows an HHA to change the Start or End Date for an existing vendor. The system allows an HHA to change a Start Date and add or change an End Date for multiple CCNs.
- 3. Change/switch to a different HHCAHPS vendor.** To change or switch to a different survey vendor, the HHA should:
- Select “Change the start/end date for an existing vendor authorization” from the Select Action dropdown list;
  - Select an End Date for the existing HHCAHPS Survey vendor, which is the last date of the calendar year quarter the vendor is authorized to submit HHCAHPS Survey data on the agency’s behalf;
  - Select the HHA(s) (CCNs) to which the authorization applies;
  - Click the “Submit” button;
  - Select “Change/switch to a different vendor” from the Select Action dropdown list;
  - Select the “new” vendor from the dropdown list;
  - Select the Start Date, which is the first day of the calendar year quarter for which the “new” vendor is being authorized to submit HHCAHPS Survey data;
  - Select the HHA(s) (CCNs) to which the authorization applies; and
  - Click the “Submit” button.
- 4. View current vendor authorizations.** This action allows an HHA to view its survey vendor authorization, including the vendor’s name and Start Date. The End Date will also show if an HHA entered an End Date.

### Survey Vendor Access to the Website’s Private Links

Survey vendors will be given full access to the private sections on the HHCAHPS Survey website *after they have been approved as an HHCAHPS Survey vendor* and the Coordination Team has received the vendor’s electronic Consent Form and “passed” training certification.

The vendor HHCAHPS Survey Administrator/Project Manager’s login credentials (i.e., username and password) will be created by the vendor user on the Vendor Registration form. We strongly recommend that a vendor’s Survey Administrator/Project

**IMPORTANT:** HHAs can change a survey vendor ONLY at the beginning of each calendar year quarter.

Manager designate a “Backup Administrator” once they are logged into the private side of the website. The backup Survey Administrator will have all of the same permissions as the primary Administrator. Having a backup Administrator ensures continued system use if the primary Administrator is unavailable or terminates employment with the vendor. After logging into the system, the primary Administrator can also add non-administrator users. ***Non-administrator users*** will only be able to view a limited number of survey reports on the private side of the website. They will not be able to carry out any of the administrative functions. After the Survey Administrator registers an additional user, the HHCAHPS system will automatically send an email with login credentials.

If the vendor’s Survey Administrator/Project Manager changes, the new person serving in this role must notify the Coordination Team and register for login credentials.

## Submitting HHCAHPS Survey XML Data Files to the Data Center

The next several sections provide information, specifications, and procedures that survey vendors must follow to successfully submit patient survey XML data files through the “Data Submission” portal on the HHCAHPS website. Additional details about the data submission process are also provided in the *Home Health Care CAHPS Survey Website and Data Submission Manual*, which is available on the HHCAHPS Survey website.

## Quarterly Data Submission Deadlines

Vendors must submit data for all three sample months in a calendar quarter by a specific data submission deadline each quarter. Survey vendors have the option of submitting an XML data file to the HHCAHPS Survey Data Center quarterly or more frequently. Because each submitted data file must pass a two-step validation process after the file is uploaded, survey vendors are strongly encouraged to submit data files well in advance of the data submission deadlines. Submitting files early gives vendors sufficient time to revise and resubmit a file in the event that a file fails the validation process. *The data files for all months in a specific quarter for each client HHA must be successfully submitted before the submission deadline for that quarter.*

## Submitting Data for a Closed HHA

If an HHA closes or is no longer active while its HHCAHPS Survey vendor is still contracted to conduct and provide survey data on its behalf, the HHA’s vendor remains in effect for the entire authorization period. Inactive HHAs are designated with an asterisk (\*) symbol on the Vendor Authorization Report. The authorized vendor must submit all of the HHCAHPS Survey data that were collected for the closed HHA to the HHCAHPS Survey Data Center.

If the vendor receives a data submission error indicating that it is not authorized to submit the data when attempting to upload an XML data file for an HHA that has closed, the vendor should contact the HHCAHPS Survey Coordination Team for assistance. The data submission deadlines

for submitting HHCAHPS Survey data to the Data Center are applicable to all HHAs, even those that are no longer in business.

## XML Data File Specifications for Data Submissions

Each XML data file should contain a Header Record, a Patient Administrative Data Record for every sampled case, and a Patient Response Record for every completed (coded 110 or 120) or partially completed (coded 310) survey. Each XML data file should contain one sample month of survey data, by CCN. *Appendix N* contains the XML data file layout for the standard header record; it provides the data file specifications and layout for HHCAHPS Survey XML data files that use simple random and proportionate stratified random sampling (PSRS). If disproportionate stratified random sampling (DSRS) is used, the vendor must use the XML data file layout for DSRS, which is contained in *Appendix O*.

All of the XML data file templates with required specifications are located on the HHCAHPS Survey website to assist survey vendors with their file preparations. Vendors are also encouraged to use the online “XML Schema Validation Tool” described later in this chapter to assist them with file preparations. Survey vendors that need assistance with the XML format should contact the HHCAHPS Survey Coordination Team.

HHAs and their survey vendor should keep in mind that an HHCAHPS Survey XML data file must be submitted for each sample month, including for sample months for which there were no patients who met survey eligibility criteria. If a data file is not submitted for each sample month, the HHA will be considered as having “missed” a month of survey participation and may be considered noncompliant with HHCAHPS Survey participation requirements.

If an XML data file for a sample month is submitted more than once, the most recent data submission will overwrite the file previously submitted for that sample month, even if those files “passed” all checks. Therefore, the final file submission must contain data for all patients who were sampled in the sample month for a specific HHA.

Each of the three XML data file sections—the Header Record, the Patient Administrative Data Record, and the Patient Response Record—is described below.

### Header Record

The Header Record contains the identifying information for the HHA for which data are included on the file, sampling information, survey administration mode, and the sampling method. Information required in the Header Record is provided below.

- **Header Type.** This is the type of Header Record (standard or DSRS).
- **Provider Name.** This is the HHA’s Provider Name.

- **Provider ID.** This is the HHA's CCN.
- **National Provider Identifier (optional).** This is the national provider ID number.
- **Sample Month.** This is the calendar year month for which the sample was selected.
- **Sample Year.** This is the calendar year in which the survey was conducted.
- **Mode of Survey Administration.** The survey mode, either mail only, telephone only, or mixed mode, *must be the same for all sample members in each sample month in the calendar quarter for the HHA.* HHAs and their survey vendors cannot change survey administration modes until a new quarter begins. Also note that the survey mode indicated in the Header Record must be one of the modes that the survey vendor is approved to use. If the mode is not one of the modes for which the vendor is approved, the Data Center will not accept the XML data file when the vendor attempts to submit it.
- **Type of Sampling.** This is the sampling method that was used to select the sample—these include census, simple random sampling (SRS), PSRS, and DSRS. See *Chapter IV* for information about each of these methods.
- **Number of Patients Served.** This is the total number of patients who had at least one visit during the sample month for skilled care, including those eligible for the survey and those who are not (under age 18, non-Medicare and non-Medicaid patients, deceased, received hospice care, received only routine maternity care, state-regulated patients, or requested that their name not be released).
- **Number of Patients on the File Submitted by the HHA.** The HHA must provide the survey vendor with a list of all patients served by the HHA during the sample month whose care was paid for by either Medicare or Medicaid, with the exception of patients who are deceased, are not 18 years old or older, currently receive hospice care, received home health care for routine maternity care only, state-regulated patients, or requested that the HHA not release their name to anyone outside the HHA. **If the HHA did not serve any patients during the sample month, the vendor must still submit an XML data file for that sample month. The HHA must, therefore, still submit a file to its vendor showing that there were 0 eligible patients.** If the HHA did not serve any patients during the sample month, enter zero ("0") for this data element on the data file.
- **Number of Eligible Patients.** This is the number of patients in the file submitted by the HHA who meet survey eligibility criteria in the sample month as of the time the sample is selected. This value can be zero only if none of the patients on the file provided by the HHA for the sample month were eligible for the survey. The vendor should not modify this count



of eligible patients based on information found during data collection (e.g., a patient is deceased).

- **Number of Patients Sampled.** This is the number of patients selected for the survey during the sample month. This number can be zero only if all of the patients included on the file that the HHA provided for the sample month were ineligible for the survey. If a value of zero is entered for this data element, the value for the Number of Eligible Patients data element must be zero.

If DSRS is used, the survey vendor must include these extra data elements in the Header Record, including:

- **DSRS Stratum Name** (note that there must be at least two strata identified for DSRS sampling).
- **DSRS Number of Patients on file submitted to vendor**, which is the number of patient records included on the file that all of the HHA locations that share a CCN provided for this stratum.
- **DSRS Number of Patients eligible in stratum**, which is the number of patients who meet survey eligibility criteria within each stratum.
- **DSRS Number of Patients sampled in stratum**, which is the number of patients sampled within the stratum.

Please remember that approved HHCAHPS vendors must submit an Exceptions Request Form and receive CMS approval prior to conducting DSRS sampling (see *Chapter XIV* for more information about the Exceptions Request Form). More information about DSRS and requirements for DSRS sample selection and file construction is provided in *Chapter IV*.

## Patient Administrative Data Record

The second section of the XML data file contains data about each patient who was sampled for the sample month, including those who responded to the survey and nonrespondents. In this section of the file, some of the information provided in the Header Record is repeated, including the HHA's CCN and the Sample Year and Sample Month. All other information included in this section of the file is about the patients included in the sample. ***There must be a Patient Administrative Data Record for every patient sampled in the sample month.*** The sample identification (SID) number assigned to each sample member must be included. *Only de-identified data will be submitted to the HHCAHPS Survey Data Center; however, the unique SID number that the survey vendor assigned to the sample member must be included on the file.* Files submitted with missing or duplicate SID numbers will be rejected.

Most of the information required in the Patient Administrative Data Record is provided by, or derived from, information the HHA submits on the monthly patient information file. The Patient Administrative Data Record will include the following data elements *for each sampled patient*. See *Appendix N* for instructions and coding specifications for each element.

- **Provider ID.** This is the HHA's CCN.
- **National Provider Identifier (optional).** This is the HHA's NPI.
- **Sample Month.** This is the calendar year month for which the sample was selected.
- **Sample Year.** This is the calendar year in which the survey is conducted.
- **Sample ID Number.** This is the unique de-identified SID number the survey vendor assigns to the sampled patient record. Additional information about the guidelines surrounding an SID can be found in *Chapter IV*.
- **Patient Age.** The vendor will calculate the sample member's age based on the date of birth provided by the HHA and last day of the sample month. If a sampled patient has an unknown date of birth (because it was not provided by the HHA but meets the other eligibility criteria and is considered eligible), the vendor is unable to calculate the patient's age and should apply code "M" (Unknown/Missing) for this variable.
- **Sex.** This is the patient's sex as indicated on the HHA's monthly patient information file. If a sampled patient's sex is unknown, the vendor should apply code "M" (Unknown/Missing) for this variable.
- **Number of Skilled Visits.** This is the total number of skilled home health visits the patient had in the sample month. See *Chapter IV* for additional information as to how a "skilled visit" is defined for the HHCAHPS Survey.
- **Number of Lookback Visits.** This is the total number of skilled home health visits the patient had in the lookback period (i.e., sample month and the month preceding the sample month). See *Chapter IV* for additional guidance for calculating this number.
- **Admission Source.** This is the place of residence or medical care setting from which the patient was admitted. See *Chapter IV* for additional information. The source of admission can be coded as hospital (acute or long-term) with "1"; rehabilitation facility (hospital) with "2"; skilled nursing facility (or swing bed in hospital) with "3"; other nursing home (long-term care) with "4"; other inpatient facility with "5"; and/or directly from the community (e.g., private home, assisted living, group home, adult foster care) with "6."

- **Payer Source.** This is the source(s) of payment for the patient's home health care. Note that multiple sources may apply. See *Chapter IV* for additional information. The payer source can be coded as Medicare, Medicaid, private health insurance or other source.

As described in *Chapter IV*, there may be situations in which the HHA is not able to provide the source of payment for patients it served during a sample month in time for the survey to be fielded for that sample month. If this happens, the vendor should include the patients on the sample frame provided they meet other survey eligibility criteria and survey the patients if they are sampled. If the HHA never provides the source of payment, the vendor should treat the patient(s) as eligible, code the payer source data element as "Missing," code the disposition of each case as appropriate, and then submit the data for all sampled and surveyed patients to the HHCAHPS Data Center.

- If the HHA provides the payer sources before the data collection period has ended, and one or more patients surveyed is not covered by Medicare or Medicaid, the vendor should code the patient as ineligible on the XML data file.
- The data submission tool also accommodates the situation in which the payer source is not provided by the HHA but can be assumed, using the code "**A—assumed**," as described below.
  - If the HHA does not provide the payment source on the monthly patient information file, the vendor should check with the HHA to determine whether the HHA believes that the patient is covered by Medicare or Medicaid. If the HHA cannot confirm the payer source but believes that the sample member's care is or will be paid for by Medicare (for example), the survey vendor should assign a value of "**A—assumed**" to the payer-Medicare data element for that sample member. This should be done for each applicable payer source data element (see *Exhibit 10.4*).
  - The value "A" should only be assigned if the HHA is unable to provide the payer status for a patient but believes that the patient's care is covered by Medicare (or Medicaid, Private Pay, etc.). If the HHA does not have any idea what the payment source was or will be, the survey vendor should code each payment source data element as "M" for missing.

**Exhibit 10.4**  
**Payer Source Data Elements**

XML Element	Valid Values
Payer (e.g., Medicare) <payer-medicare>	1 = Medicare A = Assumed M = Unknown/Missing
Payer (e.g., Medicaid) <payer-medicaid>	1 = Medicaid A = Assumed M = Unknown/Missing
Payer (e.g., private insurance) <payer-private>	1 = Private health insurance A = Assumed M = Unknown/Missing
Payer <payer-other>	1 = Other A = Assumed M = Unknown/Missing

- **HMO Indicator.** This is to indicate if the patient is enrolled in a health maintenance organization (HMO). This indicator should be coded Yes (“1”) if the patient is enrolled in a Medicare Advantage plan or a Medicaid managed care plan.
- **Dual Eligibility.** This is to indicate if the patient is dually eligible for Medicare and Medicaid coverage. This indicator should be coded Yes (“1”) if the patient is dually eligible.
- **Primary Diagnosis Code.** This is the ICD-10-CM code for the underlying reason for the home health care such as the principal diagnosis if the patient was admitted from a hospital. The source of diagnosis codes may be the plan of care, OASIS assessment, record of hospital stay, or other record documenting the patient admission.

HHAs should provide ICD-10 codes as the primary diagnosis. Z-codes as the primary diagnosis, while not preferred, are allowed and will be accepted. External cause codes (ICD-10-CM codes beginning with V, W, X, or Y) are not allowed as the primary diagnosis but are allowed for the other diagnoses. In the XML data file, vendors must left justify the diagnosis code, retain the leading zero, and exclude the decimal (if applicable).

- **Other Diagnosis Codes.** These are comorbid conditions that are relevant for the care of the patient. The relevant comorbidities are ICD-10-CM diagnosis codes. The sources may be the same as for the primary diagnosis. HHAs can provide up to five other diagnoses for each patient included on the file. ICD-10-CM codes beginning with V, W, X, or Y will be accepted for the Other Diagnosis data elements. In the XML data file, vendors must left justify the other diagnosis codes, retain the leading zeros, and exclude decimals (if applicable).

- **ESRD Indicator.** This is the indicator of whether the patient has End-Stage Renal Disease. This indicator should be coded Yes (“1”) if any of the following diagnosis codes are present: I12.0, I13.11, I13.2, N18.6, Z91.15, or Z99.2.

**NOTE:** For Activities of Daily Living (ADLs), HHAs can provide either the total count of ADLs for which the patient is not fully independent and/or the code for each of the five individual ADL data elements on the monthly patient information file that they submit to the survey vendor.

The vendor should include the same information received from the HHA in the XML data file. That is, the vendor should provide in its XML file the five individual ADL counts, or the total count of ADL deficits, or both if provided by the HHA. HHCAHPS Survey vendors are not allowed to calculate the total count of ADLs for which the sample patient is not fully independent.

- **ADL Deficits.** This is the total count of ADLs for which the patient is not fully independent. If the HHA provides this total count of ADL, it should be the total number of the five ADL data elements not coded as a “0” as taken from OASIS.

If an HHA submits a value for the ADL deficits total count data element that exceeds 5, vendors should recode this data element to “5.”

- **Individual ADL Deficits.** The HHA should report the five individual ADL codes as taken from the list in the patient’s OASIS assessment. They are Ability to Dress Upper Body (M1810), Ability to Dress Lower Body (M1820), Bathing (M1830), Toilet Transferring (M1840), and Transferring (M1850). When reporting these ADL codes, the HHA must use the most current code on file for those data elements.

If the HHA provides the OASIS values for the five individual ADL data elements on its file, the vendor should enter the code provided for each of the five ADLs that were assessed for that patient on the XML data file. The only acceptable range of codes for each of the five individual ADL Deficits is “0” to “5” and “M” (missing).

- **Final Survey Status.** This is the 3-digit disposition code, or status code, assigned by the survey vendor to indicate the final status of the sampled patient record. A list of HHCAHPS Survey final disposition codes and code descriptions can be found in **Table 9.1**.
- **Survey Language.** The Survey Language included in the Patient Administrative Data Record is the identified approved language in which the patient completed the survey, either English (code “1”), Spanish (code “2”), Chinese (code “3”), Russian (code “4”), Vietnamese (“5”), or Armenian (“6”). The Survey Language variable must be coded “1” through “6” if one of the following two criteria are met: the mail or telephone survey resulted in a

completed survey (code 110 or 120, respectively) or a breakoff interview (code 310) in one of the approved languages. Note: If the survey was administered by telephone, the Survey Language variable must be coded either a “1,” “2,” “4,” or “5” since the HHCAHPS telephone survey is only available in English, Spanish, Russian and Vietnamese. Because a value is required for this variable, there may be instances when the code for Missing (“M”) should be applied (i.e., all scenarios where the survey does not result in a complete [code 110 or 120] or a breakoff [code 310]).

- **Proxy Flag.** This is an indicator if a proxy respondent completed the HHCAHPS Survey on behalf of the sampled patient. See *Chapter IX* for additional guidance on identifying a proxy for mail and telephone modes.
- **Number of Supplemental Questions.** This is the total count of HHA-specific supplemental questions included in the HHCAHPS Survey. This could include the 10 supplemental questions included in *Appendix K*, the “Consent to Share Responses” question, and other HHA-specific questions.
- **Survey Mode.** The Survey Mode included in the Patient Administrative Data Record is the data collection mode the patient used to complete the survey, mail (code “1”), telephone (code “2”), or web (code “3”).
  - All Mail Mode-Only CCNs must be coded as “1” and must meet one of the following two criteria: the mail questionnaire was returned and is a completed survey (code 110), or it is considered a breakoff (code 310).
  - The Survey Mode variable must only be coded a “2” for telephone if one of the following two criteria are met: the vendor spoke to the sampled patient by phone and the interview resulted in a completed interview (code 120), or a breakoff (code 310).
  - For mixed mode, the Survey Mode variable must only be coded a “3” if one of the two criteria are met: survey data was received and is a completed survey (code 130), or it is considered a breakoff (code 310).

Because a value is required for this variable, there may be instances when the code for Not Applicable (“X”) is needed (i.e., all scenarios where the survey does not result in a complete [code 110, 120 or 130] or a breakoff [code 310]). For example, if the mail questionnaire is never returned, is received blank, or if the sample member is never reached by phone, or the telephone interview is never initiated, the Survey Mode variable should be coded “X” (Not Applicable).

## Patient Response Record

The third section of the XML data file is the Patient Survey Response Record, which contains the responses to the HHCAHPS Survey from every respondent who completed or partially completed the survey during the sample month. **Only the HHCAHPS Survey questions should be submitted. Do not submit responses to non-HHCAHPS questions (i.e., supplemental questions) that were added to the survey instrument.** The only records that should be included are those with a final survey disposition code for a completed survey (Codes 110 and 120) and breakoff (Code 310). For all patient response records that are included on the file, all response fields must have a legitimate value, which can include “Missing,” or “Not Applicable.”

The decision whether to have a vendor key the responses to the two open-ended survey items — “Some other language” (response option 3) in Q32 and “Helped in some other way” (response option 5) in Q34—is up to each individual HHA in consultation with its vendor. Vendors should not include responses to open-ended survey items on the XML data files submitted to the HHCAHPS Survey Data Center. CMS, however, encourages survey vendors to review the open-ended entries so that they can provide feedback to the Coordination Team about adding additional preprinted response options to these survey items if needed.

## XML Survey Data File Submission Procedures

Survey vendors need to log into the secure portion of the HHCAHPS website to access the data submission tool. Prior to submitting XML data files, it is recommended that vendors run the online “XML Schema Validation Tool” posted on the HHCAHPS website for each data file. This Validation Tool is formatted in accordance with the XML Data File Specifications described in this chapter. The Validation Tool contains some, but not all, of the same validation checks that are applied when the data file is submitted to the Data Center, so using the Validation Tool in advance will reduce the number of attempts vendor have to make when they submit the data file.

To submit XML data files, click on the “Data Submission Tool” dropdown link under the “Data Submission” menu. HHCAHPS Survey vendors can submit data files to the HHCAHPS Data Center in one of two ways: as a single XML data file or as a ZIP file containing multiple XML data files.

Vendors should be aware that submitting additional XML data files for a sample month for a CCN will overwrite any previously submitted file for that month, even if that previously submitted file was successfully submitted.

The data submission steps are summarized as follows:

1. Log onto the HHCAHPS Survey website.

2. Click the “Data Submission Tool” link under the Data Submission menu. The data submission tool page will display (as shown in *Exhibit 10.5*).
3. Click the “Choose Files” / “Browse” button to select the file to upload. Up to five XML data files can be uploaded at a time. The Choose Files/Browse button permits users to locate and directly upload a file that has been saved in their own computer system. Survey vendors can select either a single XML data file or a single ZIP file that contains multiple XML data files.
4. After selecting the file to be uploaded, click “Upload” to submit the file. The Data Upload Summary Report based on the file selected will appear. A link to this report will also be emailed to the user submitting the XML data file.

**Exhibit 10.5**  
**Link to Data Submission Tool**

The screenshot shows the 'Data Submission Tool' page of the Home Health Care CAHPS Survey website. The page has a blue header with the site name and a navigation bar with links like Home, Vendor Dashboard, General Information, Training, Forms for Vendors, Survey and Protocols, Data Submission (active), and For HHAs. Below the navigation bar, the page title is 'Data Submission Tool'. Instructions state: 'Please click **Choose File** to locate the XML or ZIP file(s) you wish to upload on your computer then click the **Upload** button.' It also mentions that for a directory of XML files, they should be in a single ZIP file. A red warning line says: 'If your file has any errors during the data file upload process or the secondary validation checks, you will need to correct the errors and upload your file again.' A link for more tips is provided. There are five 'Choose Files' buttons, each with 'No file chosen' text next to it, and an 'Upload' button at the bottom.

All XML data files submitted to the HHCAHPS Data Center go through a two-step validation process in the Data Center. Files must pass both checks to be successfully submitted to the Data Center.



The first check of the submitted data file includes making sure that the XML data file is properly formatted, data range checks, and additional data checks. If the survey vendor has an incorrectly formatted XML file, the data upload process will stop immediately and send an error message to the vendor that describes the problem detected. After the system verifies that a properly formatted template has been used, it will begin a series of data checks. It will look for any fields in the Header Record with missing data. The system will also check for any duplicate sample identification (SID) numbers to make sure a vendor has not used an SID more than once for a given HHA in a given quarter. Finally, the system will check that the vendor is authorized to upload data for the particular HHA. ***Any files during this first check for which problems are detected will be immediately rejected by the Data Center.***

Files that have successfully passed the initial upload validation process are then run through a second validation process. HHCAHPS Survey XML data files must pass this secondary validation check (run within an hour) before they are formally accepted into the Data Center. The second validation process includes a check to make sure that each record with a final status code (110, 120, or 310) has a patient response record and a consistency check to make sure the values in the header record match the values in the patient administrative record. In addition, the system will run a completeness algorithm to verify that all patient response records included on the file meet survey completeness criteria (this step will be used to ensure that the appropriate cases are assigned a disposition code of “complete” but will not be a reason for rejecting a file if cases are miscoded). Finally, DSRS files will also have a check to make sure the number of records in each stratum match the stratum size value in the header record.

Vendors are emailed the results of the first and second validation checks along with a link to a Data Submission Summary Report. Survey vendors are strongly encouraged to check their reports each time they submit XML data files. More details about these reports are provided in ***Chapter XI*** and also in the *Home Health Care CAHPS Survey Website and Data Submission Manual*, which is available on the HHCAHPS Survey website.

## **Data Submission Quality Control Guidelines**

The following guidelines are provided to assist vendors in making sure that XML data files are prepared properly and successfully submitted. Implementing adequate quality control on data submission procedures and submitting each file well in advance of the data submission deadline will help ensure that each HHA’s monthly data files are accepted and that high-quality data are submitted. Quality control checks should be conducted by a different staff person than the one who completed the initial task.

Examples of QC that can be conducted during the file development process are provided below.

## Overall Quality Control Checks and Reminders

- Check the XML data file name to make sure that it conforms to HHCAHPS file naming conventions. We recommend that the file name should include the HHA's CCN, sample month, and sample year.
- Confirm that an XML data file has been accepted for each sample month for each HHA even if the HHA submitted a monthly patient information file that did not have any patients that met survey eligibility criteria.
- Zero-eligible files: Survey vendors are reminded that if none of the patients for whom information is provided on the monthly patient information file is eligible for the HHCAHPS Survey, the vendor must still prepare and submit an XML data file for that sample month. The vendor must indicate on the file that there were 0 eligible cases in the Number Eligible data element and enter all other information required in the Header Record section of the XML data file. If the vendor does not submit a file, CMS will view the HHA as having "missed" a sample month, so there will be no documentation on file that the HHA met the participation requirements for that sample month. Vendors are required to obtain from their clients either a file showing that there were no eligible patients or an email from the HHA to this effect, for each month in which there are no eligible patients.
- Survey vendors should make sure that they do not submit a zero-eligible file for an HHA that did not submit a monthly patient information file or provide email documentation that they did not serve any eligible patients. HHCAHPS Survey vendors are not required to submit a DNR for situations where there are 0 eligible cases; however, they are required to submit a DNR if the HHA did not submit a file at all.
- Generate data distributions (frequencies of responses) on selected data elements and inspect the output for anomalies. A visual inspection of data frequencies is a quick way to identify problems. For example, if the race data element for all patients entered on the XML data file is American Indian, this could be an indication that the race data element is incorrect. Similarly, if the Overall Rating of Care data element has a value of "2" for all patients on the file, this is likely an indication that there is a problem. Implementing this quality control check on a sample of the data records will ensure that data are correctly exported from the data source onto the XML data file.
- Vendors should check the Survey Vendor Authorization Report regularly to make sure that each of their HHA clients has authorized them to submit data and that the "Start Date" the HHA entered is the correct date for the first month of the quarter for which the vendor collected data. XML data files will be rejected if an HHA has not authorized its vendor to submit its data.

### **XML Header Record Quality Control**

- Verify that the Number of Eligible Patients included on the file is less than or equal to the Number of Patients Served during the sample month. It should never be more than the Number of Patients Served.
- Verify that the Number of Patients Sampled is less than or equal to the Number of Patients Served.
- Verify that the Number of Patients on File(s) Submitted to Vendor is greater than or equal to the Number of Patients Sampled.
- Verify that the Number of Eligible Patients is greater than or equal to the Number of Patients Sampled. Except for very small HHAs, the Number of Eligible Patients should always be greater than the Number of Patients Sampled.
- Verify that the Sample Month entered on the XML data file to verify that the sample month is correct. The HHCAHPS Data Center will not accept a data file for a sample month in a previous data submission quarter, but it will accept files for months in the current and upcoming data submission quarters. Similarly, make sure that the Sample Month on the file correctly indicates the month in which the patients received skilled home health care.

### **XML Patient Administrative Data Records Quality Control**

- Check to make sure that the total number of patients for which the vendor has included administrative information in the Patient Administrative Record section of the XML data file equals the Number of Patients Sampled.
- Confirm that there have not been any duplicate SID numbers assigned in the XML data files across months in the data submission period or across prior data submission periods. An SID number can only be assigned to one patient and cannot be reused within quarters, across quarters, or across years.
- Make sure that the correct code is entered on the Patient Administrative Data Record to indicate whether a proxy respondent was used on both completed mail and telephone survey cases.
- Verify that all final disposition codes are correct. Vendors must make sure that no data are submitted for non-interview cases that are coded as deceased, ineligible, refusal, etc. Similarly, vendors should change the disposition code for a completed survey that does not pass the HHCAHPS completeness criteria to 310—Breakoff.

- Check that a response value has been entered for all data elements on the file. If data are missing for a data element, either the missing code (“M”) or the code for Not Applicable must be entered (see *Appendix N* for valid values).
- Select a sample of patients for whom data are entered on the XML data file, and compare the data elements entered in the Patient Administrative Data Record section of the XML with the information that the HHA provided for the sample patient on the monthly patient information file. Implementing this quality control check on a sample of the data records will ensure that data are correctly exported from the data source onto the XML data file.

### XML Patient Response Records Quality Control

- Select a sample of completed surveys for whom data are entered on the XML data file, and compare the entries in the Patient Response Record section of the XML with the hardcopy questionnaire or scanned image of the patient’s completed survey; or, if the survey was completed by telephone, with the original CATI or telephone survey data file. Implementing this quality control check on a sample of the data records will ensure that data are correctly exported from the data source onto the XML data file.
- Check the completeness algorithm (described in *Chapter IX*) for all cases for which there is a Patient Response Record on the XML data file. The Data Center also checks respondent records on the XML data file to confirm that they meet HHCAHPS completeness criteria.

## **XI. HOME HEALTH CARE CAHPS SURVEY WEBSITE REPORTS**

### **Overview**

The HHCAHPS Survey Data Center will generate and provide via the HHCAHPS Survey website a number of reports to indicate the status of data submissions and the quality of the data submitted. These reports are described in the following sections.

### **Reports for Survey Vendors**

Survey vendors will be able to access a number of reports via the secured section of the HHCAHPS Survey website. The most important of these is tied to the data submission and file review process—the *Data Submission Summary Report*. Closely tied in with this report is another way to view the data, which allows vendors to quickly identify whether incorrect vendor authorizations are causing a data submission failure—the *Data Submission Validation Status Report*. Another important report is the *Survey Vendor Authorization Report*, which allows the survey vendor to view all home health agencies (HHAs) that have authorized the vendor to collect and submit data on their behalf. A third report, the *Annual Payment Update (APU) Participation Summary Report*, shows the months in the HHCAHPS Survey participation period for which the vendor has successfully submitted an HHCAHPS Survey XML data file. Each of these reports is discussed separately below.

### **Data Submission Summary Report**

The Data Submission Report is generated at two different points in time. First, it is available to survey vendors immediately after the initial validation check has been run on uploaded XML data files. The Report is then updated after the second validation checks have been run.

After the survey vendor uploads an XML data file or files, the system will run the initial validation, checking for the correct file layout, missing data, duplicate SID numbers, invalid responses, and other items. The results of the initial validation check will be available in the Data Submission Report link that is e-mailed to the vendor. Examples of sample data submission reports at this stage can be found in Section 5 of the *Website User and Data Submission Manual*, available on the HHCAHPS Survey website.

If the XML data file successfully passes this initial check, the file will immediately go through the second data validation check and be completed within an hour. HHCAHPS Survey vendors will be notified via e-mail that the results of the second validation check have been appended to the Data Submission Summary Report for each file that was uploaded. The Report will provide

sufficient detail by CCN of errors that caused the files to be rejected, so that the vendor can fix those errors and resubmit the file(s). The Report will also indicate if the file has successfully passed this second validation check and been processed for public reporting.

Files will be accepted or rejected based on the CCN. That is, if all of the records for a given CCN are accepted, the vendor does not need to resubmit that file. However, if the vendor submitted a file for multiple CCNs and one or more of those agencies has invalid records, the vendor will need to resubmit a file containing all records for the CCNs that had invalid records.

Survey vendors are strongly advised to submit files well in advance of the quarterly submission deadline. Submitting in advance gives vendors time to thoroughly check their Data Submission Reports, fix all errors, and confirm successful two-step resubmission prior to the 11:59 PM data submission deadline date for each quarter.

### **Data Submission History and Validation Status Reports**

HHCAHPS Survey vendors can view a history of their data submission activities via three reports under the Data Submission Report menu option: *Data Submission History*, *Data Submission History by Upload Date*, and *Data Submission Validation Status Report*. The *Data Submission History* report allows vendors to see a summary or detailed list of data submission activity. The *Data Submission History by Upload Date* allows vendors to search for a data submission report by upload date. The *Data Submission Validation Status* report shows vendors their latest submissions by CCN, with failed submissions pulled to the top, along with a column showing whether the failure is the result of a vendor authorization issue. This report was developed to allow vendors to quickly identify whether there are any HHAs that need to initiate or correct a vendor authorization.

### **Survey Vendor Authorization Report**

The *Survey Vendor Authorization Report* allows survey vendors to view a list of HHAs that have authorized the vendor to collect and submit data on their behalf. A survey vendor under contract with an HHA that has not yet been formally authorized by the HHA to submit data on the agency's behalf should contact the HHA and ask it to do so. Any files a vendor submits for an HHA that has not formally authorized the vendor to submit data on its behalf will be rejected by the HHCAHPS Survey XML data file submission system, because there is no formal link between the vendor and the HHA. *It is the vendor's responsibility to ensure that any HHA with which it is contracted to conduct the HHCAHPS Survey completes the authorization process.* The HHCAHPS Data Center will reject data files if the HHA has not authorized the vendor to submit data on its behalf, or if the Start date entered on the form that the vendor submitted is later than the first day of the sample month that the HHA begins its participation in the HHCAHPS Survey.

If an HHA closes or is no longer active while its HHCAHPS Survey vendor is still contracted to conduct and provide survey data on its behalf, the vendor authorization that that HHA submitted will remain in effect for the entire authorization period. Closed and inactive HHAs are designated with an asterisk (\*) symbol on the Vendor Authorization Report. The authorized vendor must submit the HHCAHPS Survey data that were collected for the closed HHA to the HHCAHPS Data Center.

### **APU (Annual Payment Update) Participation Summary Report**

The *APU Participation Summary Report* shows the sample months in each HHCAHPS Survey participation period for which the vendor has successfully submitted an XML data file. Vendors should use this report in conjunction with their own data submission tracking reports to confirm that they have submitted an XML data file for each sample month and that the file was accepted. To access the *APU Participation Summary Report*, click on the Data Submission Reports link on the HHCAHPS website, then click the link to this report. Vendors can choose the APU participation period to be viewed. The APU participation period corresponds to the months for which Medicare-certified HHAs must administer the HHCAHPS Survey to receive the APU. For example, the HHCAHPS participation period for the CY (Calendar Year) 2021 APU is from April 2019 through March 2020.

## **Reports for Home Health Agencies**

HHAs are able to access two reports via the secured section of the HHCAHPS Survey website. The first report, the *Data Submission History Report*, is intended to provide a means for the agency to monitor its vendor's data submission activities and should be reviewed on a monthly or quarterly basis, depending on the agreement that the agency has worked out with the vendor in terms of frequency of data submission. The second report available to HHAs is the *HHCAHPS Survey Results for Public Reporting*—this report is a preview of the HHCAHPS Survey results that are compiled for each HHA on a quarterly basis prior to being publicly reported. These reports are discussed below.

### **Data Submission History Report**

The *Data Submission History Report* is available to HHAs from the “For HHAs” menu on the HHCAHPS Survey website. HHAs that have contracted with a survey vendor will be able to log in to the website and view, print, and download a report that includes information on the number of submissions and the submission status of their contracted vendor's monthly or quarterly file submissions.

The *Data Submission History Report* displays all of the dates on which the Data Center accepted the XML data files the vendor submitted for the HHA. Only files that passed *both* the initial edit checks implemented during file upload and those that passed the second set of edit checks will be

listed on this report. The purpose of this report is to allow an HHA to monitor whether its vendor is successfully submitting data files by the required quarterly data submission deadlines. An HHA can use this report for reference when it follows up with its vendor if expected data submissions do not appear.

To protect the confidentiality of each HHA and the vendor it has selected, only the HHA and its authorized vendor will be able to view the submission history relating to that agency's data.

### **HHCAHPS Survey Preview Report for Public Reporting**

The HHCAHPS Survey Preview Report provides HHAs with a preview of their agency's survey results that will be publicly reported on the Care Compare website on [www.medicare.gov/care-compare/](https://www.medicare.gov/care-compare/). The preview report is made available approximately 3 weeks before the HHCAHPS Survey results are publicly reported. Agencies are able to access their Preview Report(s) via the secure side of the HHCAHPS website. To access the reports, agencies must log into the HHCAHPS website using their username and password and then select the "Preview Reports" link under the "For HHAs" menu. HHAs participating in the HHCAHPS Survey will have access to their own reports. The Preview Report will not be available to the HHCAHPS Survey vendor or to anyone other than the HHA.



## **XII. OVERSIGHT ACTIVITIES**

### **Overview**

This chapter describes oversight activities that are conducted by the HHCAHPS Survey Coordination Team to ensure that the survey is being administered according to required HHCAHPS Survey protocols. Requirements for vendor Quality Assurance Plans (QAPs), data review activities to be conducted by the Coordination Team, communication between the Coordination Team and the vendors, and site visit procedures are described in the following sections.

### **Quality Assurance Plan**

All vendors approved to conduct the HHCAHPS Survey must submit a QAP, a document that describes how the vendor implements, complies with and provides oversight of all sampling, survey, and data processing activities associated with the HHCAHPS Survey.

The first QAP must be submitted within 6 weeks of the data submission deadline date after the vendor's first quarterly data submission. It must be updated and submitted annually thereafter and at any time that changes occur in staff or vendor capabilities or systems, or if the organization is acquired/merged with another survey vendor.

A Model QAP Outline is included in *Appendix P* and is available on the HHCAHPS website (under the "Forms for Vendors" menu) to assist vendors in the development of their own QAP. The vendor's QAP should include the following sections:

- Organization Background and Staff Experience
- Work Plan
- Sampling Plan
- Survey Implementation Plan
- Data Security, Confidentiality, and Privacy Plan
- Questionnaire Attachments

Within each section, the vendor must specify all key staff responsible for implementing or overseeing the activity or activities, procedures, and methods being used, and quality assurance

activities that will be implemented. Changes to key staff must be reported to the HHCAHPS Survey Coordination Team. There should be sufficient detail provided for all of these components so that the Centers for Medicare & Medicaid Services (CMS) can evaluate whether the vendor is complying with all approved protocols. If CMS and the Coordination Team do not feel that the vendor's QAP has sufficient detail to make this determination, the Coordination Team will request that the vendor make additions or edits to its QAP and resubmit it. Vendors will also be required to submit either a copy of the mail questionnaire (for mail and mixed-mode surveys) or the screenshots from their electronic telephone interview (for telephone surveys) as part of their QAP. *Note that the submission of a completed QAP is one of the components of the vendor approval process.*

When preparing the QAP, vendors should review and refer to the Model QAP Outline provided on the HHCAHPS website and in **Appendix P** to ensure that they provide all information requested, including detailed information about systems, protocols, and processes, so that the HHCAHPS Survey Coordination Team can assess how the survey is being implemented. It is recommended that vendors organize the information in their QAPs to conform to the sections included in the Model QAP Outline and make sure that the QAP is paginated for ease of reference and review by CMS and the Coordination Team. Approved survey vendors must submit their QAP annually or whenever they make any HHCAHPS personnel or protocol changes. It is important that each annual QAP Update reflects only new changes implemented since the last approved version of the QAP.

## Data Review

The HHCAHPS Survey Coordination Team conduct ongoing reviews of the data submitted by each survey vendor. As discussed in **Chapter X** of this manual, XML data files are reviewed immediately upon submission for proper formatting, completeness, accuracy of record count, and out-of-range and missing values. In addition, the Coordination Team will run a series of edits on the data to check for such issues as outlier response rate patterns or unusual data elements.

The HHCAHPS Survey Coordination Team will attempt to resolve data issues with the vendor through the use of conference calls or email exchanges. If the Coordination Team believes that there are any significant issues with a vendor's data, or if repeated discussions and contact with a vendor fail to result in complete and accurate data submissions, a more thorough review of the vendor's data processing and survey implementation activities may be initiated. At that time, the Coordination Team may request copies of documentation associated with whatever the data issue is—for example, if out-of-range values are found repeatedly, the Coordination Team may request copies of documents showing the training program used to train data entry staff, training records, and documentation that recommended quality assurance practices associated with inputting data were followed. Vendors are expected to comply with all such requests for documentation.

## Communication Between Survey Vendors and the Coordination Team

The HHCAHPS Survey Coordination Team welcomes communication from vendors related to the HHCAHPS Survey implementation process. Vendors can also request teleconference calls to ensure their successful implementation of the HHCAHPS Survey. For phone and email communications relevant to specific HHAs, vendors must provide the HHA name and CMS Certification Number (CCN).

The HHCAHPS Survey Coordination Team also schedules conference calls with selected vendors to review vendor procedures and ensure adherence to the HHCAHPS Survey protocols and guidelines. The Coordination Team makes periodic calls to selected vendors to assess the status of sampling, data collection, and file processing issues in general. These calls are scheduled in advance so that appropriate members of the vendor's project team can participate.

## Site Visits to Survey Vendors

The HHCAHPS Survey Coordination Team conducts site visits to all approved vendors. The purpose of the site visits is to allow the Coordination Team to observe the entire HHCAHPS Survey implementation process, from the sampling stage through file preparation and submission.

The HHCAHPS Survey Coordination Team expects at a minimum to accomplish the following on each site visit:

- Interviews with the vendor's key HHCAHPS Survey project staff, including the Survey Administrator/Project Manager, Sampling Manager, and Computer Programmer.
- A "walk through" of the systems and processes used from the point of obtaining a monthly patient information file from an HHA to preparation of a final data file, including but not limited to a review of:
  - Software/programs used to select and store the sample; how patient contact information (name and address) and sample identification (SID) number are printed on letters accompanying questionnaire mailings or provided to a call center for telephone survey data collection; questionnaire production, mailout, and receipt facilities/processes; telephone survey operation facilities/processes, including listening to interviews;
  - All data processing activities, including how final status codes are assigned; and
  - File preparation and submission activities; and file storage facilities.

- A review of all documentation associated with any of the above steps. The documentation to be reviewed includes but is not limited to:
  - Signed confidentiality forms for all applicable staff, including subcontractors;
  - Training records, such as for data entry or telephone interviewing staff;
  - Monitoring logs, with dates and times telephone interviewers were monitored, and the results of those monitoring sessions;
  - Telephone interview scripts, including introductory scripts and responses to frequently asked questions;
  - Verification records, for either data entry or scanning processes, showing the level of quality control for keyed questionnaires; and
  - Quality control processes documentation for all survey activities.

The Coordination Team may make either scheduled or unscheduled visits to the vendor's site. Scheduled visits will be planned far enough in advance to ensure that all appropriate vendor staff are able to participate in the site visit review process. For unscheduled visits, the Coordination Team will give the vendor a 3-day window during which the team may conduct the onsite review.

Generally, the site visit team will consist of two to three individuals, although the size of the team may vary and may include representatives from CMS. All discussions, observations, and materials reviewed during the site visit will remain confidential, as documented in the Data User Agreement completed in advance of the site visit. Thus, although the Coordination Team appreciates that certain systems or processes may be proprietary to a vendor, full cooperation with the site visit team is expected so that the team may adequately assess vendor compliance with all HHCAHPS Survey protocols and guidelines.

After each site visit, the Coordination Team will prepare and submit to CMS a *Site Visit Report*, which will summarize the findings from each site visit, including any issues observed. The *Site Visit Report* will include corrective actions that the vendor will be required to take to correct any deficiencies or problems noted. The Coordination Team will provide the vendor with the *Site Visit Report* after it has been reviewed by CMS project staff. The Coordination Team may request clarification, additional documentation, or changes to any aspect of the implementation process, if needed. The vendor will then be given a specified period of time in which to provide the additional information or submit documentation showing that it has implemented the requested process or system change. The Coordination Team will follow up with the vendor by teleconference or with additional site visits as needed.

## Corrective Action Plans

If a vendor fails to demonstrate adherence to the HHCAHPS Survey protocols and guidelines, as evidenced by ongoing problems with its submitted data or as observed in its implementation process during a site visit, CMS may ask the Coordination Team to either increase oversight of the vendor's activities (e.g., review of submitted XML data files and recorded telephone interviews, conduct live monitoring of interviewers) or, if necessary, put the vendor on a corrective action plan.

If the vendor is placed on a corrective action plan, the Coordination Team will work out a schedule with CMS by which the vendor must comply with the tasks set forth in the corrective action plan. These will include interim monitoring dates, where the Coordination Team and the vendor will meet via teleconference to discuss the status of the plan and what changes the vendor has made or is in the process of making. The nature of the requested changes that the vendor is asked to implement will dictate the kind of "deliverables" the vendor will be expected to provide and the dates by which the deliverables must be provided.

Survey vendors that fail to comply with the corrective oversight activities described above or whose implementation of the HHCAHPS Survey is found to be unsatisfactory after the opportunity is given to correct deficiencies may be subject to having their approved status rescinded. Further, any HHA survey responses collected by the vendor may be withheld from public reporting. The affected HHA(s) will be notified by the HHCAHPS Survey Coordination Team of their vendor's failure to comply with oversight activities or unsatisfactory implementation so that the HHA(s) can contract with another approved vendor going forward.

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## **XIII. PUBLIC REPORTING**

### **Overview**

This chapter describes the public reporting activities associated with the HHCAHPS Survey. Publicly reported data are available on the Medicare Care Compare website on [www.medicare.gov/care-compare/](http://www.medicare.gov/care-compare/). Results from the HHCAHPS Survey are published quarterly and include each HHA's most recent four quarters of data.

This chapter describes the measures that are publicly reported and explains how the results are adjusted. The chapter concludes with a discussion of star ratings, *Home Health Agency Preview Reports* and a table showing the quarters included in each public reporting period.

### **Measures That Are Reported**

HHCAHPS Survey results are reported for three composites and two global items:

#### **Composite Measures**

- Care of Patients (Q9, Q16, Q19, and Q24)
- Communications Between Providers and Patients (Q2, Q15, Q17, Q18, Q22, and Q23)
- Specific Care Issues (Q3, Q4, Q5, Q10, Q12, Q13, and Q14)

#### **Global Items**

- Overall rating of care (Q20)
- Patient willingness to recommend HHA to family or friends (Q25)

Each of the three composite measures consists of four or more questions from the survey that are about related topics. The results from the questions that comprise a composite are reported as one score. Composite scores are compiled by calculating the proportion of cases that responded to each answer choice in the questions that comprise the composite. Once the proportions of responses to all answer choices in the questions in the composite are calculated, the average proportion of those responding to each answer choice in all questions in the composite is calculated. Only questions that are answered by survey respondents are included in the calculation of composite scores.

## Adjustment and Reporting of Results

In 2009, the Centers for Medicare & Medicaid Services (CMS) conducted a mode experiment to test the effects of using three data collection modes: mail only, telephone only, and mixed mode (mail with telephone follow-up of nonrespondents). Since that time, the HHCAHPS Survey Coordination Team has repeated the same analyses conducted on mode experiment data using data collected by HHCAHPS Survey vendors for sample months in Quarter 4 of calendar year 2010 (CY2010,Q4) through Quarter 2 of calendar year 2011 (CY2011,Q2).

Some patients' assessments of the care they received from HHAs may be influenced by patient characteristics that are beyond the HHAs' control. CMS used the data from the mode experiment and the data collected from CY2010,Q4 through CY2011,Q2 to determine whether and to what extent characteristics of patients participating in the HHCAHPS Survey statistically affect survey results. Statistical models were developed to adjust or control for these patient characteristics when survey results are publicly reported. Some patients may not respond to the survey, and this may impact the accuracy and comparability of results. Therefore, the data from the mode experiment and the aforementioned quarters of the national implementation were analyzed to detect potential nonresponse bias. The results of these analyses determined applicable statistical adjustments that are made on each quarter of the HHCAHPS Survey data.

HHCAHPS Survey results are published on Medicare's Care Compare website at [www.medicare.gov/care-compare/](http://www.medicare.gov/care-compare/). Each HHA's results are compared with national and state averages. Results are reported for a rolling four quarters of data that are updated quarterly by replacing the oldest quarter of data with data from the most recent quarter. **Table 13.1** shows a crosswalk of the composite measures and global ratings mapped to the text that is displayed on Medicare's Care Compare website.

**Table 13.1**  
**Crosswalk of Composite Measures and Global Ratings to Medicare's Care Compare Website Text**

HHCAHPS Composite Measurements/ Global Ratings	HHCAHPS Questions Included in Composite/ Global Rating	Text Displayed on Medicare's Care Compare Website
Care of Patients	Q9, Q16, Q19, and Q24	How often the home health team gave care in a professional way
Communications Between Providers and Patients	Q2, Q15, Q17, Q18, Q22, and Q23	How well did the home health team communicate with patients
Specific Care Issues	Q3, Q4, Q5, Q10, Q12, Q13, and Q14	Did the home health team discuss medicines, pain, and home safety with patients
Overall rating of care	Q20	How do patients rate the overall care from the home health agency
Patient willingness to recommend HHA to family or friends	Q25	Would patients recommend the home health agency to friends and family



## Star Ratings

Five HHCAHPS star ratings were reported on Medicare’s Home Health Compare website beginning with the January 2016 refresh of the publicly reported data: one for each of the three publicly reported HHCAHPS composite measures, one for the Overall Rating of Care measure, and one Survey Summary Star, which is a simple average of the four HHCAHPS measure star ratings. With CMS’s transition to its new Care Compare website, only the Survey Summary Star is currently being reported. CMS continues, however, to make the full set of five-star rating measures available to the public via its Provider Data Catalog (PDC) on [data.cms.gov/provider-data](https://data.cms.gov/provider-data).

To receive HHCAHPS star ratings, home health agencies must have at least 40 completed HHCAHPS Surveys over the publicly reported four-quarter period. HHAs with fewer than 40 completed surveys will not receive star ratings; however, their individual HHCAHPS measure scores will still be publicly reported as long as they are eligible to be reported during that time period (i.e., the agency has 12 months of HHCAHPS Survey data). More information on how the star ratings are calculated can be found on the HHCAHPS website.

## Agency Preview Reports

Prior to publishing the results on Medicare’s Care Compare website and on the accompanying PDC, CMS makes a Preview Report available on the HHCAHPS website so that each HHA can review the results that will be publicly reported, including star ratings, if applicable. HHCAHPS Survey data were publicly reported for the first time in April 2012, based on survey results from data collected for the sample months October 2010 through September 2011. Star ratings were publicly reported for the first time in January 2016. Each subsequent quarterly public reporting period includes survey results from data collected for the prior 12 months, as the oldest quarter’s data are dropped and the newest quarter’s data are added.

## Public Reporting Periods

*Table 13.2* shows the quarters included in each Public Reporting period during CY2025.

**Table 13.2**  
**Public Reporting for the Home Health Care CAHPS Survey**

<b>CY 2025 HHCAHPS Public Reporting Period</b>	<b>January 2025</b>	<b>April 2025</b>	<b>July 2025</b>	<b>October 2025</b>
Results represent patients who received skilled home care	July 2023–June 2024	October 2023–September 2024	January 2024–December 2024	April 2024–March 2025
Quarters that results represent	CY2023,Q3–CY2024,Q2	CY2023,Q4–CY2024,Q3	CY2024,Q1–CY2024,Q4	CY2024,Q2–CY2025,Q1
Preview reports will be posted on the HHCAHPS website	Preview Report was posted in December 2024	Preview Report will be posted in March 2025	Preview Report will be posted in June 2025	Preview Report will be posted in September 2025

## **XIV. EXCEPTIONS REQUEST PROCESS AND DISCREPANCY NOTIFICATION REPORT**

### **Overview**

This chapter describes the process to be used to request an exception to the HHCAHPS Survey protocols, including guidelines for submitting an Exceptions Request Form (ERF). This chapter also covers the process for alerting the HHCAHPS Survey Coordination Team of an unplanned discrepancy in the collected or submitted survey data. Vendors are expected to submit a Discrepancy Notification Report (DNR) whenever there has been an inadvertent or temporary deviation from the standard HHCAHPS Survey protocols.

### **Exceptions Request Process**

The ERF (see *Appendix Q*) is designed to allow the survey vendor to request a planned deviation from the standard HHCAHPS Survey protocols. The form is designed to allow the survey vendor to request the same exception for multiple home health agencies (HHAs) for which it is responsible for collecting data. The ERF can be accessed and submitted online (<https://homehealthcahps.org>). The HHCAHPS Survey Coordination Team has identified three allowable exceptions on the HHCAHPS Survey at this time:

- the use of **disproportionate stratified random sampling (DSRS)**;
- **displaying an agency's name or logo on outgoing survey envelopes**; and
- **conducting HHCAHPS operations from a remote location** (other than your standard place of business).

Vendors must complete and submit an ERF to obtain approval to implement any of these exceptions. In addition, vendors are asked to submit an ERF for any other exceptions to the HHCAHPS Survey protocol, including any modifications to the cover letters provided in the Appendices. CMS and the Coordination Team will make a determination after reviewing each request whether to approve the exception.

### **Use of Disproportionate Stratified Random Sampling (DSRS)**

Vendors who wish to implement DSRS must submit an ERF, following the guidance provided in *Chapter IV* of this Manual. In brief, the vendor must:

- Describe the process for identifying the different strata;

- Use the same name for each stratum in each month in the quarter;
- Make sure that each stratum has a minimum of 10 patients eligible to be included in the survey during the sample month; and
- Provide additional information about each stratum as noted in *Chapter IV*.

If a vendor's ERF for DSRS is approved, the vendor must use the DSRS XML data file layout to submit data for the agency. See *Chapter XIII* for more information.

### **Displaying an Agency's Name or Logo on Outgoing Envelopes**

Vendors who wish to use an agency's name or logo on outgoing envelopes must submit an ERF indicating that they have the agency's approval to display the name or logo on the envelope and the agency believes there are no HIPAA risks. It is up to each vendor to determine what kind of documentation or assurances it needs from its clients for its own internal recordkeeping to feel comfortable submitting the ERF. The documentation pertaining to such a request will not be reviewed during site visits.

The ERF should include a statement that the vendor has discussed or will discuss the potential for HIPAA risks with its current and future client(s) and has or will obtain approval from the client(s) to display the facility name and/or logo on the envelope or through the envelope window. Vendors only need to submit one ERF to cover all current and future clients.

### **Conducting HHCAHPS Operations From a Remote Location**

Vendors conducting or planning to conduct HHCAHPS Survey operations from a remote location (other than the vendor's place of business) must summarize which type(s) of staff are impacted and thoroughly describe how remote operations will be conducted to ensure compliance with HIPAA, data security, and quality assurance requirements. Vendors are required to update and resubmit their remote-work Exceptions Request every two years for CMS's consideration to allow their HHCAHPS remote operations to continue.

### **Review Process**

The Coordination Team will review the vendor's exceptions request, evaluating the methodological strengths and weaknesses of the proposed approach. The Coordination Team will let the survey vendor know whether the exceptions request has been approved or denied by CMS. If denied, the vendor will have five business days to appeal the decision. To submit an appeal, the vendor needs to check "Appeal of Exception Denial" in Box 1a on the ERF and update the form to provide further information about the exception being requested. The Coordination Team will review the appeal and return a final decision to the survey vendor within 10 business days.

## Discrepancy Notification Report

The DNR (see *Appendix R*) is designed to allow the survey vendor to notify the HHCAHPS Survey Coordination Team of an *unplanned deviation* from the HHCAHPS Survey protocols that will require some form of corrective action on the part of the survey vendor. CMS reviews this information as part of its evaluation of whether HHAs have met the HHCAHPS Survey participation requirements for each calendar year annual payment update (APU). Examples of instances when a DNR is required include the following:

- The vendor or HHA inadvertently omitted from the sample frame patients who were eligible for the survey;
- The vendor is unable to initiate the survey within 21 days after the sample month ends and when the survey is initiated from the 22nd through the 26th day after the sample month ended;
- A data element was incorrectly coded and submitted on the XML data file (e.g., the “proxy” indicator was incorrectly computed);
- There has been a natural disaster or event that has interrupted data collection in such a way as to adversely affect survey outcomes; and
- The HHA was unable to provide the vendor with a file for the sample month, for whatever reason (note that the reason must be specified in the DNR).

The DNR can be accessed and submitted online via the HHCAHPS Survey website (<https://homehealthcahps.org>). An Excel template is also available for vendors to submit with their online DNR. The Excel template contains fields for all required pieces of information the Coordination Team needs to evaluate the discrepancy.

The vendor is expected to notify the HHCAHPS Survey Coordination Team ***within 24 hours after the discovery of the discrepancy***. The vendor must also notify all affected HHAs that a DNR has been submitted to the Coordination Team on their behalf. The DNR must clearly describe the discrepancy and the action proposed by the vendor to correct the discrepancy, along with a proposed timeline to correct the discrepancy. At a minimum, the following information must be included on the report form:

- The HHA’s CMS Certification Number (CCN);
- Sample month and year;
- Number of affected patients;

- A description of the discrepancy and whether the deviation from HHCAHPS Survey protocol was caused by the vendor or HHA; and
- Remediation plan for the affected month and actions taken to avoid the situation in the future.

Vendors are required to submit a DNR if an HHA client does not submit a monthly patient information file for a sample month; however, survey vendors do not need to continue submitting DNRs for HHAs that are not submitting monthly patient information files **once the HHA has failed to submit a monthly patient information file for three consecutive sample months**. It is the responsibility of the HHCAHPS Survey vendor to track the number of months the HHA has failed to submit a monthly patient information file and to submit a DNR for the first three months that this occurs.

Vendors are reminded that **no DNR is needed** if an HHA has notified the vendor via submission of a zero-eligible file or an email that it has no eligible patients in a given sample month. If an HHA submits a file to its vendor with no eligible patients, the vendor must **still** submit an XML data file for that HHA for that sample month indicating that there were no eligible patients. Also, **no DNR is needed** when vendors submit an email request to CMS/the Coordination Team to initiate the HHCAHPS Survey more than 26 days after the sample month ends. Instead, the email that the vendor submits requesting approval to field the survey will be retained as documentation of the request.

### Discrepancy Report Review Process

The Coordination Team will review the vendor's DNR and evaluate the impact of the discrepancy on the publicly reported data. Depending on the type of discrepancy, a footnote may be added to the publicly reported data. The Coordination Team will let the survey vendor know whether additional information is required to either document or correct the discrepancy.

**APPENDIX A:**  
**VENDOR APPLICATION FORM**

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# HOME HEALTH CARE CAHPS SURVEY VENDOR APPLICATION FORM

## Introduction

This application is to be completed by survey vendor organizations who wish to be approved to conduct the Home Health Care CAHPS (HHCAHPS) Survey.

Before completing this application, organizations should review the Minimum Business Requirements (MBRs) document on the HHCAHPS website

(<https://homehealthcahps.org/Forms-for-Vendors/Minimum-Business-Requirements> ).

## Application Restrictions

Please note that any organization that owns, operates, or provides staffing for a home health agency (HHA) will not be permitted to administer its own HHCAHPS Survey or administer the survey on behalf of any other HHA. Therefore, if your organization partly or wholly owns, operates, or provides staffing for an HHA or if your organization does not meet the minimum business requirements, please do not complete and submit this application.

## Definitions


- **Vendor organization or vendor:** The survey vendor organization submitting this application. The vendor oversees the work of any subcontractor (if applicable) and bears ultimate responsibility for oversight and data quality on the HHCAHPS Survey.
- **Subcontractor:** A separate organization that the vendor contracts with to conduct one or more of the following activities on the HHCAHPS Survey: telephone survey data collection, printing, mail assembly, other mailout activities, mail or questionnaire receipt and processing, construction of XML data files, HHCAHPS toll-free hotline management.
- **You:** “You” refers to the individual completing this application on behalf of the vendor organization.

## Instructions For Completing This Form

When completing this application, note the following:

- You will need to provide an answer to all relevant questions.

- You will need to “Save and Continue” each section before moving to the next section. To save a section, click on the “Save and Continue” button at the bottom of the screen.
- In order to “Save and Continue,” you must complete all items in the section. You have 60 minutes to complete and save each section before the application times out. If the application times out, you will need to re-complete any section that you did not save.
- When you have completed all parts of the application and are ready to submit it, please click the “Submit” button that appears on the lower left of the screen.
- After you submit the application, you will receive a confirmation email message with a link that you may use to access your application at any time.
- Each time you access and update your application, you must submit the application again.
- The application should be updated if any of the information in the form changes. For example, when key personnel change, the organization is acquired/merges with another survey vendor, a subcontractor is added/removed, or when applying for approval to conduct a new survey mode.

All survey vendors must designate an HHCAHPS Survey Administrator/Project Manager who will be the main point of contact for the HHCAHPS Coordination Team (see “Organization and Contact Information” tab of the Vendor Application below). This individual must complete an electronic vendor consent form, which will be available from your Dashboard. Completion and submission of this application certifies that you, on behalf of the vendor organization, have read and met the [MBRs](#)  for the HHCAHPS Survey and will abide by the requirements included in this application.

### **Requirement to Reapply**

Vendor organizations that do not have any HHA clients after two years from the date of their interim approval will have their approval revoked. If you wish to maintain your approved vendor status at that time, you must reapply. To reapply, you must update your online vendor application, review the self-paced Introduction to the HHCAHPS Survey, complete and pass the associated training certification, and attend all subsequent Update Training sessions.

[SUBMIT / UPDATE APPLICATION BUTTON]

## **I. ORGANIZATION AND CONTACT INFORMATION**

The following general information should be filled out about the Vendor.

## A. Vendor Organization Information

Complete the following fields with the Vendor's organizational information. For the address fields (Mailing Address and Physical Address), please provide the location in which the HHCAHPS operations would take place.

Company Name [REQUIRED]:

Mailing Address 1 [REQUIRED]:

Mailing Address 2:

City [REQUIRED]:

State [REQUIRED]:

ZIP Code [REQUIRED]:

*Physical address same as mailing address? [BUTTON]*

Physical Address 1 [REQUIRED]:

Physical Address 2:

City [REQUIRED]:

State [REQUIRED]:

ZIP Code [REQUIRED]:

(Area Code) Telephone number: [REQUIRED]

(Area Code) Fax number:

Website [REQUIRED]:

## II. KEY PROJECT STAFF

### A. Vendor's HHCAHPS Survey Administrator/Project Manager

Each Vendor must designate a Survey Administrator/Project Manager. This individual will be responsible for the following:

1. Serving as the main point of contact with the HHCAHPS Survey Coordination Team.
2. Designating another individual within the organization as the backup Administrator.
3. Approving each staff member within the organization who will have access to the HHCAHPS Survey website.
4. Removing access or approving the removal of access for users who should no longer be authorized to access the HHCAHPS Survey website.
5. Notifying the Coordination Team if a new HHCAHPS Survey Administrator/Project Manager needs to be identified (example: personnel change).
6. Maintaining the confidentiality of all data submitted to the HHCAHPS Data Center.

Note: This designated person must be a different person than the Sampling Manager.

In the space below, please provide the contact information of the person whom you are designating as the HHCAHPS Survey Administrator/Project Manager for your organization. You'll notice the Name and Email Address fields are pre-filled based on the information that was provided on the online Vendor Registration Form.

Name [PREFILLED FROM VENDOR REGISTRATION FORM]:

Title:

Degree/License (e.g., BA, PhD, MBA, PMA):

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP Code:

(Area Code) Telephone number:

(Area Code) Fax number:

Email address [PREFILLED FROM VENDOR REGISTRATION FORM]:

## **B. Personnel—Vendor**

Please answer the following questions focusing on the Vendor's personnel experience and capabilities.

1. Does your organization employ and have available to work on the HHCAHPS Survey a Sampling Manager with sample frame development and sample selection experience, including experience using different sampling methods (simple random sampling, proportionate stratified random sampling, and disproportionate stratified random sampling)? Note: This designated person must be a different person than the Survey Administrator/Project Manager.

☐ Yes      ☐ No

Please indicate the name of the Sampling Manager assigned to the HHCAHPS Survey:

2. Does your organization employ and have available to work on HHCAHPS a Computer Programmer(s) with experience receiving encrypted data files in different formats/software packages electronically from an external organization; processing survey data needed for survey administration and survey response data; preparing data files for electronic submission; and submitting data files to an external organization?

☐ Yes      ☐ No

Please indicate the name of the Lead Computer Programmer assigned to the HHCAHPS Survey:

3. Please explain any "No" responses above:

## **C. Indicate Mode You Are Applying For**

Check the survey administration mode(s) for which the Vendor is applying, indicate whether you will be using a subcontractor for that mode, and provide the subcontractor name, number of years of experience they have for conducting surveys using that mode (at the time of application), the role they will play on HHCAHPS, and the equipment and systems they will use. Note that a subcontractor does not have to be an approved HHCAHPS vendor to be considered as a subcontractor. We strongly encourage that all subcontractors have strong qualifications, experience, data security measures, and quality assurance capabilities.

1. Mail Only

☐ Applying for

Using a Subcontractor(s)?

☐ Yes      ☐ No

If Yes, please provide following information for all subcontractors:

**Subcontractor** Name:

Number of years of **experience** that the subcontractor has been conducting mail surveys:

\_\_\_\_\_

Please describe in detail the **role** and tasks this subcontractor will be performing on the HHCAHPS Survey:

Please list specific **equipment and systems** that this subcontractor will use to accomplish the task:

2. Telephone Only

☐ Applying for

Using a Subcontractor(s)?

☐ Yes      ☐ No

If Yes, please provide following information for all subcontractors:

**Subcontractor** Name:

Number of years of **experience** that the subcontractor has been conducting telephone surveys: \_\_\_\_\_

Please describe in detail the **role** and tasks this subcontractor will be performing on the HHCAHPS Survey:

Please list specific **equipment and systems** that this subcontractor will use to accomplish the task:

3. Mixed Mode (Mail and Telephone)

☐ Applying for

Using a Subcontractor(s) for mail activities?

☐ Yes      ☐ No

If Yes, please provide following information for all subcontractors:

**Subcontractor Name:**

Number of years of **experience** that the subcontractor has been conducting mail surveys:

\_\_\_\_\_

Please describe in detail the **role** and tasks this subcontractor will be performing on the HHCAHPS Survey:

Please list specific **equipment and systems** that this subcontractor will use to accomplish the task:

Using a Subcontractor(s) for telephone activities?

☐ Yes

☐ No

If Yes, please provide following information for all subcontractors:


**Subcontractor Name:**

Number of years of **experience** that the subcontractor has been conducting telephone surveys: \_\_\_\_\_

Please describe in detail the **role** and tasks this subcontractor will be performing on the HHCAHPS Survey:

Please list specific **equipment and systems** that this subcontractor will use to accomplish the task:

### III. SURVEY VENDOR REQUIREMENTS

As mentioned at the top of the Application, survey vendors should review the [MBRs](#)  and vendor participation requirements. Any organization that owns, operates, or provides staffing for a home health agency (HHA) will not be permitted to administer its own HHCAHPS Survey or administer the survey on behalf of any other HHA.

**A. Relevant Business Experience**

1. Number of years Vendor has operated as a business (at the time of application): \_\_\_\_\_
2. Number of years Vendor has conducted Surveys of Individuals: \_\_\_\_\_

A “Survey of Individuals” is defined as the collection of data from individuals selected by statistical sampling methods and the data collected are used for statistical purposes. Polling questions, focus groups, cognitive interviews, surveys of fewer than 600 individuals, surveys that did not involve statistical sampling methods, internet or web surveys, and interactive voice recognition surveys will not satisfy the “survey of individuals” requirement.

The Organization (Vendor and any subcontractors) must have conducted surveys where a sample of individuals was selected for at least 2 years. If staff within the Organization have relevant experience obtained while in the employment of a different organization, that experience may not be counted toward the 2-year minimum of survey experience.

3. Vendor’s Survey Experience for each data collection mode for which Vendor is seeking CMS approval. Indicate number of years of Vendor’s experience conducting surveys:
  - ☐ Mail Only  
Years: \_\_\_\_\_
  - ☐ Telephone Only  
Years: \_\_\_\_\_
  - ☐ Mixed Mode (Mail and Telephone)  
Years: \_\_\_\_\_
4. Please list surveys (involving at least 600 individuals) for which you have been approved or worked as a vendor or subcontractor in the past five years. Please list other CMS or patient experience surveys, including other CAHPS surveys, first.

Survey Name	Sponsoring Organization	Vendor or Subcontractor?

**B. Work with Other Organizations**

The HHCAHPS Survey vendor model presumes that a vendor will contract directly with client HHAs. To ensure compliance with all HHCAHPS protocols, a vendor must disclose working



relationships with any other organization that is involved with communications about or implementation of the HHCAHPS Survey (as a subcontractor, partner, or prime through collaboration, merger, or acquisition). For example, the survey vendor is contacted by another organization that wants to hire that vendor to implement the HHCAHPS Survey on their client HHAs' behalf.

1. Does your organization work with or through a third-party organization that holds the primary contract with any HHAs for which your organization implements the HHCAHPS Survey?

☐ Yes      ☐ No

2. If "Yes," please explain:

### **C. Work with RTI International**

RTI International (RTI) supports CMS with the implementation of the HHCAHPS Survey by providing oversight of CMS-approved survey vendors. As such, any pre-existing working relationships between RTI and vendor applicants must be disclosed as part of the application process.

1. Does any division, group or individual within your organization have any current or planned contracts with RTI in any capacity (e.g., a collaborator, client, subcontractor, consultant, etc.)?

☐ Yes      ☐ No

2. If "Yes," please explain:

### **D. Facilities, Systems and Security Policies—Vendor and Subcontractor(s)**

Please answer the following items focusing on the Vendor and subcontractor's experience and capabilities with facilities, systems, and security policies.

1. Has a secure commercial work environment.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

2. Meets all local commercial code requirements.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

3. Will conduct all HHCAHPS operations within the United States.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

4. Have the physical facilities, electronic equipment, and software to receive sample files from participating HHAs and upload HHCAHPS data to the Data Center.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
5. Has physical facilities for processing and storage of all data collection materials.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
6. Has computers and computer software and any other equipment needed for survey implementation (e.g., scanners, printers, computer-assisted telephone interviewing [CATI] or alternative electronic system, live monitoring interviewing, data entry system).
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
7. Has call center or telephone bank facilities for telephone survey implementation.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
8. Has and will implement systems and security policies, which protect the security of personally identifiable information (PII) as defined by HIPAA. This includes sample data and survey data.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
9. Has an electronic survey management system to track fielded surveys throughout the data collection period.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
10. Has policies and procedures in place for authorizing and de-authorizing individuals to access PII and survey data (including background checks, training, signed agreements).
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
11. Has policies and procedures in place for preventing unauthorized individuals from accessing PII and survey data in physical format (including key card/locked access, locked file cabinets).
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

12. Has policies and procedures in place for preventing unauthorized individuals from accessing data in electronic format (including password protections, firewalls, data encryption software, personnel access limitation procedures, and virus and spyware protection).

☐ Yes, Vendor and/or Subcontractor

☐ Yes, Vendor Only

☐ No, neither

13. Has policies and procedures in place for safeguarding PII and survey data in physical format against loss or destruction (including fire and building safety codes).

☐ Yes, Vendor and/or Subcontractor

☐ Yes, Vendor Only

☐ No, neither

14. Has policies and procedures in place for safeguarding PII and survey data in electronic format against loss or destruction (e.g., offsite daily backups).

☐ Yes, Vendor and/or Subcontractor

☐ Yes, Vendor Only

☐ No, neither

15. Has a disaster recovery plan for survey data in the event of a disaster.

☐ Yes, Vendor and/or Subcontractor

☐ Yes, Vendor Only

☐ No, neither

16. Has policies and procedures in place for destruction of PII and survey data when specified.

☐ Yes, Vendor and/or Subcontractor

☐ Yes, Vendor Only

☐ No, neither

17. Please explain any “No, neither” responses above:

### **E. Sample Frame Development and Sample Selection—Vendor**

Please answer the following questions focusing on the Vendor’s sample frame development and sample selection experience and capabilities.

1. Has ability to construct a sample frame that includes all patients who meet survey eligibility criteria.

☐ Yes

☐ No

2. Will be able to work with individual HHAs to obtain patient data for sampling and is able to accept the data electronically or on hard copy, depending on how the HHA provides it.

☐ Yes

☐ No

3. Is able to convert sampling information from paper to electronic file format so that quality control checks can be performed on both the sample frame and the selected sample by the HHCAHPS Survey Oversight Team.

☐ Yes      ☐ No

4. Is able to draw the sample following specified guidelines as described in the *HHCAHPS Survey Protocols and Guidelines Manual* and adequately document the process.

☐ Yes      ☐ No

5. Please explain any “No” responses above:

#### **F. Survey Administration Requirements, by Mode**

Please provide responses for the modes you are applying for.

##### ***Mail-Only Survey Administration***

Vendor and/or Subcontractor have the capability to do the following mail survey administration activities:

1. Obtain and verify addresses of sampled patients.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

2. Print according to HHCAHPS formatting guidelines professional-quality survey instruments (containing single-coded questions, code-all-that-apply questions) and materials.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

3. Assign a unique sample identification number (SID) to each sampled patient and match the SID to the status/outcome for each sample member.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

4. Merge and print sample patient name and address, and the name of the HHA on personalized mail survey cover letters and print unique sample identification on the survey questionnaire.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

5. Assemble and mail survey materials.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

6. Receive and process (key entry or scanning) completed questionnaires received, including the ability to accept responses to single coded questions and code-all-that apply questions.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

7. Maintain electronic or hardcopy records of mailing dates.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

8. Track and identify nonrespondents for follow-up mailing.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

9. Provide a toll-free customer support line to receive and address telephone calls from sample members within 48 hours for all languages offered by the vendor.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

10. Assign final status codes in accordance with HHCAHPS coding requirements to describe the final result of work on each sampled case.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

11. Please explain any “No, neither” responses above:

### ***Telephone-Only Survey Administration***

Vendor and/or Subcontractor have the capability to do the following telephone survey administration activities:

1. Obtain and verify telephone numbers.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

2. Develop computer programs for computer-assisted telephone interview (CATI) instruments.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

3. Collect data using CATI or alternative electronic system which allows seamless administration of single-coded and code-all-that-apply questions.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
4. Accept and key responses to single coded questions and code-all-that apply questions.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
5. Schedule call backs to nonrespondents at varying times of the day and week.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
6. Assign a unique sample identification number (SID) to each sampled patient and match SIDs to the status/outcome for each sample member.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
7. Provide a toll-free customer support line to receive and address telephone calls from sample members within 48 hours for all languages offered by the vendor.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
8. Conduct live monitoring of interviewers.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
9. Maintain electronic or hardcopy records of interviewers monitored (for telephone administration).
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
10. Assign final status codes in accordance with the HHCAHPS coding guidelines to reflect the results of attempts to obtain completed interviews with sampled cases.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
11. Please explain any “No, neither” responses above:

***Mixed Mode (Mail with Telephone Follow-Up) Survey Administration***

Vendor and/or Subcontractor have the capability to do the following mixed-mode (i.e., mail with telephone follow-up of nonrespondents) survey administration activities:

1. Adhere to all Mail-Only and Telephone-Only Survey Administration requirements described above.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

2. Track and identify nonrespondents for follow-up telephone attempts.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

3. Track cases from mail survey through telephone follow-up activities.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

4. Please explain any “No, neither” responses above:

### **G. Data Processing and File Submission—Vendor**

Please answer the following questions focusing on the Vendor’s data processing and file submission experience and capabilities.

1. Has capability to scan or key, develop data files, and edit and clean data according to standard protocols.

☐ Yes      ☐ No

2. Has prior experience and the capability to submit data electronically in the specified format (XML) via a secured website, similar to the HHCAHPS Survey website.

☐ Yes      ☐ No

3. Has prior experience and the capability to follow all data cleaning and data submission rules, including:

- a. Verification that data are de-identified and contain no duplicate cases.

☐ Yes      ☐ No

- b. Ability to export data from the electronic data collection system to an XML template, confirm that the data were exported correctly and that the XML files are formatted correctly and contain the correct data headers and data records.

☐ Yes      ☐ No

- c. Verification that the XML template is correctly formatted and contains the proper data headers and data records.

☐ Yes      ☐ No

- d. Willingness to work with the HHCAHPS Survey Coordination Team to resolve questions about data and data file submission problems.

☐ Yes      ☐ No

4. Please explain any “No” responses above:

### **H. Quality Assurance–Vendor and Subcontractor(s)**

Vendor and Subcontractor(s) must have experience incorporating quality assurance into all sampling, data collection, data processing, and data file construction activities as noted below. Vendor agrees to participate in all required training and quality assurance activities necessary to ensure the successful implementation of the HHCAHPS Survey.

#### ***Well-Documented Quality Control Procedures***

1. Vendor and subcontractor incorporate well-documented quality control procedures for training of staff involved in survey operations.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

2. Vendor incorporates well-documented quality control procedures for sample frame construction and sample selection.

☐ Yes      ☐ No

3. Vendor and subcontractor incorporate well-documented quality control procedures for printing, mailing, and recording of receipt of incoming survey questionnaires.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

4. Vendor and subcontractor incorporate well-documented quality control procedures for telephone administration of survey, including live monitoring capabilities.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

5. Vendor and subcontractor incorporate well-documented quality control procedures for coding and editing of survey data and survey-related materials.

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither



6. Vendor and subcontractor incorporate well-documented quality control procedures for scanning or keying survey data.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
7. Vendor incorporates well-documented quality control procedures for preparation of final case-level data files for submission.
- ☐ Yes      ☐ No
8. Vendor and subcontractor incorporate well-documented quality control procedures on all other functions and processes that affect the implementation of the HHCAHPS Survey.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
9. Please explain any “No” or “No, neither” responses above:

**Documentation Requirements**

1. Vendor and subcontractor agree to keep electronic or hardcopy files of individuals trained and training dates.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
2. Vendor and subcontractor agree to maintain electronic or hardcopy records of interviewers monitored (for telephone administration).
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
3. Vendor and subcontractor agree to maintain electronic or hardcopy records of mailing dates.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
4. Vendor and subcontractor agree to maintain other documentation necessary to allow the HHCAHPS Survey Oversight Team to review procedures implemented, should the vendor be selected for a site visit.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither
5. Vendor and subcontractor agree to maintain documentation of actions required (and taken) as a result of any decisions made during site visits by the Coordination Team.
- ☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

6. Please explain any “No, neither” responses above:

**Participation Requirements**

1. Vendor and subcontractor agree to review and follow all procedures described in the *HHCAHPS Survey Protocols and Guidelines Manual* as relevant for their approved survey mode(s).

☐ Yes, Vendor and/or Subcontractor      ☐ Yes, Vendor Only      ☐ No, neither

2. Vendor agrees to review the Introduction to the HHCAHPS Survey Training and complete the post-training certification and attend any subsequent Update Training sessions. Failure to do so will jeopardize their standing as an approved vendor.

☐ Yes      ☐ No

3. Subcontractors with significant roles on HHCAHPS and/or who are in receipt of patient identifying data agree to participate in all relevant vendor training sessions.

☐ Yes      ☐ No

4. Vendor agrees to participate in vendor oversight activities, including, but not limited to, conference calls, site visits, and Quality Assurance Plan submissions as requested by the Coordination Team as part of overall quality monitoring activities.

☐ Yes      ☐ No

5. Vendor agrees to provide documentation as requested for site visits and conference calls, including, but not limited to, staff training records, telephone interviewer monitoring records, sample frame development documentation, and data file construction documentation.

☐ Yes      ☐ No

6. Vendor acknowledges that review of and agreement with the HHCAHPS Survey vendor MBRs and Participation Requirements are necessary for participation and public reporting of the HHCAHPS Survey results.

☐ Yes      ☐ No

7. Please explain any “No” or “No, neither” responses above:

#### IV. ACKNOWLEDGEMENT

I certify that:

- I have reviewed and agree to meet the Survey Vendor Requirements for the HHCAHPS Survey, listed in this form.
- The statements herein are true, complete, and accurate to the best of my knowledge, and I accept the obligation to comply with the HHCAHPS Survey Vendor Requirements.

☐ Click here indicating that you (Survey Administrator/Project Manager) agree to the terms stated above.

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**APPENDIX B:**  
**SAMPLE FILE LAYOUT—**  
**HOME HEALTH CARE CAHPS SURVEY**

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## EXAMPLE OF A SAMPLE FILE LAYOUT HOME HEALTH CARE CAHPS SURVEY

The following table is an example of a sample file layout. The sample frame file is for the survey vendor's internal use only; vendors may use this example as a guide for developing sample frame files for the Home Health Care CAHPS Survey.

Some of the data elements shown in the example below are provided by the HHA; others are created by the vendor. Note that the sample frame file should include all of the data elements that will be needed for data submission. However, data submitted to the Home Health Care CAHPS Survey Data Center will be de-identified—that is, the data will not contain any information that can identify a patient. **Data elements in the sample file layout shown below that will not be included on the data file submitted to the Home Health Care CAHPS Survey Data Center are bolded and *italicized*.**

**Sample File Layout**

<b>Data Element</b>	<b>Length</b>	<b>Value Labels and Use</b>	<b>Required for Data Submission</b>
Provider Name	100	Name of Home Health Agency	Yes
Provider ID	6	CMS Certification Number (CCN, formerly known as the Medicare Provider ID Number)	Yes
NPI	10	National Provider ID Number	Optional (Can be submitted if available)
Sample Month	2	Home Health Care CAHPS Survey sampling month	Yes
Sample Year	4	Year of sample month	Yes
No. of Patients Served	6	Total number of patients the HHA served during the sample month	Yes

**SAMPLE FILE LAYOUT (continued)**

<b>Data Element</b>	<b>Length</b>	<b>Value Labels and Use</b>	<b>Required for Data Submission</b>
No. Patients on file(s) submitted to Vendor	6	Include the total number of patients on the file(s) submitted by the HHA.  Note that HHAs will exclude from the files that they submit to survey vendors patients who are deceased, those who requested that their name not be released to anyone else, patients who received home health visits for routine maternity care only, those currently receiving hospice care, and patients who have a certain condition or disease and live in a state that has regulations or laws restricting the release of patient information about patients with those conditions or illnesses.	Yes
Eligible patients	6	Number of patients eligible for survey in the sample month	Yes
Number of Patients Sampled	6	Number of patients sampled during this sample month	Yes
Sample ID No.	16	Survey vendors will assign a unique, de-identified sample identification number (SID) to each patient. The SID number will be used to track the survey status of the patient throughout the survey administration process and to designate sample patients on the data file submitted to the Data Center.	Yes
<i>Patient First Name</i>	<i>30</i>	<i>The name of the patient is needed to generate and send personalized mail survey materials to sample members and/or for telephone survey data collection.</i>	<i>No</i>
<i>Patient Middle Initial</i>	<i>1</i>	<i>The name of the patient is needed to generate and send personalized mail survey materials to sample members and/or for telephone survey data collection.</i>	<i>No</i>
<i>Patient Last Name</i>	<i>30</i>	<i>The name of the patient is needed to generate and send personalized mail survey materials to sample members and/or for telephone survey data collection.</i>	<i>No</i>
Patient Sex	1	1 = Male 2 = Female M = Unknown/Missing	Yes



**SAMPLE FILE LAYOUT (continued)**

<b>Data Element</b>	<b>Length</b>	<b>Value Labels and Use</b>	<b>Required for Data Submission</b>
<i>Patient Date of Birth</i>	<i>8</i>	<i>MMDDYYYY</i> <i>Used by survey vendor to calculate patient age prior to submitting data to the Home Health Care CAHPS Survey Data Center.</i>	<i>No</i>
<i>Patient Mailing Address 1</i>	<i>50</i>	<i>Patient's street or post office box number</i> <i>Address information needed for surveying patients in surveys using mail data collection mode</i>	<i>No</i>
<i>Patient Mailing Address 2</i>	<i>50</i>	<i>Second line of patient address (if needed)</i>	<i>No</i>
<i>Patient Address City</i>	<i>50</i>	<i>Mailing address city</i>	<i>No</i>
<i>Patient Address State</i>	<i>2</i>	<i>Mailing address state. Use 2-character postal abbreviation</i>	<i>No</i>
<i>Patient Address Zip Code</i>	<i>9</i>	<i>9-digit Mailing Address Zip Code</i> <i>(5-digit zip code followed by 4-digit extension; no hyphens, separators or delimiters)</i>	<i>No</i>
<i>Telephone Number including area code</i>	<i>10</i>	<i>Patient's home telephone number. Needed for telephone survey administration.</i> <i>Include 3-digit area code and 7-digit number: no dashes or spaces, separators, or delimiters.</i>	<i>No</i>
<i>Medical Record Number</i>	<i>20</i>	<i>Patient's Medical Record Number</i>	<i>No</i>
Number of skilled visits	2	Number of <u>skilled</u> home health visits patient had in sample month.  Skilled home health care visits are visits by registered nurses, physical therapists, occupational therapists and speech therapists. (Therapy Assistants are also included.) Visits by home health aides are not included in this number.  Used by survey vendor to confirm patient meets survey eligibility requirements	Yes
Lookback Period Visits	3	Total number of skilled home health care visits patient had in the lookback period.  Used by survey vendor to confirm patient meets survey eligibility criteria.	Yes

**SAMPLE FILE LAYOUT (continued)**

<b>Data Element</b>	<b>Length</b>	<b>Value Labels and Use</b>	<b>Required for Data Submission</b>
Admission Source	1	<p>Source of patient admission for home health care.</p> <p>Inpatient setting:            1 = Hospital (acute or long-term)            2 = Rehabilitation facility (hospital)            3 = Skilled Nursing Facility (or swing bed in hospital)            4 = Other nursing home (long-term care)            5 = Other inpatient facility</p> <p>Non-inpatient setting:            6 = Directly from community (e.g., private home, assisted living, group home, adult foster care)            M = Unknown/Missing</p> <p>Will be used in analysis. Note that multiple entries are allowed (i.e., code all that apply.)</p>	Yes
Payer (e.g., Medicare, Medicaid, private insurance)	1	<p>Source(s) of payment for home health care.</p> <p>1 = Medicare            2 = Medicaid            3 = Private health insurance            4 = Other            M = Unknown/Missing</p> <p>Will be used in analysis. Note that multiple entries are allowed (i.e., code all that apply). Also note that in the XML file the vendor will indicate whether the source of payment is known, assumed or missing.</p>	Yes
HMO Indicator	1	<p>Is patient in an HMO?</p> <p>1 = Yes            2 = No            M = Unknown/Missing</p> <p>Will be used in analysis.</p>	Yes
Dually eligible for Medicare and Medicaid?	1	<p>Is patient dually eligible for Medicare and Medicaid coverage?</p> <p>1 = Yes            2 = No            3 = Not applicable            M = Unknown/Missing</p> <p>Will be used in analysis.</p>	Yes

**SAMPLE FILE LAYOUT (continued)**

<b>Data Element</b>	<b>Length</b>	<b>Value Labels and Use</b>	<b>Required for Data Submission</b>
Primary Diagnosis	7	Underlying condition/procedure requiring home health care  [ICD-10-CM Code for underlying condition, including Z-codes. External cause codes (ICD-10-CM codes beginning with V, W, X, or Y) are not allowed as the primary diagnosis but are allowed for the other diagnoses.]Will be used in analysis.	Yes
Other diagnosis (ICD-10 codes) (Up to 5 codes)	7	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes. ICD-10-CM codes beginning with V, W, X, or Y codes are also allowed.  (ICD-10 code)  Will be used in analysis.	No
Surgical Discharge	1	Is care related to surgical discharge? 1 = Yes 2 = No M = Unknown/Missing  Will be used in analysis.	Yes
End-Stage Renal Disease (ESRD)	1	Does patient have end-stage renal disease? 1 = Yes 2 = No M = Unknown/Missing  Will be used in analysis.	Yes
ADL Deficits	1	Number of activities of daily living (ADLs) for which patient is not independent. Either this field or the ADL fields below should be included on the file. Enter the number of OASIS ADL items listed below for which the patient has, or would have, a response code greater than 0.  (0-5, M = Missing)	Yes
ADL Dress Upper	1	Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps.  0, 1, 2, 3  M = Missing  0 = fully independent	Yes

**SAMPLE FILE LAYOUT (continued)**

<b>Data Element</b>	<b>Length</b>	<b>Value Labels and Use</b>	<b>Required for Data Submission</b>
ADL Dress Lower	1	Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes. 0, 1, 2, 3 M = Missing 0 = fully independent	Yes
ADL Bathing	1	Bathing: Ability to wash entire body. Excludes grooming (washing face and hands only). 0, 1, 2, 3, 4, 5, 6 M = Missing 0 = fully independent	Yes
ADL Toilet Transferring	1	Toileting: Ability to get to and from the toilet or bedside commode. 0, 1, 2, 3, 4 M = Missing 0 = fully independent	Yes
ADL Transferring	1	Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast. 0, 1, 2, 3, 4, 5 M = Missing 0 = fully independent	Yes
Type of Sampling	1	1 = Census 2 = Simple Random Sampling 3 = Proportionate Stratified Random Sampling 4 = Disproportionate Stratified Random Sampling Use Code 1 if a census of patients (100% of eligible patients) is included in the survey.	Yes

**NOTE: If the type of sampling is “4-Disproportionate Stratified Random Sampling” (DSRS) the following three fields are required.** These three variables will be repeated for each stratum in the sample. Also, at least two strata names must be defined and strata names must be the same within a quarter. In addition, each stratum must contain a minimum of ten sampled patients, in every stratum in every month in the quarter.

**SAMPLE FILE LAYOUT (continued)**

<b>Data Element</b>	<b>Length</b>	<b>Value Labels and Use</b>	<b>Required for Data Submission</b>
DSRS Stratum Name	45	Stratum name	Yes, if DSRS
DSRS No. of Patients Eligible in stratum	6	Number of patients <u>eligible</u> within the stratum	Yes, if DSRS
DSRS No. of Patients Sampled in stratum	6	This is the number of <u>sampled</u> patients within the stratum. This variable will be used to weight the data.	Yes, if DSRS

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**APPENDIX C:**

**ENGLISH:**

**MAIL SURVEY COVER LETTERS,**  
**REGULAR AND SCANNABLE QUESTIONNAIRES,**  
**TELEPHONE INTERVIEW SCRIPT,**  
**PROXY INTERVIEW SCRIPT**

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**Sample Cover Letter for First Questionnaire Mailing**  
Home Health Care CAHPS Survey  
To be Printed on Home Health Agency or Vendor Letterhead

---

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»


«City\_Name», «State\_Code» «Zip\_Zip4»

Dear «FirstName» «LastName»:

This is an important survey from Medicare for people who get home health care. **Please take a few minutes to share your experiences with «HHA» and return the survey in the enclosed postage-paid envelope.** Your feedback helps Medicare improve the overall quality of home health care, and helps others choose a home health agency.

**Your voice matters.** We want your answers to reflect your own views and not anyone from the agency named above. If you need help with the survey, please ask a family member or a friend.

Participation is voluntary, and your information is kept private by law. No one can connect your name to your answers.



**We care about your  
home health care  
experience.**

If you have any questions about this survey, please call VENDOR NAME, (toll-free) at 1-XXX-XXX-XXXX.

Thank you for helping to improve home health care.

Sincerely,

Name

Home Health Agency Administrator

[PRINT SAMPLE ID HERE]

Si tiene preguntas o desea recibir la versión de la encuesta en español, por favor llámenos al número que aparece arriba.

**Sample Cover Letter for Second Questionnaire Mailing to Mail Survey Nonrespondents**

Home Health Care CAHPS Survey

To be Printed on Home Health Agency or Vendor Letterhead

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Dear «FirstName» «LastName»:

You recently got a survey from Medicare about your experiences with «HHA». **If you already sent this survey back, thank you! You don't need to do anything else.**

This is a friendly reminder that we're very interested in learning about your experiences. Your feedback will help others choose a home health care agency and will help Medicare improve the overall quality of home health care.

**Please take a few minutes to complete and return the survey in the postage-paid envelope included.**

**Your voice matters.** We know your time is valuable. Participation is voluntary, and your information is kept private by law. No one can connect your name to your answers.

For questions about this survey, please call VENDOR NAME, (toll-free) at 1-XXX-XXX-XXXX.

Thank you for helping to improve home health care.

Sincerely,

Name

Home Health Agency Administrator

**We care about your care experiences.**

If you need help with the survey, please ask a family member or friend.

[PRINT SAMPLE ID HERE]

Si tiene preguntas o desea recibir la versión de la encuesta en español, por favor llámenos al número que aparece arriba.

OMB #: 0938-1066 Expires July 31, 2026
---

# HOME HEALTH CARE CAHPS<sup>®</sup> SURVEY

## 2025

## 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?

- <sup>1</sup> ☐ Yes
- <sup>2</sup> ☐ 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?

- <sup>1</sup> ☐ Yes
- <sup>2</sup> ☐ No → If No, go to Q24.
- <sup>3</sup> ☐ 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?

- <sup>1</sup> ☐ Same day
- <sup>2</sup> ☐ 1 to 5 days
- <sup>3</sup> ☐ 6 to 14 days
- <sup>4</sup> ☐ More than 14 days
- <sup>5</sup> ☐ 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?

- <sup>1</sup> ☐ Yes
- <sup>2</sup> ☐ No

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

- <sup>1</sup> ☐ Definitely no
- <sup>2</sup> ☐ Probably no
- <sup>3</sup> ☐ Probably yes
- <sup>4</sup> ☐ 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 ☐ American Indian or Alaska Native
- 2 ☐ Asian
- 3 ☐ Black or African American
- 4 ☐ Native Hawaiian or other Pacific Islander
- 5 ☐ White

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.**

OMB #: 0938-1066  
Expires July 31, 2026

# **HOME HEALTH CARE CAHPS® SURVEY**

## **(ALTERNATIVE INSTRUCTIONS, SCANNABLE FORMS)**

### **2025**

**SURVEY INSTRUCTIONS**

- Answer all the questions by completely filling in the circle 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.

- Yes
- 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?
- 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
  - 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?
- Yes
  - No
  - 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?
- Yes
  - No
  - 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?
- ☐ Yes
  - ☐ 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?
- ☐ Yes
  - ☐ 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?
- ☐ Yes
  - ☐ 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?
- ☐ Never
  - ☐ Sometimes
  - ☐ Usually
  - ☐ Always
  - ☐ 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?
- ☐ Yes
  - ☐ 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?
- ☐ Yes
  - ☐ 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?
- ☐ Yes
  - ☐ No
  - ☐ I did **not** take any new prescription medicines or change any medicines

- |   |   |
|---|---|
| <p>13. In the last 2 months of care, did home health providers from this agency talk with you about <b>when</b> to take these medicines?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> I did <b>not</b> take any new prescription medicines or change any medicines</p><br><p>14. In the last 2 months of care, did home health providers from this agency talk with you about the <b>side effects</b> of these medicines?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> I did <b>not</b> take any new prescription medicines or change any medicines</p><br><p>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?</p> <p><input type="radio"/> Never</p> <p><input type="radio"/> Sometimes</p> <p><input type="radio"/> Usually</p> <p><input type="radio"/> Always</p><br><p>16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?</p> <p><input type="radio"/> Never</p> <p><input type="radio"/> Sometimes</p> <p><input type="radio"/> Usually</p> <p><input type="radio"/> Always</p> | <p>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?</p> <p><input type="radio"/> Never</p> <p><input type="radio"/> Sometimes</p> <p><input type="radio"/> Usually</p> <p><input type="radio"/> Always</p><br><p>18. In the last 2 months of care, how often did home health providers from this agency listen carefully to you?</p> <p><input type="radio"/> Never</p> <p><input type="radio"/> Sometimes</p> <p><input type="radio"/> Usually</p> <p><input type="radio"/> Always</p><br><p>19. In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?</p> <p><input type="radio"/> Never</p> <p><input type="radio"/> Sometimes</p> <p><input type="radio"/> Usually</p> <p><input type="radio"/> Always</p> |
|---|---|

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?
- ☐ Yes
  - ☐ 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?

- ☐ Yes
- ☐ No → If No, go to Q24.
- ☐ 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?

- ☐ Same day
- ☐ 1 to 5 days
- ☐ 6 to 14 days
- ☐ More than 14 days
- ☐ 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?

- ☐ Yes
- ☐ No

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

- ☐ Definitely no
- ☐ Probably no
- ☐ Probably yes
- ☐ Definitely yes

**ABOUT YOU**

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

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

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

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

28. Do you live alone?

- ☐ Yes
- ☐ No

29. 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

30. Are you Hispanic or Latino/Latina?

- ☐ Yes
- ☐ No

31. What is your race? Please select one or more.

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

32. What language do you mainly speak at home?

- ☐ English
- ☐ Spanish
- ☐ Some other language:

---

*(Please print.)*

33. Did someone help you complete this survey?

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

34. How did that person help you? Select 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:

---

*(Please print.)*

- ☐ No one helped me complete this survey

**Thank you!**

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



**TELEPHONE INTERVIEW SCRIPT  
FOR THE HOME HEALTH CARE CAHPS SURVEY**

INTRO1 Hello, may I please speak to [SAMPLE MEMBER'S NAME]?

- 1 YES → [GO TO INTRO2]
- 2 NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
- 3 NO [REFUSAL] → [GO TO TERMINATE SCREEN]
- 4 MENTALLY/PHYSICALLY INCAPABLE → [GO TO PROXY SCRIPT]
- 5 M MISSING/DK

IF ASKED WHO IS CALLING:

This is [INTERVIEWER NAME] calling from [ORGANIZATION]. I'd like to speak to [SAMPLE MEMBER'S NAME] about a health care study.

IF PERSON ON PHONE VOLUNTEERS THEY ARE SAMPLE MEMBER'S PARTNER, CHILD, PARENT, SIBLING, GRANDCHILD, OR POWER OF ATTORNEY AND THEY ASK WHY WE ARE CALLING:

I would like to talk to [SAMPLE MEMBER'S NAME] about their experiences with the home health care that they received from [HOME HEALTH AGENCY].

INTRO2 Hello, this is [INTERVIEWER NAME] calling on behalf of [HOME HEALTH AGENCY]. The agency is participating in a national survey to measure the quality of care people receive from home health care agencies. The results will help other people who need to choose a home health care agency.

Your participation in this survey is voluntary. The interview will take about 12 minutes to complete, and this call may be monitored or recorded for quality improvement purposes.

**NOTE: THE LENGTH OF THE INTERVIEW WILL DEPEND ON WHETHER THE HHA ADDS SUPPLEMENTAL QUESTIONS TO ITS HOME HEALTH CARE CAHPS SURVEY.**

- INTRO3      INTRO3 AND INTRO4 USED ONLY IF CALLING SAMPLE MEMBER BACK TO COMPLETE A SURVEY THAT WAS BEGUN IN A PREVIOUS CALL. NOTE THAT THE SAMPLE MEMBER MUST HAVE ANSWERED AT LEAST ONE QUESTION IN THE SURVEY IN A PRECEDING CALL.
- Hello, may I please speak to [SAMPLE MEMBER’S NAME]?
- IF ASKED WHO IS CALLING:  
This is [INTERVIEWER NAME] calling from [VENDOR]. I’d like to speak to [SAMPLE MEMBER’S NAME] about a study about health care.
- 1   YES, SAMPLE MEMBER IS AVAILABLE AND ON PHONE NOW → [GO TO INTRO4]
  - 2   NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
  - 3   NO [REFUSAL] → [GO TO Q\_REF SCREEN]
  - 4   MENTALLY/PHYSICALLY INCAPABLE → [GO TO PROXY SCRIPT]
- INTRO4      Hello, I am calling to continue the survey that we started in a previous call, regarding the care that you received from [HOME HEALTH AGENCY]. I’d like to continue with the interview now.
- 1   CONTINUE WITH INTERVIEW AT FIRST UNANSWERED QUESTION
  - 2   NO, NOT RIGHT NOW → [SET CALLBACK]
  - 3   NO [REFUSAL] → [GO TO Q\_REF SCREEN]
- Q1.          According to our records, you got care from the home health agency, [HOME HEALTH AGENCY]. Is that right?
- 1   YES → [GO TO Q2\_INTRO]
  - 2   NO → [GO TO Q\_INELIG]
- M   MISSING/DK → [GO TO Q\_INELIG]
- Q2\_INTRO      As you answer the questions in this survey, think only about your experience with this agency.
- Q2.          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
- M   MISSING/DK

Q3. 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

M MISSING/DK

Q4. 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

M MISSING/DK

Q5. 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

M MISSING/DK

Q6\_INTRO These next questions are about all the different staff from [HOME HEALTH AGENCY] 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.

Q6. In the last 2 months of care, was one of your home health providers from this agency a nurse?

- 1 YES
- 2 NO

M MISSING/DK

- Q7. 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
- M MISSING/DK
- Q8. 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
- M MISSING/DK
- Q9. 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? Would you say...
- 1 Never,
  - 2 Sometimes,
  - 3 Usually,
  - 4 Always, or
  - 5 you only had one provider in the last 2 months of care?
- M MISSING/DK
- Q10. In the last 2 months of care, did you and a home health provider from this agency talk about pain?
- 1 YES
  - 2 NO
- M MISSING/DK
- Q11. 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 → [GO TO Q15]
- M MISSING/DK → [GO TO Q15]

- Q12. 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
- M MISSING/DK
- Q13. 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
- M MISSING/DK
- Q14. 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
- M MISSING/DK
- Q15. 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? Would you say...
- 1 Never,
  - 2 Sometimes,
  - 3 Usually, or
  - 4 Always?
- M MISSING/DK
- Q16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible? Would you say...
- 1 Never,
  - 2 Sometimes,
  - 3 Usually, or
  - 4 Always?
- M MISSING/DK

Q17. 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? Would you say...

- 1 Never,
- 2 Sometimes,
- 3 Usually, or
- 4 Always?

M MISSING/DK

Q18. In the last 2 months of care, how often did home health providers from this agency listen carefully to you? Would you say...

- 1 Never,
- 2 Sometimes,
- 3 Usually, or
- 4 Always?

M MISSING/DK

Q19. In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect? Would you say...

- 1 Never,
- 2 Sometimes,
- 3 Usually, or
- 4 Always?

M MISSING/DK

Q20\_INTRO We want to know your rating of your care from this agency's home health providers.

Q20. 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?

READ RESPONSE CHOICES ONLY IF NECESSARY

00 0 Worst home health care possible

01 1

02 2

03 3

04 4

05 5

06 6

07 7

08 8

09 9

10 10 Best home health care possible

M MISSING/DK

Q21\_INTRO The next questions are about the office of [HOME HEALTH AGENCY].

Q21. In the last 2 months of care, did you contact this agency's **office** to get help or advice?

1 YES

2 NO → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q22. 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 → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q23. When you contacted this agency's office, how long did it take for you to get the help or advice you needed? Would you say...

- 1 Same day,
- 2 1 to 5 days,
- 3 6 to 14 days, or
- 4 More than 14 days?

M MISSING/DK

Q24. In the last 2 months of care, did you have any problems with the care you got through this agency?

- 1 YES
- 2 NO

M MISSING/DK

Q25. Would you recommend this agency to your family or friends if they needed home health care? Would you say...

- 1 Definitely no,
- 2 Probably no,
- 3 Probably yes, or
- 4 Definitely yes?

M MISSING/DK

Q26\_INTRO This last set of questions asks for information about you. Please listen to all response choices before making a selection.

Q26. In general, how would you rate your overall health? Would you say that it is...

- 1 Excellent,
- 2 Very good,
- 3 Good,
- 4 Fair, or
- 5 Poor?

M MISSING/DK



- Q27. In general, how would you rate your overall mental or emotional health? Would you say that it is...
- 1 Excellent,
  - 2 Very good,
  - 3 Good,
  - 4 Fair, or
  - 5 Poor?
- M MISSING/DK
- Q28. Do you live alone?
- 1 YES
  - 2 NO
- M MISSING/DK
- Q29. What is the highest grade or level of school that you have completed? Would you say...
- 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, or
  - 6 More than 4-year college degree?
- M MISSING/DK
- Q30. Are you Hispanic or Latino/Latina?
- 1 YES
  - 2 NO
- M MISSING/DK

Q31. What is your race? You may choose one or more of the following. Are you...

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

M MISSING/DK

Q32. What language do you mainly speak at home? Would you say...

- 1 English, → [GO TO Q\_END]
- 2 Spanish, or → [GO TO Q\_END]
- 3 Some other language? → [GO TO 32A]

M MISSING/DK [GO TO Q\_END]

Q32A What other language do you mainly speak at home? (ENTER RESPONSE BELOW).

{ALLOW UP TO 50 CHARACTERS}

M MISSING/DK

Q\_END These are all the questions I have for you. Thank you for your time. Have a good (day/evening).

INELIGIBLE SCREEN:

Q\_INELIG Thank you for your time. Have a good (day/evening).

REFUSAL SCREEN:

Q\_REF Thank you for your time. Have a good (day/evening).

**PROXY TELEPHONE INTERVIEW SCRIPT  
FOR THE HOME HEALTH CARE CAHPS SURVEY**

PROXY ID    Is there somebody such as a family member or friend who is familiar with  
[SAMPLE MEMBER'S NAME]'s health care experiences?

PROBE TO FIND OUT IF PERSON IS AVAILABLE IN HOUSEHOLD TO DO  
INTERVIEW.

- 1   YES → [GO TO PROXY\_INTRO]
- 2   NO → [COLLECT NAME AND TELEPHONE NUMBER OF PROXY  
AND SET A CALLBACK, OR IF NO PROXY EXISTS, GO TO  
Q\_END AND CODE AS MENTALLY/PHYSICALLY  
INCAPABLE]

IF ASKED WHO IS CALLING:

This is [INTERVIEWER NAME] calling from [ORGANIZATION]. I'd like to  
speak with someone who is knowledgeable about [SAMPLE MEMBER  
NAME]'s health and health care experiences for a study [ORGANIZATION] is  
conducting about health care.

PROXY\_INTRO    [Hello, this is {INTERVIEWER NAME} calling on behalf of {HOME  
HEALTH AGENCY}}. The agency is participating in a national survey to  
measure the quality of care people receive from home health care  
agencies. The results will help other people who need to choose a home  
health care agency.

[SAMPLE MEMBER NAME]'s participation in this survey is voluntary.  
The interview will take about 12 minutes to complete, and this call may be  
monitored or recorded for quality improvement purposes.

**NOTE: THE LENGTH OF THE INTERVIEW WILL DEPEND ON  
WHETHER THE HHA ADDS SUPPLEMENTAL QUESTIONS TO  
ITS HOME HEALTH CARE CAHPS SURVEY.**

- INTRO3      INTRO3 AND INTRO4 USED ONLY IF CALLING PROXY BACK TO COMPLETE A SURVEY THAT WAS BEGUN IN A PREVIOUS CALL. NOTE THAT THE PROXY MUST HAVE ANSWERED AT LEAST ONE QUESTION IN THE SURVEY IN A PRECEDING CALL.
- Hello, may I please speak to [PROXY NAME]?
- IF ASKED WHO IS CALLING:  
This is [INTERVIEWER NAME] calling from [VENDOR]. I'd like to speak to [PROXY NAME] about a study about health care.
- 1   YES, PROXY IS AVAILABLE AND ON PHONE NOW → [GO TO INTRO4]
  - 2   NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
  - 3   NO [REFUSAL] → [GO TO Q\_REF SCREEN]
- INTRO4      Hello, I am calling to continue the survey that we started in a previous call, regarding the care that [SAMPLE MEMBER NAME] received from [HOME HEALTH AGENCY]. I'd like to continue with the interview now.
- 1   CONTINUE WITH INTERVIEW AT FIRST UNANSWERED QUESTION
  - 2   NO, NOT RIGHT NOW → [SET CALLBACK]
  - 3   NO [REFUSAL] → [GO TO Q\_REF SCREEN]
- Q1.          According to our records, [SAMPLE MEMBER NAME] got care from the home health agency, [HOME HEALTH AGENCY]. Is that right?
- 1   YES → [GO TO Q2\_INTRO]
  - 2   NO → [GO TO Q\_INELIG]
- M   MISSING/DK → [GO TO Q\_INELIG]

Q2\_INTRO As you answer the questions in this survey, think only about [SAMPLE MEMBER NAME]'s experience with this agency. Please try to answer the questions as best you can from [SAMPLE MEMBER NAME]'s point-of-view. If you need to, you can answer the questions from the point-of-view of a family member or caregiver helping [SAMPLE MEMBER NAME].

Q2. When [SAMPLE MEMBER NAME] first started getting home health care from this agency, did someone from the agency tell [him/her] what care and services [he/she] would get?

- 1 YES
- 2 NO
- 3 DO NOT REMEMBER

M MISSING/DK

Q3. When [SAMPLE MEMBER NAME] first started getting home health care from this agency, did someone from the agency **talk with [him/her]** about how to set up [his/her] home so [he/she] can move around safely?

- 1 YES
- 2 NO
- 3 DO NOT REMEMBER

M MISSING/DK

Q4. When [SAMPLE MEMBER NAME] started getting home health care from this agency, did someone from the agency talk with [him/her] about all the **prescription and over-the-counter medicines** [he/she] was taking?

- 1 YES
- 2 NO
- 3 DO NOT REMEMBER

M MISSING/DK

Q5. When [SAMPLE MEMBER NAME] started getting home health care from this agency, did someone from the agency ask to **see** all the prescription and over-the-counter medicines [he/she] was taking?

- 1 YES
- 2 NO
- 3 DO NOT REMEMBER

M MISSING/DK

- Q6\_INTRO    These next questions are about all the different staff from [HOME HEALTH AGENCY] who gave [SAMPLE MEMBER NAME] care in the last 2 months. Do not include care [SAMPLE MEMBER NAME] got from staff from another home health care agency. Do not include care [he/she] got from family or friends.
- Q6.            In the last 2 months of care, was one of [SAMPLE MEMBER NAME]'s home health providers from this agency a nurse?
- 1    YES
- 2    NO
- M    MISSING/DK
- Q7.            In the last 2 months of care, was one of [SAMPLE MEMBER NAME]'s home health providers from this agency a physical, occupational, or speech therapist?
- 1    YES
- 2    NO
- M    MISSING/DK
- Q8.            In the last 2 months of care, was one of [SAMPLE MEMBER NAME]'s home health providers from this agency a home health or personal care aide?
- 1    YES
- 2    NO
- M    MISSING/DK
- Q9.            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 [SAMPLE MEMBER NAME] got at home? Would you say...
- 1    Never,
- 2    Sometimes,
- 3    Usually,
- 4    Always, or
- 5    [SAMPLE MEMBER NAME] only had one provider in the last 2 months of care?
- M    MISSING/DK

- Q10. In the last 2 months of care, did [SAMPLE MEMBER NAME] and a home health provider from this agency talk about pain?
- 1 YES
  - 2 NO
- M MISSING/DK
- Q11. In the last 2 months of care, did [SAMPLE MEMBER NAME] take any new prescription medicine or change any of the medicines [he/she] was taking?
- 1 YES
  - 2 NO → [GO TO Q15]
- M MISSING/DK → [GO TO Q15]
- Q12. In the last 2 months of care, did home health providers from this agency talk with [SAMPLE MEMBER NAME] about the **purpose** for taking [his/her] new or changed prescription medicines?
- 1 YES
  - 2 NO
- M MISSING/DK
- Q13. In the last 2 months of care, did home health providers from this agency talk with [SAMPLE MEMBER NAME] about **when** to take these medicines?
- 1 YES
  - 2 NO
- M MISSING/DK
- Q14. In the last 2 months of care, did home health providers from this agency talk with [SAMPLE MEMBER NAME] about the **side effects** of these medicines?
- 1 YES
  - 2 NO
- M MISSING/DK

Q15. In the last 2 months of care, how often did home health providers from this agency keep [SAMPLE MEMBER NAME] informed about when they would arrive at [his/her] home? Would you say...

- 1 Never,
- 2 Sometimes,
- 3 Usually, or
- 4 Always?

M MISSING/DK

Q16. In the last 2 months of care, how often did home health providers from this agency treat [SAMPLE MEMBER NAME] as gently as possible? Would you say...

- 1 Never,
- 2 Sometimes,
- 3 Usually, or
- 4 Always?

M MISSING/DK

Q17. 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? Would you say...

- 1 Never,
- 2 Sometimes,
- 3 Usually, or
- 4 Always?

M MISSING/DK

Q18. In the last 2 months of care, how often did home health providers from this agency listen carefully to [SAMPLE MEMBER NAME]? Would you say...

- 1 Never,
- 2 Sometimes,
- 3 Usually, or
- 4 Always?

M MISSING/DK



Q19. In the last 2 months of care, how often did home health providers from this agency treat [SAMPLE MEMBER NAME] with courtesy and respect? Would you say...

- 1 Never,
- 2 Sometimes,
- 3 Usually, or
- 4 Always?

M MISSING/DK

Q20\_INTRO We want to know [SAMPLE MEMBER NAME]'s rating of [his/her] care from this agency's home health providers. Please try to answer the questions as best you can from [SAMPLE MEMBER NAME]'s point-of-view. If you need to, you can answer the questions from the point-of-view of a family member or caregiver helping [SAMPLE MEMBER NAME].

Q20. 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 [SAMPLE MEMBER NAME] use to rate [his/her] care from this agency's home health providers?

READ RESPONSE CHOICES ONLY IF NECESSARY

00 0 Worst home health care possible

01 1

02 2

03 3

04 4

05 5

06 6

07 7

08 8

09 9

10 10 Best home health care possible

M MISSING/DK

Q21\_INTRO The next questions are about the office of [HOME HEALTH AGENCY].

Q21. In the last 2 months of care, did [SAMPLE MEMBER NAME] contact this agency's **office** to get help or advice?

- 1 YES
- 2 NO → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q22. In the last 2 months of care, when [SAMPLE MEMBER NAME] contacted this agency's office did [he/she] get the help or advice [he/she] needed?

- 1 YES
- 2 NO → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q23. When [SAMPLE MEMBER NAME] contacted this agency's office, how long did it take for [him/her] to get the help or advice [he/she] needed? Would you say...

- 1 Same day,
- 2 1 to 5 days,
- 3 6 to 14 days, or
- 4 More than 14 days?

M MISSING/DK

Q24. In the last 2 months of care, did [SAMPLE MEMBER NAME] have any problems with the care [he/she] got through this agency?

- 1 YES
- 2 NO

M MISSING/DK

Q25. Would [SAMPLE MEMBER NAME] recommend this agency to [his/her] family or friends if they needed home health care? Would you say...

- 1 Definitely no,
- 2 Probably no,
- 3 Probably yes, or
- 4 Definitely yes?

M MISSING/DK

Q26\_INTRO This last set of questions asks for information about [SAMPLE MEMBER NAME]. Please listen to all response choices before making a selection.

Q26. In general, how would [SAMPLE MEMBER NAME] rate [his/her] overall health? Would you say that it is...

- 1 Excellent,
- 2 Very good,
- 3 Good,
- 4 Fair, or
- 5 Poor?

M MISSING/DK

Q27. In general, how would [SAMPLE MEMBER NAME] rate [his/her] overall mental or emotional health? Would you say that it is...

- 1 Excellent,
- 2 Very good,
- 3 Good,
- 4 Fair, or
- 5 Poor?

M MISSING/DK

Q28. Does [SAMPLE MEMBER NAME] live alone?

- 1 YES
- 2 NO

M MISSING/DK

Q29. What is the highest grade or level of school that [SAMPLE MEMBER NAME] has completed? Would you say...

- 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, or
- 6 More than 4-year college degree?

M MISSING/DK

Q30. Is [SAMPLE MEMBER NAME] Hispanic or Latino/Latina?

- 1 YES
- 2 NO

M MISSING/DK

Q31. What is [SAMPLE MEMBER NAME]'s race? You may choose one or more of the following. Is he/she...

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

M MISSING/DK

Q32. What language does [SAMPLE MEMBER NAME] mainly speak at home? Would you say...

- 1 English, → [GO TO Q\_END]
- 2 Spanish, or → [GO TO Q\_END]
- 3 Some other language? → [GO TO Q32A]

M MISSING/DK [GO TO Q\_END]

Q32A What other language does [SAMPLE MEMBER NAME] mainly speak at home? (ENTER RESPONSE BELOW).

{ALLOW UP TO 50 CHARACTERS}

M MISSING/DK

Q\_END These are all the questions I have for you. Thank you for your time. Have a good (day/evening).

INELIGIBLE SCREEN:

Q\_INELIG Thank you for your time. Have a good (day/evening).

REFUSAL SCREEN:

Q\_REF Thank you for your time. Have a good (day/evening).

**APPENDIX D:**

**SPANISH:**

**MAIL SURVEY COVER LETTERS,**  
**REGULAR AND SCANNABLE QUESTIONNAIRES,**  
**TELEPHONE INTERVIEW SCRIPT,**  
**PROXY INTERVIEW SCRIPT**

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## Sample Cover Letter for First Questionnaire Mailing in Spanish

Home Health Care CAHPS Survey

To be Printed on Home Health Agency or Vendor Letterhead

---

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Estimado(a) «FirstName» «LastName»:

Esta es una encuesta importante de Medicare para las personas que reciben cuidado de la salud en el hogar. **Tómese unos minutos para compartir sus experiencias con «HHA» y devuelva la encuesta en el sobre adjunto que no necesita estampilla.** Sus comentarios ayudarán a Medicare a mejorar la calidad general del cuidado de la salud en el hogar y a otras personas a elegir una agencia de salud en el hogar.

**Su voz cuenta.** Queremos que sus respuestas reflejen sus propias opiniones y no las de nadie de la agencia mencionada anteriormente. Si necesita ayuda con la encuesta, pídale ayuda a un miembro de su familia o a una amistad.

La participación es voluntaria y su información se mantiene privada por ley. Nadie puede asociar su nombre con sus respuestas.

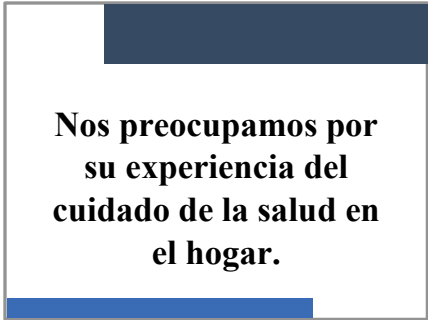
Si tiene alguna pregunta sobre esta encuesta, llame a VENDOR NAME, (gratis) al 1-XXX-XXX-XXXX.

Gracias por ayudar a mejorar el cuidado de la salud en el hogar.

Atentamente,

Name

Administrador(a) de la agencia de cuidados de la salud en el hogar



**Nos preocupamos por  
su experiencia del  
cuidado de la salud en  
el hogar.**

[PRINT SAMPLE ID HERE]

**Sample Cover Letter for Second Questionnaire**  
**Mailing to Mail Survey Nonrespondents in Spanish**  
Home Health Care CAHPS Survey  
To be Printed on Home Health Agency or Vendor Letterhead

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Estimado(a) «FirstName» «LastName»:

Recientemente recibió una encuesta de Medicare sobre sus experiencias con «HHA». **Si ya ha devuelto esta encuesta, ¡muchas gracias! No es necesario que haga nada más.**

Este es un recordatorio de que estamos muy interesados en saber sobre de sus experiencias. Sus comentarios ayudarán a otras personas a elegir una agencia del cuidado de la salud en el hogar y ayudarán a Medicare a mejorar la calidad general del cuidado de la salud el hogar.

**Tómese unos minutos para completar y devolver la encuesta en el sobre adjunto que no necesita estampilla.**

**Su voz cuenta.** Sabemos que su tiempo es valioso. La participación es voluntaria y su información se mantiene privada por ley. Nadie puede asociar su nombre a sus respuestas.

Si tiene alguna pregunta sobre esta encuesta, llame a VENDOR NAME, (gratis) al 1-XXX-XXX-XXXX.

Gracias por ayudar a mejorar el cuidado de la salud en el hogar.

Atentamente,

Name

Administrador(a) de la agencia de cuidados de la salud en el hogar

[PRINT SAMPLE ID HERE]

**Nos preocupamos por sus  
experiencias del cuidado de  
la salud.**

Si necesita ayuda con la encuesta,  
pídale ayuda un miembro de su  
familia o a una amistad.



OMB #: 0938-1066 Vence 31 de julio de 2026
---

# **ENCUESTA DE CAHPS<sup>®</sup> SOBRE CUIDADO DE LA SALUD EN EL HOGAR 2025**

## INSTRUCCIONES PARA LA ENCUESTA

- Responda todas las preguntas marcando el encasillado a la izquierda de su respuesta.
- A veces se le indica que debe saltarse algunas preguntas de esta encuesta. Cuando ocurra, verá una flecha con una nota que le indica qué pregunta es la siguiente, de esta manera:

☒ Sí → Si respondió Sí, vaya a la pregunta 1, en la página 1.

☐ No

## CUIDADO DE LA SALUD QUE USTED RECIBIÓ EN EL HOGAR

1. Según nuestro registro, usted recibió servicios por parte de [AGENCY NAME], una agencia que brinda cuidado de la salud en el hogar. ¿Es eso correcto?

Al responder las preguntas de esta encuesta, piense solamente acerca de sus experiencias con esta agencia.

<sup>1</sup> ☐ Sí

<sup>2</sup> ☐ No → Si respondió que No, por favor, deténgase y devuelva la encuesta en el sobre provisto.

2. Cuando recién empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia le dijo qué tipo de atención y de servicios le darían?

<sup>1</sup> ☐ Sí

<sup>2</sup> ☐ No

<sup>3</sup> ☐ No recuerda

3. Cuando recién empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia le **habló** sobre cómo debía colocar las cosas en el hogar para poder moverse con mayor seguridad?

<sup>1</sup> ☐ Sí

<sup>2</sup> ☐ No

<sup>3</sup> ☐ No recuerda

4. Cuando empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia habló con usted acerca de todos los **medicamentos** que usted estaba tomando ya sean **los recetados por un médico o los que se compran sin receta**?

<sup>1</sup> ☐ Sí

<sup>2</sup> ☐ No

<sup>3</sup> ☐ No recuerda

5. Cuando empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de la agencia le pidió **ver** todos los medicamentos que usted estaba tomando ya sean los recetados por un médico o los que se compran sin receta?

1 ☐ Sí  
2 ☐ No  
3 ☐ No recuerda

**SU CUIDADO DE LOS  
PROVEEDORES DEL CUIDADO DE  
LA SALUD EN EL HOGAR EN LOS  
ÚLTIMOS 2 MESES**

Las siguientes preguntas son sobre todo el personal de la agencia [AGENCY NAME] que lo/la atendieron en los últimos 2 meses. No incluya la atención que recibió del personal de otra agencia de cuidado de la salud en el hogar. No incluya los cuidados que usted recibió de familiares o amigos.

6. En los últimos 2 meses en que recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia una enfermera o un enfermero?

1 ☐ Sí  
2 ☐ No

7. En los últimos 2 meses en que recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia un especialista en terapia física, terapia de trabajo o terapia del habla?

1 ☐ Sí  
2 ☐ No

8. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia un asistente de salud en el hogar o un asistente de cuidados personales?

1 ☐ Sí  
2 ☐ No

9. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia los proveedores del cuidado de la salud de esta agencia parecían estar informados y al día acerca de todo el cuidado o tratamiento que recibió en el hogar?

1 ☐ Nunca  
2 ☐ A veces  
3 ☐ La mayoría de las veces  
4 ☐ Siempre  
5 ☐ En los últimos dos meses en que recibí cuidado de la salud en el hogar solamente me atendió un proveedor

10. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿habló con alguna de las personas de esta agencia acerca del dolor que usted sentía?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No

11. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿tomó algún nuevo medicamento recetado o hizo un cambio respecto a alguno de los medicamentos que estaba tomando?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No → Si respondió No, vaya a la pregunta 15.

12. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿alguno de los proveedores del cuidado de la salud de esta agencia habló con usted acerca de la **razón** por la cual usted debía tomar el nuevo medicamento que le recetó el médico o la razón por la cual usted debía hacer algún cambio con respecto a algún medicamento que estaba tomando?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No  
<sup>3</sup> ☐ No tomé ningún medicamento nuevo de receta médica ni cambié de medicamento

13. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿alguno de los proveedores del cuidado de la salud de esta agencia habló con usted acerca de **cuándo** debía tomar esos medicamentos?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No  
<sup>3</sup> ☐ No tomé ningún medicamento nuevo de receta médica ni cambié de medicamento

14. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿conversaron con usted los proveedores del cuidado de la salud de esta agencia sobre los **efectos secundarios** de estos medicamentos?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No  
<sup>3</sup> ☐ No tomé ningún medicamento nuevo de receta médica ni cambié de medicamento

15. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la mantuvieron informado(a) los proveedores del cuidado de la salud de esta agencia sobre cuándo llegarían a su hogar?

- <sup>1</sup> ☐ Nunca  
<sup>2</sup> ☐ A veces  
<sup>3</sup> ☐ La mayoría de las veces  
<sup>4</sup> ☐ Siempre

16. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la trataron los proveedores del cuidado de la salud de esta agencia lo más gentilmente posible?

1 ☐ Nunca  
2 ☐ A veces  
3 ☐ La mayoría de las veces  
4 ☐ Siempre

17. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia le explicaron los proveedores del cuidado de la salud de esta agencia las cosas de una manera que era fácil de entender?

1 ☐ Nunca  
2 ☐ A veces  
3 ☐ La mayoría de las veces  
4 ☐ Siempre

18. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia los proveedores del cuidado de la salud de esta agencia lo/la escucharon con atención?

1 ☐ Nunca  
2 ☐ A veces  
3 ☐ La mayoría de las veces  
4 ☐ Siempre

19. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia le trataron los proveedores del cuidado de la salud de esta agencia con cortesía y respeto?

1 ☐ Nunca  
2 ☐ A veces  
3 ☐ La mayoría de las veces  
4 ☐ Siempre

20. Queremos saber cómo calificaría usted la calidad de la atención que le brindaron los proveedores del cuidado de la salud de esta agencia.

Usando un número de 0 a 10, donde 0 es el peor cuidado de la salud en el hogar posible y 10 es el mejor cuidado de la salud en el hogar posible, ¿qué número usaría para calificar el cuidado de los proveedores del cuidado de la salud en el hogar de esta agencia?

☐ 0 El peor cuidado de la salud en el hogar posible

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

☐ 8

☐ 9

☐ 10 El mejor cuidado de la salud en el hogar posible

**LA AGENCIA QUE LE BRINDÓ  
CUIDADO DE LA SALUD EN EL  
HOGAR**

Las siguientes preguntas son sobre la oficina de [AGENCY NAME].

21. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿se comunicó con la **oficina** de esta agencia para recibir orientación o ayuda?

1 ☐ Sí  
2 ☐ No → Si respondió No, vaya a la pregunta 24.

22. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, cuando usted se comunicó con la oficina de esta agencia ¿recibió la orientación o ayuda que necesitaba?

1 ☐ Sí  
2 ☐ No → Si respondió No, vaya a la pregunta 24.  
3 ☐ No me comuniqué con esta agencia

23. Cuando se comunicó con la oficina de esta agencia, ¿cuánto tiempo necesitó para obtener la orientación o ayuda que necesitaba?

1 ☐ Lo/la atendieron ese mismo día  
2 ☐ De 1 a 5 días  
3 ☐ De 6 a 14 días  
4 ☐ Más de 14 días  
5 ☐ No me comuniqué con esta agencia

24. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿tuvo algún problema con los servicios que recibió de esta agencia?

1 ☐ Sí  
2 ☐ No

25. ¿Recomendaría esta agencia a sus familiares o a sus amistades si ellos necesitaran cuidado de la salud en el hogar?

1 ☐ Definitivamente no  
2 ☐ Probablemente no  
3 ☐ Probablemente sí  
4 ☐ Definitivamente sí

**ACERCA DE USTED**

26. En general, ¿cómo calificaría toda su salud?

1 ☐ Excelente  
2 ☐ Muy buena  
3 ☐ Buena  
4 ☐ Regular  
5 ☐ Mala

27. En general, ¿cómo calificaría su salud mental o emocional?

1 ☐ Excelente  
2 ☐ Muy buena  
3 ☐ Buena  
4 ☐ Regular  
5 ☐ Mala

28. ¿Vive usted solo(a)?

- 1 ☐ Sí  
2 ☐ No

29. ¿Cuál es el grado o nivel escolar más alto que ha completado?

- 1 ☐ 8 años de escuela o menos  
2 ☐ 9 a 12 años de escuela, pero sin graduarse  
3 ☐ Graduado de “high school” (escuela secundaria), diploma de GED (escuela secundaria, preparatoria o su equivalente)  
4 ☐ Algunos cursos universitarios o un título universitario de un programa de 2 años  
5 ☐ Título universitario de 4 años  
6 ☐ Título universitario de más de 4 años

30. ¿Es usted hispano(a) o latino(a)?

- 1 ☐ Sí  
2 ☐ No

31. ¿A qué raza pertenece? Por favor marque una o más.

- 1 ☐ Indígena Americana o Nativa de Alaska  
2 ☐ Asiática  
3 ☐ Negra o Afro Americana  
4 ☐ Nativa de Hawai o de otras Islas del Pacífico  
5 ☐ Blanca

32. ¿Principalmente qué idioma habla en el hogar?

- 1 ☐ Inglés  
2 ☐ Español  
3 ☐ Algún otro idioma:

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*(Por favor escriba en letra de imprenta.)*

33. ¿Alguien le ayudó a completar esta encuesta?

- 1 ☐ Sí  
2 ☐ No → Si respondió que No, por favor, devuelva la encuesta completada en el sobre con timbre postal pre-pagado.

34. ¿En qué manera le ayudó esa persona?  
Marque todo lo que corresponda.

- 1 ☐ Me leyó las preguntas  
2 ☐ Anotó mis respuestas  
3 ☐ Respondió las preguntas por mí  
4 ☐ Tradujo las preguntas a mi idioma  
5 ☐ Me ayudó de alguna otra manera:

*(Por favor escriba en letra de  
impresa.)*

- 6 ☐ Nadie me ayudó a completar  
esta encuesta

**¡Muchas gracias!**

**Por favor, devuelva la encuesta  
completada en el sobre con timbre  
postal pre-pagado.**



OMB #: 0938-1066  
Vence 31 de julio de 2026

# **ENCUESTA DE CAHPS<sup>®</sup> SOBRE CUIDADO DE LA SALUD EN EL HOGAR**

## **(ALTERNATIVE INSTRUCTIONS, SCANNABLE FORMS)**

### **2025**

## Instrucciones para la encuesta

- Responda todas las preguntas llenando por completo el círculo a la izquierda de su respuesta.
- A veces se le indica que debe saltarse algunas preguntas de esta encuesta. Cuando ocurra, verá una flecha con una nota que le indica qué pregunta es la siguiente, de esta manera:
  - Sí → Si respondió Sí, vaya a la pregunta 1, en la página 1.
  - No

## Cuidado de la salud que usted recibió en el hogar

1. Según nuestro registro, usted recibió servicios por parte de [AGENCY NAME], una agencia que brinda cuidado de la salud en el hogar. ¿Es eso correcto?  
  
Al responder las preguntas de esta encuesta, piense solamente acerca de sus experiencias con esta agencia.
  - Sí
  - No → Si respondió que No, por favor, deténgase y devuelva la encuesta en el sobre provisto.

2. Cuando recién empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia le dijo qué tipo de atención y de servicios le darían?
  - Sí
  - No
  - No recuerda
3. Cuando recién empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia le habló sobre cómo debía colocar las cosas en el hogar para poder moverse con mayor seguridad?
  - Sí
  - No
  - No recuerda
4. Cuando empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia habló con usted acerca de todos los **medicamentos** que usted estaba tomando ya sean **los recetados por un médico o los que se compran sin receta**?
  - Sí
  - No
  - No recuerda

5. Cuando empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de la agencia le pidió **ver** todos los medicamentos que usted estaba tomando ya sean los recetados por un médico o los que se compran sin receta?

☐ Sí

☐ No

☐ No recuerda

**Su cuidado de los  
proveedores del cuidado de  
la salud en el hogar en los  
últimos 2 meses**

Las siguientes preguntas son sobre todo el personal de la agencia [AGENCY NAME] que lo/la atendieron en los últimos 2 meses. No incluya la atención que recibió del personal de otra agencia de cuidado de la salud en el hogar. No incluya los cuidados que usted recibió de familiares o amigos.

6. En los últimos 2 meses en que recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia una enfermera o un enfermero?
- ☐ Sí
- ☐ No

7. En los últimos 2 meses en que recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia un especialista en terapia física, terapia de trabajo o terapia del habla?

☐ Sí

☐ No

8. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia un asistente de salud en el hogar o un asistente de cuidados personales?

☐ Sí

☐ No

9. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia los proveedores del cuidado de la salud de esta agencia parecían estar informados y al día acerca de todo el cuidado o tratamiento que recibió en el hogar?

☐ Nunca

☐ A veces

☐ La mayoría de las veces

☐ Siempre

☐ En los últimos dos meses en que recibí cuidado de la salud en el hogar solamente me atendió un proveedor

- |  |  |
|--|--|
| <p><b>10.</b> En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿habló con alguna de las personas de esta agencia acerca del dolor que usted sentía?</p> <p><input type="radio"/> Sí</p> <p><input type="radio"/> No</p>  | <p><b>13.</b> En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿alguno de los proveedores del cuidado de la salud de esta agencia habló con usted acerca de <b>cuándo</b> debía tomar esos medicamentos?</p> <p><input type="radio"/> Sí</p> <p><input type="radio"/> No</p> <p><input type="radio"/> <b>No</b> tomé ningún medicamento nuevo de receta médica ni cambié de medicamento</p>  |
| <p><b>11.</b> En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿tomó algún nuevo medicamento recetado o hizo un cambio respecto a alguno de los medicamentos que estaba tomando?</p> <p><input type="radio"/> Sí</p> <p><input type="radio"/> No ➔ <b>Si respondió No, vaya a la pregunta 15.</b></p>  | <p><b>14.</b> En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿conversaron con usted los proveedores del cuidado de la salud de esta agencia sobre los <b>efectos secundarios</b> de estos medicamentos?</p> <p><input type="radio"/> Sí</p> <p><input type="radio"/> No</p> <p><input type="radio"/> <b>No</b> tomé ningún medicamento nuevo de receta médica ni cambié de medicamento</p> |
| <p><b>12.</b> En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿alguno de los proveedores del cuidado de la salud de esta agencia habló con usted acerca de la <b>razón</b> por la cual usted debía tomar el nuevo medicamento que le recetó el médico o la razón por la cual usted debía hacer algún cambio con respecto a algún medicamento que estaba tomando?</p> <p><input type="radio"/> Sí</p> <p><input type="radio"/> No</p> <p><input type="radio"/> <b>No</b> tomé ningún medicamento nuevo de receta médica ni cambié de medicamento</p> | <p><b>15.</b> En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la mantuvieron informado(a) los proveedores del cuidado de la salud de esta agencia sobre cuándo llegarían a su hogar?</p> <p><input type="radio"/> Nunca</p> <p><input type="radio"/> A veces</p> <p><input type="radio"/> La mayoría de las veces</p> <p><input type="radio"/> Siempre</p>           |

16. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la trataron los proveedores del cuidado de la salud de esta agencia lo más gentilmente posible?

- ☐ Nunca
- ☐ A veces
- ☐ La mayoría de las veces
- ☐ Siempre

17. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia le explicaron los proveedores del cuidado de la salud de esta agencia las cosas de una manera que era fácil de entender?

- ☐ Nunca
- ☐ A veces
- ☐ La mayoría de las veces
- ☐ Siempre

18. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia los proveedores del cuidado de la salud de esta agencia lo/la escucharon con atención?

- ☐ Nunca
- ☐ A veces
- ☐ La mayoría de las veces
- ☐ Siempre

19. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia le trataron los proveedores del cuidado de la salud de esta agencia con cortesía y respeto?

- ☐ Nunca
- ☐ A veces
- ☐ La mayoría de las veces
- ☐ Siempre

20. Queremos saber cómo calificaría usted la calidad de la atención que le brindaron los proveedores del cuidado de la salud de esta agencia.

Usando un número de 0 a 10, donde 0 es el peor cuidado de la salud en el hogar posible y 10 es el mejor cuidado de la salud en el hogar posible, ¿qué número usaría para calificar el cuidado de los proveedores del cuidado de la salud en el hogar de esta agencia?

- ☐ 0 El peor cuidado de la salud en el hogar posible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 El mejor cuidado de la salud en el hogar posible

## La agencia que le brindó cuidado de la salud en el hogar

Las siguientes preguntas son sobre la oficina de [AGENCY NAME].

21. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿se comunicó con la **oficina** de esta agencia para recibir orientación o ayuda?

☐ Sí  
☐ No → **Si respondió No, vaya a la pregunta 24.**

22. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, cuando usted se comunicó con la oficina de esta agencia ¿recibió la orientación o ayuda que necesitaba?

☐ Sí  
☐ No → **Si respondió No, vaya a la pregunta 24.**  
☐ **No** me comuniqué con esta agencia

23. Cuando se comunicó con la oficina de esta agencia, ¿cuánto tiempo necesitó para obtener la orientación o ayuda que necesitaba?

☐ Lo/la atendieron ese mismo día  
☐ De 1 a 5 días  
☐ De 6 a 14 días  
☐ Más de 14 días  
☐ **No** me comuniqué con esta agencia

24. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿tuvo algún problema con los servicios que recibió de esta agencia?

☐ Sí  
☐ No

25. ¿Recomendaría esta agencia a sus familiares o a sus amistades si ellos necesitaran cuidado de la salud en el hogar?

☐ Definitivamente no  
☐ Probablemente no  
☐ Probablemente sí  
☐ Definitivamente sí

## Acerca de usted

26. En general, ¿cómo calificaría toda su salud?

☐ Excelente  
☐ Muy buena  
☐ Buena  
☐ Regular  
☐ Mala

27. En general, ¿cómo calificaría su salud mental o emocional?

☐ Excelente  
☐ Muy buena  
☐ Buena  
☐ Regular  
☐ Mala

- |  |  |
|--|--|
| <p><b>28.</b> ¿Vive usted solo(a)?</p> <ul style="list-style-type: none"><li><input type="radio"/> Sí</li><li><input type="radio"/> No</li></ul> <p><b>29.</b> ¿Cuál es el grado o nivel escolar más alto que ha completado?</p> <ul style="list-style-type: none"><li><input type="radio"/> 8 años de escuela o menos</li><li><input type="radio"/> 9 a 12 años de escuela, pero sin graduarse</li><li><input type="radio"/> Graduado de high school (escuela secundaria), diploma de GED (escuela secundaria, preparatoria o su equivalente)</li><li><input type="radio"/> Algunos cursos universitarios o un título universitario de un programa de 2 años</li><li><input type="radio"/> Título universitario de 4 años</li><li><input type="radio"/> Título universitario de más de 4 años</li></ul> <p><b>30.</b> ¿Es usted hispano(a) o latino(a)?</p> <ul style="list-style-type: none"><li><input type="radio"/> Sí</li><li><input type="radio"/> No</li></ul> | <p><b>31.</b> ¿A qué raza pertenece? Por favor seleccione una o más.</p> <ul style="list-style-type: none"><li><input type="radio"/> Indígena Americana o Nativa de Alaska</li><li><input type="radio"/> Asiática</li><li><input type="radio"/> Negra o Afro Americana</li><li><input type="radio"/> Nativa de Hawai o de otras Islas del Pacífico</li><li><input type="radio"/> Blanca</li></ul> <p><b>32.</b> ¿Principalmente qué idioma habla en el hogar?</p> <ul style="list-style-type: none"><li><input type="radio"/> Inglés</li><li><input type="radio"/> Español</li><li><input type="radio"/> Algún otro idioma:</li></ul> <p style="text-align: center;"><hr/><i>(Por favor escriba en letra de imprenta.)</i></p> <p><b>33.</b> ¿Alguien le ayudó a completar esta encuesta?</p> <ul style="list-style-type: none"><li><input type="radio"/> Sí</li><li><input type="radio"/> No ➔ <b>Si respondió que No, por favor, devuelva la encuesta completada en el sobre con timbre postal pre-pagado.</b></li></ul> |
|--|--|

34. ¿En qué manera le ayudó esa persona?  
Seleccione todo lo que corresponda.

- ☐ Me leyó las preguntas
- ☐ Anotó mis respuestas
- ☐ Respondió las preguntas por mí
- ☐ Tradujo las preguntas a mi idioma
- ☐ Me ayudó de alguna otra manera:

---

*(Por favor escriba en letra de  
imprenta.)*

- ☐ Nadie me ayudó a completar esta encuesta

**¡Muchas gracias!**

**Por favor, devuelva la encuesta  
completada en el sobre con timbre  
postal pre-pagado.**



**TELEPHONE INTERVIEW SCRIPT FOR THE  
HOME HEALTH CARE CAHPS SURVEY IN SPANISH**

INTRO1 (Buenos días/Buenas tardes/Buenas noches), ¿podría hablar con [SAMPLE MEMBER'S NAME]?

- 1 YES → [GO TO INTRO2]
- 2 NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
- 3 NO [REFUSAL] → [GO TO TERMINATE SCREEN]
- 4 MENTALLY/PHYSICALLY INCAPABLE → [GO TO PROXY SCRIPT]

M MISSING/DK

IF ASKED WHO IS CALLING:

Mi nombre es [INTERVIEWER NAME] y llamo de [ORGANIZATION].  
Quisiera hablar con [SAMPLE MEMBER'S NAME] acerca de un estudio  
sobre el cuidado de la salud.

IF PERSON ON PHONE VOLUNTEERS THEY ARE SAMPLE MEMBER'S  
PARTNER, CHILD, PARENT, SIBLING, GRANDCHILD, OR POWER OF  
ATTORNEY AND THEY ASK WHY WE ARE CALLING:

Quisiera hablar con [SAMPLE MEMBER'S NAME] sobre sus experiencias con  
el cuidado de la salud en el hogar que recibió de [HOME HEALTH AGENCY].

INTRO2 (Buenos días/Buenas tardes/Buenas noches) mi nombre es [INTERVIEWER NAME] y llamo de parte de [HOME HEALTH AGENCY]. La agencia está participando en una encuesta nacional para evaluar la calidad de los servicios que reciben las personas por parte de las agencias dedicadas al cuidado de las personas en el hogar. Los resultados ayudarán a otras personas que tienen que elegir una agencia que les brinde cuidado de la salud en el hogar.

Su participación en esta encuesta es voluntaria. El completar la entrevista tomará alrededor de 12 minutos y es posible que esta llamada sea supervisada o grabada con fines de control de calidad.

**NOTE: THE LENGTH OF THE INTERVIEW WILL DEPEND ON WHETHER THE  
HHA ADDS SUPPLEMENTAL QUESTIONS TO ITS HOME HEALTH CARE CAHPS  
SURVEY.**

- INTRO3      INTRO3 AND INTRO4 USED ONLY IF CALLING SAMPLE MEMBER  
BACK TO COMPLETE A SURVEY THAT WAS BEGUN IN A PREVIOUS  
CALL. NOTE THAT THE SAMPLE MEMBER MUST HAVE ANSWERED  
AT LEAST ONE QUESTION IN THE SURVEY IN A PRECEDING CALL.
- (Buenos días/Buenas tardes), ¿puedo hablar con [SAMPLE MEMBER'S  
NAME]?
- IF ASKED WHO IS CALLING:  
Mi nombre es [INTERVIEWER NAME] y estoy llamando de [VENDOR]. Me  
gustaría hablar con [SAMPLE MEMBER'S NAME] acerca de un estudio sobre la  
atención médica.
- 1   YES, SAMPLE MEMBER IS AVAILABLE AND ON PHONE NOW →  
[GO TO INTRO4]
  - 2   NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
  - 3   NO [REFUSAL] → [GO TO Q\_REF SCREEN]
  - 4   MENTALLY/PHYSICALLY INCAPABLE → [GO TO PROXY SCRIPT]
- INTRO4      (Buenos días/Buenas tardes), le llamo para continuar la encuesta que comenzamos  
en una llamada anterior, acerca de la atención que usted recibió de [HOME  
HEALTH AGENCY]. Me gustaría continuar la entrevista ahora.
- 1   CONTINUE WITH INTERVIEW AT FIRST UNANSWERED QUESTION
  - 2   NO, NOT RIGHT NOW → [SET CALLBACK]
  - 3   NO [REFUSAL] → [GO TO Q\_REF SCREEN]
- Q1.          Según nuestro registro, usted recibió servicios por parte de [HOME HEALTH  
AGENCY], una agencia que brinda cuidado de la salud en el hogar. ¿Es eso  
correcto?
- 1   SÍ → [GO TO Q2\_INTRO]
  - 2   NO → [GO TO Q\_INELIG]
- M   MISSING/DK → [GO TO Q\_INELIG]

- Q2\_INTRO Al responder las preguntas de esta encuesta, piense solamente acerca de sus experiencias con esta agencia.
- Q2. Cuando recién empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia le dijo qué tipo de atención y de servicios le darían?
- 1 SÍ
  - 2 NO
  - 3 NO RECUERDA
- M MISSING/DK
- Q3. Cuando recién empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia **le habló** sobre cómo debía colocar las cosas en el hogar para poder moverse con mayor seguridad?
- 1 SÍ
  - 2 NO
  - 3 NO RECUERDA
- M MISSING/DK
- Q4. Cuando empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia habló con usted acerca de todos los **medicamentos** que usted estaba tomando ya sean **los recetados por un médico o los que se compran sin receta**?
- 1 SÍ
  - 2 NO
  - 3 NO RECUERDA
- M MISSING/DK
- Q5. Cuando empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de la agencia le pidió **ver** todos los medicamentos que usted estaba tomando ya sean los recetados por un médico o los que se compran sin receta?
- 1 SÍ
  - 2 NO
  - 3 NO RECUERDA
- M MISSING/DK

- Q6\_INTRO Las siguientes preguntas son sobre todo el personal de la agencia [HOME HEALTH AGENCY] que lo/la atendieron en los últimos 2 meses. No incluya la atención que recibió del personal de otra agencia de cuidado de la salud en el hogar. No incluya los cuidados que usted recibió de familiares o amigos.
- Q6. En los últimos 2 meses en que recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia una enfermera o un enfermero?
- 1 SÍ
  - 2 NO
- M MISSING/DK
- Q7. En los últimos 2 meses en que recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia un especialista en terapia física, terapia de trabajo o terapia del habla?
- 1 SÍ
  - 2 NO
- M MISSING/DK
- Q8. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia un asistente de salud en el hogar o un asistente de cuidados personales?
- 1 SÍ
  - 2 NO
- M MISSING/DK
- Q9. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia los proveedores del cuidado de la salud de esta agencia parecían estar informados y estar al día acerca de todo el cuidado o tratamiento que usted recibía en el hogar? ¿Diría usted que...
- 1 Nunca,
  - 2 A veces,
  - 3 La mayoría de las veces,
  - 4 Siempre, o
  - 5 En los últimos dos meses en que usted recibió cuidado de la salud en el hogar, solamente lo/la atendió un proveedor?
- M MISSING/DK

- Q10. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿habló con alguna de las personas de esta agencia acerca del dolor que usted sentía?
- 1 SÍ  
2 NO
- M MISSING/DK
- Q11. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿tomó algún nuevo medicamento recetado o hizo un cambio respecto a alguno de los medicamentos que estaba tomando?
- 1 SÍ  
2 NO → [GO TO Q15]
- M MISSING/DK → [GO TO Q15]
- Q12. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿alguno de los proveedores del cuidado de la salud de esta agencia habló con usted acerca de la **razón** por la cual usted debía tomar el nuevo medicamento que le recetó el médico o la razón por la cual usted debía hacer algún cambio con respecto a algún medicamento que estaba tomando?
- 1 SÍ  
2 NO
- M MISSING/DK
- Q13. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿alguno de los proveedores del cuidado de la salud de esta agencia habló con usted acerca de **cuándo** debía tomar esos medicamentos?
- 1 SÍ  
2 NO
- M MISSING/DK

- Q14. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿conversaron con usted los proveedores del cuidado de la salud de esta agencia sobre los **efectos secundarios** de estos medicamentos?
- 1 SÍ
  - 2 NO
- M MISSING/DK
- Q15. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la mantuvieron informado(a) los proveedores del cuidado de la salud de esta agencia sobre cuándo llegarían a su hogar? ¿Diría usted que...
- 1 Nunca,
  - 2 A veces,
  - 3 La mayoría de las veces, o
  - 4 Siempre?
- M MISSING/DK
- Q16. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la trataron los proveedores del cuidado de la salud de esta agencia lo más gentilmente posible? ¿Diría usted que...
- 1 Nunca,
  - 2 A veces,
  - 3 La mayoría de las veces, o
  - 4 Siempre?
- M MISSING/DK
- Q17. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia le explicaron los proveedores del cuidado de la salud de esta agencia las cosas de una manera que era fácil de entender? ¿Diría usted que...
- 1 Nunca,
  - 2 A veces,
  - 3 La mayoría de las veces, o
  - 4 Siempre?
- M MISSING/DK

Q18. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia los proveedores del cuidado de la salud de esta agencia lo/la escucharon con atención? ¿Diría usted que...

- 1 Nunca,
- 2 A veces,
- 3 La mayoría de las veces, o
- 4 Siempre?

M MISSING/DK

Q19. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿con qué frecuencia le trataron los proveedores del cuidado de la salud de esta agencia con cortesía y respeto? ¿Diría usted que...

- 1 Nunca,
- 2 A veces,
- 3 La mayoría de las veces, o
- 4 Siempre?

M MISSING/DK

Q20\_INTRO Queremos saber cómo calificaría usted la calidad de la atención que le brindaron los proveedores del cuidado de la salud de esta agencia.

Q20. Usando un número de 0 a 10, donde 0 es el peor cuidado de la salud en el hogar posible y 10 es el mejor cuidado de la salud en el hogar posible, ¿qué número usaría para calificar el cuidado de los proveedores del cuidado de la salud en el hogar de esta agencia?

READ RESPONSE CHOICES ONLY IF NECESSARY

00 0 El peor cuidado de la salud en el hogar posible

01 1

02 2

03 3

04 4

05 5

06 6

07 7

08 8

09 9

10 10 El mejor cuidado de la salud en el hogar posible

M MISSING/DK

Q21\_INTRO Las siguientes preguntas son sobre la oficina de [HOME HEALTH AGENCY].

Q21. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿se comunicó con la **oficina** de esta agencia para recibir orientación o ayuda?

1 SÍ

2 NO → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q22. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, cuando usted se comunicó con la oficina de esta agencia ¿recibió la orientación o ayuda que necesitaba?

1 SÍ

2 NO → [GO TO Q24]

M MISSING/DK → [GO TO Q24]



- Q23. Cuando se comunicó con la oficina de esta agencia, ¿cuánto tiempo necesitó para obtener la orientación o ayuda que necesitaba? ¿Diría usted que...
- 1 El mismo día,
  - 2 De 1 a 5 días,
  - 3 De 6 a 14 días, o
  - 4 Más de 14 días?
- M MISSING/DK
- Q24. En los últimos 2 meses en que usted recibió cuidado de la salud en el hogar, ¿tuvo algún problema con los servicios que recibió de esta agencia?
- 1 SÍ
  - 2 NO
- M MISSING/DK
- Q25. ¿Recomendaría esta agencia a sus familiares o a sus amistades si ellos necesitaran cuidado de la salud en el hogar? ¿Diría usted que...
- 1 Definitivamente no,
  - 2 Probablemente no,
  - 3 Probablemente sí, o
  - 4 Definitivamente sí?
- M MISSING/DK
- Q26\_INTRO Esta última serie de preguntas se refiere a información sobre usted. Por favor escuche todas las opciones de respuesta antes de seleccionar su respuesta.
- Q26. En general, ¿cómo calificaría toda su salud? ¿Diría usted que es...
- 1 Excelente,
  - 2 Muy buena,
  - 3 Buena,
  - 4 Regular, o
  - 5 Mala?
- M MISSING/DK

- Q27. En general, ¿cómo calificaría su salud mental o emocional? ¿Diría usted que es...
- 1 Excelente,
  - 2 Muy buena,
  - 3 Buena,
  - 4 Regular, o
  - 5 Mala?
- M MISSING/DK
- Q28. ¿Vive usted solo(a)?
- 1 SÍ
  - 2 NO
- M MISSING/DK
- Q29. ¿Cuál es el grado o nivel escolar más alto que ha completado? ¿Diría usted que...
- 1 8 años de escuela o menos,
  - 2 9 a 12 años de escuela, pero sin graduarse,
  - 3 Graduado de “high school” (escuela secundaria), diploma de GED (escuela secundaria, preparatoria o su equivalente),
  - 4 Algunos cursos universitarios o un título universitario de un programa de 2 años,
  - 5 Título universitario de 4 años, o
  - 6 Título universitario de más de 4 años?
- M MISSING/DK
- Q30. ¿Es usted hispano(a) o latino(a)?
- 1 SÍ
  - 2 NO
- M MISSING/DK

Q31. ¿A qué raza pertenece? Puede elegir una o más de las siguientes categorías. ¿Es usted de raza...

- 1 Indígena Americana o Nativa de Alaska,
- 2 Asiática,
- 3 Negra o Afro Americana,
- 4 Nativa de Hawai o de otras Islas del Pacífico, o
- 5 Blanca?

M MISSING/DK

Q32. ¿Principalmente qué idioma habla en el hogar? ¿Diría usted que...

- 1 Inglés, → [GO TO Q\_END]
- 2 Español, o → [GO TO Q\_END]
- 3 Algún otro idioma? → [GO TO 32A]

M MISSING/DK → [GO TO Q\_END]

Q32A ¿Qué otro idioma habla usted por lo general en el hogar? (ENTER RESPONSE BELOW).

{ALLOW UP TO 50 CHARACTERS}

M MISSING/DK

Q\_END Esas son todas las preguntas que tengo para usted. Muchas gracias por su tiempo. Que tenga muy buenos(as) (días/tardes/noches).

INELIGIBLE SCREEN:

Q\_INELIG Muchas gracias por su tiempo. Que tenga muy buenos(as) (días/tardes/noches).

REFUSAL SCREEN:

Q\_REF Muchas gracias por su tiempo. Que tenga muy buenos(as) (días/tardes/noches).

## PROXY TELEPHONE INTERVIEW SCRIPT FOR THE HOME HEALTH CARE CAHPS SURVEY IN SPANISH

PROXY ID ¿Hay alguien, tal como un familiar o una amistad, que esté familiarizado con las experiencias del cuidado de la salud de [SAMPLE MEMBER'S NAME]?

PROBE TO FIND OUT IF PERSON IS AVAILABLE IN HOUSEHOLD TO DO INTERVIEW.

- 1 SÍ → [GO TO PROXY\_INTRO]
- 2 NO → [COLLECT NAME AND TELEPHONE NUMBER OF PROXY AND SET A CALLBACK, OR IF NO PROXY EXISTS, GO TO Q\_END AND CODE AS MENTALLY/PHYSICALLY INCAPABLE]

IF ASKED WHO IS CALLING:

Mi nombre es [INTERVIEWER NAME] y llamo de [ORGANIZATION.]  
Quisiera hablar con alguna persona que esté familiarizada con la salud y experiencias de cuidado de la salud de [SAMPLE MEMBER NAME], para un estudio de [ORGANIZATION] sobre el cuidado de la salud.

PROXY\_INTRO [(Buenos días/Buenas tardes/Buenas noches) mi nombre es {INTERVIEWER NAME} y llamo de parte de {HOME HEALTH AGENCY}]. La agencia está participando en una encuesta nacional para evaluar la calidad de los servicios que reciben las personas por parte de las agencias dedicadas al cuidado de las personas en el hogar. Los resultados ayudarán a otras personas que tienen que elegir una agencia que les brinde cuidado de la salud en el hogar.

La participación de [SAMPLE MEMBER NAME] en esta encuesta es voluntaria. El completar la entrevista tomará alrededor de 12 minutos y es posible que esta llamada sea supervisada o grabada con fines de control de calidad.

**NOTE: THE LENGTH OF THE INTERVIEW WILL DEPEND ON WHETHER THE HHA ADDS SUPPLEMENTAL QUESTIONS TO ITS HOME HEALTH CARE CAHPS SURVEY.**

INTRO3 INTRO3 AND INTRO4 USED ONLY IF CALLING PROXY BACK TO COMPLETE A SURVEY THAT WAS BEGUN IN A PREVIOUS CALL. NOTE THAT THE PROXY MUST HAVE ANSWERED AT LEAST ONE QUESTION IN THE SURVEY IN A PRECEDING CALL.

(Buenos días/Buenas tardes), ¿puedo hablar con [PROXY NAME]?

IF ASKED WHO IS CALLING:

Mi nombre es [INTERVIEWER NAME] y estoy llamando de [VENDOR]. Me gustaría hablar con [PROXY NAME] acerca de un estudio sobre la atención médica.

- 1 YES, PROXY IS AVAILABLE AND ON PHONE NOW → [GO TO INTRO4]
- 2 NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
- 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]

INTRO4 (Buenos días/Buenas tardes), le llamo para continuar la encuesta que comenzamos en una llamada anterior, acerca de la atención que [SAMPLE MEMBER NAME] recibió de [HOME HEALTH AGENCY]. Me gustaría continuar la entrevista ahora.

- 1 CONTINUE WITH INTERVIEW AT FIRST UNANSWERED QUESTION
- 2 NO, NOT RIGHT NOW → [SET CALLBACK]
- 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]

Q1. Según nuestro registro, [SAMPLE MEMBER NAME] recibió servicios por parte de [HOME HEALTH AGENCY], una agencia que brinda cuidado de la salud en el hogar. ¿Es eso correcto?

- 1 SÍ → [GO TO Q2\_INTRO]
- 2 NO → [GO TO Q\_INELIG]

M MISSING/DK → [GO TO Q\_INELIG]

Q2\_INTRO Al responder las preguntas de esta encuesta, piense solamente acerca de las experiencias de [SAMPLE MEMBER NAME] con esta agencia. Por favor trate de responder las preguntas lo mejor que pueda desde el punto de vista de [SAMPLE MEMBER NAME]. Si es necesario, puede responder las preguntas desde el punto de vista de un miembro de la familia o de la persona que ayuda al cuidado de [SAMPLE MEMBER NAME].

Q2. Cuando [SAMPLE MEMBER NAME] recién empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia le dijo a [él/ella] qué tipo de atención y de servicios le darían?

- 1 SÍ
- 2 NO
- 3 NO RECUERDA

M MISSING/DK

Q3. Cuando [SAMPLE MEMBER NAME] recién empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia **habló con [él/ella]** sobre cómo debía colocar las cosas en el hogar para poder moverse con mayor seguridad?

- 1 SÍ
- 2 NO
- 3 NO RECUERDA

M MISSING/DK

Q4. Cuando [SAMPLE MEMBER NAME] empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de esta agencia habló con [él/ella] acerca de todos los **medicamentos** que [él/ella] estaba tomando ya sean **los recetados por un médico o los que se compran sin receta**?

- 1 SÍ
- 2 NO
- 3 NO RECUERDA

M MISSING/DK

Q5. Cuando [SAMPLE MEMBER NAME] empezó a recibir cuidado de la salud en el hogar por parte de esta agencia, ¿alguna persona de la agencia le pidió **ver** todos los medicamentos que [él/ella] estaba tomando ya sean los recetados por un médico o los que se compran sin receta?

- 1 SÍ
- 2 NO
- 3 NO RECUERDA

M MISSING/DK

- Q6\_INTRO Las siguientes preguntas son sobre todo el personal de la agencia [HOME HEALTH AGENCY] que atendió a [SAMPLE MEMBER NAME] en los últimos 2 meses. No incluya la atención que [SAMPLE MEMBER NAME] recibió del personal de otra agencia de cuidado de la salud en el hogar. No incluya los cuidados que [él/ella] recibió de familiares o amigos.
- Q6. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia una enfermera o un enfermero?
- 1 SÍ
- 2 NO
- M MISSING/DK
- Q7. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia un especialista en terapia física, terapia de trabajo o terapia del habla?
- 1 SÍ
- 2 NO
- M MISSING/DK
- Q8. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿fue uno de los proveedores del cuidado de la salud de esta agencia un asistente de salud en el hogar o un asistente de cuidados personales?
- 1 SÍ
- 2 NO
- M MISSING/DK

Q9. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿con qué frecuencia los proveedores del cuidado de la salud de esta agencia parecían estar informados y estar al día acerca de todo el cuidado o tratamiento que [él/ella] recibía en el hogar? ¿Diría usted que...

- 1 Nunca,
- 2 A veces,
- 3 La mayoría de las veces,
- 4 Siempre, o
- 5 En los últimos dos meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, solamente lo/la atendió un proveedor?

M MISSING/DK

Q10. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿habló [él/ella] con alguna de las personas de esta agencia acerca del dolor que sentía?

- 1 SÍ
- 2 NO

M MISSING/DK

Q11. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿tomó [él/ella] algún nuevo medicamento recetado o hizo un cambio respecto a alguno de los medicamentos que estaba tomando?

- 1 SÍ
- 2 NO → [GO TO Q15]

M MISSING/DK → [GO TO Q15]

Q12. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿alguno de los proveedores del cuidado de la salud de esta agencia habló con [él/ella] acerca de la **razón** por la cual [él/ella] debía tomar el nuevo medicamento que le recetó el médico o la razón por la cual [él/ella] debía hacer algún cambio con respecto a algún medicamento que estaba tomando?

- 1 SÍ
- 2 NO

M MISSING/DK



Q13. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿alguno de los proveedores del cuidado de la salud de esta agencia habló con [él/ella] acerca de **cuándo** debía tomar esos medicamentos?

- 1 SÍ
- 2 NO

M MISSING/DK

Q14. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿conversaron con [él/ella] los proveedores del cuidado de la salud de esta agencia sobre los **efectos secundarios** de estos medicamentos?

- 1 SÍ
- 2 NO

M MISSING/DK

Q15. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la mantuvieron informado(a) los proveedores del cuidado de la salud de esta agencia sobre cuándo llegarían a su hogar? ¿Diría usted que...

- 1 Nunca,
- 2 A veces,
- 3 La mayoría de las veces, o
- 4 Siempre?

M MISSING/DK

Q16. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la trataron los proveedores del cuidado de la salud de esta agencia lo más gentilmente posible? ¿Diría usted que...

- 1 Nunca,
- 2 A veces,
- 3 La mayoría de las veces, o
- 4 Siempre?

M MISSING/DK

Q17. En los últimos 2 meses en que recibió cuidado de la salud en el hogar, ¿con qué frecuencia le explicaron los proveedores del cuidado de la salud de esta agencia las cosas de una manera que era fácil de entender? ¿Diría usted que...

- 1 Nunca,
- 2 A veces,
- 3 La mayoría de las veces, o
- 4 Siempre?

M MISSING/DK

Q18. En los últimos 2 meses en que recibió cuidado de la salud en el hogar, ¿con qué frecuencia los proveedores del cuidado de la salud de esta agencia lo/la escucharon a [él/ella] con atención? ¿Diría usted que...

- 1 Nunca,
- 2 A veces,
- 3 La mayoría de las veces, o
- 4 Siempre?

M MISSING/DK

Q19. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿con qué frecuencia lo/la trataron los proveedores del cuidado de la salud de esta agencia con cortesía y respeto? ¿Diría usted que...

- 1 Nunca,
- 2 A veces,
- 3 La mayoría de las veces, o
- 4 Siempre?

M MISSING/DK

Q20\_INTRO Queremos saber cómo calificaría [SAMPLE MEMBER NAME] la calidad de la atención que le brindaron los proveedores del cuidado de la salud de esta agencia. Por favor trate de responder las preguntas lo mejor que pueda desde el punto de vista de [SAMPLE MEMBER NAME]. Si es necesario, puede responder las preguntas desde el punto de vista de un miembro de la familia o de la persona que ayuda al cuidado de [SAMPLE MEMBER NAME].

Q20. Usando un número de 0 a 10, donde 0 es el peor cuidado de la salud en el hogar posible y 10 es el mejor cuidado de la salud en el hogar posible, ¿qué número usaría [SAMPLE MEMBER NAME] para calificar el cuidado de los proveedores del cuidado de la salud en el hogar de esta agencia?

READ RESPONSE CHOICES ONLY IF NECESSARY

00 0 El peor cuidado de la salud en el hogar posible

01 1

02 2

03 3

04 4

05 5

06 6

07 7

08 8

09 9

10 10 El mejor cuidado de la salud en el hogar posible

M MISSING/DK

Q21\_INTRO Las siguientes preguntas son sobre la oficina de [HOME HEALTH AGENCY].

Q21. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿se comunicó [él/ella] con la **oficina** de esta agencia para recibir orientación o ayuda?

1 SÍ

2 NO → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q22. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, cuando [él/ella] se comunicó con la oficina de esta agencia ¿recibió [él/ella] la orientación o ayuda que necesitaba?

- 1 SÍ
- 2 NO → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q23. Cuando [SAMPLE MEMBER NAME] se comunicó con la oficina de esta agencia, ¿cuánto tiempo necesitó para obtener la orientación o ayuda que [él/ella] necesitaba? ¿Diría usted que...

- 1 El mismo día,
- 2 De 1 a 5 días,
- 3 De 6 a 14 días, o
- 4 Más de 14 días?

M MISSING/DK

Q24. En los últimos 2 meses en que [SAMPLE MEMBER NAME] recibió cuidado de la salud en el hogar, ¿tuvo [él/ella] algún problema con los servicios que recibió de esta agencia?

- 1 SÍ
- 2 NO

M MISSING/DK

Q25. ¿Recomendaría [SAMPLE MEMBER NAME] esta agencia a sus familiares o a sus amistades si ellos necesitaran cuidado de la salud en el hogar? ¿Diría usted que...

- 1 Definitivamente no,
- 2 Probablemente no,
- 3 Probablemente sí, o
- 4 Definitivamente sí?

M MISSING/DK

Q26\_INTRO Esta última serie de preguntas se refiere a información sobre [SAMPLE MEMBER NAME]. Por favor escuche todas las opciones de respuesta antes de seleccionar su respuesta.

Q26. En general, ¿cómo calificaría [SAMPLE MEMBER NAME] toda su salud?  
¿Diría usted que es...

- 1 Excelente,
- 2 Muy buena,
- 3 Buena,
- 4 Regular, o
- 5 Mala?

M MISSING/DK

Q27. En general, ¿cómo calificaría [SAMPLE MEMBER NAME] su salud mental o emocional? ¿Diría usted que es...

- 1 Excelente,
- 2 Muy buena,
- 3 Buena,
- 4 Regular, o
- 5 Mala?

M MISSING/DK

Q28. ¿Vive [SAMPLE MEMBER NAME] solo(a)?

- 1 SÍ
- 2 NO

M MISSING/DK

- Q29. ¿Cuál es el grado o nivel escolar más alto que ha completado [SAMPLE MEMBER NAME]? ¿Diría usted que...
- 1 8 años de escuela o menos,
  - 2 9 a 12 años de escuela, pero sin graduarse,
  - 3 Graduado de “high school” (escuela secundaria), diploma de GED (escuela secundaria, preparatoria o su equivalente),
  - 4 Algunos cursos universitarios o un título universitario de un programa de 2 años,
  - 5 Título universitario de 4 años, o
  - 6 Título universitario de más de 4 años?
- M MISSING/DK
- Q30. ¿Es [SAMPLE MEMBER NAME] hispano(a) o latino(a)?
- 1 SÍ
  - 2 NO
- M MISSING/DK
- Q31. ¿A qué raza pertenece [SAMPLE MEMBER NAME]? Puede elegir una o más de las siguientes categorías. ¿Es [él/ella] de raza...
- 1 Indígena Americana o Nativa de Alaska,
  - 2 Asiática,
  - 3 Negra o Afro Americana,
  - 4 Nativa de Hawai o de otras Islas del Pacífico, o
  - 5 Blanca?
- M MISSING/DK
- Q32. ¿Principalmente qué idioma habla [SAMPLE MEMBER NAME] en el hogar? ¿Diría usted que...
- 1 Inglés, ➔ [GO TO Q\_END]
  - 2 Español, o ➔ [GO TO Q\_END]
  - 3 Algún otro idioma? ➔ [GO TO 32A]
- M MISSING/DK ➔ [GO TO Q\_END]

Q32A ¿Qué otro idioma habla [SAMPLE MEMBER NAME] por lo general en el hogar?  
(ENTER RESPONSE BELOW).

{ALLOW UP TO 50 CHARACTERS}

M MISSING/DK

Q\_END Esas son todas las preguntas que tengo para usted. Muchas gracias por su tiempo.  
Que tenga muy buenos(as) (días/tardes/noches).

INELIGIBLE SCREEN:

Q\_INELIG Muchas gracias por su tiempo. Que tenga muy buenos(as) (días/tardes/noches).

REFUSAL SCREEN:

Q\_REF Muchas gracias por su tiempo. Que tenga muy buenos(as) (días/tardes/noches).

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**APPENDIX E:**  
**CHINESE—SIMPLIFIED:**  
**MAIL SURVEY COVER LETTERS,**  
**REGULAR AND SCANNABLE QUESTIONNAIRES**

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## Sample Cover Letter for First Questionnaire Mailing in Chinese Simplified

Home Health Care CAHPS Survey

To be Printed on Home Health Agency or Vendor Letterhead

---

«LastName» «FirstName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

尊敬的 «LastName» «FirstName»:

这是 Medicare 针对接受居家健康护理的人士开展的一项重要调查。请花一点时间分享您在 «HHA» 的体验，并使用随附的已付邮资信封寄回该调查表。您的反馈意见不仅有助于 Medicare 提高居家健康护理的整体质量，而且能帮助其他人选择居家健康机构。

**您的意见至关重要。**我们希望您的回答反映的是您自己的看法，而非上述机构中任何人的观点。如果您在完成调查时需要协助，请向家人或朋友寻求帮助。

参与调查完全出于自愿，您的信息将依法保密。任何人都无法将您的姓名与您的回答进行关联。

如果您对本调查有任何疑问，请致电 VENDOR NAME，  
免费电话：1-XXX-XXX-XXXX。

感谢您帮助改善居家健康护理服务。

此致

Name

居家健康机构管理员

我们关心您的居家健康  
护理体验。

[PRINT SAMPLE ID HERE]

**Sample Cover Letter**  
**for Second Questionnaire Mailing to Mail Survey Nonrespondents in Chinese Simplified**  
Home Health Care CAHPS Survey  
To be Printed on Home Health Agency or Vendor Letterhead

---

«LastName» «FirstName» «MailDate»  
«Address1» «Address2»  
«City\_Name», «State\_Code» «Zip\_Zip4»

尊敬的 «LastName» «FirstName»:

您最近收到了一份 Medicare 针对您在 «HHA» 的体验而进行的调查。如果您已将此调查表寄回，我谨在此深表感谢！您无需采取任何其他措施。

温馨提示，我们非常想了解您的体验。您的反馈意见不仅可以帮助其他人选择居家健康护理机构，而且还有助于 Medicare 提高居家健康护理的整体质量。

请花一点时间完成该调查并使用随附的已付邮资信封寄回。

**您的意见至关重要。**我们知道您的时间非常宝贵。参与调查完全出于自愿，您的信息将依法保密。任何人都无法将您的姓名与您的回答进行关联。

如对本调查有疑问，请致电 VENDOR NAME，  
免费电话：1-XXX-XXX-XXXX。

感谢您帮助改善居家健康护理服务。

此致

Name  
居家健康机构管理员

**我们关心您的护理体验。**

如果您在完成调查时需要协助，  
请向家人或朋友寻求帮助。

[PRINT SAMPLE ID HERE]

OMB #: 0938-1066  
將於2026年7月31日失效

# 居家健康护理 CAHPS® 调查问卷

## 2025

## 调查问卷说明

- 通过勾选答案左侧的方框，回答所有问题。
- 在本调查问卷中，有时会让您跳过某些问题。当出现这种情况时，你会看到一个箭头和一个说明，告诉您下一步回答什么问题，像这样：

☒ 是 → 如果是，转至第 1 页中的问题 1。

☐ 否

## 您的居家健康护理

1. 根据我们的记录，您曾从居家健康护理机构【机构名称】获得护理。是吗？

当您回答本调查问卷中的问题时，仅考虑您从该机构获得护理的经历。

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否 → 如果否，请停止作答，并用提供的信封将本调查问卷寄回给我们。

2. 当您第一次开始从该机构获得居家健康护理时，该机构是否有人告诉过您将向您提供什么护理和服务？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

<sup>3</sup> ☐ 不记得

3. 当您第一次开始从该机构获得居家健康护理时，该机构是否有人与您讨论如何布置您的家以便您能安全走动？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

<sup>3</sup> ☐ 不记得

4. 当您开始从该机构获得居家健康护理时，该机构是否有人与您讨论您在服用的所有处方和非处方药物？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

<sup>3</sup> ☐ 不记得

5. 当您开始从该机构获得居家健康护理时，该机构是否有人要求查看您在服用的所有处方和非处方药物？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

<sup>3</sup> ☐ 不记得

January 2025

**在过去 2 个月内您从居家健康  
护理提供者那里获得的护理**

接下来的这些问题是关于过去 2 个月内为您提供护理的 [机构名称] 的所有工作人员。不包括您从其它居家健康护理机构的工作人员处获得的护理。不包括您从家人或朋友处获得的护理。

6. 在过去 2 个月的护理期间，来自该机构的您的居家健康护理提供者之一是否为护士？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

7. 在过去 2 个月的护理期间，来自该机构的您的居家健康护理提供者之一是否为物理治疗师、职业治疗师或语言治疗师？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

8. 在过去 2 个月的护理期间，来自该机构的您的居家健康护理提供者之一是否为居家健康或个人护理助手？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

9. 在过去 2 个月的护理期间，对于您在家获得的所有护理或治疗，该机构的居家健康护理提供者多经常看起来知情并了解最新情况？

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是

<sup>5</sup> ☐ 在过去 2 个月的护理期间，我仅有一位提供者

10. 在过去 2 个月的护理期间，您和该机构的一位居家健康护理提供者是否讨论过有关疼痛的问题？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

11. 在过去 2 个月的护理期间，您是否服用任何新的处方药或改变您在服用的任何药物？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否 → 如果否，转至问题 15。

12. 在过去 2 个月的护理期间，该机构的居家健康护理提供者是否与您讨论过服用新的处方药或改变处方药的目的？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

<sup>3</sup> ☐ 我没有服用任何新的处方药物或改变任何药物

13. 在过去 2 个月的护理期间, 该机构的居家健康护理提供者是否与您讨论过**何时**服用这些药物?

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

<sup>3</sup> ☐ 我**没有**服用任何新的处方药物或改变任何药物

14. 在过去 2 个月的护理期间, 该机构的居家健康护理提供者是否与您讨论过这些药物的**副作用**?

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

<sup>3</sup> ☐ 我**没有**服用任何新的处方药物或改变任何药物

15. 在过去 2 个月的护理期间, 该机构的居家健康护理提供者多经常通知您他们何时到达您家?

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是

16. 在过去 2 个月的护理期间, 该机构的居家健康护理提供者多经常尽可能温和地对待您?

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是

17. 在过去 2 个月的护理期间, 该机构的居家健康护理提供者多经常以简易的方式向您解释事情?

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是

18. 在过去 2 个月的护理期间, 该机构的居家健康护理提供者多经常认真听您说话?

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是

19. 在过去 2 个月的护理期间, 该机构的居家健康护理提供者多经常以礼貌和尊重的态度对待您?

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是



January 2025

20. 我们想知道您对从该机构的居家健康护理提供者提供的护理的评价。

使用 0 至 10 之间的任何数字，其中 0 表示最差居家健康护理，10 表示最佳居家健康护理，哪个数字可用来评价您从该机构的居家健康护理提供者那里获得的护理？

- ☐ 0 最差居家健康护理
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 最佳居家健康护理

### 您的居家健康护理机构

接下来的问题是关于 [机构名称] 的办公室的。

21. 在过去 2 个月的护理期间，您是否联系过该机构的办公室，以寻求帮助或建议？

- <sup>1</sup> ☐ 是
- <sup>2</sup> ☐ 否 → 如果否，转至问题 24。

22. 在过去 2 个月的护理期间，当您联系该机构的办公室时，您是否获得了您所需要的帮助或建议？

- <sup>1</sup> ☐ 是
- <sup>2</sup> ☐ 否 → 如果否，转至问题 24。
- <sup>3</sup> ☐ 我没有联系该机构

23. 当您联系该机构的办公室时，您花费了多长时间才获得您所需要的帮助或建议？

- <sup>1</sup> ☐ 当天
- <sup>2</sup> ☐ 1 至 5 天
- <sup>3</sup> ☐ 6 至 14 天
- <sup>4</sup> ☐ 多于 14 天
- <sup>5</sup> ☐ 我没有联系该机构

24. 在过去 2 个月的护理期间，对于您从该机构获得的护理，您是否遇到过任何问题？

- <sup>1</sup> ☐ 是
- <sup>2</sup> ☐ 否

25. 如果您的家人或朋友需要居家健康护理，您是否会向他们推荐该机构？

- <sup>1</sup> ☐ 肯定不会
- <sup>2</sup> ☐ 可能不会
- <sup>3</sup> ☐ 可能会
- <sup>4</sup> ☐ 肯定会

关于您本人

26. 总体而言，您如何评价您的整体健康状况？

<sup>1</sup> ☐ 极好

<sup>2</sup> ☐ 很好

<sup>3</sup> ☐ 好

<sup>4</sup> ☐ 一般

<sup>5</sup> ☐ 差

27. 总体而言，您如何评价您的整体精神或情绪健康状况？

<sup>1</sup> ☐ 极好

<sup>2</sup> ☐ 很好

<sup>3</sup> ☐ 好

<sup>4</sup> ☐ 一般

<sup>5</sup> ☐ 差

28. 您是否独居？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

29. 您已完成的最高级别或水平的年级或院校是什么？

<sup>1</sup> ☐ 8 年级或更低

<sup>2</sup> ☐ 读过高中，但未毕业

<sup>3</sup> ☐ 高中毕业或 GED

<sup>4</sup> ☐ 读过大学或有 2 年制学位

<sup>5</sup> ☐ 4 年制大学毕业

<sup>6</sup> ☐ 4 年制大学毕业以上，超过 4 年的大学教育

30. 您是否为西班牙或拉丁美洲人？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

31. 您的种族是什么？请选择一项或多项。

<sup>1</sup> ☐ 美洲印第安人或阿拉斯加原住民

<sup>2</sup> ☐ 亚洲人

<sup>3</sup> ☐ 黑人或非裔美国人

<sup>4</sup> ☐ 夏威夷原住民或其他太平洋岛上居民

<sup>5</sup> ☐ 白人

January 2025

32. 您在家主要讲哪种语言？

<sup>1</sup> ☐ 英语

<sup>2</sup> ☐ 西班牙语

<sup>3</sup> ☐ 其它语言：

(请用正楷填写。)

33. 是否有人帮助您填写本调查问卷？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否 ➔ 如果否，请用邮资已付  
的信封将填妥的调查问  
卷寄回给我们。

34. 那人是如何帮助您的？勾选所有适用  
项。

<sup>1</sup> ☐ 为我读问题

<sup>2</sup> ☐ 写下我给出的答案

<sup>3</sup> ☐ 替我回答问题

<sup>4</sup> ☐ 将问题译成我的语言

<sup>5</sup> ☐ 以其它方式帮助：

(请用正楷填写。)

<sup>6</sup> ☐ 没人帮助我填写本调查问卷

谢谢！

请用邮资已付的信封将填妥的  
调查问卷寄回给我们。

OMB #: 0938-1066  
將於2026年7月31日失效

# 居家健康护理 CAHPS® 调查问卷

(ALTERNATIVE INSTRUCTIONS,  
SCANNABLE FORMS)

2025

January 2025

## 调查问卷说明

- 通过涂满答案左侧的圆圈，回答所有问题。
  - 在本调查问卷中，有时会让您跳过某些问题。当出现这种情况时，您会看到一个箭头和一个说明，告诉您下一步回答什么问题，像这样：
    - 是 ➔ 如果是，转至第 1 页中的问题 1。
- 否

## 您的居家健康护理

1. 根据我们的记录，您曾从居家健康护理机构 [机构名称] 获得护理。是吗？  
当您回答本调查问卷中的问题时，仅考虑您从该机构获得护理的经历。  
○ 是  
○ 否 ➔ 如果否，请停止作答，并用提供的信封将本调查问卷寄回给我们。
2. 当您第一次开始从该机构获得居家健康护理时，该机构是否有人告诉过您将向您提供什么护理和服务？  
○ 是  
○ 否  
○ 不记得

3. 当您第一次开始从该机构获得居家健康护理时，该机构是否有人与您讨论如何布置您的家以便您能安全走动？  
○ 是  
○ 否  
○ 不记得
4. 当您开始从该机构获得居家健康护理时，该机构是否有人与您讨论您在服用的所有处方和非处方药物？  
○ 是  
○ 否  
○ 不记得
5. 当您开始从该机构获得居家健康护理时，该机构是否有人要求查看您在服用的所有处方和非处方药物？  
○ 是  
○ 否  
○ 不记得

**在过去 2 个月内您从居家健康  
护理提供者那里获得的护理**

接下来的这些问题是关于过去 2 个月内为您提供护理的【机构名称】的所有工作人员。不包括您从其它居家健康护理机构的工作人员处获得的护理。不包括您从家人或朋友处获得的护理。

6. 在过去 2 个月的护理期间，来自该机构的您的居家健康护理提供者之一是否为护士？

☐ 是  
☐ 否

7. 在过去 2 个月的护理期间，来自该机构的您的居家健康护理提供者之一是否为物理治疗师、职业治疗师或语言治疗师？

☐ 是  
☐ 否

8. 在过去 2 个月的护理期间，来自该机构的您的居家健康护理提供者之一是否为居家健康或个人护理助手？

☐ 是  
☐ 否

9. 在过去 2 个月的护理期间，对于您在家获得的所有护理或治疗，该机构的居家健康护理提供者多经常看起来知情并了解最新情况？

☐ 从不  
☐ 有时  
☐ 经常  
☐ 总是  
☐ 在过去 2 个月的护理期间，我仅有一位提供者

10. 在过去 2 个月的护理期间，您和该机构的一位居家健康护理提供者是否讨论过有关疼痛的问题？

☐ 是  
☐ 否

11. 在过去 2 个月的护理期间，您是否服用任何新的处方药或改变您在服用的任何药物？

☐ 是  
☐ 否 ➔ 如果否，转至问题 15。

12. 在过去 2 个月的护理期间，该机构的居家健康护理提供者是否与您讨论过服用新的处方药或改变处方药的目的？

☐ 是  
☐ 否  
☐ 我没有服用任何新的处方药物或改变任何药物

- |  |  |
|--|--|
| <p>13. 在过去 2 个月的护理期间，该机构的居家健康管理提供者是否与您讨论过<b>何时</b>服用这些药物？</p> <p><input type="radio"/> 是</p> <p><input type="radio"/> 否</p> <p><input type="radio"/> 我<b>没有</b>服用任何新的处方药物或改变任何药物</p><br><p>14. 在过去 2 个月的护理期间，该机构的居家健康管理提供者是否与您讨论过这些药物的<b>副作用</b>？</p> <p><input type="radio"/> 是</p> <p><input type="radio"/> 否</p> <p><input type="radio"/> 我<b>没有</b>服用任何新的处方药物或改变任何药物</p><br><p>15. 在过去 2 个月的护理期间，该机构的居家健康管理提供者多经常通知您他们何时到达您家？</p> <p><input type="radio"/> 从不</p> <p><input type="radio"/> 有时</p> <p><input type="radio"/> 经常</p> <p><input type="radio"/> 总是</p><br><p>16. 在过去 2 个月的护理期间，该机构的居家健康管理提供者多经常尽可能温和地对待您？</p> <p><input type="radio"/> 从不</p> <p><input type="radio"/> 有时</p> <p><input type="radio"/> 经常</p> <p><input type="radio"/> 总是</p> | <p>17. 在过去 2 个月的护理期间，该机构的居家健康管理提供者多经常以简易的方式向您解释事情？</p> <p><input type="radio"/> 从不</p> <p><input type="radio"/> 有时</p> <p><input type="radio"/> 经常</p> <p><input type="radio"/> 总是</p><br><p>18. 在过去 2 个月的护理期间，该机构的居家健康管理提供者多经常认真听您说话？</p> <p><input type="radio"/> 从不</p> <p><input type="radio"/> 有时</p> <p><input type="radio"/> 经常</p> <p><input type="radio"/> 总是</p><br><p>19. 在过去 2 个月的护理期间，该机构的居家健康管理提供者多经常以礼貌和尊重的态度对待您？</p> <p><input type="radio"/> 从不</p> <p><input type="radio"/> 有时</p> <p><input type="radio"/> 经常</p> <p><input type="radio"/> 总是</p> |
|--|--|

20. 我们想知道您对从该机构的居家健康护理提供者提供的护理的评价。

使用 0 至 10 之间的任何数字，其中 0 表示最差居家健康护理，10 表示最佳居家健康护理，哪个数字可用来评价您从该机构的居家健康护理提供者那里获得的护理？

- ☐ 0 最差居家健康护理
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 最佳居家健康护理

### 您的居家健康护理机构

接下来的问题是关于 [机构名称] 的办公室的。

21. 在过去 2 个月的护理期间，您是否联系过该机构的办公室，以寻求帮助或建议？
- ☐ 是
  - ☐ 否 → 如果否，转至问题 24。

22. 在过去 2 个月的护理期间，当您联系该机构的办公室时，您是否获得了您所需要的帮助或建议？

- ☐ 是
- ☐ 否 → 如果否，转至问题 24。
- ☐ 我没有联系该机构

23. 当您联系该机构的办公室时，您花费了多长时间才获得您所需要的帮助或建议？

- ☐ 当天
- ☐ 1 至 5 天
- ☐ 6 至 14 天
- ☐ 多于 14 天
- ☐ 我没有联系该机构

24. 在过去 2 个月的护理期间，对于您从该机构获得的护理，您是否遇到过任何问题？

- ☐ 是
- ☐ 否

25. 如果您的家人或朋友需要居家健康护理，您是否会向他们推荐该机构？

- ☐ 肯定不会
- ☐ 可能不会
- ☐ 可能会
- ☐ 肯定会



## 关于您本人

26. 总体而言，您如何评价您的整体健康状况？

- ☐ 极好  
☐ 很好  
☐ 好  
☐ 一般  
☐ 差

27. 总体而言，您如何评价您的整体精神或情绪健康状况？

- ☐ 极好  
☐ 很好  
☐ 好  
☐ 一般  
☐ 差

28. 您是否独居？

- ☐ 是  
☐ 否

29. 您已完成的最高级别或水平的年级或院校是什么？

- ☐ 8 年级或更低  
☐ 读过高中，但未毕业  
☐ 高中毕业或 GED  
☐ 读过大学或有 2 年制学位  
☐ 4 年制大学毕业  
☐ 4 年制大学毕业以上，超过 4 年的大学教育

30. 您是否为西班牙或拉丁美洲人？

- ☐ 是  
☐ 否

31. 您的种族是什么？请选择一项或多项。

- ☐ 美洲印第安人或阿拉斯加原住民  
☐ 亚洲人  
☐ 黑人或非裔美国人  
☐ 夏威夷原住民或其他太平洋岛上居民  
☐ 白人

32. 您在家主要讲哪种语言？

- ☐ 英语  
☐ 西班牙语  
☐ 其它语言：

（请用正楷填写。）

33. 是否有人帮助您填写本调查问卷？

☐ 是

☐ 否 ➔ 如果否，请用邮资已付  
的信封将填妥的调查问卷  
寄回给我们。

34. 那人是如何帮助您的？勾选所有适用项。

☐ 为我读问题

☐ 写下我给出的答案

☐ 替我回答问题

☐ 将问题译成我的语言

☐ 以其它方式帮助：

---

（请用正楷填写。）

☐ 没人帮助我填写本调查问卷

谢谢！

请用邮资已付的信封将填妥的  
调查问卷寄回给我们。

**APPENDIX F:**  
**CHINESE—TRADITIONAL:**  
**MAIL SURVEY COVER LETTERS,**  
**REGULAR AND SCANNABLE QUESTIONNAIRES**

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## Sample Cover Letter for First Questionnaire Mailing in Chinese Traditional

### Home Health Care CAHPS Survey

To be Printed on Home Health Agency or Vendor Letterhead

---

«LastName» «FirstName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

尊敬的 «LastName» «FirstName»:

這是 Medicare 針對接受居家健康護理人士開展的一項重要調查。請花一些時間分享您在 «HHA» 的體驗，並使用隨附的已付郵資信封將調查表寄回。您的反饋不僅有助於 Medicare 提高居家健康護理的整體品質，還能幫助其他人選擇居家健康護理機構。

**您的意見至關重要。**我們希望您的回答反映的是您自己的看法，而非上述機構中任何人的觀點。若您在完成調查時需要協助，請向您的家人或朋友求助。

參與調查純屬自願，您的資訊將依法保密。任何人都無法將您的名字與您的回答進行關聯。

若您對本調查有任何疑問，請致電 VENDOR NAME，免費電話：1-XXX-XXX-XXXX。

感謝您幫助改善居家健康護理服務。

謹致，

Name

居家健康機構管理員

**我們關心您的居家健康護理體驗。**

[PRINT SAMPLE ID HERE]

**Sample Cover Letter**  
**for Second Questionnaire Mailing to Mail Survey Nonrespondents in Chinese Traditional**  
Home Health Care CAHPS Survey  
To be Printed on Home Health Agency or Vendor Letterhead

«LastName» «FirstName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

尊敬的 «LastName» «FirstName»:

您最近收到了一份 Medicare 針對您在 «HHA» 的體驗而進行的調查。若您已將此調查表寄回，我謹在此深表感謝！您無需採取任何其他措施。

溫馨提示，我們非常想瞭解您的體驗。您的反饋不僅有助於其他人選擇居家健康護理機構，還能幫助 Medicare 提高居家健康護理的整體品質。

請花一點時間完成該調查並使用隨附的已付郵資信封將其寄回。

您的意見至關重要。我們知道您的時間非常寶貴。參與調查純屬自願，您的資訊將依法保密。任何人都無法將您的名字與您的回答進行關聯。

若您對本調查有疑問，請致電 VENDOR NAME，  
免費電話：1-XXX-XXX-XXXX。

感謝您幫助改善居家健康護理服務。

謹致，

Name

居家健康機構管理員

**我們關心您的護理體驗。**

若您在完成調查時需要協助，請  
向您的家人或朋友求助。

[PRINT SAMPLE ID HERE]

OMB #: 0938-1066  
將於2026年7月31日失效

# 居家健康護理 CAHPS® 調查問卷

## 2025

### 調查問卷說明

- 通過勾選答案左側的方框，回答所有問題。
- 在本調查問卷中，有時會告知您跳過某些問題。當出現這種情況時，您會看到一個箭頭和一個說明，告知您下一個要回答的問題，像這樣：

☒ 是 ➔ 如果是，移往第 1 頁的問題 1。

☐ 否

### 您的居家健康護理

1. 根據我們的記錄，您曾經從居家健康護理機構[機構名稱]獲得護理。是嗎？  
您在回答本調查中的問題時，只考慮您從該機構獲得護理的經歷。  
1 ☐ 是  
2 ☐ 否 ➔ 如果否，請停止作答，並用提供的信封把問卷寄回給我們。
2. 當您第一次開始從此機構獲得居家健康護理時，此機構是否有人告訴過您將向您提供什麼護理和服務？  
1 ☐ 是  
2 ☐ 否  
3 ☐ 不記得

3. 當您第一次開始從此機構獲得居家健康護理時，此機構是否有人與您說過如何佈置您的家以便您可以安全走動？  
1 ☐ 是  
2 ☐ 否  
3 ☐ 不記得
4. 當您開始從此機構獲得居家健康護理時，此機構是否有人與您說起您正服用的所有處方和非處方藥物？  
1 ☐ 是  
2 ☐ 否  
3 ☐ 不記得
5. 當您開始從此機構獲得居家健康護理時，此機構是否有人要求看看您在服用的所有處方和非處方藥物？  
1 ☐ 是  
2 ☐ 否  
3 ☐ 不記得



**在過去 2 個月內您從居家健康  
護理提供者那裡獲得的護理**

下面的這些問題關於過去 2 個月中為您提供護理的 [機構名稱] 的所有工作人員。不包括您從其他居家健康護理機構的工作人員處獲得的護理。不包括您從家人或朋友處獲得的護理。

6. 在過去 2 個月的護理中，來自此機構的您的居家健康護理提供者是否包括一位護士？

1 ☐ 是  
2 ☐ 否

7. 在過去 2 個月的護理中，來自此機構的居家健康護理提供者是否包括一位物理治療師、職業治療師或言語治療師？

1 ☐ 是  
2 ☐ 否

8. 在過去 2 個月的護理中，來自此機構的您的居家健康護理提供者是否包括一位居家健康護理或個人護理助手？

1 ☐ 是  
2 ☐ 否

9. 在過去 2 個月的護理中，對您在家得到的所有護理或治療，此機構的居家健康護理提供者多經常看起來瞭解並跟得上近況？

1 ☐ 從未  
2 ☐ 有時  
3 ☐ 經常  
4 ☐ 始終  
5 ☐ 在過去 2 個月中，我只有一位護理提供者

10. 在過去 2 個月的護理中，您是否和此機構的居家健康護理提供者說過有關疼痛的問題？

1 ☐ 是  
2 ☐ 否

11. 在過去 2 個月的護理中，您是否服用過任何新的處方藥或變更過您服用的任何藥物？

1 ☐ 是  
2 ☐ 否 → 如果否，移往問題 15。

12. 在過去 2 個月的護理中，此機構的居家健康護理提供者是否與您說過服用新的處方藥或變更處方藥的目的？

1 ☐ 是  
2 ☐ 否  
3 ☐ 我未服用任何新處方藥或變更任何藥物

13. 在過去 2 個月的護理中，此機構的居家健康護理提供者是否與您說過何時服用這些藥物？

- 1 ☐ 是
- 2 ☐ 否
- 3 ☐ 我未服用任何新處方藥或變更任何藥物

14. 在過去 2 個月的護理中，此機構的居家健康護理提供者是否與您說過這些藥物的副作用？

- 1 ☐ 是
- 2 ☐ 否
- 3 ☐ 我未服用任何新處方藥或變更任何藥物

15. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常通知您他們何時到您家？

- 1 ☐ 從未
- 2 ☐ 有時
- 3 ☐ 經常
- 4 ☐ 始終

16. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常盡可能溫和地對待您？

- 1 ☐ 從未
- 2 ☐ 有時
- 3 ☐ 經常
- 4 ☐ 始終

17. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常以簡易的方式向您解釋事情？

- 1 ☐ 從未
- 2 ☐ 有時
- 3 ☐ 經常
- 4 ☐ 始終

18. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常認真聽您說話？

- 1 ☐ 從未
- 2 ☐ 有時
- 3 ☐ 經常
- 4 ☐ 始終

19. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常以禮貌和尊重的態度對待您？

- 1 ☐ 從未
- 2 ☐ 有時
- 3 ☐ 經常
- 4 ☐ 始終

20. 我們想知道您對此機構的居家健康護理提供者所提供的護理的評級。

使用從 0 到 10 的任何數字，其中 0 表示最差的居家健康護理，10 表示最好的居家健康護理，哪個數字可用於評定您從此機構的居家健康護理提供者那裡獲得的護理？

- ☐ 0 最差的居家健康護理
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 最好的居家健康護理

### 您的居家健康護理機構

下面的問題是關於[機構名稱]的辦公室的。

21. 在過去 2 個月的護理中，您是否聯絡過此機構的辦公室，以取得幫助或建議？

- 1 ☐ 是
- 2 ☐ 否 → 如果否，移往問題 24。

22. 在過去 2 個月的護理中，当您聯絡此機構的辦公室時，您是否得到了所需的幫助或建議？

- 1 ☐ 是
- 2 ☐ 否 → 如果否，移往問題 24。
- 3 ☐ 我未聯絡過此機構

23. 当您聯絡此機構的辦公室時，您花費了多長時間才得到所需的幫助或建議？

- 1 ☐ 當天
- 2 ☐ 1 到 5 天
- 3 ☐ 6 到 14 天
- 4 ☐ 多於 14 天
- 5 ☐ 我未聯絡過此機構

24. 在過去 2 個月的護理中，對於您從此機構獲得的護理，您是否遇到過任何問題？

- 1 ☐ 是
- 2 ☐ 否

25. 如果您的家人或朋友需要居家健康護理，您是否會向他們推薦此機構？

- 1 ☐ 絕對不會
- 2 ☐ 可能不會
- 3 ☐ 可能會
- 4 ☐ 絕對會

關於您本人

26. 總體來說，您如何評定您的整體健康狀況？

- 1 ☐ 極好
- 2 ☐ 很好
- 3 ☐ 好
- 4 ☐ 一般
- 5 ☐ 差

27. 總體來說，您如何評定您的整體精神或情緒健康狀況？

- 1 ☐ 極好
- 2 ☐ 很好
- 3 ☐ 好
- 4 ☐ 一般
- 5 ☐ 差

28. 您是否獨居？

- 1 ☐ 是
- 2 ☐ 否

29. 您已完成的最高級別或水平的年級或院校是什麼？

- 1 ☐ 8 年級或更低
- 2 ☐ 讀過高中，但未畢業
- 3 ☐ 高中畢業或 GED
- 4 ☐ 讀過大學或有 2 年制學位
- 5 ☐ 4 年制大學畢業
- 6 ☐ 4 年制大學畢業以上，超過 4 年的大學教育

30. 您是否為西班牙人或拉丁美洲人？

- 1 ☐ 是
- 2 ☐ 否

31. 您的種族是什麼？請選取一項或多項。

- 1 ☐ 美國印地安人或阿拉斯加原住民
- 2 ☐ 亞洲人
- 3 ☐ 黑人或非裔美國人
- 4 ☐ 夏威夷原住民或其他太平洋島上居民
- 5 ☐ 白人

32. 您在家主要講哪種語言？

- 1 ☐ 英語
- 2 ☐ 西班牙語
- 3 ☐ 其他語言：

(請用正楷填寫。)

33. 是否有人協助您完成本調查問卷？

1 ☐ 是

2 ☐ 否 ➔ 如果否，請用郵資已付  
的信封把完成的調查問  
卷寄回給我們。

34. 該人員是如何協助您的？勾選所有  
適用的選項。

1 ☐ 為我讀問題

2 ☐ 寫下我提供的答案

3 ☐ 幫我回答問題

4 ☐ 將問題譯成我的語言

5 ☐ 以其他方式協助：

\_\_\_\_\_  
(請用正楷填寫。)

6 ☐ 沒人協助我完成本調查問卷

謝謝您！

請您用郵資已付的信封把完成的調查問  
卷寄回給我們。

OMB #: 0938-1066  
將於2026年7月31日失效

# 居家健康護理 CAHPS® 調查問卷

(ALTERNATIVE INSTRUCTIONS,  
SCANNABLE FORMS)

2025

## 調查問卷說明

- 通過塗滿答案左側的圓圈，回答所有問題。
- 在本調查問卷中，有時會告知您跳過某些問題。當出現這種情況時，您會看到一個箭頭和一個說明，告知您下一個要回答的問題，像這樣：
  - 是 → 如果是，移往第 1 頁的問題 1。
- 否

## 您的居家健康護理

1. 根據我們的記錄，您曾經從居家健康護理機構[機構名稱]獲得護理。是嗎？  
您在回答本調查中的問題時，只考慮您從該機構獲得護理的經歷。
  - 是
  - 否 → 如果否，請停止作答，並用提供的信封把問卷寄回給我們。
2. 當您第一次開始從此機構獲得居家健康護理時，此機構是否有人告訴您將向您提供什麼護理和服務？
  - 是
  - 否
  - 不記得

3. 當您第一次開始從此機構獲得居家健康護理時，此機構是否有人與您說過如何佈置您的家以便您可以安全走動？
  - 是
  - 否
  - 不記得
4. 當您開始從此機構獲得居家健康護理時，此機構是否有人與您說起您正服用的所有處方和非處方藥物？
  - 是
  - 否
  - 不記得
5. 當您開始從此機構獲得居家健康護理時，此機構是否有人要求看看您在服用的所有處方和非處方藥物？
  - 是
  - 否
  - 不記得

**在過去 2 個月內您從居家健康  
護理提供者那裡獲得的護理**

下面的這些問題關於過去 2 個月中為您提供護理的 [機構名稱] 的所有工作人員。不包括您從其他居家健康護理機構的工作人員處獲得的護理。不包括您從家人或朋友處獲得的護理。

6. 在過去 2 個月的護理中，來自此機構的您的居家健康護理提供者是否包括一位護士？

☐ 是  
☐ 否

7. 在過去 2 個月的護理中，來自此機構的居家健康護理提供者是否包括一位物理治療師、職業治療師或言語治療師？

☐ 是  
☐ 否

8. 在過去 2 個月的護理中，來自此機構的您的居家健康護理提供者是否包括一位居家健康護理或個人護理助手？

☐ 是  
☐ 否

9. 在過去 2 個月的護理中，對您在家得到的所有護理或治療，此機構的居家健康護理提供者多經常看起來瞭解並跟得上近況？

☐ 從未  
☐ 有時  
☐ 經常  
☐ 始終  
☐ 在過去 2 個月中，我只有一位護理提供者

10. 在過去 2 個月的護理中，您是否和此機構的居家健康護理提供者說過有關疼痛的問題？

☐ 是  
☐ 否

11. 在過去 2 個月的護理中，您是否服用過任何新的處方藥或變更過您服用的任何藥物？

☐ 是  
☐ 否 → 如果否，移往問題 15。

12. 在過去 2 個月的護理中，此機構的居家健康護理提供者是否與您說過服用新的處方藥或變更處方藥的目的？

☐ 是  
☐ 否  
☐ 我未服用任何新處方藥或變更任何藥物



- |  |   |
|--|---|
| <p>13. 在過去 2 個月的護理中，此機構的居家健康護理提供者是否與您說過何時服用這些藥物？</p> <p><input type="radio"/> 是</p> <p><input type="radio"/> 否</p> <p><input type="radio"/> 我未服用任何新處方藥或變更任何藥物</p> <p>14. 在過去 2 個月的護理中，此機構的居家健康護理提供者是否與您說過這些藥物的副作用？</p> <p><input type="radio"/> 是</p> <p><input type="radio"/> 否</p> <p><input type="radio"/> 我未服用任何新處方藥或變更任何藥物</p> <p>15. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常通知您他們何時到您家？</p> <p><input type="radio"/> 從未</p> <p><input type="radio"/> 有時</p> <p><input type="radio"/> 經常</p> <p><input type="radio"/> 始終</p> <p>16. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常盡可能溫和地對待您？</p> <p><input type="radio"/> 從未</p> <p><input type="radio"/> 有時</p> <p><input type="radio"/> 經常</p> <p><input type="radio"/> 始終</p> | <p>17. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常以簡易的方式向您解釋事情？</p> <p><input type="radio"/> 從未</p> <p><input type="radio"/> 有時</p> <p><input type="radio"/> 經常</p> <p><input type="radio"/> 始終</p> <p>18. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常認真聽您說話？</p> <p><input type="radio"/> 從未</p> <p><input type="radio"/> 有時</p> <p><input type="radio"/> 經常</p> <p><input type="radio"/> 始終</p> <p>19. 在過去 2 個月的護理中，此機構的居家健康護理提供者多經常以禮貌和尊重的態度對待您？</p> <p><input type="radio"/> 從未</p> <p><input type="radio"/> 有時</p> <p><input type="radio"/> 經常</p> <p><input type="radio"/> 始終</p> |
|--|---|

20. 我們想知道您對此機構的居家健康護理提供者所提供的護理的評級。

使用從 0 到 10 的任何數字，其中 0 表示最差的居家健康護理，10 表示最好的居家健康護理，哪個數字可用於評定您從此機構的居家健康護理提供者那裡獲得的護理？

- ☐ 0 最差的居家健康護理
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 最好的居家健康護理

### 您的居家健康護理機構

下面的問題是關於[機構名稱]的辦公室的。

21. 在過去 2 個月的護理中，您是否聯絡過此機構的辦公室，以取得幫助或建議？
- ☐ 是
  - ☐ 否 → 如果否，移往問題 24。

22. 在過去 2 個月的護理中，当您聯絡此機構的辦公室時，您是否得到了所需的幫助或建議？

- ☐ 是
- ☐ 否 → 如果否，移往問題 24。
- ☐ 我未聯絡過此機構

23. 当您聯絡此機構的辦公室時，您花費了多長時間才得到所需的幫助或建議？

- ☐ 當天
- ☐ 1 到 5 天
- ☐ 6 到 14 天
- ☐ 多於 14 天
- ☐ 我未聯絡過此機構

24. 在過去 2 個月的護理中，對於您從此機構獲得的護理，您是否遇到過任何問題？

- ☐ 是
- ☐ 否

25. 如果您的家人或朋友需要居家健康護理，您是否會向他們推薦此機構？

- ☐ 絕對不會
- ☐ 可能不會
- ☐ 可能會
- ☐ 絕對會

## 關於您本人

26. 總體來說，您如何評定您的整體健康狀況？

- ☐ 極好
- ☐ 很好
- ☐ 好
- ☐ 一般
- ☐ 差

27. 總體來說，您如何評定您的整體精神或情緒健康狀況？

- ☐ 極好
- ☐ 很好
- ☐ 好
- ☐ 一般
- ☐ 差

28. 您是否獨居？

- ☐ 是
- ☐ 否

29. 您已完成的最高級別或水平的年級或院校是什麼？

- ☐ 8 年級或更低
- ☐ 讀過高中，但未畢業
- ☐ 高中畢業或 GED
- ☐ 讀過大學或有 2 年制學位
- ☐ 4 年制大學畢業
- ☐ 4 年制大學畢業以上，超過 4 年的大學教育

30. 您是否為西班牙人或拉丁美洲人？

- ☐ 是
- ☐ 否

31. 您的種族是什麼？請選取一項或多項。

- ☐ 美國印地安人或阿拉斯加原住民
- ☐ 亞洲人
- ☐ 黑人或非裔美國人
- ☐ 夏威夷原住民或其他太平洋島上居民
- ☐ 白人

32. 您在家主要講哪種語言？

- ☐ 英語
- ☐ 西班牙語
- ☐ 其他語言：

\_\_\_\_\_  
(請用正楷填寫。)

33. 是否有人協助您完成本調查問卷？

- ☐ 是
- ☐ 否 → 如果否，請用郵資已付的信封把完成的調查問卷寄回給我們。

34. 該人員是如何協助您的？勾選所有適用的選項。

- ☐ 為我讀問題
- ☐ 寫下我提供的答案
- ☐ 幫我回答問題
- ☐ 將問題譯成我的語言
- ☐ 以其他方式協助：

\_\_\_\_\_  
(請用正楷填寫。)

- ☐ 沒人協助我完成本調查問卷

謝謝您！

請您用郵資已付的信封把完成的調查問卷寄回給我們。

**APPENDIX G:**

**RUSSIAN:**

**MAIL SURVEY COVER LETTERS,**  
**REGULAR AND SCANNABLE QUESTIONNAIRES,**  
**TELEPHONE INTERVIEW SCRIPT,**  
**PROXY INTERVIEW SCRIPT**

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## Sample Cover Letter for First Questionnaire Mailing in Russian

Home Health Care CAHPS Survey

To be Printed on Home Health Agency or Vendor Letterhead

---

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Уважаемый(-ая) «FirstName» «LastName»:

Организация Medicare проводит важный опрос среди тех, кто получает медицинское обслуживание на дому. **Уделите, пожалуйста, несколько минут, чтобы рассказать о своем опыте взаимодействия с агентством по оказанию медицинской помощи на дому (ННА) и отправьте заполненную анкету обратно, вложив ее в прилагаемый конверт с предварительно оплаченным почтовым сбором.** Ваш отзыв позволит организации Medicare повысить общее качество медицинского обслуживания на дому, и поможет другим людям в выборе агентства, предоставляющего подобные услуги.

**Ваше мнение важно для нас.** Мы хотим, чтобы Ваши ответы отражали Ваш собственный опыт, а не мнение сотрудника вышеуказанного агентства. Если Вам требуется помощь в заполнении анкеты, обратитесь к члену семьи или другу.

Участие в опросе добровольное, и мы обязуемся сохранять конфиденциальность Вашей информации в соответствии с требованиями закона. Никто не сможет соотнести Ваши личные данные с предоставленными Вами ответами.

**Нам важен Ваш  
опыт получения  
медицинских услуг  
на дому.**

Если у Вас возникли какие-либо вопросы по этому опросу, пожалуйста, позвоните VENDOR NAME по бесплатному телефону 1-XXX-XXX-XXXX. Заранее благодарим Вас за участие.

С уважением,

Name

Администратор Агентства услуг домашнего медицинского ухода

[PRINT SAMPLE ID HERE]

**Sample Cover Letter**  
**for Second Questionnaire Mailing to Mail Survey Nonrespondents in Russian**  
Home Health Care CAHPS Survey  
To be Printed on Home Health Agency or Vendor Letterhead

---

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Уважаемый(-ая) «FirstName» «LastName»:

Недавно организаця Medicare направила Вам анкету для получения информации о Вашем взаимодействии с «ННА». **Благодарим Вас, если Вы уже отправили анкету обратно! Больше ничего делать не нужно.**

Любезно напоминаем о том, что нам было бы очень интересно узнать о полученном Вами опыте. Ваш отзыв поможет другим людям в выборе агентства по оказанию медицинской помощи на дому, а организации Medicare – повысить общее качество соответствующего медицинского обслуживания.

**Уделите, пожалуйста, несколько минут, чтобы заполнить анкету, а затем отправьте ее обратно, вложив в прилагаемый конверт с предварительно оплаченным почтовым сбором.**

**Ваше мнение важно для нас.** Мы ценим Ваше время. Участие в опросе добровольное, и мы обязуемся сохранять конфиденциальность Вашей информации в соответствии с требованиями закона. Никто не сможет соотнести Ваши личные данные с предоставленными Вами ответами.

**Нам важен Ваш опыт  
получения медицинских  
услуг на дому.**

Если Вам требуется помощь в  
заполнении анкеты, обратитесь к  
члену семьи или другу.

Если у Вас возникли какие-либо вопросы по этому опросу, пожалуйста, позвоните VENDOR NAME по бесплатному телефону 1-XXX-XXX-XXXX. Заранее благодарим Вас за участие.

С уважением,

Name

Администратор Агентства услуг домашнего медицинского ухода

[PRINT SAMPLE ID HERE]



OMB #: 0938-1066  
Срок истекает 31 июля 2026 года

# ОПРОС О ДОМАШНЕМ МЕДИЦИНСКОМ УХОДЕ CAHPS®

## 2025

## ИНСТРУКЦИИ К ОПРОСУ

- Ответьте на все вопросы, отметив галочкой соответствующий квадратик слева от ответа.
- Иногда Вам необходимо будет пропустить некоторые вопросы. В этом случае Вы увидите стрелку с указанием на следующий вопрос, например:

☒ Да → Если да, то перейдите к В1 на странице 1.

☐ Нет

## ВАШ ДОМАШНИЙ МЕДИЦИНСКИЙ УХОД

1. Согласно нашим данным Вы пользовались услугами домашнего медицинского ухода агентства **[НАЗВАНИЕ АГЕНТСТВА]**. Это так?

Когда Вы будете отвечать на вопросы, всегда ссылайтесь только на услуги этого агентства.

1 ☐ Да

2 ☐ Нет → Если это не так, не отвечайте на оставшиеся вопросы и верните опрос в предоставленном конверте.

2. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, рассказал ли Вам кто-либо из агентства о характере ухода и услугах, которые будут Вам предоставляться?

1 ☐ Да

2 ☐ Нет

3 ☐ Не помню

3. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, **рассказал ли Вам** кто-либо из агентства о том, как обустроить свой дом, чтобы Вы могли безопасно в нем передвигаться?

1 ☐ Да

2 ☐ Нет

3 ☐ Не помню

4. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, спрашивал ли Вас кто-либо из агентства о **рецептурных и нерекцептурных препаратах**, которые Вы принимали?

1 ☐ Да

2 ☐ Нет

3 ☐ Не помню

5. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, просил ли Вас кто-либо из агентства **показать** им все рецептурные и нерепечтурные препараты, которые Вы принимали?

1 ☐ Да  
2 ☐ Нет  
3 ☐ Не помню

**КАЧЕСТВО УХОДА,  
ПРЕДОСТАВЛЯЕМОГО  
СОТРУДНИКАМИ АГЕНТСТВА ЗА  
ПОСЛЕДНИЕ 2 МЕСЯЦА**

Следующие вопросы относятся к различным сотрудникам [НАЗВАНИЕ АГЕНТСТВА], предоставлявшим Вам уход за последние 2 месяца. В своих ответах не ссылайтесь на сотрудников другого агентства. В своих ответах не ссылайтесь на членов семьи или друзей.

6. За последние 2 месяца ухода являлся ли кто-либо из сотрудников этого агентства, оказывающих уход, медсестрой или медбратом?

1 ☐ Да  
2 ☐ Нет

7. За последние 2 месяца являлся ли кто-либо из сотрудников этого агентства, оказывающих уход, физиотерапевтом, специалистом по трудотерапии или логопедом?

1 ☐ Да  
2 ☐ Нет

8. За последние 2 месяца являлся ли кто-либо из сотрудников этого агентства, оказывающих уход, помощником по домашнему уходу или личным помощником?

1 ☐ Да  
2 ☐ Нет

9. Как часто за последние 2 месяца сотрудники этого агентства, оказывающие уход, были хорошо проинформированы о необходимом для Вас уходе и лечении?

1 ☐ Никогда  
2 ☐ Иногда  
3 ☐ Часто  
4 ☐ Всегда  
5 ☐ За мной ухаживал всего один сотрудник за последние 2 месяца

10. За последние 2 месяца разговаривали ли Вы с ухаживающим за Вами сотрудником из этого агентства о боли?

1 ☐ Да  
2 ☐ Нет

11. За последние 2 месяца начали ли Вы принимать новые рецептурные препараты или сменили препараты, которые принимали?

1 ☐ Да  
2 ☐ Нет → Если нет, то перейдите к B15.

12. За последние 2 месяца объясняли ли Вам сотрудники этого агентства **причину** перехода на новые препараты или смены рецептурных препаратов?

1 ☐ Да

2 ☐ Нет

3 ☐ Я **не** принимал (-а) новые рецептурные препараты и не менял (-а) их.

13. За последние 2 месяца объяснили ли Вам сотрудники этого агентства, **когда** необходимо принимать эти препараты?

1 ☐ Да

2 ☐ Нет

3 ☐ Я **не** принимал (-а) новые рецептурные препараты и не менял (-а) их.

14. За последние 2 месяца рассказывали ли Вам сотрудники этого агентства о **побочных эффектах** этих препаратов?

1 ☐ Да

2 ☐ Нет

3 ☐ Я **не** принимал (-а) новые рецептурные препараты и не менял (-а) их.

15. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, информировали Вас о том, когда они приедут к Вам домой?

1 ☐ Никогда

2 ☐ Иногда

3 ☐ Часто

4 ☐ Всегда

16. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, обращались с Вами максимально деликатно?

1 ☐ Никогда

2 ☐ Иногда

3 ☐ Часто

4 ☐ Всегда

17. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие уход, объясняли Вам все простым и понятным языком?

1 ☐ Никогда

2 ☐ Иногда

3 ☐ Часто

4 ☐ Всегда

**January 2025**

**18.** Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, внимательно Вас выслушивали?

- 1 ☐ Никогда
- 2 ☐ Иногда
- 3 ☐ Часто
- 4 ☐ Всегда

**19.** Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, обращались с Вами вежливо и с уважением?

- 1 ☐ Никогда
- 2 ☐ Иногда
- 3 ☐ Часто
- 4 ☐ Всегда

**20.** Мы бы хотели узнать, как Вы оценили бы услуги по уходу, предоставляемые сотрудниками этого агентства.

По шкале от 0 до 10, где 0 означает наихудшее качество услуг по домашнему медицинскому уходу, а 10 — наилучшее качество услуг, как бы Вы оценили качество услуг по уходу, предоставляемых сотрудниками этого агентства?

- ☐ 0 Наихудшее качество услуг по домашнему медицинскому уходу
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Наилучшее качество услуг по домашнему медицинскому уходу

**ВАШЕ АГЕНТСТВО УСЛУГ ПО  
ДОМАШНЕМУ МЕДИЦИНСКОМУ  
УХОДУ**

Следующие вопросы относятся к офису  
[НАЗВАНИЕ АГЕНТСТВА].

21. За последние 2 месяца ухода  
обращались ли Вы в **офис** этого  
агентства за помощью или  
консультацией?

1 ☐ Да  
2 ☐ Нет → Если нет, то  
перейдите к B24.

22. За последние 2 месяца ухода когда  
Вы обращались в офис агентства,  
удалось ли Вам получить  
необходимую помощь или  
консультацию?

1 ☐ Да  
2 ☐ Нет → Если нет, то  
перейдите к B24.  
3 ☐ Я не обращался (-лась) в это  
агентство

23. Когда Вы обратились в офис  
агентства, как быстро Вам была  
оказана необходимая помощь или  
предоставлена консультация?

1 ☐ В тот же день  
2 ☐ Через 1-5 дней  
3 ☐ Через 6-14 дней  
4 ☐ Более чем через 14 дней  
5 ☐ Я не обращался (-лась) в это  
агентство

24. За последние 2 месяца ухода  
возникали ли у Вас проблемы с  
услугами по уходу,  
предоставляемыми этим  
агентством?

1 ☐ Да  
2 ☐ Нет

25. Вы бы порекомендовали это  
агентство членам своей семьи или  
друзьям, если бы они нуждались в  
домашнем медицинском уходе?

1 ☐ Определенно нет  
2 ☐ Скорее всего, нет  
3 ☐ Возможно  
4 ☐ Определенно да

**ВАШИ ЛИЧНЫЕ ДАННЫЕ**

26. В общих словах, как бы Вы  
оценили свое состояние здоровья?

1 ☐ Отличное  
2 ☐ Очень хорошее  
3 ☐ Хорошее  
4 ☐ Нормальное  
5 ☐ Плохое

27. В общих словах, как бы Вы оценили свое умственное или эмоциональное здоровье?

- 1 ☐ Отличное
- 2 ☐ Очень хорошее
- 3 ☐ Хорошее
- 4 ☐ Нормальное
- 5 ☐ Плохое

28. Вы проживаете один (одна)?

- 1 ☐ Да
- 2 ☐ Нет

29. Каков Ваш уровень образования?

- 1 ☐ 8 классов или меньше
- 2 ☐ Среднее образование без выпуска
- 3 ☐ Диплом об общем среднем образовании
- 4 ☐ Несколько курсов ВУЗа или диплом выпускника 2-летней программы
- 5 ☐ Диплом о высшем образовании
- 6 ☐ Аспирантура и выше

30. Вы латиноамериканского происхождения?

- 1 ☐ Да
- 2 ☐ Нет

31. К какой расе Вы принадлежите? Выберите один или несколько вариантов ответа.

- 1 ☐ Коренной житель (-ница) Америки или Аляски
- 2 ☐ Азиатского происхождения
- 3 ☐ Темнокожий (-ая) или афроамериканец (-ка)
- 4 ☐ Уроженец (-ка) Гавайских островов или других тихоокеанских островов
- 5 ☐ Белый (-ая)

32. На каком языке Вы обычно разговариваете дома?

- 1 ☐ На английском
- 2 ☐ На испанском
- 3 ☐ Другие языки:

---

*(Заполнять печатными буквами.)*

33. Помогал ли Вам кто-нибудь заполнить этот опросник?

- 1 ☐ Да
- 2 ☐ Нет → Если нет, то отправьте заполненный опросник в предоплаченном конверте.

34. Каким образом этот человек Вам помог? Отметьте все подходящие варианты.

- 1 ☐ Прочитал (-а) мне вопросы  
2 ☐ Записал (-а) мои ответы  
3 ☐ Ответил (-а) на вопросы за меня  
4 ☐ Перевел (-а) вопросы на мой родной язык  
5 ☐ Помог (-ла) в другом:

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*(Заполнять печатными  
буквами.)*

- 6 ☐ Мне никто не помогал  
заполнять этот опросник

**Спасибо!**

**Пожалуйста, отправьте  
заполненный опросник  
в конверте с предоплатой  
почтовых услуг.**



OMB #: 0938-1066

Срок истекает 31 июля 2026 года

**ОПРОС О ДОМАШНЕМ  
МЕДИЦИНСКОМ УХОДЕ CAHPS®  
(ALTERNATIVE INSTRUCTIONS,  
SCANNABLE FORMS)  
2025**

## ИНСТРУКЦИИ К ОПРОСУ

- Ответьте на все вопросы, полностью закрасив кружок слева от ответа.
- Иногда Вам необходимо будет пропустить некоторые вопросы. В этом случае Вы увидите стрелку с указанием на следующий вопрос, например:
  - Да → Если да, то перейдите к B1 на странице 1.
  - Нет

## ВАШ ДОМАШНИЙ МЕДИЦИНСКИЙ УХОД

1. Согласно нашим данным Вы пользовались услугами домашнего медицинского ухода агентства **[НАЗВАНИЕ АГЕНТСТВА]**. Это так?

Когда Вы будете отвечать на вопросы, всегда ссылайтесь только на услуги этого агентства.

- Да
- Нет → Если это не так, не отвечайте на оставшиеся вопросы и верните опрос в предоставленном конверте.

2. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, рассказал ли Вам кто-либо из агентства о характере ухода и услугах, которые будут Вам предоставляться?
- Да
  - Нет
  - Не помню
3. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, **рассказал ли Вам** кто-либо из агентства о том, как обустроить свой дом, чтобы Вы могли безопасно в нем передвигаться?
- Да
  - Нет
  - Не помню
4. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, спрашивал ли Вас кто-либо из агентства о **рецептурных и нерепециптурных препаратах**, которые Вы принимали?
- Да
  - Нет
  - Не помню

5. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, просил ли Вас кто-либо из агентства **показать** им все рецептурные и нерепечтурные препараты, которые Вы принимали?
- ☐ Да
- ☐ Нет
- ☐ Не помню

**КАЧЕСТВО УХОДА,  
ПРЕДОСТАВЛЯЕМОГО  
СОТРУДНИКАМИ АГЕНТСТВА ЗА  
ПОСЛЕДНИЕ 2 МЕСЯЦА**

Следующие вопросы относятся к различным сотрудникам [НАЗВАНИЕ АГЕНТСТВА], предоставлявшим Вам уход за последние 2 месяца. В своих ответах не ссылайтесь на сотрудников другого агентства. В своих ответах не ссылайтесь на членов семьи или друзей.

6. За последние 2 месяца ухода являлся ли кто-либо из сотрудников этого агентства, оказывающих уход, медсестрой или медбратом?
- ☐ Да
- ☐ Нет
7. За последние 2 месяца являлся ли кто-либо из сотрудников этого агентства, оказывающих уход, физиотерапевтом, специалистом по трудотерапии или логопедом?
- ☐ Да
- ☐ Нет

8. За последние 2 месяца являлся ли кто-либо из сотрудников этого агентства, оказывающих уход, помощником по домашнему уходу или личным помощником?
- ☐ Да
- ☐ Нет
9. Как часто за последние 2 месяца сотрудники этого агентства, оказывающие уход, были хорошо проинформированы о необходимом для Вас уходе и лечении?
- ☐ Никогда
- ☐ Иногда
- ☐ Часто
- ☐ Всегда
- ☐ За мной ухаживал всего один сотрудник за последние 2 месяца
10. За последние 2 месяца разговаривали ли Вы с ухаживающим за Вами сотрудником из этого агентства о боли?
- ☐ Да
- ☐ Нет
11. За последние 2 месяца начали ли Вы принимать новые рецептурные препараты или сменили препараты, которые принимали?
- ☐ Да
- ☐ Нет ➔ Если нет, то перейдите к B15.

- |   |  |
|---|--|
| <p>12. За последние 2 месяца объясняли ли Вам сотрудники этого агентства <b>причину</b> перехода на новые препараты или смены рецептурных препаратов?</p> <p><input type="radio"/> Да</p> <p><input type="radio"/> Нет</p> <p><input type="radio"/> Я <b>не</b> принимал (-а) новые рецептурные препараты и не менял (-а) их.</p> | <p>16. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, обращались с Вами максимально деликатно?</p> <p><input type="radio"/> Никогда</p> <p><input type="radio"/> Иногда</p> <p><input type="radio"/> Часто</p> <p><input type="radio"/> Всегда</p> |
| <p>13. За последние 2 месяца объяснили ли Вам сотрудники этого агентства, <b>когда</b> необходимо принимать эти препараты?</p> <p><input type="radio"/> Да</p> <p><input type="radio"/> Нет</p> <p><input type="radio"/> Я <b>не</b> принимал (-а) новые рецептурные препараты и не менял (-а) их.</p>                            | <p>17. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие уход, объясняли Вам все простым и понятным языком?</p> <p><input type="radio"/> Никогда</p> <p><input type="radio"/> Иногда</p> <p><input type="radio"/> Часто</p> <p><input type="radio"/> Всегда</p>     |
| <p>14. За последние 2 месяца рассказывали ли Вам сотрудники этого агентства о <b>побочных эффектах</b> этих препаратов?</p> <p><input type="radio"/> Да</p> <p><input type="radio"/> Нет</p> <p><input type="radio"/> Я <b>не</b> принимал (-а) новые рецептурные препараты и не менял (-а) их.</p>                               | <p>18. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, внимательно Вас выслушивали?</p> <p><input type="radio"/> Никогда</p> <p><input type="radio"/> Иногда</p> <p><input type="radio"/> Часто</p> <p><input type="radio"/> Всегда</p>             |
| <p>15. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, информировали Вас о том, когда они придут к Вам домой?</p> <p><input type="radio"/> Никогда</p> <p><input type="radio"/> Иногда</p> <p><input type="radio"/> Часто</p> <p><input type="radio"/> Всегда</p>                        | <p>19. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, обращались с Вами вежливо и с уважением?</p> <p><input type="radio"/> Никогда</p> <p><input type="radio"/> Иногда</p> <p><input type="radio"/> Часто</p> <p><input type="radio"/> Всегда</p> |

20. Мы бы хотели узнать, как Вы оценили бы услуги по уходу, предоставляемые сотрудниками этого агентства.

По шкале от 0 до 10, где 0 означает наихудшее качество услуг по домашнему медицинскому уходу, а 10 — наилучшее качество услуг, как бы Вы оценили качество услуг по уходу, предоставляемых сотрудниками этого агентства?

- ☐ 0 Наихудшее качество услуг по домашнему медицинскому уходу
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Наилучшее качество услуг по домашнему медицинскому уходу

### ВАШЕ АГЕНТСТВО УСЛУГ ПО ДОМАШНЕМУ МЕДИЦИНСКОМУ УХОДУ

Следующие вопросы относятся к офису  
[НАЗВАНИЕ АГЕНТСТВА].

21. За последние 2 месяца ухода обращались ли Вы в **офис** этого агентства за помощью или консультацией?
- ☐ Да
- ☐ Нет ➔ Если нет, то перейдите к B24.
22. За последние 2 месяца ухода когда Вы обращались в офис агентства, удалось ли Вам получить необходимую помощь или консультацию?
- ☐ Да
- ☐ Нет ➔ Если нет, то перейдите к B24.
- ☐ Я **не** обращался (-лась) в это агентство
23. Когда Вы обратились в офис агентства, как быстро Вам была оказана необходимая помощь или предоставлена консультация?
- ☐ В тот же день
- ☐ Через 1-5 дней
- ☐ Через 6-14 дней
- ☐ Более чем через 14 дней
- ☐ Я **не** обращался (-лась) в это агентство

24. За последние 2 месяца ухода возникали ли у Вас проблемы с услугами по уходу, предоставляемыми этим агентством?
- ☐ Да
  - ☐ Нет
25. Вы бы порекомендовали это агентство членам своей семьи или друзьям, если бы они нуждались в домашнем медицинском уходе?
- ☐ Определенно нет
  - ☐ Скорее всего, нет
  - ☐ Возможно
  - ☐ Определенно да

### ВАШИ ЛИЧНЫЕ ДАННЫЕ

26. В общих словах, как бы Вы оценили свое состояние здоровья?
- ☐ Отличное
  - ☐ Очень хорошее
  - ☐ Хорошее
  - ☐ Нормальное
  - ☐ Плохое
27. В общих словах, как бы Вы оценили свое умственное или эмоциональное здоровье?
- ☐ Отличное
  - ☐ Очень хорошее
  - ☐ Хорошее
  - ☐ Нормальное
  - ☐ Плохое

28. Вы проживаете один (одна)?
- ☐ Да
  - ☐ Нет
29. Каков Ваш уровень образования?
- ☐ 8 классов или меньше
  - ☐ Среднее образование без выпуска
  - ☐ Диплом об общем среднем образовании
  - ☐ Несколько курсов ВУЗа или диплом выпускника 2-летней программы
  - ☐ Диплом о высшем образовании
  - ☐ Аспирантура и выше
30. Вы латиноамериканского происхождения?
- ☐ Да
  - ☐ Нет
31. К какой расе Вы принадлежите? Выберите один или несколько вариантов ответа.
- ☐ Коренной житель (-ница) Америки или Аляски
  - ☐ Азиатского происхождения
  - ☐ Темнокожий (-ая) или афроамериканец (-ка)
  - ☐ Уроженец (-ка) Гавайских островов или других тихоокеанских островов
  - ☐ Белый (-ая)

32. На каком языке Вы обычно разговариваете дома?

- ☐ На английском
- ☐ На испанском
- ☐ Другие языки:

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*(Заполнять печатными буквами.)*

33. Помогал ли Вам кто-нибудь заполнить этот опросник?

- ☐ Да
- ☐ Нет → Если нет, то отправьте заполненный опросник в конверте с предоплатой почтовых услуг.

34. Каким образом этот человек Вам помог? Выберите все подходящие варианты.

- ☐ Прочитал (-а) мне вопросы
- ☐ Записал (-а) мои ответы
- ☐ Ответил (-а) на вопросы за меня
- ☐ Перевел (-а) вопросы на мой родной язык
- ☐ Помог (-ла) в другом:

---

*(Заполнять печатными буквами.)*

- ☐ Мне никто не помогал заполнять этот опросник

**Спасибо!**

**Пожалуйста, отправьте  
заполненный опросник  
в предоплаченном конверте.**

**TELEPHONE INTERVIEW SCRIPT  
FOR THE HOME HEALTH CARE CAHPS SURVEY IN RUSSIAN**

INTRO1      Здравствуйте! Я могу поговорить с [SAMPLE MEMBER'S NAME]?

- 1    ДА → [GO TO INTRO2]
- 2    НЕТ, ОН/ОНА НЕ МОЖЕТ СЕЙЧАС ПОДОЙТИ К ТЕЛЕФОНУ →[SET  
CALLBACK]
- 3    НЕТ [REFUSAL] → [GO TO TERMINATE SCREEN]
- 4    MENTALLY/PHYSICALLY INCAPABLE →[GO TO PROXY SCRIPT]

M MISSING/DK

IF ASKED WHO IS CALLING:

Это [INTERVIEWER NAME] из [ORGANIZATION]. Я хотел (-а) бы поговорить с [SAMPLE MEMBER'S NAME] об исследовании в области услуг здравоохранения.

IF PERSON ON PHONE VOLUNTEERS THEY ARE SAMPLE MEMBER'S PARTNER, CHILD, PARENT, SIBLING, GRANDCHILD, OR POWER OF ATTORNEY AND THEY ASK WHY WE ARE CALLING:

Я хотел(-а) бы поговорить с [SAMPLE MEMBER'S NAME] об удовлетворенности качеством услуг по медицинскому уходу на дому, которые были предоставлены агентством [HOME HEALTH AGENCY].

INTRO2      Здравствуйте! Это [INTERVIEWER NAME]. Я звоню от лица [HOME HEALTH AGENCY]. Эта организация участвует в национальном опросе о качестве услуг, предоставляемых агентствами по медицинскому уходу на дому. Результаты опроса помогут другим людям выбрать подходящее агентство, оказывающее услуги медицинского ухода на дому.

Ваше участие в этом опросе является добровольным. Опрос займет примерно 12 минут, и этот звонок может быть записан или прослушан с целью повышения качества обслуживания.

**NOTE: THE LENGTH OF THE INTERVIEW WILL DEPEND ON WHETHER THE HHA ADDS SUPPLEMENTAL QUESTIONS TO ITS HOME HEALTH CARE CAHPS SURVEY.**



- INTRO3 INTRO3 AND INTRO4 USED ONLY IF CALLING SAMPLE MEMBER BACK TO COMPLETE A SURVEY THAT WAS BEGUN IN A PREVIOUS CALL. NOTE THAT THE SAMPLE MEMBER MUST HAVE ANSWERED AT LEAST ONE QUESTION IN THE SURVEY IN A PRECEDING CALL.
- Здравствуйте, могу я поговорить с [SAMPLE MEMBER'S NAME]?
- IF ASKED WHO IS CALLING:  
 Это [INTERVIEWER NAME] Я звоню от лица [VENDOR]. Я хотел {хотела if a female interviewer} бы поговорить с [SAMPLE MEMBER'S NAME] по поводу опроса о медицинском уходе.
- 1 YES, SAMPLE MEMBER IS AVAILABLE AND ON PHONE NOW → [GO TO INTRO4]
  - 2 NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
  - 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]
  - 4 MENTALLY/PHYSICALLY INCAPABLE → [GO TO PROXY SCRIPT]
- INTRO4 Здравствуйте, я звоню продолжить опрос о медицинском уходе предоставленном Вам [HOME HEALTH AGENCY]. который мы начали в предыдущем звонке. Я хотел {хотела if a female interviewer} бы продолжить опрос.
- 1 CONTINUE WITH INTERVIEW AT FIRST UNANSWERED QUESTION
  - 2 NO, NOT RIGHT NOW → [SET CALLBACK]
  - 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]
- Q1. Согласно нашим данным Вы пользовались услугами домашнего медицинского ухода агентства [HOME HEALTH AGENCY]. Это так?
- 1 ДА →[GO TO Q2\_INTRO]
  - 2 НЕТ →[GO TO Q\_INELIG]
- M MISSING/DK →[GO TO Q\_INELIG]

- Q2\_INTRO Когда Вы будете отвечать на вопросы, всегда думайте только об услугах этого агентства.
- Q2. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, рассказал ли Вам кто-либо из агентства о характере ухода и услугах, которые будут Вам предоставляться?
- 1 ДА
  - 2 НЕТ
  - 3 Я НЕ ПОМНЮ
- M MISSING/DK
- Q3. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, **рассказал ли Вам** кто-либо из агентства о том, как обустроить свой дом, чтобы Вы могли безопасно в нем передвигаться?
- 1 ДА
  - 2 НЕТ
  - 3 Я НЕ ПОМНЮ
- M MISSING/DK
- Q4. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, спрашивал ли Вас кто-либо из агентства о **рецептурных и нерекцептурных препаратах**, которые Вы принимали?
- 1 ДА
  - 2 НЕТ
  - 3 Я НЕ ПОМНЮ
- M MISSING/DK
- Q5. Когда Вы начали пользоваться услугами домашнего медицинского ухода этого агентства, просил ли Вас кто-либо из агентства **показать** ему/ей все рецептурные и нерекцептурные препараты, которые Вы принимали?
- 1 ДА
  - 2 НЕТ
  - 3 Я НЕ ПОМНЮ
- M MISSING/DK

- Q6\_INTRO Следующие вопросы относятся к различным сотрудникам [HOME HEALTH AGENCY], предоставлявшим Вам уход за последние 2 месяца. В своих ответах не ссылайтесь на сотрудников другого агентства. В своих ответах не ссылайтесь на членов семьи или друзей.
- Q6. За последние 2 месяца являлся ли один из сотрудников этого агентства, оказывающих уход, медсестрой или медбратом?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q7. За последние 2 месяца являлся ли один из сотрудников этого агентства, оказывающих уход, физиотерапевтом, специалистом по трудотерапии или логопедом?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q8. За последние 2 месяца являлся ли один из сотрудников этого агентства, оказывающих уход, помощником по домашнему уходу или личным помощником?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q9. Как часто за последние 2 месяца сотрудники этого агентства, оказывающие уход, были хорошо проинформированы о необходимом для Вас уходе и лечении?
- 1 Никогда,
  - 2 иногда,
  - 3 часто,
  - 4 всегда, или
  - 5 за Вами ухаживал всего один сотрудник за последние 2 месяца?
- M MISSING/DK

- Q10. За последние 2 месяца разговаривали ли Вы с ухаживающим за Вами  
сотрудником из этого агентства о боли?
- 1 ДА  
2 НЕТ
- M MISSING/DK
- Q11. За последние 2 месяца начали ли Вы принимать новые рецептурные  
препараты или сменили препараты, которые принимали?
- 1 ДА  
2 НЕТ →[GO TO Q15]
- M MISSING/DK → [GO TO Q15]
- Q12. За последние 2 месяца объясняли ли Вам сотрудники этого агентства  
**причину** перехода на новые препараты или смены рецептурных  
препаратов?
- 1 ДА  
2 НЕТ
- M MISSING/DK
- Q13. За последние 2 месяца объяснили ли Вам сотрудники этого агентства, **когда**  
необходимо принимать эти препараты?
- 1 ДА  
2 НЕТ
- M MISSING/DK
- Q14. За последние 2 месяца рассказывали ли Вам сотрудники этого агентства о  
**побочных эффектах** этих препаратов?
- 1 ДА  
2 НЕТ
- M MISSING/DK

- Q15. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, информировали Вас о том, когда они придут к Вам домой?
- 1 Никогда,
  - 2 иногда,
  - 3 часто, или
  - 4 всегда?
- M MISSING/DK
- Q16. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, обращались с Вами максимально деликатно?
- 1 Никогда,
  - 2 иногда,
  - 3 часто, или
  - 4 всегда?
- M MISSING/DK
- Q17. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, объясняли Вам все простым и понятным языком?
- 1 Никогда,
  - 2 иногда,
  - 3 часто, или
  - 4 всегда?
- M MISSING/DK
- Q18. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, внимательно Вас выслушивали?
- 1 Никогда,
  - 2 иногда,
  - 3 часто, или
  - 4 всегда?
- M MISSING/DK

Q19. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие за Вами уход, обращались с Вами вежливо и с уважением?

- 1 Никогда,
- 2 иногда,
- 3 часто, или
- 4 всегда?

M MISSING/DK

Q20\_INTRO Мы бы хотели узнать, как Вы оцените услуги по уходу, предоставляемые сотрудниками этого агентства.

Q20. По шкале от 0 до 10, где 0 означает наихудшее качество услуг по домашнему медицинскому уходу, а 10 — наилучшее качество услуг, как бы Вы оценили качество услуг по уходу, предоставляемых сотрудниками этого агентства?

READ RESPONSE CHOICES ONLY IF NECESSARY

- 00 0 Наихудшее качество услуг по домашнему медицинскому уходу
- 01 1
- 02 2
- 03 3
- 04 4
- 05 5
- 06 6
- 07 7
- 08 8
- 09 9
- 10 10 Наилучшее качество услуг по домашнему медицинскому уходу

M MISSING/DK

Q21\_INTRO Следующие вопросы относятся к офису [HOME HEALTH AGENCY].

Q21. За последние 2 месяца ухода обращались ли Вы в **офис** за помощью или консультацией?

- 1 ДА
- 2 НЕТ → [GO TO Q24]]

M MISSING/DK → [GO TO Q24]]

- Q22. За последние 2 месяца ухода когда Вы обращались в офис агентства, удалось ли Вам получить необходимую помощь или консультацию?
- 1 ДА
  - 2 НЕТ →[GO TO Q24]
- M MISSING/DK → [GO TO Q24]
- Q23. Когда Вы обратились в офис агентства, как быстро Вам была оказана необходимая помощь или предоставлена консультация?
- 1 В тот же день,
  - 2 через 1-5 дней,
  - 3 через 6-14 дней, или
  - 4 более чем через 14 дней?
- M MISSING/DK
- Q24. За последние 2 месяца ухода возникали ли у Вас проблемы с услугами по уходу, предоставляемыми этим агентством?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q25. Вы бы порекомендовали это агентство членам своей семьи или друзьям, если бы они нуждались в домашнем медицинском уходе?
- 1 Определенно нет,
  - 2 скорее всего, нет,
  - 3 возможно, или
  - 4 определенно да?
- M MISSING/DK

Q26\_INTRO Этот последний раздел вопросов предназначен для получения личной информации о Вас. Пожалуйста, выслушайте все варианты ответов, прежде чем сделать выбор.

Q26. В общих словах, как бы Вы оценили свое состояние здоровья? Можно ли его описать как

- 1 отличное,
- 2 очень хорошее,
- 3 хорошее,
- 4 нормальное, или
- 5 плохое?

M MISSING/DK

Q27. В общих словах, как бы Вы оценили свое умственное или эмоциональное здоровье? Можно ли его описать как

- 1 отличное,
- 2 очень хорошее,
- 3 хорошее,
- 4 нормальное, или
- 5 плохое?

M MISSING/DK

Q28. Вы проживаете один (одна)?

- 1 ДА
- 2 НЕТ

M MISSING/DK

Q29. Каков Ваш уровень образования?

- 1 8 классов или меньше,
- 2 среднее образование без выпуска,
- 3 диплом об общем среднем образовании,
- 4 несколько курсов ВУЗа или диплом выпускника 2-летней программы,
- 5 диплом о высшем образовании, или
- 6 аспирантура или выше

M MISSING/DK



- Q30. Вы латиноамериканского происхождения?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q31. К какой расе Вы принадлежите? Вы можете выбрать один или несколько следующих вариантов. Вы
- 1 коренной житель (-ница) Америки или Аляски,
  - 2 азиатского происхождения,
  - 3 темнокожий (-ая) или афроамериканец (-ка),
  - 4 уроженец (-ка) Гавайских островов или других тихоокеанских островов, или
  - 5 белый (-ая)?
- M MISSING/DK
- Q32. На каком языке Вы обычно разговариваете дома?
- 1 На английском →[GO TO Q\_END]
  - 2 на испанском или →[GO TO Q\_END]
  - 3 на другом языке? → [GO TO 32A]
- M MISSING/DK →[GO TO Q\_END]
- Q32A На каком еще языке Вы разговариваете дома? (ENTER RESPONSE BELOW).
- {ALLOW UP TO 50 CHARACTERS}
- M MISSING/DK
- Q\_END У меня больше к Вам нет вопросов. Спасибо Вам за Ваше время. До свидания!
- INELIGIBLE SCREEN:
- Q\_INELIG Спасибо Вам за Ваше время. До свидания!
- REFUSAL SCREEN:
- Q\_REF Спасибо Вам за Ваше время. До свидания!

**PROXY TELEPHONE INTERVIEW SCRIPT  
FOR THE HOME HEALTH CARE CAHPS SURVEY IN RUSSIAN**

PROXY ID    Есть ли в доме член семьи или друг, кто был бы знаком с качеством услуг по уходу, предоставляемых [SAMPLE MEMBER'S NAME]?

PROBE TO FIND OUT IF PERSON IS AVAILABLE IN HOUSEHOLD TO DO INTERVIEW.

- 1    ДА ➔ [GO TO PROXY\_INTRO]
- 2    НЕТ ➔ [COLLECT NAME AND TELEPHONE NUMBER OF PROXY AND SET A CALLBACK, OR IF NO PROXY EXISTS, GO TO Q\_END AND CODE AS MENTALLY/PHYSICALLY INCAPABLE]

IF ASKED WHO IS CALLING:

Это [INTERVIEWER NAME] из [ORGANIZATION]. Я бы хотел (-а) поговорить с кем-нибудь, кто располагает информацией о здоровье [SAMPLE MEMBER NAME] и качестве оказываемых услуг по уходу для опроса, проводимого [ORGANIZATION], о качестве услуг по домашнему медицинскому уходу.

PROXY\_INTRO    [Здравствуйте! Это {INTERVIEWER NAME}. Я звоню от лица {HOME HEALTH AGENCY}]. Эта организация участвует в национальном опросе о качестве услуг, предоставляемых агентствами по медицинскому уходу на дому. Результаты опроса помогут другим людям выбрать подходящее агентство, оказывающее услуги медицинского ухода на дому.

Участие [SAMPLE MEMBER NAME] в этом опросе является добровольным. Опрос займет примерно 12 минут, и этот звонок может быть записан или прослушан с целью повышения качества обслуживания.

**NOTE: THE LENGTH OF THE INTERVIEW WILL DEPEND ON WHETHER THE HHA ADDS SUPPLEMENTAL QUESTIONS TO ITS HOME HEALTH CARE CAHPS SURVEY.**

INTRO3    INTRO3 AND INTRO4 USED ONLY IF CALLING PROXY BACK TO COMPLETE A SURVEY THAT WAS BEGUN IN A PREVIOUS CALL. NOTE THAT THE PROXY MUST HAVE ANSWERED AT LEAST ONE QUESTION IN THE SURVEY IN A PRECEDING CALL.

Здравствуйте, могу я поговорить с [PROXY NAME]?

IF ASKED WHO IS CALLING:

Это [INTERVIEWER NAME] Я звоню от лица [VENDOR]. Я хотел {хотела if a female interviewer} бы поговорить с [PROXY NAME] по поводу опроса о медицинском уходе.

- 1 YES, PROXY IS AVAILABLE AND ON PHONE NOW → [GO TO INTRO4]
- 2 NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
- 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]

INTRO4      Здравствуйте, я звоню продолжить опрос о медицинском уходе предоставленном [SAMPLE MEMBER NAME] [HOME HEALTH AGENCY], который мы начали в предыдущем звонке. Я хотел {хотела if a female interviewer} бы продолжить опрос.

- 1 CONTINUE WITH INTERVIEW AT FIRST UNANSWERED QUESTION
- 2 NO, NOT RIGHT NOW → [SET CALLBACK]
- 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]

Q1.            Согласно нашим данным [SAMPLE MEMBER NAME] пользовался (-лась) услугами домашнего медицинского ухода агентства [HOME HEALTH AGENCY]. Это так?

- 1 ДА → [GO TO Q2\_INTRO]
- 2 НЕТ → [GO TO Q\_INELIG]

M MISSING/DK → [GO TO Q\_INELIG]

- Q2\_INTRO    Когда Вы будете отвечать на вопросы, всегда думайте только об услугах этого агентства, предоставляемых [SAMPLE MEMBER NAME].  
Пожалуйста, постарайтесь как можно точнее ответить на вопросы с точки зрения [SAMPLE MEMBER NAME]. Если необходимо, Вы можете отвечать на вопросы с точки зрения члена семьи или лица, ухаживающего за [SAMPLE MEMBER NAME].
- Q2.            Когда [SAMPLE MEMBER NAME] начал (-а) пользоваться услугами домашнего медицинского ухода этого агентства, рассказал ли [ему/ей] кто-либо из агентства о характере ухода и услугах, которые будут [ему/ей] предоставляться?
- 1    ДА  
2    НЕТ  
3    Я НЕ ПОМНЮ
- M   MISSING/DK
- Q3.            Когда [SAMPLE MEMBER NAME] начал (-а) пользоваться услугами домашнего медицинского ухода этого агентства, **рассказал ли [ему/ей]** кто-либо из агентства о том, как обустроить свой дом, чтобы [он/она] могли безопасно в нем передвигаться?
- 1    ДА  
2    НЕТ  
3    Я НЕ ПОМНЮ
- M   MISSING/DK
- Q4.            Когда [SAMPLE MEMBER NAME] начал (-а) пользоваться услугами домашнего медицинского ухода этого агентства, спрашивал ли [его/ее] кто-либо из агентства о **рецептурных и нерекцептурных препаратах**, которые [он/она] принимали?
- 1    ДА  
2    НЕТ  
3    Я НЕ ПОМНЮ
- M   MISSING/DK

- Q5. Когда [SAMPLE MEMBER NAME] начал (-а) пользоваться услугами домашнего медицинского ухода этого агентства, просил ли [его/ее] кто-либо из агентства **показать** ему/ей все рецептурные и нерецептурные препараты, которые [он/она] принимает?
- 1 ДА
  - 2 НЕТ
  - 3 Я НЕ ПОМНЮ
- M MISSING/DK
- Q6\_INTRO Следующие вопросы относятся к различным сотрудникам [HOME HEALTH AGENCY], предоставлявшим уход [SAMPLE MEMBER NAME] за последние 2 месяца. В своих ответах не ссылайтесь на сотрудников другого агентства, предоставлявших услуги по уходу [SAMPLE MEMBER NAME]. В своих ответах не ссылайтесь на членов семьи или друзей, предоставлявшим ему/ей уход.
- Q6. За последние 2 месяца являлся ли кто-либо из сотрудников этого агентства, оказывающих уход за [SAMPLE MEMBER NAME], медсестрой или медбратом?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q7. За последние 2 месяца являлся ли кто-либо из сотрудников этого агентства, оказывающих уход за [SAMPLE MEMBER NAME], физиотерапевтом, специалистом по трудотерапии или логопедом?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q8. За последние 2 месяца являлся ли кто-либо из сотрудников этого агентства, оказывающих уход за [SAMPLE MEMBER NAME], помощником по домашнему уходу или личным помощником?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK

Q9. Как часто за последние 2 месяца сотрудники этого агентства, оказывающие уход, были хорошо проинформированы о необходимом для [SAMPLE MEMBER NAME] уходе и лечении?

- 1 Никогда,
- 2 иногда,
- 3 часто,
- 4 всегда, или
- 5 за [SAMPLE MEMBER NAME] ухаживал всего один сотрудник за последние 2 месяца?

M MISSING/DK

Q10. За последние 2 месяца разговаривал(-а) ли [SAMPLE MEMBER NAME] с ухаживающим за [SAMPLE MEMBER NAME] сотрудником из этого агентства о боли?

- 1 ДА
- 2 НЕТ

M MISSING/DK

Q11. За последние 2 месяца начал(-а) ли [SAMPLE MEMBER NAME] принимать новые рецептурные препараты или сменил(-а) препараты, которые [он/она] принимал(-а)?

- 1 ДА
- 2 НЕТ →[GO TO Q15]

M MISSING/DK →[GO TO Q15]

Q12. За последние 2 месяца объясняли ли сотрудники этого агентства [SAMPLE MEMBER NAME] **причину** перехода на новые препараты или смены рецептурных препаратов?

- 1 ДА
- 2 НЕТ

M MISSING/DK

- Q13. За последние 2 месяца объяснили ли сотрудники этого агентства [SAMPLE MEMBER NAME], **когда** необходимо принимать эти препараты?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q14. За последние 2 месяца рассказывали ли сотрудники этого агентства [SAMPLE MEMBER NAME] о **побочных эффектах** этих препаратов?
- 1 ДА
  - 2 НЕТ
- M MISSING/DK
- Q15. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие уход, информировали [SAMPLE MEMBER NAME] о том, когда они приедут домой к [нему/ней]?
- 1 Никогда,
  - 2 иногда,
  - 3 часто, или
  - 4 всегда?
- M MISSING/DK
- Q16. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие уход, максимально деликатно обращались с [SAMPLE MEMBER NAME]?
- 1 Никогда,
  - 2 иногда,
  - 3 часто, или
  - 4 всегда?
- M MISSING/DK

Q17. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие уход, объясняли все простым и понятным языком?

- 1 Никогда,
- 2 иногда,
- 3 часто, или
- 4 всегда?

M MISSING/DK

Q18. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие уход, внимательно выслушивали [SAMPLE MEMBER NAME]?

- 1 Никогда,
- 2 иногда,
- 3 часто, или
- 4 всегда?

M MISSING/DK

Q19. Как часто за последние 2 месяца сотрудники этого агентства, осуществляющие уход, обращались с [SAMPLE MEMBER NAME] вежливо и с уважением?

- 1 Никогда,
- 2 иногда,
- 3 часто, или
- 4 всегда?

M MISSING/DK



Q20\_INTRO Мы бы хотели узнать, как [SAMPLE MEMBER NAME] оценил(-а) бы услуги по уходу, предоставляемые сотрудниками этого агентства. Пожалуйста, постарайтесь как можно точнее ответить на вопросы с точки зрения [SAMPLE MEMBER NAME]. Если необходимо, Вы можете отвечать на вопросы с точки зрения члена семьи или лица, ухаживающего за [SAMPLE MEMBER NAME].

Q20. По шкале от 0 до 10, где 0 означает наихудшее качество услуг по домашнему медицинскому уходу, а 10 — наилучшее качество услуг, как бы [SAMPLE MEMBER NAME] оценил(-а) качество услуг по уходу, предоставляемых сотрудниками этого агентства?

READ RESPONSE CHOICES ONLY IF NECESSARY

- 00 0 Наихудшее качество услуг по домашнему медицинскому уходу
- 01 1
- 02 2
- 03 3
- 04 4
- 05 5
- 06 6
- 07 7
- 08 8
- 09 9
- 10 10 Наилучшее качество услуг по домашнему медицинскому уходу

M MISSING/DK

Q21\_INTRO Следующие вопросы относятся к офису [HOME HEALTH AGENCY].

Q21. За последние 2 месяца ухода обращался (-лась) ли [SAMPLE MEMBER NAME] в **офис** за помощью или консультацией?

- 1 ДА
- 2 НЕТ →[GO TO Q24]

M MISSING/DK →[GO TO Q24]

Q22. За последние 2 месяца ухода когда [SAMPLE MEMBER NAME] обращался (-лась) в офис агентства, удалось ли [ему/ей] получить необходимую помощь или консультацию?

- 1 ДА
- 2 НЕТ →[GO TO Q24]

M MISSING/DK →[GO TO Q24]

Q23. Когда [SAMPLE MEMBER NAME] обратился (-лась) в офис агентства, как быстро [ему/ей] была оказана необходимая помощь или предоставлена консультация?

- 1 В тот же день,
- 2 через 1-5 дней,
- 3 через 6-14 дней, или
- 4 более чем через 14 дней?

M MISSING/DK

Q24. За последние 2 месяца ухода возникали ли у [SAMPLE MEMBER NAME] проблемы с услугами по уходу, предоставляемыми этим агентством?

- 1 ДА
- 2 НЕТ

M MISSING/DK

Q25. Посоветовал(-а) бы [SAMPLE MEMBER NAME] это агентство членам своей семьи или друзьям, если бы они нуждались в домашнем медицинском уходе?

- 1 Определенно нет,
- 2 скорее всего, нет,
- 3 возможно, или
- 4 определенно да?

M MISSING/DK

Q26\_INTRO Этот последний раздел вопросов предназначен для получения личной информации о [SAMPLE MEMBER NAME]. Пожалуйста, выслушайте все варианты ответов, прежде чем сделать выбор.

Q26. В общих словах, как бы [SAMPLE MEMBER NAME] оценил (-а) свое состояние здоровья? Можно ли его описать как

- 1 отличное,
- 2 очень хорошее,
- 3 хорошее,
- 4 нормальное, или
- 5 плохое?

M MISSING/DK

Q27. В общих словах, как бы [SAMPLE MEMBER NAME] оценил (-а) свое умственное или эмоциональное здоровье? Можно ли его описать как

- 1 отличное,
- 2 очень хорошее,
- 3 хорошее,
- 4 нормальное, или
- 5 плохое?

M MISSING/DK

Q28. Проживает ли [SAMPLE MEMBER NAME] один (одна)?

- 1 ДА
- 2 НЕТ

M MISSING/DK

Q29. Каков уровень образования [SAMPLE MEMBER NAME]?

- 1 8 классов или меньше,
- 2 среднее образование без выпуска,
- 3 диплом об общем среднем образовании,
- 4 несколько курсов ВУЗа или диплом выпускника 2-летней программы,
- 5 диплом о высшем образовании, или
- 6 аспирантура и выше

M MISSING/DK

Q30. [SAMPLE MEMBER NAME] латиноамериканского происхождения?

- 1 ДА
- 2 НЕТ

M MISSING/DK

Q31. К какой расе принадлежит [SAMPLE MEMBER NAME]? Вы можете выбрать один или несколько следующих вариантов. Он/она

- 1 коренной житель (-ница) Америки или Аляски
- 2 азиатского происхождения
- 3 темнокожий (-ая) или афроамериканец (-ка)
- 4 уроженец (-ка) Гавайских островов или других тихоокеанских островов
- 5 белый (-ая)?

M MISSING/DK

Q32. На каком языке [SAMPLE MEMBER NAME] обычно разговаривает дома?

- 1 На английском, →[GO TO Q\_END]
- 2 на испанском или, или →[GO TO Q\_END]
- 3 на другом языке? → [GO TO Q32A]

M MISSING/DK →[GO TO Q\_END]

Q32A На каком еще языке [SAMPLE MEMBER NAME] разговаривает дома?  
(ENTER RESPONSE BELOW).

{ALLOW UP TO 50 CHARACTERS }

M MISSING/DK

Q\_END У меня больше к Вам нет вопросов. Спасибо Вам за Ваше время. До свидания!

INELIGIBLE SCREEN:

Q\_INELIG Спасибо Вам за Ваше время. До свидания!

REFUSAL SCREEN:

Q\_REF Спасибо Вам за Ваше время. До свидания!

**APPENDIX H:**

**VIETNAMESE:**

**MAIL SURVEY COVER LETTERS,**  
**REGULAR AND SCANNABLE QUESTIONNAIRES,**  
**TELEPHONE INTERVIEW SCRIPT,**  
**PROXY INTERVIEW SCRIPT**

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## Sample Cover Letter for First Questionnaire Mailing in Vietnamese

Home Health Care CAHPS Survey

To be Printed on Home Health Agency or Vendor Letterhead

---

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Kính gửi «FirstName» «LastName»:

Đây là khảo sát quan trọng từ Medicare dành cho những người tiếp nhận dịch vụ chăm sóc sức khỏe tại nhà. **Vui lòng dành ít phút để chia sẻ trải nghiệm của quý vị với «HHA» và gửi lại bản khảo sát trong phong bì đã thanh toán bưu phí kèm theo.** Ý kiến phản hồi của quý vị sẽ giúp Medicare cải thiện chất lượng tổng thể của dịch vụ chăm sóc sức khỏe tại nhà và giúp những người khác chọn được công ty chăm sóc sức khỏe tại nhà.

**Ý kiến của quý vị rất quan trọng.** Chúng tôi muốn câu trả lời phản ánh quan điểm riêng của quý vị mà không phải người khác từ công ty được nêu tên ở trên. Nếu quý vị cần trợ giúp về bản khảo sát, vui lòng nhờ một thành viên gia đình hoặc bạn bè.

Việc tham gia là tự nguyện và thông tin của quý vị sẽ được bảo mật theo luật. Không ai có thể liên kết tên của quý vị với câu trả lời.

**Chúng tôi quan tâm  
đến trải nghiệm chăm  
sóc sức khỏe tại nhà  
của quý vị.**

Nếu quý vị có bất kỳ câu hỏi nào về khảo sát này, vui lòng gọi đến VENDOR NAME, (miễn cước) theo số 1-XXX-XXX-XXXX.

Xin cảm ơn quý vị đã giúp cải thiện dịch vụ chăm sóc sức khỏe tại nhà.

Trân trọng,

Name

Quản Trị Viên Cơ Quan Chăm Sóc Sức Khỏe Tại Nhà

[PRINT SAMPLE ID HERE]

**Sample Cover Letter**  
**for Second Questionnaire Mailing to Mail Survey Nonrespondents in Vietnamese**  
Home Health Care CAHPS Survey  
To be Printed on Home Health Agency or Vendor Letterhead

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«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Kính gửi «FirstName» «LastName»:

Gần đây, quý vị đã nhận được bản khảo sát từ Medicare về trải nghiệm của quý vị với «HHA». **Nếu quý vị đã gửi lại bản khảo sát này, chúng tôi xin chân thành cảm ơn! Quý vị không cần phải làm gì khác.**

Xin nhắc lại rằng chúng tôi rất quan tâm đến việc tìm hiểu về trải nghiệm của quý vị. Ý kiến phản hồi của quý vị sẽ giúp những người khác chọn được công ty chăm sóc sức khỏe tại nhà và giúp Medicare cải thiện chất lượng tổng thể của dịch vụ chăm sóc sức khỏe tại nhà.

**Vui lòng dành ít phút để hoàn tất và gửi lại bản khảo sát trong phong bì đã thanh toán bưu phí kèm theo.**

**Ý kiến của quý vị rất quan trọng.** Chúng tôi biết thời gian của quý vị rất quý giá. Việc tham gia là tự nguyện và thông tin của quý vị sẽ được bảo mật theo luật. Không ai có thể liên kết tên của quý vị với câu trả lời.

Nếu quý vị có bất kỳ câu hỏi nào về khảo sát này, vui lòng gọi đến VENDOR NAME, (miễn cước) theo số 1-XXX-XXX-XXXX.

**Chúng tôi quan tâm đến trải nghiệm chăm sóc của quý vị.**

Nếu quý vị cần trợ giúp về bản khảo sát, vui lòng nhờ một thành viên gia đình hoặc bạn bè.

Xin cảm ơn quý vị đã giúp cải thiện dịch vụ chăm sóc sức khỏe tại nhà.

Trân trọng,

Name

Quản Trị Viên Cơ Quan Chăm Sóc Sức Khỏe Tại Nhà

[PRINT SAMPLE ID HERE]



OMB #: 0938-1066  
Hết hạn ngày 31/07/2026

# KHẢO SÁT CAHPS VỀ CHĂM SÓC SỨC KHỎE TẠI GIA<sup>®</sup>

## 2025

### HƯỚNG DẪN ĐIỀN KHẢO SÁT

- Hãy trả lời mọi câu hỏi bằng cách tô tròn ở bên trái câu trả lời của quý vị.
- Đôi khi quý vị cần phải bỏ qua một vài câu hỏi trong bản khảo sát này. Vào lúc đó, quý vị sẽ thấy dấu mũi tên cùng với ghi chú cho biết kế tiếp cần trả lời câu hỏi nào, thí dụ như:

☒ Có → Nếu trả lời Có thì chuyển sang Câu 1 ở Trang 1.

☐ Không

### CHĂM SÓC SỨC KHỎE TẠI GIA CHO QUÝ VỊ

1. Hồ sơ của chúng tôi cho thấy quý vị nhận được dịch vụ chăm sóc từ cơ quan chăm sóc sức khỏe tại gia [TÊN CƠ QUAN]. Có đúng như vậy không?

Khi quý vị trả lời các câu hỏi trong khảo sát này thì chỉ nên nhớ về những điều mình đã trải qua với cơ quan này.

1 ☐ Có

2 ☐ Không → Nếu trả lời Không thì xin ngừng và gửi lại bản khảo sát vào bao thư để sẵn.

2. Trong lần đầu tiên quý vị được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan cho biết quý vị sẽ được những loại chăm sóc và dịch vụ nào không?

1 ☐ Có

2 ☐ Không

3 ☐ Không nhớ

3. Trong lần đầu tiên quý vị được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan bàn với quý vị về cách sắp xếp lại nhà cửa để quý vị có thể đi lại an toàn hay không?

1 ☐ Có

2 ☐ Không

3 ☐ Không nhớ

4. Khi quý vị bắt đầu được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan bàn với quý vị về mọi loại thuốc mua theo toa và mua tự do mà quý vị đang dùng không?

1 ☐ Có

2 ☐ Không

3 ☐ Không nhớ

5. Khi quý vị bắt đầu được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan yêu cầu cho **xem** mọi loại thuốc theo toa và mua tự do mà quý vị đang dùng không?

1 ☐ Có

2 ☐ Không

3 ☐ Không nhớ

**DỊCH VỤ CHĂM SÓC DO NHỮNG  
NGƯỜI CHĂM SÓC SỨC KHỎE TẠI  
GIA THỰC HIỆN TRONG 2 THÁNG  
VỪA QUA**

Kế tiếp là các câu hỏi về mọi nhân viên của [TÊN CƠ QUAN] đã từng chăm sóc quý vị trong 2 tháng vừa qua. Đừng gộp chung phần chăm sóc mà nhân viên của cơ quan chăm sóc sức khỏe tại gia khác thực hiện cho quý vị. Đừng gộp chung phần chăm sóc mà gia đình hay bạn bè thực hiện cho quý vị.

6. Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là y tá không?

1 ☐ Có

2 ☐ Không

7. Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là chuyên viên trị liệu vật lý, trị liệu phục hồi các kỹ năng thường ngày, hoặc trị liệu âm ngữ không?

1 ☐ Có

2 ☐ Không

8. Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là trợ tá chăm sóc riêng hay chăm sóc sức khỏe tại gia không?

1 ☐ Có

2 ☐ Không

9. Trong 2 tháng chăm sóc vừa qua, những người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên tỏ ra hiểu biết và cập nhật thông tin về mọi hoạt động chăm sóc hay điều trị tại nhà cho quý vị không?

1 ☐ Chưa bao giờ

2 ☐ Thỉnh thoảng

3 ☐ Thường khi

4 ☐ Luôn luôn

5 ☐ Tôi chỉ có một người chăm sóc sức khỏe trong 2 tháng chăm sóc vừa qua

10. Trong 2 tháng chăm sóc vừa qua, quý vị và người chăm sóc sức khỏe tại gia từ cơ quan này có bàn về cơn đau không?

1 ☐ Có

2 ☐ Không

11. Trong 2 tháng chăm sóc vừa qua, quý vị có dùng bất cứ loại thuốc mới nào theo toa hoặc thay đổi bất kỳ loại thuốc nào đang dùng không?

1 ☐ Có

2 ☐ Không → Nếu trả lời Không thì chuyển sang Câu 15.

12. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về mục đích dùng thuốc mới theo toa hoặc thay đổi thuốc theo toa không?

1 ☐ Có

2 ☐ Không

3 ☐ Tôi **không** dùng bất cứ thuốc mới nào theo toa, và cũng không thay đổi bất kỳ loại thuốc nào

13. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về **lúc nào** nên dùng các loại thuốc đó không?

1 ☐ Có

2 ☐ Không

3 ☐ Tôi **không** dùng bất cứ thuốc mới nào theo toa, và cũng không thay đổi bất kỳ loại thuốc nào

14. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về những **phản ứng phụ** của các loại thuốc đó không?

1 ☐ Có

2 ☐ Không

3 ☐ Tôi **không** dùng bất cứ thuốc mới nào theo toa, và cũng không thay đổi bất kỳ loại thuốc nào

15. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên báo cho quý vị biết lúc nào họ sẽ đến nhà quý không?

1 ☐ Chưa bao giờ

2 ☐ thỉnh thoảng

3 ☐ Thường khi

4 ☐ Luôn luôn

16. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên đối xử nhẹ nhàng êm dịu với quý vị không?

1 ☐ Chưa bao giờ  
2 ☐ Thỉnh thoảng  
3 ☐ Thường khi  
4 ☐ Luôn luôn

17. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên giải thích mọi điều theo cách dễ hiểu không?

1 ☐ Chưa bao giờ  
2 ☐ Thỉnh thoảng  
3 ☐ Thường khi  
4 ☐ Luôn luôn

18. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên chăm chú lắng nghe quý vị không?

1 ☐ Chưa bao giờ  
2 ☐ Thỉnh thoảng  
3 ☐ Thường khi  
4 ☐ Luôn luôn

19. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên đối xử nhã nhặn và tôn trọng quý vị không?

1 ☐ Chưa bao giờ  
2 ☐ Thỉnh thoảng  
3 ☐ Thường khi  
4 ☐ Luôn luôn

20. Chúng tôi muốn biết đánh giá của quý vị về công việc chăm sóc của những người chăm sóc sức khỏe tại gia từ cơ quan này.

Tính theo thang điểm từ 0 tới 10, trong đó 0 là chăm sóc sức khỏe tại gia tệ nhất và 10 là chăm sóc sức khỏe tại gia tốt nhất, quý vị sẽ dùng số mấy để đánh giá công việc chăm sóc của người chăm sóc sức khỏe tại gia từ cơ quan này?

☐ 0 Chăm sóc sức khỏe tại gia tệ nhất  
☐ 1  
☐ 2  
☐ 3  
☐ 4  
☐ 5  
☐ 6  
☐ 7  
☐ 8  
☐ 9  
☐ 10 Chăm sóc sức khỏe tại gia tốt nhất

**CƠ QUAN CHĂM SÓC SỨC KHỎE TẠI  
GIA CHO QUÝ VỊ**

Kế tiếp là các câu hỏi về văn phòng của  
[TÊN CƠ QUAN].

21. Trong 2 tháng chăm sóc vừa qua, quý vị có liên lạc với **văn phòng** của cơ quan này để được giúp đỡ hoặc khuyên bảo không?

1 ☐ Có  
2 ☐ Không → Nếu trả lời Không thì chuyển sang Câu 24.

22. Trong 2 tháng chăm sóc vừa qua, khi liên lạc với văn phòng của cơ quan này, quý vị có được giúp đỡ hoặc khuyên bảo đúng như mình cần không?

1 ☐ Có  
2 ☐ Không → Nếu trả lời Không thì chuyển sang Câu 24.

3 ☐ Tôi **không** liên lạc với cơ quan này

23. Khi liên lạc với văn phòng của cơ quan này quý vị phải chờ bao lâu mới có người giúp đỡ hoặc khuyên bảo những điều quý vị cần?

1 ☐ Trong cùng ngày  
2 ☐ 1 đến 5 ngày  
3 ☐ 6 đến 14 ngày  
4 ☐ Nhiều hơn 14 ngày  
5 ☐ Tôi **không** liên lạc với cơ quan này

24. Trong 2 tháng chăm sóc vừa qua, quý vị có bất cứ vấn đề rắc rối nào với sự chăm sóc nhận được qua cơ quan này không?

1 ☐ Có  
2 ☐ Không

25. Nếu gia đình hay bạn bè cần chăm sóc sức khỏe tại gia thì quý vị có khuyên họ sử dụng dịch vụ của cơ quan này không?

1 ☐ Chắc chắn là không  
2 ☐ Có lẽ là không  
3 ☐ Có lẽ là có  
4 ☐ Chắc chắn là có

**NÓI VỀ QUÝ VỊ**

**26.** Nói chung quý vị đánh giá tình hình sức khỏe tổng quát của mình ra sao?

- 1 ☐ Tuyệt vời  
2 ☐ Rất tốt  
3 ☐ Tốt  
4 ☐ Tạm được  
5 ☐ Rất tệ

**27.** Nói chung quý vị đánh giá tình hình sức khỏe tinh thần hoặc tâm trạng tổng quát của mình ra sao?

- 1 ☐ Tuyệt vời  
2 ☐ Rất tốt  
3 ☐ Tốt  
4 ☐ Tạm được  
5 ☐ Rất tệ

**28.** Có phải quý vị sống riêng một mình không?

- 1 ☐ Có  
2 ☐ Không

**29.** Quý vị đã học hết cấp bậc hay năm học cao nhất nào tại trường?

- 1 ☐ Lớp 8 trở xuống  
2 ☐ Học vài năm trung học, nhưng chưa tốt nghiệp  
3 ☐ Tốt nghiệp trung học hoặc có GED (Chứng Chỉ Tương Đương)  
4 ☐ Học vài năm đại học hoặc có bằng cấp 2 năm  
5 ☐ Tốt nghiệp đại học 4 năm  
6 ☐ Cao hơn trình độ đại học 4 năm

**30.** Có phải quý vị có nguồn gốc Tây Bồ Nha hoặc La Tinh?

- 1 ☐ Có  
2 ☐ Không

**31.** Quý vị thuộc sắc tộc nào? Nên chọn một hoặc nhiều câu.

- 1 ☐ Mỹ Da Đỏ hay Dân Bản Xứ Alaska  
2 ☐ Á Châu  
3 ☐ Da Đen hay Mỹ gốc Phi Châu  
4 ☐ Thổ Dân Hạ Uy Di hay Hải Đảo Thái Bình Dương khác  
5 ☐ Da Trắng

32. Quý vị thường nói thứ tiếng nào khi ở nhà?

- 1 ☐ Tiếng Anh  
2 ☐ Tiếng Tây Ban Nha  
3 ☐ Ngôn ngữ khác:

\_\_\_\_\_  
(Nên viết bằng chữ in.)

33. Có người nào giúp quý vị điền bản khảo sát này không?

- 1 ☐ Có  
2 ☐ Không → Nếu trả lời Không thì xin gửi lại bản khảo sát đã điền vào bao thư đã trả bưu phí.

34. Người đó giúp quý vị như thế nào?  
Chọn mọi câu thích hợp.

- 1 ☐ Đọc câu hỏi cho tôi nghe  
2 ☐ Ghi lại câu trả lời của tôi  
3 ☐ Trả lời câu hỏi dùm tôi  
4 ☐ Dịch câu hỏi ra ngôn ngữ của tôi  
5 ☐ Giúp theo cách khác:

\_\_\_\_\_  
(Nên viết bằng chữ in.)

- 6 ☐ Không một người nào giúp tôi điền bản khảo sát này

**Xin cảm ơn quý vị!**

**Xin gửi lại bản khảo sát đã điền vào bao thư đã trả bưu phí.**



OMB #: 0938-1066  
Hết hạn ngày 31/07/2026

# **KHẢO SÁT CAHPS VỀ CHĂM SÓC SỨC KHỎE TẠI GIA<sup>®</sup>**

**(ALTERNATIVE INSTRUCTIONS,  
SCANNABLE FORMS)**

**2025**

### Hướng Dẫn Điền Khảo Sát

- Hãy trả lời mọi câu hỏi bằng cách tô tròn ở bên trái câu trả lời của quý vị.
- Đôi khi quý vị cần phải bỏ qua một vài câu hỏi trong bản khảo sát này. Vào lúc đó, quý vị sẽ thấy dấu mũi tên cùng với ghi chú cho biết kế tiếp cần trả lời câu hỏi nào, thí dụ như:
  - Có → Nếu trả lời Có thì chuyển sang Câu 1 ở trang 1.
  - Không

### Chăm Sóc Sức Khỏe Tại Gia cho Quý Vị

1. Hồ sơ của chúng tôi cho thấy quý vị nhận được dịch vụ chăm sóc từ cơ quan chăm sóc sức khỏe tại gia [TÊN CƠ QUAN]. Có đúng như vậy không?

Khi quý vị trả lời các câu hỏi trong khảo sát này thì chỉ nên nhớ về những điều mình đã trải qua với cơ quan này.

- Có
- Không → Nếu trả lời Không thì xin ngừng và gọi lại bản khảo sát vào bao thư để sẵn.

2. Trong lần đầu tiên quý vị được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan cho biết quý vị sẽ được những loại chăm sóc và dịch vụ nào không?

- Có
- Không
- Không nhớ

3. Trong lần đầu tiên quý vị được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan bàn với quý vị về cách sắp xếp lại nhà cửa để quý vị có thể đi lại an toàn hay không?

- Có
- Không
- Không nhớ

4. Khi quý vị bắt đầu được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan bàn với quý vị về mọi loại thuốc mua theo toa và mua tự do mà quý vị đang dùng không?

- Có
- Không
- Không nhớ

5. Khi quý vị bắt đầu được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan yêu cầu cho **xem** mọi loại thuốc theo toa và mua tự do mà quý vị đang dùng không?

☐ Có  
☐ Không  
☐ Không nhớ

**Dịch Vụ Chăm Sóc do Những Người Chăm Sóc Sức Khỏe Tại Gia thực hiện trong 2 Tháng Vừa Qua**

Kế tiếp là các câu hỏi về mọi nhân viên của [TÊN CƠ QUAN] đã từng chăm sóc quý vị trong 2 tháng vừa qua. Đừng gộp chung phần chăm sóc mà nhân viên của cơ quan chăm sóc sức khỏe tại gia khác thực hiện cho quý vị. Đừng gộp chung phần chăm sóc mà gia đình hay bạn bè thực hiện cho quý vị.

6. Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là y tá không?

☐ Có  
☐ Không

7. Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là chuyên viên trị liệu vật lý, trị liệu phục hồi các kỹ năng thường ngày, hoặc trị liệu âm ngữ không?

☐ Có  
☐ Không

8. Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là trợ tá chăm sóc riêng hay chăm sóc sức khỏe tại gia không?

☐ Có  
☐ Không

9. Trong 2 tháng chăm sóc vừa qua, những người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên tỏ ra hiểu biết và cập nhật thông tin về mọi hoạt động chăm sóc hay điều trị tại nhà cho quý vị không?

☐ Chưa bao giờ  
☐ Thỉnh thoảng  
☐ Thường khi  
☐ Luôn luôn  
☐ Tôi chỉ có một người chăm sóc sức khỏe trong 2 tháng chăm sóc vừa qua

- |   |   |
|---|---|
| <p>10. Trong 2 tháng chăm sóc vừa qua, quý vị và người chăm sóc sức khỏe tại gia từ cơ quan này có bàn về cơn đau không?</p> <p><input type="radio"/> Có</p> <p><input type="radio"/> Không</p><br><p>11. Trong 2 tháng chăm sóc vừa qua, quý vị có dùng bất cứ loại thuốc mới nào theo toa hoặc thay đổi bất kỳ loại thuốc nào đang dùng không?</p> <p><input type="radio"/> Có</p> <p><input type="radio"/> Không → Nếu trả lời Không thì chuyển sang Câu 15.</p><br><p>12. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về <b>mục đích</b> dùng thuốc mới theo toa hoặc thay đổi thuốc theo toa không?</p> <p><input type="radio"/> Có</p> <p><input type="radio"/> Không</p> <p><input type="radio"/> Tôi <b>không</b> dùng bất cứ thuốc mới nào theo toa, và cũng không thay đổi bất kỳ loại thuốc nào</p> | <p>13. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về <b>lúc nào</b> nên dùng các loại thuốc đó không?</p> <p><input type="radio"/> Có</p> <p><input type="radio"/> Không</p> <p><input type="radio"/> Tôi <b>không</b> dùng bất cứ thuốc mới nào theo toa, và cũng không thay đổi bất kỳ loại thuốc nào</p><br><p>14. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về những <b>phản ứng phụ</b> của các loại thuốc đó không?</p> <p><input type="radio"/> Có</p> <p><input type="radio"/> Không</p> <p><input type="radio"/> Tôi <b>không</b> dùng bất cứ thuốc mới nào theo toa, và cũng không thay đổi bất kỳ loại thuốc nào</p><br><p>15. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên báo cho quý vị biết lúc nào họ sẽ đến nhà quý không?</p> <p><input type="radio"/> Chưa bao giờ</p> <p><input type="radio"/> thỉnh thoảng</p> <p><input type="radio"/> Thường khi</p> <p><input type="radio"/> Luôn luôn</p> |
|---|---|

**16.** Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên đối xử nhẹ nhàng êm dịu với quý vị không?

- ☐ Chưa bao giờ
- ☐ Thỉnh thoảng
- ☐ Thường khi
- ☐ Luôn luôn

**17.** Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên giải thích mọi điều theo cách dễ hiểu không?

- ☐ Chưa bao giờ
- ☐ Thỉnh thoảng
- ☐ Thường khi
- ☐ Luôn luôn

**18.** Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên chăm chú lắng nghe quý vị không?

- ☐ Chưa bao giờ
- ☐ Thỉnh thoảng
- ☐ Thường khi
- ☐ Luôn luôn

**19.** Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên đối xử nhã nhặn và tôn trọng quý vị không?

- ☐ Chưa bao giờ
- ☐ Thỉnh thoảng
- ☐ Thường khi
- ☐ Luôn luôn

**20.** Chúng tôi muốn biết đánh giá của quý vị về công việc chăm sóc của những người chăm sóc sức khỏe tại gia từ cơ quan này.

Tính theo thang điểm từ 0 tới 10, trong đó 0 là chăm sóc sức khỏe tại gia tệ nhất và 10 là chăm sóc sức khỏe tại gia tốt nhất, quý vị sẽ dùng số mấy để đánh giá công việc chăm sóc của người chăm sóc sức khỏe tại gia từ cơ quan này?

- ☐ 0 Chăm sóc sức khỏe tại gia tệ nhất
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Chăm sóc sức khỏe tại gia tốt nhất

**Cơ Quan Chăm Sóc Sức Khỏe Tại  
Gia cho Quý Vị**

Kế tiếp là các câu hỏi về văn phòng của  
[TÊN CƠ QUAN].

21. Trong 2 tháng chăm sóc vừa qua, quý vị có liên lạc với **văn phòng** của cơ quan này để được giúp đỡ hoặc khuyên bảo không?

☐ Có  
☐ Không → Nếu trả lời Không thì chuyển sang Câu 24.

22. Trong 2 tháng chăm sóc vừa qua, khi liên lạc với văn phòng của cơ quan này, quý vị có được giúp đỡ hoặc khuyên bảo đúng như mình cần không?

☐ Có  
☐ Không → Nếu trả lời Không thì chuyển sang Câu 24.

☐ Tôi **không** liên lạc với cơ quan này

23. Khi liên lạc với văn phòng của cơ quan này quý vị phải chờ bao lâu mới có người giúp đỡ hoặc khuyên bảo những điều quý vị cần?

☐ Trong cùng ngày  
☐ 1 đến 5 ngày  
☐ 6 đến 14 ngày  
☐ Nhiều hơn 14 ngày  
☐ Tôi **không** liên lạc với cơ quan này

24. Trong 2 tháng chăm sóc vừa qua, quý vị có bất cứ vấn đề rắc rối nào với sự chăm sóc nhận được qua cơ quan này không?

☐ Có  
☐ Không

25. Nếu gia đình hay bạn bè cần chăm sóc sức khỏe tại gia thì quý vị có khuyên họ sử dụng dịch vụ của cơ quan này không?

☐ Chắc chắn là không  
☐ Có lẽ là không  
☐ Có lẽ là có  
☐ Chắc chắn là có

**Nói Về Quý Vị**

**26.** Nói chung quý vị đánh giá tình hình sức khỏe tổng quát của mình ra sao?

- ☐ Tuyệt vời
- ☐ Rất tốt
- ☐ Tốt
- ☐ Tạm được
- ☐ Rất tệ

**27.** Nói chung quý vị đánh giá tình hình sức khỏe tinh thần hoặc tâm trạng tổng quát của mình ra sao?

- ☐ Tuyệt vời
- ☐ Rất tốt
- ☐ Tốt
- ☐ Tạm được
- ☐ Rất tệ

**28.** Có phải quý vị sống riêng một mình không?

- ☐ Có
- ☐ Không

**29.** Quý vị đã học hết cấp bậc hay năm học cao nhất nào tại trường?

- ☐ Lớp 8 trở xuống
- ☐ Học vài năm trung học, nhưng chưa tốt nghiệp
- ☐ Tốt nghiệp trung học hoặc có GED (Chứng Chỉ Tương Đương)
- ☐ Học vài năm đại học hoặc có bằng cấp 2 năm
- ☐ Tốt nghiệp đại học 4 năm
- ☐ Cao hơn trình độ đại học 4 năm

**30.** Có phải quý vị có nguồn gốc Tây Bồ Nha hoặc La Tinh?

- ☐ Có
- ☐ Không

**31.** Quý vị thuộc sắc tộc nào? Nên chọn một hoặc nhiều câu.

- ☐ Mỹ Da Đỏ hay Dân Bản Xứ Alaska
- ☐ Á Châu
- ☐ Da Đen hay Mỹ gốc Phi Châu
- ☐ Thổ Dân Hạ Uy Di hay Hải Đảo Thái Bình Dương khác
- ☐ Da Trắng

32. Quý vị thường nói thứ tiếng nào khi ở nhà?

- ☐ Tiếng Anh
- ☐ Tiếng Tây Ban Nha
- ☐ Ngôn ngữ khác:

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*(Nên viết bằng chữ in.)*

33. Có người nào giúp quý vị điền bản khảo sát này không?

- ☐ Có
- ☐ Không → **Nếu trả lời Không thì xin gửi lại bản khảo sát đã điền vào bao thư đã trả bưu phí.**

34. Người đó giúp quý vị như thế nào?  
Chọn mọi câu thích hợp.

- ☐ Đọc câu hỏi cho tôi nghe
- ☐ Ghi lại câu trả lời của tôi
- ☐ Trả lời câu hỏi dùm tôi
- ☐ Dịch câu hỏi ra ngôn ngữ của tôi
- ☐ Giúp theo cách khác:

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*(Nên viết bằng chữ in.)*

- ☐ Không một người nào giúp tôi điền bản khảo sát này

**Xin cảm ơn quý vị!**

**Xin gửi lại bản khảo sát đã điền  
vào bao thư đã trả bưu phí.**



**TELEPHONE INTERVIEW SCRIPT**  
**FOR THE HOME HEALTH CARE CAHPS SURVEY IN VIETNAMESE**

INTRO1 Xin chào. Tôi có thể nói chuyện với [SAMPLE MEMBER'S NAME] không?

- 1 CÓ → [GO TO INTRO2]
- 2 KHÔNG, HIỆN TẠI KHÔNG CÓ MẶT → [SET CALLBACK]
- 3 KHÔNG [TỪ CHỐI] → [GO TO TERMINATE SCREEN]
- 4 TÌNH TRẠNG TINH THẦN/THỂ CHẤT KHÔNG CHO PHÉP → [GO TO PROXY SCRIPT]

M MISSING/DK

IF ASKED WHO IS CALLING:

Tôi là [INTERVIEWER NAME], gọi từ [ORGANIZATION]. Xin cho phép nói chuyện với [SAMPLE MEMBER'S NAME] về cuộc nghiên cứu về chăm sóc sức khỏe.

IF PERSON ON PHONE VOLUNTEERS THEY ARE SAMPLE MEMBER'S PARTNER, CHILD, PARENT, SIBLING, GRANDCHILD, OR POWER OF ATTORNEY AND THEY ASK WHY WE ARE CALLING:

Xin cho phép tôi nói chuyện với [SAMPLE MEMBER'S NAME] về trải nghiệm của họ với dịch vụ chăm sóc sức khỏe tại gia mà họ nhận được từ [HOME HEALTH AGENCY].

INTRO2 Xin chào. Tôi là [INTERVIEWER NAME], và gọi trên danh nghĩa [HOME HEALTH AGENCY]. Cơ quan này đang tham gia một cuộc khảo sát toàn quốc để đánh giá chất lượng chăm sóc bệnh nhân nhận từ các cơ quan chăm sóc sức khỏe tại gia. Kết quả này sẽ giúp các bệnh nhân khác cần chọn cơ quan chăm sóc sức khỏe tại gia.

Tham gia vào cuộc khảo sát này là điều tự nguyện. Cần khoảng 12 phút thì mới phỏng vấn xong và lần gọi này có thể được kiểm tra hay ghi âm cho mục đích cải tiến phẩm chất.

**NOTE: THE LENGTH OF THE INTERVIEW WILL DEPEND ON WHETHER THE HHA ADDS SUPPLEMENTAL QUESTIONS TO ITS HOME HEALTH CARE CAHPS SURVEY.**

INTRO3      INTRO3 AND INTRO4 USED ONLY IF CALLING SAMPLE MEMBER BACK TO COMPLETE A SURVEY THAT WAS BEGUN IN A PREVIOUS CALL. NOTE THAT THE SAMPLE MEMBER MUST HAVE ANSWERED AT LEAST ONE QUESTION IN THE SURVEY IN A PRECEDING CALL.

Xin chào, tôi có thể nói chuyện với [SAMPLE MEMBER'S NAME]?

IF ASKED WHO IS CALLING:

Tôi là [INTERVIEWER NAME] gọi từ [VENDOR]. Tôi muốn nói chuyện với [SAMPLE MEMBER'S NAME] về một nghiên cứu về chăm sóc sức khỏe.

1. YES, SAMPLE MEMBER IS AVAILABLE AND ON PHONE NOW → [GO TO INTRO4]
2. NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
3. NO [REFUSAL] → [GO TO Q\_REF SCREEN]
4. MENTALLY/PHYSICALLY INCAPABLE → [GO TO PROXY SCRIPT]

INTRO4      Xin chào, tôi gọi để tiếp tục cuộc khảo sát mà chúng tôi đã bắt đầu trong một lần gọi trước, liên quan đến sự chăm sóc mà bạn nhận được từ [HOME HEALTH AGENCY]. Tôi muốn tiếp tục cuộc phỏng vấn ngay bây giờ.

- 1 CONTINUE WITH INTERVIEW AT FIRST UNANSWERED QUESTION
- 2 NO, NOT RIGHT NOW → [SET CALLBACK]
- 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]

Q1.            Hồ sơ của chúng tôi cho thấy quý vị nhận được dịch vụ chăm sóc từ cơ quan chăm sóc sức khỏe tại gia [HOME HEALTH AGENCY]. Có đúng như vậy không?

- 1 CÓ → [GO TO Q2\_INTRO]
- 2 KHÔNG → [GO TO Q\_INELIG]

M MISSING/DK → [GO TO Q\_INELIG]

- Q2\_INTRO Khi quý vị trả lời các câu hỏi trong khảo sát này thì chỉ nên nhớ về những điều mình đã trải qua với cơ quan này.
- Q2. Trong lần đầu tiên quý vị được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan cho biết quý vị sẽ nhận những chăm sóc và dịch vụ nào không?
- 1 CÓ
  - 2 KHÔNG
  - 3 KHÔNG NHỚ
- M MISSING/DK
- Q3. Trong lần đầu tiên quý vị được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan **bàn với quý vị** về cách sắp xếp lại nhà cửa để quý vị có thể đi lại an toàn hay không?
- 1 CÓ
  - 2 KHÔNG
  - 3 KHÔNG NHỚ
- M MISSING/DK
- Q4. Khi quý vị bắt đầu được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan bàn với quý vị về mọi loại **thuốc mua theo toa và mua tự do** mà quý vị đang dùng không?
- 1 CÓ
  - 2 KHÔNG
  - 3 KHÔNG NHỚ
- M MISSING/DK
- Q5. Khi quý vị bắt đầu được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan yêu cầu cho **xem** mọi loại thuốc theo toa và mua tự do mà quý vị đang dùng không?
- 1 CÓ
  - 2 KHÔNG
  - 3 KHÔNG NHỚ
- M MISSING/DK

- Q6\_INTRO    Kế tiếp là các câu hỏi về mọi nhân viên của [HOME HEALTH AGENCY] đã từng chăm sóc quý vị trong 2 tháng vừa qua. Đừng gộp chung phần chăm sóc mà nhân viên của cơ quan chăm sóc sức khỏe tại gia khác thực hiện cho quý vị. Đừng gộp chung phần chăm sóc mà gia đình hay bạn bè thực hiện cho quý vị.
- Q6.            Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là y tá không?
- 1    CÓ
- 2    KHÔNG
- M   MISSING/DK
- Q7.            Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là chuyên viên trị liệu vật lý, trị liệu phục hồi các kỹ năng thường ngày, hoặc trị liệu âm ngữ không?
- 1    CÓ
- 2    KHÔNG
- M   MISSING/DK
- Q8.            Trong 2 tháng chăm sóc vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là trợ tá chăm sóc riêng hay chăm sóc sức khỏe tại gia không?
- 1    CÓ
- 2    KHÔNG
- M   MISSING/DK
- Q9.            Trong 2 tháng chăm sóc vừa qua, những người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên tỏ vẻ hiểu biết và cập nhật thông tin về mọi hoạt động chăm sóc hay điều trị cho quý vị tại nhà không? Có thể nói là...
- 1    Chưa bao giờ,
- 2    thỉnh thoảng,
- 3    Thường khi,
- 4    Luôn luôn, hoặc
- 5    Quý vị chỉ có một người chăm sóc sức khỏe trong 2 tháng chăm sóc vừa qua?
- M   MISSING/DK

- Q10. Trong 2 tháng chăm sóc vừa qua, quý vị và người chăm sóc sức khỏe tại gia từ cơ quan này có bàn về cơn đau không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK
- Q11. Trong 2 tháng chăm sóc vừa qua, quý vị có dùng bất cứ loại thuốc mới nào theo toa hoặc thay đổi bất kỳ loại thuốc nào đang dùng không?
- 1 CÓ
  - 2 KHÔNG → [GO TO Q15]
- M MISSING/DK → [GO TO Q15]
- Q12. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về **mục đích** dùng thuốc mới theo toa hoặc thay đổi thuốc theo toa không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK
- Q13. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về **lúc nào** nên dùng các loại thuốc đó không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK
- Q14. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với quý vị về những **phản ứng phụ** của các loại thuốc đó không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK

- Q15. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên báo cho quý vị biết về lúc nào họ sẽ đến nhà quý vị không? Có thể nói là...
- 1 Chưa bao giờ,
  - 2 thỉnh thoảng,
  - 3 Thường khi, hoặc
  - 4 Luôn luôn?
- M MISSING/DK
- Q16. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên đối xử nhẹ nhàng êm dịu với quý vị không? Có thể nói là...
- 1 Chưa bao giờ,
  - 2 thỉnh thoảng,
  - 3 Thường khi, hoặc
  - 4 Luôn luôn?
- M MISSING/DK
- Q17. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên giải thích mọi điều theo cách dễ hiểu không? Có thể nói là...
- 1 Chưa bao giờ,
  - 2 thỉnh thoảng,
  - 3 Thường khi, hoặc
  - 4 Luôn luôn?
- M MISSING/DK
- Q18. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên chăm chú lắng nghe quý vị không? Có thể nói là...
- 1 Chưa bao giờ,
  - 2 thỉnh thoảng,
  - 3 Thường khi, hoặc
  - 4 Luôn luôn?
- M MISSING/DK

Q19. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên đối xử nhã nhặn và tôn trọng quý vị không? Có thể nói là...

- 1 Chưa bao giờ,
- 2 Thỉnh thoảng,
- 3 Thường khi, hoặc
- 4 Luôn luôn?

M MISSING/DK

Q20\_INTRO Chúng tôi muốn biết đánh giá của quý vị về công việc chăm sóc của những người chăm sóc sức khỏe tại gia từ cơ quan này.

Q20. Tính theo thang điểm từ 0 tới 10, trong đó 0 là chăm sóc sức khỏe tại gia tệ nhất và 10 là chăm sóc sức khỏe tại gia tốt nhất, quý vị sẽ dùng số mấy để đánh giá công việc chăm sóc của người chăm sóc sức khỏe tại gia từ cơ quan này?

READ RESPONSE CHOICES ONLY IF NECESSARY

- 00 0 Chăm sóc sức khỏe tại gia tệ nhất
- 01 1
- 02 2
- 03 3
- 04 4
- 05 5
- 06 6
- 07 7
- 08 8
- 09 9
- 10 10 Chăm sóc sức khỏe tại gia tốt nhất

M MISSING/DK

Q21\_INTRO Kế tiếp là các câu hỏi về văn phòng của [HOME HEALTH AGENCY].

Q21. Trong 2 tháng chăm sóc vừa qua, quý vị có liên lạc với **văn phòng** của cơ quan này để được giúp đỡ hoặc khuyên bảo không?

- 1 CÓ
- 2 KHÔNG → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q22. Trong 2 tháng chăm sóc vừa qua, khi liên lạc với văn phòng của cơ quan này, quý vị có được giúp đỡ hoặc khuyên bảo đúng như mình cần không?

- 1 CÓ
- 2 KHÔNG → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q23. Khi liên lạc với văn phòng của cơ quan này quý vị phải chờ bao lâu mới có người giúp đỡ hoặc khuyên bảo những điều quý vị cần? Có thể nói là...

- 1 Trong cùng ngày,
- 2 1 đến 5 ngày,
- 3 6 đến 14 ngày, hoặc
- 4 Nhiều hơn 14 ngày?

M MISSING/DK

Q24. Trong 2 tháng chăm sóc vừa qua, quý vị có bất cứ vấn đề rắc rối nào với sự chăm sóc nhận được qua cơ quan này không?

- 1 CÓ
- 2 KHÔNG

M MISSING/DK

Q25. Nếu gia đình hay bạn bè cần chăm sóc sức khỏe tại gia thì quý vị có khuyên họ sử dụng dịch vụ của cơ quan này không? Có thể nói là...

- 1 Chắc chắn là không,
- 2 Có lẽ là không,
- 3 Có lẽ là có, hoặc
- 4 Chắc chắn là có?

M MISSING/DK



Q26\_INTRO Cuối cùng là loạt câu hỏi thu thập thông tin về quý vị. Xin hãy nghe hết mọi câu trả lời rồi mới cho biết lựa chọn.

Q26. Nói chung quý vị đánh giá tình hình sức khỏe tổng thể của mình ra sao? Có thể nói là...

- 1 Tuyệt vời,
- 2 Rất tốt,
- 3 Tốt,
- 4 Tạm được, hoặc
- 5 Rất tệ?

M MISSING/DK

Q27. Nói chung quý vị đánh giá tình hình sức khỏe tinh thần hoặc tâm trạng tổng thể của mình ra sao? Có thể nói là...

- 1 Tuyệt vời,
- 2 Rất tốt,
- 3 Tốt,
- 4 Tạm được, hoặc
- 5 Rất tệ?

M MISSING/DK

Q28. Có phải quý vị sống riêng một mình không?

- 1 CÓ
- 2 KHÔNG

M MISSING/DK

Q29. Quý vị đã học hết cấp bậc hay năm học cao nhất nào tại trường? Có thể nói là...

- 1 Lớp 8 trở xuống,
- 2 Học vài năm trung học, nhưng chưa tốt nghiệp,
- 3 Tốt nghiệp trung học hoặc có GED (Chứng Chỉ Tương Đương),
- 4 Học vài năm đại học hoặc có bằng cấp 2 năm,
- 5 Tốt nghiệp đại học 4 năm, hoặc
- 6 Cao hơn trình độ đại học 4 năm?

M MISSING/DK

- Q30. Có phải quý vị có nguồn gốc Tây Bồ Nha hoặc La Tinh?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK
- Q31. Quý vị thuộc sắc tộc nào? Có thể chọn một hoặc nhiều câu sau đây. Có phải quý vị là...
- 1 Mỹ Da Đỏ hay Dân Bản Xứ Alaska,
  - 2 Á Châu,
  - 3 Da Đen hay Mỹ gốc Phi Châu,
  - 4 Thổ Dân Hạ Uy Di hay Hải Đảo Thái Bình Dương khác, hoặc
  - 5 Da Trắng?
- M MISSING/DK
- Q32. Quý vị thường nói thứ tiếng nào khi ở nhà? Có thể nói là...
- 1 Tiếng Anh → [GO TO Q\_END]
  - 2 Tiếng Tây Ban Nha, hoặc → [GO TO Q\_END]
  - 3 Ngôn ngữ khác? → [GO TO 32A]
- M MISSING/DK → [GO TO Q\_END]
- Q32A Quý vị cũng thường nói thứ tiếng nào nữa khi ở nhà? (ENTER RESPONSE BELOW).
- { ALLOW UP TO 50 CHARACTERS }
- M MISSING/DK
- Q\_END Đó là tất cả những câu hỏi của chúng tôi. Xin cảm ơn quý vị đã dành chút thì giờ để tham gia cuộc khảo sát này. Xin chào quý vị!

INELIGIBLE SCREEN:

Q\_INELIG Xin cảm ơn quý vị đã dành chút thì giờ để tham gia cuộc khảo sát này. Xin chào quý vị!

REFUSAL SCREEN:

Q\_REF Xin cảm ơn quý vị đã dành chút thì giờ để tham gia cuộc khảo sát này. Xin chào quý vị!

**PROXY TELEPHONE INTERVIEW SCRIPT  
FOR THE HOME HEALTH CARE CAHPS SURVEY IN VIETNAMESE**

PROXY ID    Có người nào, thí dụ như người thân hay bạn bè, biết về những trải nghiệm của [SAMPLE MEMBER'S NAME] khi được chăm sóc sức khỏe không?

PROBE TO FIND OUT IF PERSON IS AVAILABLE IN HOUSEHOLD TO DO INTERVIEW.

- 1    CÓ → [GO TO PROXY\_INTRO]
- 2    KHÔNG → [COLLECT NAME AND TELEPHONE NUMBER OF PROXY AND SET A CALLBACK, OR IF NO PROXY EXISTS, GO TO Q\_END AND CODE AS MENTALLY/PHYSICALLY INCAPABLE]

IF ASKED WHO IS CALLING:

Tôi là [INTERVIEWER NAME], gọi từ [ORGANIZATION]. Xin cho phép gặp người nào biết nhiều về tình trạng sức khỏe và quá trình chăm sóc sức khỏe của [SAMPLE MEMBER NAME] để tham gia một cuộc nghiên cứu do [ORGANIZATION] thực hiện về vấn đề chăm sóc sức khỏe.

PROXY\_INTRO    [Xin chào. Tôi là {INTERVIEWER NAME}, và gọi trên danh nghĩa {HOME HEALTH AGENCY}]. Cơ quan này đang tham gia một cuộc khảo sát toàn quốc để đánh giá chất lượng chăm sóc bệnh nhân nhận từ các cơ quan chăm sóc sức khỏe tại gia. Kết quả này sẽ giúp các bệnh nhân khác cần chọn cơ quan chăm sóc sức khỏe tại gia.

Việc [SAMPLE MEMBER NAME] tham gia vào cuộc khảo sát này là điều tự nguyện. Cần khoảng 12 phút thì mới phỏng vấn xong và lần gọi này có thể được kiểm tra hay ghi âm cho mục đích cải tiến phẩm chất.

**NOTE: THE LENGTH OF THE INTERVIEW WILL DEPEND ON WHETHER THE HHA ADDS SUPPLEMENTAL QUESTIONS TO ITS HOME HEALTH CARE CAHPS SURVEY.**

- INTRO3 INTRO3 AND INTRO4 USED ONLY IF CALLING PROXY BACK TO COMPLETE A SURVEY THAT WAS BEGUN IN A PREVIOUS CALL. NOTE THAT THE PROXY MUST HAVE ANSWERED AT LEAST ONE QUESTION IN THE SURVEY IN A PRECEDING CALL.
- Xin chào, tôi có thể nói chuyện với [PROXY NAME]?
- IF ASKED WHO IS CALLING:  
Tôi là [INTERVIEWER NAME] gọi từ [VENDOR]. Tôi muốn nói chuyện với [PROXY NAME] về một nghiên cứu về chăm sóc sức khỏe.
- 1 YES, PROXY IS AVAILABLE AND ON PHONE NOW → [GO TO INTRO4]
  - 2 NO, NOT AVAILABLE RIGHT NOW → [SET CALLBACK]
  - 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]
- INTRO4 Xin chào, tôi gọi để tiếp tục cuộc khảo sát mà chúng tôi đã bắt đầu trong một lần gọi trước, liên quan đến sự chăm sóc mà [SAMPLE MEMBER NAME] nhận được từ [HOME HEALTH AGENCY]. Tôi muốn tiếp tục cuộc phỏng vấn ngay bây giờ.
- 1 CONTINUE WITH INTERVIEW AT FIRST UNANSWERED QUESTION
  - 2 NO, NOT RIGHT NOW → [SET CALLBACK]
  - 3 NO [REFUSAL] → [GO TO Q\_REF SCREEN]
- Q1. Hồ sơ của chúng tôi cho thấy [SAMPLE MEMBER NAME] nhận được dịch vụ chăm sóc từ cơ quan chăm sóc sức khỏe tại gia [HOME HEALTH AGENCY]. Có đúng như vậy không?
- 1 CÓ → [GO TO Q2\_INTRO]
  - 2 KHÔNG → [GO TO Q\_INELIG]
- M MISSING/DK → [GO TO Q\_INELIG]

- Q2\_INTRO Khi quý vị trả lời các câu hỏi trong khảo sát này thì chỉ nên nhớ về những điều [SAMPLE MEMBER NAME] đã trải qua với cơ quan này. Nên cố gắng trả lời câu hỏi sao cho gần đúng nhất với quan điểm của [SAMPLE MEMBER NAME]. Nếu cần thiết, quý vị có thể trả lời câu hỏi theo quan điểm của người trong gia đình hoặc người đang trông nom săn sóc cho [SAMPLE MEMBER NAME].
- Q2. Trong lần đầu tiên [SAMPLE MEMBER NAME] được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan cho biết bệnh nhân sẽ nhận những chăm sóc và dịch vụ nào không?
- 1 CÓ
  - 2 KHÔNG
  - 3 KHÔNG NHỚ
- M MISSING/DK
- Q3. Trong lần đầu tiên [SAMPLE MEMBER NAME] được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan **bàn với bệnh nhân** về cách sắp xếp lại nhà cửa để bệnh nhân có thể đi lại an toàn hay không?
- 1 CÓ
  - 2 KHÔNG
  - 3 KHÔNG NHỚ
- M MISSING/DK
- Q4. Khi [SAMPLE MEMBER NAME] bắt đầu được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan bàn với bệnh nhân về mọi loại **thuốc mua theo toa và mua tự do** mà bệnh nhân đang dùng không?
- 1 CÓ
  - 2 KHÔNG
  - 3 KHÔNG NHỚ
- M MISSING/DK

- Q5. Khi [SAMPLE MEMBER NAME] bắt đầu được cơ quan này chăm sóc sức khỏe tại gia, có người nào trong cơ quan yêu cầu cho **xem** mọi loại thuốc theo toa và mua tự do mà bệnh nhân đang dùng không?
- 1 CÓ
  - 2 KHÔNG
  - 3 KHÔNG NHỚ
- M MISSING/DK
- Q6\_INTRO Kế tiếp là các câu hỏi về mọi nhân viên của [HOME HEALTH AGENCY] đã từng chăm sóc [SAMPLE MEMBER NAME] trong 2 tháng vừa qua. Đừng gộp chung phần chăm sóc mà nhân viên của cơ quan chăm sóc sức khỏe tại gia khác thực hiện cho [SAMPLE MEMBER NAME]. Đừng gộp chung phần chăm sóc mà gia đình hay bạn bè thực hiện cho bệnh nhân.
- Q6. Trong 2 tháng chăm sóc [SAMPLE MEMBER NAME] vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là y tá không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK
- Q7. Trong 2 tháng chăm sóc [SAMPLE MEMBER NAME] vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là chuyên viên trị liệu vật lý, trị liệu phục hồi các kỹ năng thường ngày, hoặc trị liệu âm ngữ không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK
- Q8. Trong 2 tháng chăm sóc [SAMPLE MEMBER NAME] vừa qua, có người chăm sóc sức khỏe tại gia nào từ cơ quan này là trợ tá chăm sóc riêng hay chăm sóc sức khỏe tại gia không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK

Q9. Trong 2 tháng chăm sóc vừa qua, những người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên tổ vẽ hiểu biết và cập nhật thông tin về mọi hoạt động chăm sóc hay điều trị cho [SAMPLE MEMBER NAME] tại nhà không? Có thể nói là...

- 1 Chưa bao giờ,
- 2 Thỉnh thoảng,
- 3 Thường khi,
- 4 Luôn luôn, hoặc
- 5 [TÊN BỆNH NHÂN MẪU] chỉ có một người chăm sóc sức khỏe trong 2 tháng chăm sóc vừa qua?

M MISSING/DK

Q10. Trong 2 tháng chăm sóc vừa qua, [SAMPLE MEMBER NAME] và người chăm sóc sức khỏe tại gia từ cơ quan này có bàn về cơn đau không?

- 1 CÓ
- 2 KHÔNG

M MISSING/DK

Q11. Trong 2 tháng chăm sóc vừa qua, [SAMPLE MEMBER NAME] có dùng bất cứ loại thuốc mới nào theo toa hoặc thay đổi bất kỳ loại thuốc nào đang dùng không?

- 1 CÓ
- 2 KHÔNG → [GO TO Q15]

M MISSING/DK → [GO TO Q15]

Q12. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với [SAMPLE MEMBER NAME] về **mục đích** dùng thuốc mới theo toa hoặc thay đổi thuốc theo toa không?

- 1 CÓ
- 2 KHÔNG

M MISSING/DK



- Q13. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với [SAMPLE MEMBER NAME] về **lúc nào** nên dùng các loại thuốc đó không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK
- Q14. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có bàn với [SAMPLE MEMBER NAME] về những **phản ứng phụ** của các loại thuốc đó không?
- 1 CÓ
  - 2 KHÔNG
- M MISSING/DK
- Q15. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên báo cho [SAMPLE MEMBER NAME] biết về lúc nào họ sẽ đến nhà không? Có thể nói là...
- 1 Chưa bao giờ,
  - 2 thỉnh thoảng,
  - 3 Thường khi, hoặc
  - 4 Luôn luôn?
- M MISSING/DK
- Q16. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên đối xử nhẹ nhàng êm dịu với [SAMPLE MEMBER NAME] không? Có thể nói là...
- 1 Chưa bao giờ,
  - 2 thỉnh thoảng,
  - 3 Thường khi, hoặc
  - 4 Luôn luôn?
- M MISSING/DK

Q17. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên giải thích mọi điều theo cách dễ hiểu đối với không? Có thể nói là...

- 1 Chưa bao giờ,
- 2 Thỉnh thoảng,
- 3 Thường khi, hoặc
- 4 Luôn luôn?

M MISSING/DK

Q18. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên chăm chú lắng nghe [SAMPLE MEMBER NAME] không? Có thể nói là...

- 1 Chưa bao giờ,
- 2 Thỉnh thoảng,
- 3 Thường khi, hoặc
- 4 Luôn luôn?

M MISSING/DK

Q19. Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan này có thường xuyên đối xử nhã nhặn và tôn trọng [SAMPLE MEMBER NAME] không? Có thể nói là...

- 1 Chưa bao giờ,
- 2 Thỉnh thoảng,
- 3 Thường khi, hoặc
- 4 Luôn luôn?

M MISSING/DK

Q20\_INTRO Chúng tôi muốn biết đánh giá của [SAMPLE MEMBER NAME] về công việc chăm sóc của những người chăm sóc sức khỏe tại gia từ cơ quan này. Nên cố gắng trả lời câu hỏi sao cho gần đúng nhất với quan điểm của [SAMPLE MEMBER NAME]. Nếu cần thiết, quý vị có thể trả lời câu hỏi theo quan điểm của người trong gia đình hoặc người đang trông nom săn sóc cho [SAMPLE MEMBER NAME].

Q20. Tính theo thang điểm từ 0 tới 10, trong đó 0 là chăm sóc sức khỏe tại gia tệ nhất và 10 là chăm sóc sức khỏe tại gia tốt nhất, [SAMPLE MEMBER NAME] sẽ dùng số mấy để đánh giá công việc chăm sóc của người chăm sóc sức khỏe tại gia từ cơ quan này?

READ RESPONSE CHOICES ONLY IF NECESSARY

00 0 Chăm sóc sức khỏe tại gia tệ nhất

01 1

02 2

03 3

04 4

05 5

06 6

07 7

08 8

09 9

10 10 Chăm sóc sức khỏe tại gia tốt nhất

M MISSING/DK

Q21\_INTRO Kế tiếp là các câu hỏi về văn phòng của [HOME HEALTH AGENCY].

Q21. Trong 2 tháng chăm sóc vừa qua, [SAMPLE MEMBER NAME] có liên lạc với **văn phòng** của cơ quan này để được giúp đỡ hoặc khuyên bảo không?

1 CÓ

2 KHÔNG → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q22. Trong 2 tháng chăm sóc vừa qua, khi liên lạc với văn phòng của cơ quan này, [SAMPLE MEMBER NAME] có được giúp đỡ hoặc khuyên bảo đúng như mình cần không?

- 1 CÓ
- 2 KHÔNG → [GO TO Q24]

M MISSING/DK → [GO TO Q24]

Q23. Khi [SAMPLE MEMBER NAME] liên lạc với văn phòng của cơ quan này thì phải chờ bao lâu mới có được người giúp đỡ hoặc khuyên bảo những điều họ cần? Có thể nói là...

- 1 Trong cùng ngày,
- 2 1 đến 5 ngày,
- 3 6 đến 14 ngày, hoặc
- 4 Nhiều hơn 14 ngày?

M MISSING/DK

Q24. Trong 2 tháng chăm sóc vừa qua, [SAMPLE MEMBER NAME] có bất cứ vấn đề rắc rối nào với sự chăm sóc nhận được qua cơ quan này không?

- 1 CÓ
- 2 KHÔNG

M MISSING/DK

Q25. Nếu gia đình hay bạn bè cần chăm sóc sức khỏe tại gia thì [SAMPLE MEMBER NAME] có khuyên họ sử dụng dịch vụ của cơ quan này không? Có thể nói là...

- 1 Chắc chắn là không,
- 2 Có lẽ là không,
- 3 Có lẽ là có, hoặc
- 4 Chắc chắn là có?

M MISSING/DK

Q26\_INTRO Cuối cùng là loạt câu hỏi thu thập thông tin về [SAMPLE MEMBER NAME]. Xin hãy nghe hết mọi câu trả lời rồi mới cho biết lựa chọn.

Q26. Nói chung [SAMPLE MEMBER NAME] đánh giá tình hình sức khỏe tổng quát của mình ra sao? Có thể nói là...

- 1 Tuyệt vời,
- 2 Rất tốt,
- 3 Tốt,
- 4 Tạm được, hoặc
- 5 Rất tệ?

M MISSING/DK

Q27. Nói chung [SAMPLE MEMBER NAME] đánh giá tình hình sức khỏe tinh thần hoặc tâm trạng tổng quát của mình ra sao? Có thể nói là...

- 1 Tuyệt vời,
- 2 Rất tốt,
- 3 Tốt,
- 4 Tạm được, hoặc
- 5 Rất tệ?

M MISSING/DK

Q28. Có phải [SAMPLE MEMBER NAME] sống riêng một mình không?

- 1 CÓ
- 2 KHÔNG

M MISSING/DK

Q29. [SAMPLE MEMBER NAME] đã học hết cấp bậc hay năm học cao nhất nào tại trường? Có thể nói là...

- 1 Lớp 8 trở xuống,
- 2 Học vài năm trung học, nhưng chưa tốt nghiệp,
- 3 Tốt nghiệp trung học hoặc có GED (Chứng Chỉ Tương Đương),
- 4 Học vài năm đại học hoặc có bằng cấp 2 năm,
- 5 Tốt nghiệp đại học 4 năm, hoặc
- 6 Cao hơn trình độ đại học 4 năm?

M MISSING/DK

Q30. Có phải [SAMPLE MEMBER NAME] có nguồn gốc Tây Bồ Nha hoặc La Tinh?

- 1 CÓ
- 2 KHÔNG

M MISSING/DK

Q31. [SAMPLE MEMBER NAME] thuộc sắc tộc nào? Có thể chọn một hoặc nhiều câu sau đây. Có phải người đó là....

- 1 Mỹ Da Đỏ hay Dân Bản Xứ Alaska
- 2 Á Châu
- 3 Da Đen hay Mỹ gốc Phi Châu
- 4 Thổ Dân Hạ Uy Di hay Hải Đảo Thái Bình Dương khác
- 5 Da Trắng?

M MISSING/DK

Q32. [SAMPLE MEMBER NAME] thường nói thứ tiếng nào khi ở nhà?

- 1 Tiếng Anh, → [GO TO Q\_END]
- 2 Tiếng Tây Ban Nha, hoặc → [GO TO Q\_END]
- 3 Ngôn ngữ khác? → [GO TO Q32A]

M MISSING/DK → [GO TO Q\_END]

Q32A [SAMPLE MEMBER NAME] cũng thường nói thứ tiếng nào nữa khi ở nhà?  
(ENTER RESPONSE BELOW).

{ ALLOW UP TO 50 CHARACTERS }

M MISSING/DK

Q\_END Đó là tất cả những câu hỏi của chúng tôi. Xin cảm ơn quý vị đã dành chút thì giờ để tham gia cuộc khảo sát này. Xin chào quý vị!

INELIGIBLE SCREEN:

Q\_INELIG Xin cảm ơn quý vị đã dành chút thì giờ để tham gia cuộc khảo sát này. Xin chào quý vị!

REFUSAL SCREEN:

Q\_REF Xin cảm ơn quý vị đã dành chút thì giờ để tham gia cuộc khảo sát này. Xin chào quý vị!

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**APPENDIX I:**  
**ARMENIAN:**  
**MAIL SURVEY COVER LETTERS,**  
**REGULAR AND SCANNABLE QUESTIONNAIRES**

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## Sample Cover Letter for First Questionnaire Mailing in Armenian

Home Health Care CAHPS Survey

To be Printed on Home Health Agency or Vendor Letterhead

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Հարգելի «FirstName» «LastName»,

Սա կարևոր հարցախույզ է Medicare-ից՝ տնային պալատաններում առողջական խնամք ստացող անձանց համար: **Խնդրում ենք ժամանակ տրամադրել «HHA»-ի հետ Ձեր փորձով կիսվելու և այս հարցախույզի պատասխանները ներփակ կանխավճարված ծրարով վերադարձնելու համար:** Ձեր կարծիքն օգնում է Medicare-ին բարելավել տնային առողջական խնամքի ընդհանուր որակը՝ օգնելով նաև ուրիշներին տնային առողջական խնամք տրամադրող գործակալություն ընտրելու հարցում:

**Ձեր ձայնը կարևոր է:** Մենք կցանկանայինք, որ Ձեր պատասխաններն արտացոլեն Ձեր սեփական տեսակետները, ոչ թե վերը նշված գործակալությունից ինչ-որ մեկի կարծիքը: Եթե հարցախույզի հետ կապված օգնության կարիք ունեք, ապա դիմեք ընտանիքի անդամի, կամ ընկերոջ:

**Մենք գնահատում ենք տնային առողջական խնամքի հարցում Ձեր փորձը:**

Մասնակցությունը կամավոր է, և Ձեր տվյալների խորհրդապահությունն ապահովված է օրենքով: Ոչ ոք չի կարող Ձեր անունը կապել Ձեր պատասխանների հետ:

Եթե այս հարցախույզի մասին հարցեր ունեք, ապա զանգահարեք VENDOR NAME, 1-XXX-XXX-XXXX հեռախոսահամարով (անվճար):

Շնորհակալություն տնային առողջական խնամքը բարելավելու հարցում Ձեր օգնության համար:

Հարգանքով,

Name

Տնային առողջական խնամքի գործակալության տնօրեն

[PRINT SAMPLE ID HERE]

**Sample Cover Letter for Second Questionnaire Mailing to Mail Survey Nonrespondents in  
Armenian**

Home Health Care CAHPS Survey

To be Printed on Home Health Agency or Vendor Letterhead

«FirstName» «LastName»

«MailDate»

«Address1» «Address2»

«City\_Name», «State\_Code» «Zip\_Zip4»

Հարգելի «FirstName» «LastName»,

Դուք վերջերս հարցախույզ էիք ստացել Medicare-ից՝ «HHA»-ի հետ Ձեր  
փորձառության մասին: **Եթե հարցախույզն արդեն վերադարձրել եք, ապա  
շնորհակալություն: Հավելյալ որևէ բանի կարիք չկա:**

Սա ընկերական հիշեցում է, որ մենք կցանկանայինք գիտենալ Ձեր փորձառության  
մասին: Ձեր կարծիքը կօգնի ուրիշներին՝ ընտրել տնային առողջական խնամքի  
գործակալություն, ու կօգնի նաև, որ Medicare-ը բարելավի տնային առողջական  
խնամքի ընդհանուր որակը:

**Խնդրում ենք մի քանի բույե տրամադրել հարցախույզը լրացնելու և ներփակ  
կանխավճարված ծրարով այն վերադարձնելու  
համար:**

**Ձեր ձայնը կարևոր է:** Մենք գնահատում ենք Ձեր  
Ժամանակը: Մասնակցությունը կամավոր է, և Ձեր  
տվյալների խորհրդապահությունն ապահովված է  
օրենքով: Ոչ ոք չի կարող Ձեր անունը կապել Ձեր  
պատասխանների հետ:

Եթե այս հարցախույզի մասին հարցեր ունեք, ապա  
զանգահարեք VENDOR NAME, 1-XXX-XXX-XXXX  
հեռախոսահամարով (անվճար):

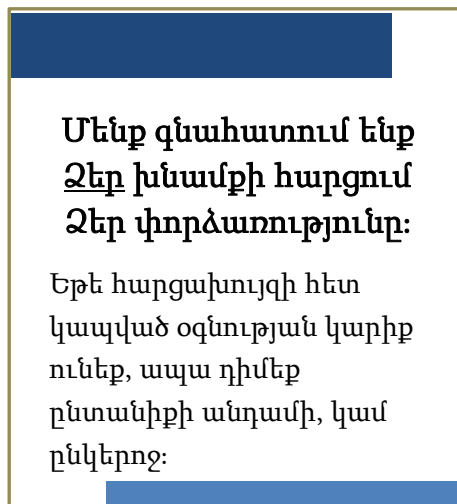
Շնորհակալություն տնային առողջական խնամքը  
բարելավելու հարցում Ձեր օգնության համար:

Հարգանքով,

Name

Տնային առողջական խնամքի գործակալության տնօրեն

[PRINT SAMPLE ID HERE]



OMB #: 0938-1066

Վավեր է մինչև 2026 թ. հուլիսի 31-ին

**ՏՆԱՅԻՆ ԱՌՈՂՋԱԿԱՆ ԽՆԱՄՔԻ ՎԵՐԱԲԵՐՅԱԼ  
CAHPS® ՀԱՐՑԱԹԵՐԹԻԿ**

**2025**

**ՀԱՐՑԱԹԵՐԹԻՎԸ ԼՐԱՑՆԵԼՈՒ  
ՑՈՒՑՈՒՄՆԵՐ**

- Պատասխանեք բոլոր հարցերին՝ նշելով Ձեր պատասխանի ձախ կողմում գտնվող համապատասխան վանդակը:
- Երբեմն Ձեզ կխնդրենք որոշ հարցեր քաջ թողնել: Նման դեպքում կտեսնեք սլաք, որը կուղղորդի Ձեզ հաջորդ հարցին, օրինակ.

☒ Այո → Եթե «Այո», անցեք էջ 1, Հ1:  
☐ Ոչ

**ՁԵՐ ՏՆԱՅԻՆ ԱՌՈՂՋԱԿԱՆ ԽՆԱՄՔԸ**

1. Ըստ մեր տվյալների, Դուք օգտվում եք [ԳՈՐԾԱԿԱԼՈՒԹՅԱՆ ԱՆՈՒՆԸ] տնային առողջական խնամքի գործակալությունից: Ճի՞շտ է:

Թերթիկի հարցերին պատասխանելիս հենվեք միայն այդ գործակալության հետ Ձեր անձնական փորձի վրա:

- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ → Եթե «Ոչ», խնդրում ենք դադարեցնել հարցաթերթիկի լրացումն ու տրամադրված ծրարով այն վերադարձնել:

2. Երբ այս գործակալությունից սկսեցիք տնային առողջական խնամք ստանալ, արդյո՞ք գործակալությունից որևէ մեկն ասաց Ձեզ՝ ինչ խնամք ու ծառայություններ կարող եք ստանալ:

- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Չեմ հիշում

3. Երբ այս գործակալությունից սկսեցիք տնային առողջական խնամք ստանալ, արդյո՞ք գործակալությունից որևէ մեկն ասաց Ձեզ՝ ինչպես կահավորել տունը, որպեսզի ապահով տեղաշարժվեք:

- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Չեմ հիշում

4. Երբ այս գործակալությունից սկսեցիք տնային առողջական խնամք ստանալ, արդյո՞ք գործակալությունից որևէ մեկը խոսեց Ձեզ հետ դեղատոմսային և ընդհանուր վաճառքում գտնվող այն բոլոր դեղամիջոցների մասին, որոնք ընդունում էիք:

- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Չեմ հիշում

5. Երբ այս գործակալությունից սկսեցիք տնային առողջական խնամք ստանալ, արդյո՞ք գործակալությունից որևէ մեկը խնդրեց **տեսնել** դեղատոմսային և ընդհանուր վաճառքում գտնվող այն բոլոր դեղամիջոցները, որոնք ընդունում էիք:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ

<sup>3</sup> ☐ Չեմ հիշում

**ՏՆԱՅԻՆ ԱՌՈՂՋԱԿԱՆ ԽՆԱՄՔԻ  
ՄԱՏԱԿԱՐԱՐՆԵՐԻ ԿՈՂՄԻՑ ՎԵՐՁԻՆ  
2 ԱՄՍՈՒՄ ՁԵՁ ՏՐԱՄԱԴՐՎԱԾ  
ԽՆԱՄՔԸ**

Հետևյալ հարցերը վերաբերում են **[ԳՈՐԾԱԿԱԼՈՒԹՅԱՆ ԱՆՈՒՆԸ]**-ի այն բոլոր աշխատակիցներին, ովքեր վերջին 2 ամսում Ձեզ խնամել են: Մի՛ ներառեք տնային առողջական խնամքի մեկ այլ գործակալության աշխատակիցներից ստացած խնամքը: Մի՛ ներառեք նաև ազգականներից կամ ընկերներից ստացած խնամքը:

6. Խնամքի վերջին 2 ամսում այս գործակալությունից Ձեզ տնային առողջական խնամք տրամադրողների թվում բուժակ եղե՞լ է:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ

7. Խնամքի վերջին 2 ամսում այս գործակալությունից Ձեզ տնային առողջական խնամք տրամադրողների թվում ֆիզիկական, մասնագիտական, կամ խոսակցական թերապևտ եղե՞լ է:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ

8. Խնամքի վերջին 2 ամսում այս գործակալությունից Ձեզ տնային առողջական խնամք տրամադրողների թվում տնային առողջական կամ անձնական խնամքի օգնական եղե՞լ է:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ

9. Խնամքի վերջին 2 ամսում այս գործակալության տնային առողջության մատակարարները որքա՞ն հաճախ են քաջատեղյակ եղել Ձեր տնային խնամքի կամ բուժման ողջ ընթացքի մասին:

<sup>1</sup> ☐ Երբեք

<sup>2</sup> ☐ Երբեմն

<sup>3</sup> ☐ Սովորաբար

<sup>4</sup> ☐ Միշտ

<sup>5</sup> ☐ Խնամքի վերջին 2 ամսում ես միայն մեկ մատակարար եմ ունեցել:

10. Խնամքի վերջին 2 ամսում այս գործակալության տնային առողջական խնամքի որևէ մատակարարի հետ խոսել էք ցավի մասին:
- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
11. Խնամքի վերջին 2 ամսում դեղատոմսային որևէ նոր դեղամիջոց ընդունել էք, կամ փոխել էք, արդյոք, մինչ այդ ընդունած որևէ դեղամիջոց:
- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ → Եթե «Ոչ», անցեք Հ15:
12. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի որևէ մատակարար խոսել է Ձեզ հետ Ձեր նոր կամ փոփոխված դեղատոմսային դեղամիջոցի ընդունման **անհրաժեշտության** մասին:
- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Ես դեղատոմսային նոր դեղամիջոց չեմ ընդունել և դեղամիջոցներս չեմ փոխել

13. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները խոսել էն Ձեզ հետ այն մասին, թե **երբ** պետք է սկսել այդ դեղամիջոցների ընդունումը:
- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Ես դեղատոմսային նոր դեղամիջոց չեմ ընդունել և դեղամիջոցներս չեմ փոխել
14. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները խոսել էն Ձեզ հետ այդ դեղամիջոցների **կողմնակի ազդեցությունների** մասին:
- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Ես դեղատոմսային նոր դեղամիջոց չեմ ընդունել և դեղամիջոցներս չեմ փոխել
15. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքան հաճախ են Ձեզ տեղեկացրել՝ երբ են ժամանելու Ձեզ այցելության:
- <sup>1</sup> ☐ Երբեք
- <sup>2</sup> ☐ Երբեմն
- <sup>3</sup> ☐ Սովորաբար
- <sup>4</sup> ☐ Միշտ



16. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են Ձեզ հնարավորինս սիրալիր վերաբերվել:

- <sup>1</sup> ☐ Երբեք  
<sup>2</sup> ☐ Երբեմն  
<sup>3</sup> ☐ Սովորաբար  
<sup>4</sup> ☐ Միշտ

17. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են Ձեզ մատչելի ձևով բացատրել իրողությունը:

- <sup>1</sup> ☐ Երբեք  
<sup>2</sup> ☐ Երբեմն  
<sup>3</sup> ☐ Սովորաբար  
<sup>4</sup> ☐ Միշտ

18. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են ուշադիր լսել Ձեզ:

- <sup>1</sup> ☐ Երբեք  
<sup>2</sup> ☐ Երբեմն  
<sup>3</sup> ☐ Սովորաբար  
<sup>4</sup> ☐ Միշտ

19. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են Ձեզ հետ կիրթ ու հարգալիք վերաբերվել:

- <sup>1</sup> ☐ Երբեք  
<sup>2</sup> ☐ Երբեմն  
<sup>3</sup> ☐ Սովորաբար  
<sup>4</sup> ☐ Միշտ

20. Ինչպիսի՞ն է այս գործակալության տնային առողջության մատակարարների կողմից Ձեզ տրամադրված խնամքի՝ Ձեր գնահատականը:

0-10 սանդղակով, որտեղ 0-ն տնային առողջական խնամքի հնարավոր վատթարագույն ցուցանիշն է, իսկ 10-ը՝ լավագույնը, ինչպե՞ս կգնահատեիք այս գործակալության տնային առողջական խնամքի մատակարարների կողմից Ձեզ տրամադրված խնամքը:

- ☐ 0 Հնարավոր վատթարագույն տնային առողջական խնամք  
☐ 1  
☐ 2  
☐ 3  
☐ 4  
☐ 5  
☐ 6  
☐ 7  
☐ 8  
☐ 9  
☐ 10 Հնարավոր լավագույն տնային առողջական խնամք

**ՁԵՐ ՏՆԱՅԻՆ ԱՌՈՂՋԱԿԱՆ  
ԳՈՐԾԱԿԱԼՈՒԹՅՈՒՆԸ**

Հետևյալ հարցերը վերաբերում են  
[ԳՈՐԾԱԿԱԼՈՒԹՅԱՆ ԱՆՈՒՆԸ]-ի  
գրասենյակին:

21. Խնամքի վերջին 2 ամսում դիմե՞լ եք, արդյոք, գործակալության գրասենյակ՝ օգնության կամ խորհրդատվության:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ → Եթե «Ոչ», անցեք Հ24:

22. Խնամքի վերջին 2 ամսում գործակալության գրասենյակ դիմելիս ստացե՞լ եք, արդյոք, անհրաժեշտ օգնությունը կամ խորհրդատվությունը:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ → Եթե «Ոչ», անցեք Հ24:

<sup>3</sup> ☐ Այս գործակալությանը չեմ դիմել

23. Այս գործակալության գրասենյակ դիմելիս անհրաժեշտ օգնությունը կամ խորհուրդը որքա՞ն արագ եք ստացել:

<sup>1</sup> ☐ Նույն օրը

<sup>2</sup> ☐ 1-ից 5 օր

<sup>3</sup> ☐ 6-ից 14 օր

<sup>4</sup> ☐ Ավելի, քան 14 օր

<sup>5</sup> ☐ Այս գործակալությանը չեմ դիմել

24. Խնամքի վերջին 2 ամսում գործակալության գործունեության հետ կապված որևէ խնդիր ունեցե՞լ եք:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ

25. Ձեր ընտանիքի անդամներին կամ ընկերներին խորհուրդ կտայի՞ք օգտվել այս գործակալության տնային առողջական խնամքի ծառայություններից:

<sup>1</sup> ☐ Միանշանակ ոչ

<sup>2</sup> ☐ Հավանաբար ոչ

<sup>3</sup> ☐ Հավանաբար այո

<sup>4</sup> ☐ Միանշանակ այո

**ՁԵՐ ՄԱՍԻՆ**

26. Ընդհանուր առմամբ, ինչպե՞ս կգնահատեիք Ձեր ընդհանուր առողջական վիճակը:

<sup>1</sup> ☐ Գերազանց

<sup>2</sup> ☐ Շատ լավ

<sup>3</sup> ☐ Լավ

<sup>4</sup> ☐ Բավարար

<sup>5</sup> ☐ Վատ

27. Ընդհանուր առմամբ, ինչպե՞ս կգնահատեիք Ձեր հոգեկան կամ զգայական առողջության ընդհանուր վիճակը:

<sup>1</sup> ☐ Գերազանց

<sup>2</sup> ☐ Շատ լավ

<sup>3</sup> ☐ Լավ

<sup>4</sup> ☐ Բավարար

<sup>5</sup> ☐ Վատ

28. Դուք միայնա՞կ եք ապրում:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ

29. Ի՞նչ կրթություն ունեք:

<sup>1</sup> ☐ 8-րդ դասարան կամ պակաս

<sup>2</sup> ☐ որոշ ավագ դպրոց, բայց չեմ ավարտել

<sup>3</sup> ☐ ավագ դպրոցի շրջանավարտ կամ ընդհանուր համարժեքության դիպլոմակիր (GED)

<sup>4</sup> ☐ Որոշ քոլեջ, կամ 2-ամյա ծրագրի շրջանավարտ

<sup>5</sup> ☐ 4-ամյա քոլեջի շրջանավարտ

<sup>6</sup> ☐ 4-ամյա քոլեջից ավելի

30. Արդյո՞ք հիսպանիկ կամ լատինամերիկյան ծագում ունեք:

<sup>1</sup> ☐ Այո

<sup>2</sup> ☐ Ոչ

31. Ռասայական պատկանելությունը. ընտրեք մեկ կամ ավելի տարբերակ:

<sup>1</sup> ☐ Հնդկացի կամ Այասկայի բնիկ

<sup>2</sup> ☐ Ասիացի

<sup>3</sup> ☐ Սևամորթ կամ աֆրո-ամերիկացի

<sup>4</sup> ☐ Բնիկ հավայացի կամ Խաղաղ օվկիանոսի այլ կղզիաբնակ

<sup>5</sup> ☐ Սպիտակամորթ

32. Տանը հիմնականում ի՞նչ լեզվով եք խոսում:

<sup>1</sup> ☐ Անգլերեն

<sup>2</sup> ☐ Իսպաներեն

<sup>3</sup> ☐ Մեկ այլ լեզու

\_\_\_\_\_  
(Խնդրում ենք տպատառ նշել)

33. Այս հարցաթերթիկը լրացնելիս  
որևէ մեկն օգնե՞լ է Ձեզ:
- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ → Եթե «Ոչ», խնդրում ենք  
լրացված հարցաթերթիկը  
վերադարձնել տրամադրվող  
նախապես վճարված  
ծրարով:
34. Ինչպե՞ս է այդ անձն օգնել Ձեզ:  
Նշեք բոլոր համապատասխան  
վանդակները:
- <sup>1</sup> ☐ Հարցերն ինձ ընթերցել է
- <sup>2</sup> ☐ Գրառել է պատասխաններս
- <sup>3</sup> ☐ Իմ փոխարեն պատասխանել  
է հարցերին
- <sup>4</sup> ☐ Հարցերը թարգմանել է իմ  
լեզվով
- <sup>5</sup> ☐ Օգնել է այլ կերպ
- \_\_\_\_\_
- (Խնդրում ենք տպատառ նշել)
- <sup>6</sup> ☐ Այս հարցաթերթիկը  
լրացնելիս ինձ ոչ ոք չի օգնել
- Շնորհակալություն:**
- Լրացված հարցաթերթիկը խնդրում  
ենք վերադարձնել կից տրամադրվող  
նախապես վճարված ծրարով:**

OMB #: 0938-1066

Վավեր է մինչև 2026 թ. հուլիսի 31-ին

**ՏՆԱՅԻՆ ԱՌՈՂՋԱԿԱՆ ԽՆԱՄՔԻ ՎԵՐԱԲԵՐՅԱԼ  
CAHPS® ՀԱՐՑԱԹԵՐԹԻԿ**

**(ALTERNATIVE INSTRUCTIONS,  
SCANNABLE FORMS)**

**2025**

**ՀԱՐՑԱԹԵՐԹԻՎԸ ԼՐԱՑՆԵԼՈՒ  
ՑՈՒՑՈՒՄՆԵՐ**

- Պատասխանեք բոլոր հարցերին՝ նշելով Ձեր պատասխանի ձախ կողմում գտնվող համապատասխան շրջանակը:
- Երբեմն Ձեզ կխնդրենք որոշ հարցեր բաց թողնել: Նման դեպքում կտեսնեք սլաք, որը կուղղորդի Ձեզ հաջորդ հարցին, օրինակ.
  - Այո → Եթե «Այո», անցեք էջ 1, Հ1:
  - Ոչ

**ՁԵՐ ՏՆԱՅԻՆ ԱՌՈՂՋԱԿԱՆ ԽՆԱՄՔԸ**

1. Ըստ մեր տվյալների, Դուք օգտվում եք [ԳՈՐԾԱԿԱԼՈՒԹՅԱՆ ԱՆՈՒՆԸ] տնային առողջական խնամքի գործակալությունից: Ճի՞շտ է:
 

Թերթիկի հարցերին պատասխանելիս հենվեք միայն այդ գործակալության հետ Ձեր անձնական փորձի վրա:

  - Այո
  - Ոչ → Եթե «Ոչ», խնդրում ենք դադարեցնել հարցաթերթիկի լրացումն ու տրամադրված ծրարով այն վերադարձնել:

2. Երբ այս գործակալությունից սկսեցիք տնային առողջական խնամք ստանալ, արդյո՞ք գործակալությունից որևէ մեկն ասաց Ձեզ՝ ինչ խնամք ու ծառայություններ կարող եք ստանալ:
  - Այո
  - Ոչ
  - Չեմ հիշում
3. Երբ այս գործակալությունից սկսեցիք տնային առողջական խնամք ստանալ, արդյո՞ք գործակալությունից որևէ մեկն ասաց Ձեզ՝ ինչպես կահավորել տունը, որպեսզի ապահով տեղաշարժվեք:
  - Այո
  - Ոչ
  - Չեմ հիշում
4. Երբ այս գործակալությունից սկսեցիք տնային առողջական խնամք ստանալ, արդյո՞ք գործակալությունից որևէ մեկը խոսեց Ձեզ հետ դեղատոմսային և ընդհանուր վաճառքում գտնվող այն բոլոր դեղամիջոցների մասին, որոնք ընդունում էիք:
  - Այո
  - Ոչ
  - Չեմ հիշում

5. Երբ այս գործակալությունից սկսեցիք տնային առողջական խնամք ստանալ, արդյո՞ք գործակալությունից որևէ մեկը խնդրեց **տեսնել** դեղատոմսային և ընդհանուր վաճառքում գտնվող այն բոլոր դեղամիջոցները, որոնք ընդունում էիք:

- ☐ Այո  
☐ Ոչ  
☐ Չեմ հիշում

**ՏՆԱՅԻՆ ԱՌՈՂՋԱԿԱՆ ԽՆԱՄՔԻ  
ՄԱՏԱԿԱՐԱՐՆԵՐԻ ԿՈՂՄԻՑ ՎԵՐՁԻՆ  
2 ԱՄՍՈՒՄ ՁԵՁ ՏՐԱՄԱԴՐՎԱԾ  
ԽՆԱՄՔԸ**

Հետևյալ հարցերը վերաբերում են **[ԳՈՐԾԱԿԱԼՈՒԹՅԱՆ ԱՆՈՒՆԸ]**-ի այն բոլոր աշխատակիցներին, ովքեր վերջին 2 ամսում Ձեզ խնամել են: Մի՛ ներառեք տնային առողջական խնամքի մեկ այլ գործակալության աշխատակիցներից ստացած խնամքը: Մի՛ ներառեք նաև ազգականներից կամ ընկերներից ստացած խնամքը:

6. Խնամքի վերջին 2 ամսում այս գործակալությունից Ձեզ տնային առողջական խնամք տրամադրողների թվում բուժակ եղե՞լ է:

☐ Այո  
☐ Ոչ

7. Խնամքի վերջին 2 ամսում այս գործակալությունից Ձեզ տնային առողջական խնամք տրամադրողների թվում ֆիզիկական, մասնագիտական, կամ խոսակցական թերապևտ եղե՞լ է:

- ☐ Այո  
☐ Ոչ

8. Խնամքի վերջին 2 ամսում այս գործակալությունից Ձեզ տնային առողջական խնամք տրամադրողների թվում տնային առողջական կամ անձնական խնամքի օգնական եղե՞լ է:

- ☐ Այո  
☐ Ոչ

9. Խնամքի վերջին 2 ամսում այս գործակալության տնային առողջության մատակարարները որքա՞ն հաճախ են քաջատեղյակ եղել Ձեր տնային խնամքի կամ բուժման ողջ ընթացքի մասին:

- ☐ Երբեք  
☐ Երբեմն  
☐ Սովորաբար  
☐ Միշտ  
☐ Խնամքի վերջին 2 ամսում ես միայն մեկ մատակարար եմ ունեցել:

10. Խնամքի վերջին 2 ամսում այս գործակալության տնային առողջական խնամքի որևէ մատակարարի հետ խոսել էք ցավի մասին:

- ☐ Այո
- ☐ Ոչ

11. Խնամքի վերջին 2 ամսում դեղատոմսային որևէ նոր դեղամիջոց ընդունել էք, կամ փոխել էք, արդյոք, մինչ այդ ընդունած որևէ դեղամիջոց:

- ☐ Այո
- ☐ Ոչ → Եթե «Ոչ», անցեք Հ15:

12. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի որևէ մատակարար խոսել է Ձեզ հետ Ձեր նոր կամ փոփոխված դեղատոմսային դեղամիջոցի ընդունման **անհրաժեշտության** մասին:

- ☐ Այո
- ☐ Ոչ
- ☐ Ես դեղատոմսային նոր դեղամիջոց չեմ ընդունել և դեղամիջոցներս չեմ փոխել

13. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները խոսել էն Ձեզ հետ այն մասին, թե **երբ** պետք է սկսել այդ դեղամիջոցների ընդունումը:

- ☐ Այո
- ☐ Ոչ
- ☐ Ես դեղատոմսային նոր դեղամիջոց չեմ ընդունել և դեղամիջոցներս չեմ փոխել

14. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները խոսել էն Ձեզ հետ այդ դեղամիջոցների **կողմնակի ազդեցությունների** մասին:

- ☐ Այո
- ☐ Ոչ
- ☐ Ես դեղատոմսային նոր դեղամիջոց չեմ ընդունել և դեղամիջոցներս չեմ փոխել

15. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են Ձեզ տեղեկացրել՝ երբ են ժամանելու Ձեզ այցելության:

- ☐ Երբեք
- ☐ Երբեմն
- ☐ Սովորաբար
- ☐ Միշտ



16. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են Ձեզ հնարավորինս սիրալիր վերաբերվել:
- ☐ Երբեք
- ☐ Երբեմն
- ☐ Սովորաբար
- ☐ Միշտ
17. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են Ձեզ մատչելի ձևով բացատրել իրողությունը:
- ☐ Երբեք
- ☐ Երբեմն
- ☐ Սովորաբար
- ☐ Միշտ
18. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են ուշադիր լսել Ձեզ:
- ☐ Երբեք
- ☐ Երբեմն
- ☐ Սովորաբար
- ☐ Միշտ

19. Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են Ձեզ հետ կիրթ ու հարգալիր վերաբերվել:
- ☐ Երբեք
- ☐ Երբեմն
- ☐ Սովորաբար
- ☐ Միշտ
20. Ինչպիսի՞ն է այս գործակալության տնային առողջության մատակարարների կողմից Ձեզ տրամադրված խնամքի՝ Ձեր գնահատականը:
- 0-10 սանդղակով, որտեղ 0-ն տնային առողջական խնամքի հնարավոր վատթարագույն ցուցանիշն է, իսկ 10-ը՝ լավագույնը, ինչպե՞ս կգնահատեիք այս գործակալության տնային առողջական խնամքի մատակարարների կողմից Ձեզ տրամադրված խնամքը:
- ☐ 0 Հնարավոր վատթարագույն տնային առողջական խնամք
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Հնարավոր լավագույն տնային առողջական խնամք

**ՁԵՐ ՏՆԱՅԻՆ ԱՌՈՂՋԱԿԱՆ  
ԳՈՐԾԱԿԱԼՈՒԹՅՈՒՆԸ**

Հետևյալ հարցերը վերաբերում են  
[ԳՈՐԾԱԿԱԼՈՒԹՅԱՆ ԱՆՈՒՆԸ]-ի  
գրասենյակին:

21. Խնամքի վերջին 2 ամսում դիմե՞լ եք, արդյոք, գործակալության գրասենյակ՝ օգնության կամ խորհրդատվության:

- ☐ Այո
- ☐ Ոչ → Եթե «Ոչ», անցեք Հ24:

22. Խնամքի վերջին 2 ամսում գործակալության գրասենյակ դիմելիս ստացե՞լ եք, արդյոք, անհրաժեշտ օգնությունը կամ խորհրդատվությունը:

- ☐ Այո
- ☐ Ոչ → Եթե «Ոչ», անցեք Հ24:
- ☐ Այս գործակալությանը չեմ դիմել

23. Այս գործակալության գրասենյակ դիմելիս անհրաժեշտ օգնությունը կամ խորհուրդը որքա՞ն արագ եք ստացել:

- ☐ Նույն օրը
- ☐ 1-ից 5 օր
- ☐ 6-ից 14 օր
- ☐ Ավելի, քան 14 օր
- ☐ Այս գործակալությանը չեմ դիմել

24. Խնամքի վերջին 2 ամսում գործակալության գործունեության հետ կապված որևէ խնդիր ունեցե՞լ եք:

- ☐ Այո
- ☐ Ոչ

25. Ձեր ընտանիքի անդամներին կամ ընկերներին խորհուրդ կտայի՞ք օգտվել այս գործակալության տնային առողջական խնամքի ծառայություններից:

- ☐ Միանշանակ ոչ
- ☐ Հավանաբար ոչ
- ☐ Հավանաբար այո
- ☐ Միանշանակ այո

**ՁԵՐ ՄԱՍԻՆ**

26. Ընդհանուր առմամբ, ինչպե՞ս կգնահատեիք Ձեր ընդհանուր առողջական վիճակը:

- ☐ Գերազանց
- ☐ Շատ լավ
- ☐ Լավ
- ☐ Բավարար
- ☐ Վատ

27. Ընդհանուր առմամբ, ինչպե՞ս կգնահատեիք Ձեր հոգեկան կամ զգայական առողջության ընդհանուր վիճակը:

- ☐ Գերազանց
- ☐ Շատ լավ
- ☐ Լավ
- ☐ Բավարար
- ☐ Վատ

28. Դուք միայնա՞կ եք ապրում:

- ☐ Այո
- ☐ Ոչ

29. Ի՞նչ կրթություն ունեք:

- ☐ 8-րդ դասարան կամ պակաս
- ☐ որոշ ավագ դպրոց, բայց չեմ ավարտել
- ☐ ավագ դպրոցի շրջանավարտ կամ ընդհանուր համարժեքության դիպլոմակիր (GED)
- ☐ Որոշ քոլեջ, կամ 2-ամյա ծրագրի շրջանավարտ
- ☐ 4-ամյա քոլեջի շրջանավարտ
- ☐ 4-ամյա քոլեջից ավելի

30. Արդյո՞ք հիսպանիկ կամ լատինամերիկյան ծագում ունեք:

- ☐ Այո
- ☐ Ոչ

31. Ռասայական պատկանելությունը. ընտրեք մեկ կամ ավելի տարբերակ:

- ☐ Հնդկացի կամ Ալյասկայի բնիկ
- ☐ Ասիացի
- ☐ Սևամորթ կամ աֆրո-ամերիկացի
- ☐ Բնիկ հավայացի կամ Խաղաղ օվկիանոսի այլ կղզիաբնակ
- ☐ Սպիտակամորթ

32. Տանը հիմնականում ի՞նչ լեզվով եք խոսում:

- ☐ Անգլերեն
- ☐ Իսպաներեն
- ☐ Մեկ այլ լեզու

*(Խնդրում ենք տպատառ նշել)*

33. Այս հարցաթերթիկը լրացնելիս որևէ մեկն օգնե՞լ է Ձեզ:

- ☐ Այո
- ☐ Ոչ → Եթե «Ոչ», խնդրում ենք լրացված հարցաթերթիկը վերադարձնել տրամադրվող նախապես վճարված ծրարով:

34. Ինչպե՞ս է այդ անձն օգնել Ձեզ:  
Նշեք բոլոր համապատասխան  
վանդակները:

- ☐ Հարցերն ինձ ընթերցել է
- ☐ Գրառել է պատասխաններս
- ☐ Իմ փոխարեն պատասխանել է  
հարցերին
- ☐ Հարցերը թարգմանել է իմ  
լեզվով
- ☐ Օգնել է այլ կերպ

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*(Խնդրում ենք տպատառ նշել)*

- ☐ Այս հարցաթերթիկը լրացնելիս  
ինձ ոչ ոք չի օգնել

**Շնորհակալություն:**

**Լրացված հարցաթերթիկը խնդրում  
ենք վերադարձնել կից տրամադրվող  
նախապես վճարված ծրարով:**

**APPENDIX J:**

**OMB PAPERWORK REDUCTION ACT LANGUAGE  
IN ENGLISH, SPANISH, CHINESE, RUSSIAN, VIETNAMESE, AND  
ARMENIAN LANGUAGES**

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## OMB Paperwork Reduction Act Language

The Office of Management and Budget (OMB) Paperwork Reduction Act language below must be included in the Home Health Care CAHPS Survey mailings. It can be included in the cover letter or on the front or back of the questionnaire. It does not need to be included in both the cover letter and the questionnaire.

### ENGLISH

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. The expiration date for OMB control number 0938-1066 is July 31, 2026. 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.

## **OMB Paperwork Reduction Act Language**

The Office of Management and Budget (OMB) Paperwork Reduction Act language below must be included in the Home Health Care CAHPS Survey mailings. It can be included in the cover letter or on the front or back of the questionnaire. It does not need to be included in both the cover letter and the questionnaire.

### **SPANISH**

Según la Ley de Reducción de Trabajo Administrativo de 1995 (The Paperwork Reduction Act of 1995), ninguna persona tiene la obligación de responder a un cuestionario para recaudar información a menos que este lleve un número de control válido de la Oficina de Administración y Presupuesto (OMB, por sus siglas en inglés). El número de control OMB válido para este cuestionario es 0938-1066. La fecha de vencimiento del número de control OMB 0938-1066 es el 31 de julio de 2026. Se estima que el tiempo promedio necesario para completar este cuestionario es de 12 minutos por respuesta, incluyendo el tiempo para revisar las instrucciones, buscar fuentes de datos existentes, recaudar los datos necesarios y completar y revisar el cuestionario. Si tiene algún comentario respecto a la exactitud del tiempo estimado o sugerencias para mejorar este formulario, por favor escriba a: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.



## OMB Paperwork Reduction Act Language

The Office of Management and Budget (OMB) Paperwork Reduction Act language below must be included in the Home Health Care CAHPS Survey mailings. It can be included in the cover letter or on the front or back of the questionnaire. It does not need to be included in both the cover letter and the questionnaire.

### SIMPLIFIED CHINESE

根据 1995 年减少纸张使用法案，如果问卷上没有有效的 OMB 控制数码，任何人都无须回答问卷上的任何问题。这项问卷持有有效的 OMB 控制数码：0938-1066。OMB 控制数码 0938-1066 将于 2026 年 7 月 31 日失效。完成这份问卷，估计需要十二分钟。这包括阅读问卷的说明，寻找现有的资料，收集和整理所需的信息，以及完成和审阅所提供的信息。如果您对完成这份问卷所估计的时间或对如何改进这项问卷有任何看法，请写信给：

Centers for Medicare & Medicaid Services,  
7500 Security Boulevard, Mail Stop C1-25-05,  
Baltimore, Maryland 21244-1850

## **OMB Paperwork Reduction Act Language**

The Office of Management and Budget (OMB) Paperwork Reduction Act language below must be included in the Home Health Care CAHPS Survey mailings. It can be included in the cover letter or on the front or back of the questionnaire. It does not need to be included in both the cover letter and the questionnaire.

### **TRADITIONAL CHINESE**

根據1995 年減少紙張使用法案，如果問卷上未顯示有效 OMB控制編號，任何人都無需回答問卷上的任何問題。此項問卷的有效 OMB控制編號是0938-1066。OMB控制數碼0938-1066將於2026年7月31日失效。完成這份問卷平均所需的時間預計為12分鐘，其中包括查看問卷的說明，搜尋現有的資料，彙集整理所需的資料，以及完成和查看所提供的資訊。如果您有任何關於時間預計精確度的意見或改善此項問卷的建議，請寫信至：

Centers for Medicare & Medicaid Services,  
7500 Security Boulevard, Mail Stop C1-25-05,  
Baltimore, Maryland 21244-1850

## OMB Paperwork Reduction Act Language

The Office of Management and Budget (OMB) Paperwork Reduction Act language below must be included in the Home Health Care CAHPS Survey mailings. It can be included in the cover letter or on the front or back of the questionnaire. It does not need to be included in both the cover letter and the questionnaire.

### RUSSIAN

В соответствии с Законом США «О сокращении объема канцелярских работ» 1995 года лица не обязаны отвечать на просьбу о сборе информации, если в ней не указан действительный контрольный номер АБУ (ОМВ). Контрольный номер АБУ для данного сбора информации: 0938-1066. Срок действия АБУ 0938-1066 истекает 31 июля 2026 года. Время, необходимое для сбора информации в рамках данного опроса, составляет в среднем 12 минут на человека, включая время на инструктаж, поиск существующих источников данных, сбор необходимых данных, выполнение и обзор опроса. Если у Вас есть замечания относительно точности приблизительного времени проведения опроса или улучшения содержания данного бланка, пишите по адресу: Centers for Medicare & Medicaid Services (Центры услуг Программ Medicare и Medicaid), 7500 Security Boulevard, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

## **OMB Paperwork Reduction Act Language**

The Office of Management and Budget (OMB) Paperwork Reduction Act language below must be included in the Home Health Care CAHPS Survey mailings. It can be included in the cover letter or on the front or back of the questionnaire. It does not need to be included in both the cover letter and the questionnaire.

### **VIETNAMESE**

Theo Đạo Luật Giảm Công Việc Giấy Tờ năm 1995, không một người nào bị bắt buộc phải hồi đáp yêu cầu thu thập thông tin, trừ khi đã xuất trình số kiểm soát hợp lệ theo OMB. Số kiểm soát hợp lệ theo OMB đối với hoạt động thu thập thông tin này là 0938-1066. Ngày hết hạn cho số kiểm soát OMB 0938-1066 là 31/07/2026. Theo ước tính, thời gian trung bình cần thiết để hoàn tất quá trình thu thập thông tin này là 12 phút cho một câu trả lời, trong đó kể cả thời gian xem lại các hướng dẫn, tìm nguồn dữ liệu hiện có, thu lượm dữ liệu cần thiết, điền vào và xem lại toàn bộ quá trình. Nếu quý vị có góp ý gì về độ chính xác của thời gian đã ước tính, hoặc muốn đề nghị cách thức cải tiến mẫu này, thì nên viết thư cho: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

## OMB Paperwork Reduction Act Language

The Office of Management and Budget (OMB) Paperwork Reduction Act language below must be included in the Home Health Care CAHPS Survey mailings. It can be included in the cover letter or on the front or back of the questionnaire. It does not need to be included in both the cover letter and the questionnaire.

### ARMENIAN

Ըստ Թղթաբանության կրճատման մասին 1995 թ. Օրենքի (Paperwork Reduction Act of 1995), տեղեկահավաք հարցմանը պատասխանելը պարտադիր չէ, եթե այն OMB-ի (ԱՄՆ Նախագահի աշխատակազմի Կառավարման և բյուջետային հարցերի գրասենյակ) վավեր հսկիչ համար չի կրում: Այս տեղեկահավաք հարցման OMB վավեր հսկիչ համարն է 0938-1066: OMB-ի 0938-1066 հսկիչ համարի վավերության ժամկետը Վավեր է մինչև 2026 թ. հուլիսի 31-ին: Այս տեղեկահավաքի լրացման անհրաժեշտ ժամանակը գնահատված է միջինը 12 րոպե՝ մեկ պատասխանի համար, ներառյալ հրահանգներին ծանոթանալը, տվյալների առկա աղբյուրներ փնտրելը, անհրաժեշտ տվյալները հավաքելն ու հավաքված տեղեկատվությունը գննելը: Եթե ժամանակային գնահատումների ճշգրտության, կամ այս թերթիկը բարելավելու կապակցությամբ մեկնաբանություն ունեք, ապա խնդրում ենք գրավոր դիմել հետևյալ հասցեով. Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

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**APPENDIX K:**

**SUPPLEMENTAL QUESTIONS IN ENGLISH, SPANISH, CHINESE,  
RUSSIAN, VIETNAMESE, AND ARMENIAN LANGUAGES**

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**HOME HEALTH CARE CAHPS SURVEY**  
**SUPPLEMENTAL ITEMS: ENGLISH**

- S1.** Did this home health care start as soon as you thought you needed?
- 1 ☐ Yes  
2 ☐ No
- S2.** Did your care from this agency follow a stay in a hospital, nursing home, or rehabilitation center?
- 1 ☐ Yes  
2 ☐ No
- S3.** In the last 2 months of care, how often did you have a hard time speaking with or understanding home health providers from this agency because you spoke different languages?
- 1 ☐ Never  
2 ☐ Sometimes  
3 ☐ Usually  
4 ☐ Always
- S4.** In the last 2 months of care, how often did home health providers from this agency behave in a professional manner?
- 1 ☐ Never  
2 ☐ Sometimes  
3 ☐ Usually  
4 ☐ Always
- S5.** In the last 2 months of care, how often did you feel that home health providers from this agency really cared about you?
- 1 ☐ Never  
2 ☐ Sometimes  
3 ☐ Usually  
4 ☐ Always
- S6.** In the last 2 months of care, did you contact this agency's office about any problems?
- 1 ☐ Yes  
2 ☐ No  
3 ☐ Did not have problems

**S7.** In the last 2 months of care, did this agency solve your problem as soon as you needed?

- <sup>1</sup> ☐ Yes
- <sup>2</sup> ☐ No
- <sup>3</sup> ☐ I am still waiting
- <sup>4</sup> ☐ I did not call (Go to S9)

**S8.** Are you satisfied with how this agency solved your problem?

- <sup>1</sup> ☐ Yes
- <sup>2</sup> ☐ No
- <sup>3</sup> ☐ I am still waiting
- <sup>4</sup> ☐ I did not call (Go to S9)

**S9.** Using any number from 0 to 10, where 0 is the worst home health agency possible and 10 is the best home health agency possible, what number would you use to rate this home health agency?

- ☐ 0 Worst home health agency possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best home health agency possible

**S10.** Is there anything else you'd like to say about the care you got from this home health agency?

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## **HOME HEALTH CARE CAHPS SURVEY**

### **SUPPLEMENTAL ITEMS: SPANISH**

**S1.** ¿El cuidado de la salud en el hogar que usted recibió por parte de esta agencia empezó tan pronto como usted pensaba que lo necesitaba?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No

**S2.** ¿El cuidado de la salud en el hogar que usted recibió por parte de esta agencia fue después de haber estado internado(a) en un hospital, un hogar de ancianos o un centro de rehabilitación?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No

**S3.** En los últimos 2 meses en que recibió cuidado de la salud, ¿con qué frecuencia le fue difícil hablar o entender a los proveedores del cuidado de la salud en el hogar de esta agencia porque ustedes hablaban idiomas distintos?

- <sup>1</sup> ☐ Nunca  
<sup>2</sup> ☐ A veces  
<sup>3</sup> ☐ La mayoría de las veces  
<sup>4</sup> ☐ Siempre

**S4.** En los últimos 2 meses en que usted recibió cuidado de la salud, ¿con qué frecuencia los proveedores del cuidado de la salud en el hogar de esta agencia se comportaron de manera profesional?

- <sup>1</sup> ☐ Nunca  
<sup>2</sup> ☐ A veces  
<sup>3</sup> ☐ La mayoría de las veces  
<sup>4</sup> ☐ Siempre

**S5.** En los últimos 2 meses en que usted recibió cuidado de la salud, ¿con qué frecuencia sintió que los proveedores del cuidado de la salud en el hogar de esta agencia realmente se preocupaban por usted?

- <sup>1</sup> ☐ Nunca  
<sup>2</sup> ☐ A veces  
<sup>3</sup> ☐ La mayoría de las veces  
<sup>4</sup> ☐ Siempre

**S6.** En los últimos 2 meses en que recibió cuidado de la salud, ¿se comunicó usted con la oficina de esta agencia sobre algún problema?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No  
<sup>3</sup> ☐ No tuvo ningún problema

**S7.** En los últimos 2 meses en que recibió cuidado de la salud, ¿esta agencia resolvió su problema tan pronto como usted lo necesitaba?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No  
<sup>3</sup> ☐ Todavía estoy esperando que lo resuelvan  
<sup>4</sup> ☐ No llamé a esta agencia (Vaya a la pregunta S9)

**S8.** ¿Está satisfecho(a) con la manera en que esta agencia resolvió su problema?

- <sup>1</sup> ☐ Sí  
<sup>2</sup> ☐ No  
<sup>3</sup> ☐ Todavía estoy esperando que lo resuelvan  
<sup>4</sup> ☐ No llamé a esta agencia (Vaya a la pregunta S9)

**S9.** Usando un número de 0 a 10, donde 0 es la peor agencia de cuidado de la salud en el hogar posible y 10 es la mejor agencia de cuidado de la salud en el hogar posible, ¿qué número usaría para calificar a esta agencia de cuidado de la salud en el hogar?

- ☐ 0 La peor agencia de cuidado de la salud en el hogar  
☐ 1  
☐ 2  
☐ 3  
☐ 4  
☐ 5  
☐ 6  
☐ 7  
☐ 8  
☐ 9  
☐ 10 La mejor agencia de cuidado de la salud en el hogar

**S10.** ¿Hay alguna otra cosa que usted quisiera decir sobre la atención que recibió de esta agencia de cuidado de la salud en el hogar?

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**HOME HEALTH CARE CAHPS SURVEY**  
**SUPPLEMENTAL ITEMS: SIMPLIFIED CHINESE**

**S1.** 该居家健康护理是否在您需要的时候就能立即开始？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

**S2.** 您是否从医院、疗养院或康复中心出院后获得该机构的护理？

<sup>1</sup> ☐ 是

<sup>2</sup> ☐ 否

**S3.** 在过去 2 个月的护理期间，由于语言不通而与该机构的居家健康护理提供者交流时遇到困难，这种情况对您来说有多经常发生？

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是

**S4.** 在过去 2 个月的护理期间，该机构居家健康护理提供者的行为举止多经常显得专业？

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是

**S5.** 在过去 2 个月的护理期间，您认为该机构居家健康护理提供者多经常真心关心您？

<sup>1</sup> ☐ 从不

<sup>2</sup> ☐ 有时

<sup>3</sup> ☐ 经常

<sup>4</sup> ☐ 总是

**S6.** 在过去 2 个月的护理期间，您是否因任何问题联系过该机构的办公室？

- <sup>1</sup> ☐ 是  
<sup>2</sup> ☐ 否  
<sup>3</sup> ☐ 不曾有过问题

**S7.** 在过去 2 个月的护理期间，该机构是否在您一有需要时就解决您的问题？

- <sup>1</sup> ☐ 是  
<sup>2</sup> ☐ 否  
<sup>3</sup> ☐ 我仍在等待  
<sup>4</sup> ☐ 我没有打过电话（转至 S9）

**S8.** 您对该机构解决问题的方式是否满意？

- <sup>1</sup> ☐ 是  
<sup>2</sup> ☐ 否  
<sup>3</sup> ☐ 我仍在等待  
<sup>4</sup> ☐ 我没有打过电话（转至 S9）

**S9.** 如果使用 0 至 10 之间的任何数字，其中 0 表示最差居家健康护理机构，10 表示最佳居家健康护理机构，您会用哪个数字来评价该居家健康护理机构？

- ☐ 0 最差居家健康护理机构  
☐ 1  
☐ 2  
☐ 3  
☐ 4  
☐ 5  
☐ 6  
☐ 7  
☐ 8  
☐ 9  
☐ 10 最佳居家健康护理机构

**S10.** 您对该居家健康护理机构的护理还有什么意见或评价？

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**HOME HEALTH CARE CAHPS SURVEY**  
**SUPPLEMENTAL ITEMS: TRADITIONAL CHINESE**

**S1.** 此居家健康護理是否於您認為有需要時立即開始？

- <sup>1</sup> ☐ 是  
<sup>2</sup> ☐ 否

**S2.** 您是否從醫院、養老院或復健中心出院后接受此機構的護理？

- <sup>1</sup> ☐ 是  
<sup>2</sup> ☐ 否

**S3.** 在過去 2 個月的護理中，由於所說語言不同而與此機構的居家健康護理提供者產生交流困難，這種情形對您有多經常發生？

- <sup>1</sup> ☐ 從未  
<sup>2</sup> ☐ 有時  
<sup>3</sup> ☐ 經常  
<sup>4</sup> ☐ 始終

**S4.** 在過去 2 個月的護理中，此機構居家健康護理提供者的行為舉止多經常顯得專業？

- <sup>1</sup> ☐ 從未  
<sup>2</sup> ☐ 有時  
<sup>3</sup> ☐ 經常  
<sup>4</sup> ☐ 始終

**S5.** 在過去 2 個月的護理中，您多經常會感覺到此機構居家健康護理提供者真正關心您？

- <sup>1</sup> ☐ 從未  
<sup>2</sup> ☐ 有時  
<sup>3</sup> ☐ 經常  
<sup>4</sup> ☐ 始終

**S6.** 在過去 2 個月的護理中，您是否因任何問題聯絡過此機構的辦公室？

- <sup>1</sup> ☐ 是  
<sup>2</sup> ☐ 否  
<sup>3</sup> ☐ 未曾有過問題



**S7.** 在過去 2 個月的護理中，此機構是否在您一有需要時立即解決您的問題？

- <sup>1</sup> ☐ 是  
<sup>2</sup> ☐ 否  
<sup>3</sup> ☐ 我仍在等待  
<sup>4</sup> ☐ 我沒有打過電話（移往 S9）

**S8.** 您是否滿意此機構解決問題的方式？

- <sup>1</sup> ☐ 是  
<sup>2</sup> ☐ 否  
<sup>3</sup> ☐ 我仍在等待  
<sup>4</sup> ☐ 我沒有打過電話（移往 S9）

**S9.** 使用從 0 到 10 的任何數字，其中 0 表示最差的居家健康護理機構，10 表示最好的居家健康護理機構，哪個數字可用於評定此居家健康護理機構？

- ☐ 0 最差的居家健康護理機構  
☐ 1  
☐ 2  
☐ 3  
☐ 4  
☐ 5  
☐ 6  
☐ 7  
☐ 8  
☐ 9  
☐ 10 最好的居家健康護理機構

**S10.** 您對於此居家健康護理機構的護理還有什麼意見和評價？

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## **HOME HEALTH CARE CAHPS SURVEY**

### **SUPPLEMENTAL ITEMS: RUSSIAN**

**S1.** Вы начали получать медицинский уход на дому так же скоро, как и предполагали?

- 1 ☐ Да  
2 ☐ Нет

**S2.** Являлись ли эти услуги по уходу на дому следствием лечения в больнице, доме престарелых или реабилитационном центре?

- 1 ☐ Да  
2 ☐ Нет

**S3.** Как часто за последние 2 месяца ухода Вам было трудно разговаривать или понимать сотрудников этого агентства услуг домашнего медицинского ухода из-за языкового барьера?

- 1 ☐ Никогда  
2 ☐ Иногда  
3 ☐ Часто  
4 ☐ Всегда

**S4.** Как часто за последние 2 месяца ухода сотрудники этого агентства вели себя профессионально?

- 1 ☐ Никогда  
2 ☐ Иногда  
3 ☐ Часто  
4 ☐ Всегда

**S5.** Как часто за последние 2 месяца ухода Вы чувствовали, что Ваше благополучие не безразлично сотрудникам этого агентства?

- 1 ☐ Никогда  
2 ☐ Иногда  
3 ☐ Часто  
4 ☐ Всегда

**S6.** За последние 2 месяца ухода обращались ли Вы в офис этого агентства с какими-либо проблемами?

- 1 ☐ Да  
2 ☐ Нет  
3 ☐ У меня не возникало проблем

**S7.** За последние 2 месяца ухода удавалось ли сотрудникам агентства разрешить Вашу проблему, как только она возникла?

- 1 ☐ Да  
2 ☐ Нет  
3 ☐ Я все еще ожидаю разрешения своей проблемы  
4 ☐ Я не звонил(-а) в агентство (перейдите к ДВ9)

**S8.** Довольны ли Вы полученным решением?

- 1 ☐ Да  
2 ☐ Нет  
3 ☐ Я все еще ожидаю разрешения своей проблемы  
4 ☐ Я не звонил(-а) в агентство (перейдите к ДВ9)

**S9.** По шкале от 0 до 10, где 0 означает наихудшее агентство услуг по домашнему медицинскому уходу, а 10 — наилучшее агентство услуг, как бы Вы оценили это агентство услуг домашнего медицинского ухода?

- ☐ 0 Наихудшее агентство услуг по домашнему медицинскому уходу  
☐ 1  
☐ 2  
☐ 3  
☐ 4  
☐ 5  
☐ 6  
☐ 7  
☐ 8  
☐ 9  
☐ 10 Наилучшее агентство услуг по домашнему медицинскому уходу

**S10.** Хотели бы Вы добавить еще что-нибудь о качестве услуг этого агентства?

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**HOME HEALTH CARE CAHPS SURVEY  
SUPPLEMENTAL ITEMS: VIETNAMESE**

- S1.** Công việc chăm sóc sức khỏe tại gia này có bắt đầu ngay khi quý vị nghĩ là cần thiết không?
- <sup>1</sup> ☐ Có
- <sup>2</sup> ☐ Không
- S2.** Có phải công việc chăm sóc từ cơ quan này là phần tiếp nối sau khi quý vị lưu lại tại bệnh viện, viện điều dưỡng, hoặc trung tâm phục hồi?
- <sup>1</sup> ☐ Có
- <sup>2</sup> ☐ Không
- S3.** Trong 2 tháng chăm sóc vừa qua, quý vị có thường xuyên gặp phải việc bất đồng ngôn ngữ khi cần nói chuyện hay hiểu ý người chăm sóc sức khỏe tại gia từ cơ quan này không?
- <sup>1</sup> ☐ Chưa bao giờ
- <sup>2</sup> ☐ Thỉnh thoảng
- <sup>3</sup> ☐ Thường khi
- <sup>4</sup> ☐ Luôn luôn
- S4.** Trong 2 tháng chăm sóc vừa qua, người chăm sóc sức khỏe tại gia từ cơ quan có thường xuyên cư xử với thái độ chuyên nghiệp không?
- <sup>1</sup> ☐ Chưa bao giờ
- <sup>2</sup> ☐ Thỉnh thoảng
- <sup>3</sup> ☐ Thường khi
- <sup>4</sup> ☐ Luôn luôn
- S5.** Trong 2 tháng chăm sóc vừa qua, quý vị có thường xuyên cảm thấy rằng người chăm sóc sức khỏe tại gia từ cơ quan này thật lòng quan tâm đến quý vị không?
- <sup>1</sup> ☐ Chưa bao giờ
- <sup>2</sup> ☐ Thỉnh thoảng
- <sup>3</sup> ☐ Thường khi
- <sup>4</sup> ☐ Luôn luôn

- S6.** Trong 2 tháng chăm sóc vừa qua, quý vị có liên lạc với văn phòng của cơ quan này để cho biết về bất cứ vấn đề gì không?
- <sup>1</sup> ☐ Có
- <sup>2</sup> ☐ Không
- <sup>3</sup> ☐ Không có vấn đề rắc rối nào
- S7.** Trong 2 tháng chăm sóc vừa qua, cơ quan này có giải quyết vấn đề ngay khi quý vị cần không?
- <sup>1</sup> ☐ Có
- <sup>2</sup> ☐ Không
- <sup>3</sup> ☐ Tôi vẫn còn chờ giải quyết
- <sup>4</sup> ☐ Tôi không gọi đến đó (Chuyển sang S9)
- S8.** Quý vị có hài lòng với cách cơ quan này giải quyết vấn đề của quý vị không?
- <sup>1</sup> ☐ Có
- <sup>2</sup> ☐ Không
- <sup>3</sup> ☐ Tôi vẫn còn chờ giải quyết
- <sup>4</sup> ☐ Tôi không gọi đến đó (Chuyển sang S9)
- S9.** Tính theo thang điểm từ 0 tới 10, trong đó 0 là cơ quan chăm sóc sức khỏe tại gia tệ nhất và 10 là cơ quan chăm sóc sức khỏe tại gia tốt nhất, quý vị sẽ dùng số mấy để đánh giá cơ quan chăm sóc sức khỏe tại gia này?
- ☐ 0 Cơ quan chăm sóc sức khỏe tại gia tệ nhất
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Cơ quan chăm sóc sức khỏe tại gia tốt nhất

**S10.** Quý vị còn muốn nói điều gì khác về sự chăm sóc do cơ quan chăm sóc sức khỏe tại gia này thực hiện không?

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## **HOME HEALTH CARE CAHPS SURVEY**

### **SUPPLEMENTAL ITEMS: ARMENIAN**

- S1.** Արդյո՞ք տնային առողջական խնամքի այս ծրագիրը սկսվեց Ձեզ մոտ դրա կարիքն առաջանալուն պես:
- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- S2.** Արդյո՞ք այս գործակալության կողմից Ձեզ խնամքի տրամադրումը հետևեց հիվանդանոցում, ծերանոցում, կամ վերականգնողական կենտրոնում բուժման կուրսին:
- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- S3.** Խնամքի վերջին 2 ամսում տնային առողջական խնամքի Ձեր մատակարարների հետ շփվելիս որքա՞ն հաճախ եք դժվարություն ունեցել լեզվական տարբերության պատճառով:
- <sup>1</sup> ☐ Երբեք
- <sup>2</sup> ☐ Երբեմն
- <sup>3</sup> ☐ Հաճախ
- <sup>4</sup> ☐ Միշտ
- S4.** Խնամքի վերջին 2 ամսում այս գործակալության տնային խնամքի մատակարարները որքա՞ն հաճախ են իրենց արհեստավարժ կերպով դրսևորել:
- <sup>1</sup> ☐ Երբեք
- <sup>2</sup> ☐ Երբեմն
- <sup>3</sup> ☐ Հաճախ
- <sup>4</sup> ☐ Միշտ

S5. Խնամքի վերջին 2 ամսում որքա՞ն հաճախ եք ունեցել այն զգացումը, որ այս գործակալության տնային խնամքի մատակարարներն իրապես հոգատար են Ձեր հանդեպ:

- <sup>1</sup> ☐ Երբեք
- <sup>2</sup> ☐ Երբեմն
- <sup>3</sup> ☐ Հաճախ
- <sup>4</sup> ☐ Միշտ

S6. Խնամքի վերջին 2 ամսում այս գործակալությանը որևէ խնդրի կապակցությամբ դիմե՞լ եք:

- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Խնդիրներ չեմ ունեցել

S7. Խնամքի վերջին 2 ամսում այս գործակալությունը Ձեզ համար հնարավորինս արագ լուծե՞լ է, արդյոք, Ձեր խնդիրը:

- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Դեռ սպասում եմ
- <sup>4</sup> ☐ Չեմ գանգահարել (անցեք S9)

S8. Արդյո՞ք Դուք բավարարված եք տվյալ գործակալության կողմից խնդրի լուծմամբ:

- <sup>1</sup> ☐ Այո
- <sup>2</sup> ☐ Ոչ
- <sup>3</sup> ☐ Դեռ սպասում եմ
- <sup>4</sup> ☐ Չեմ գանգահարել (անցեք S9)



**S9.** 0-10 սանդղակով, որտեղ 0-ն տնային առողջական խնամքի գործակալության հնարավոր վատթարագույն ցուցանիշն է, իսկ 10-ը՝ լավագույնը, ի՞նչ գնահատական կտայիք տնային առողջական խնամքի այս գործակալությանը:

- ☐ 0 Հնարավոր վատթարագույն տնային առողջական խնամքի գործակալություն
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Հնարավոր լավագույն տնային առողջական խնամքի գործակալություն

**S10.** Կա՞, արդյոք, առողջական խնամքի այս գործակալությունից Ձեր ստացած ծառայությունների մասին որևէ այլ բան, որի մասին կցանկանայիք պատմել:

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**APPENDIX L:**  
**FAQS FOR TELEPHONE INTERVIEWERS**

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## **FREQUENTLY ASKED QUESTIONS THE HOME HEALTH CARE CAHPS SURVEY**

### **Who is sponsoring this survey?**

*[Agency Name]* has asked our company to conduct this survey to help them evaluate the care that its health providers give to you in your home. The survey is part of a national study that will help consumers make more informed choices about home health care providers. The results of this study will be publicly reported on the Internet at Home Health Compare at <https://www.medicare.gov/care-compare>.

*[THE FOLLOWING QUESTIONS AND ANSWERS ARE TO BE USED ONLY WHEN THE INTERVIEWER IS SPEAKING WITH THE SAMPLED PATIENT. IF THE INTERVIEWER IS NOT SPEAKING WITH THE PATIENT, THE INTERVIEWER SHOULD ONLY INDICATE THAT THE STUDY IS ABOUT HEALTH CARE.]*

### **Who is conducting this survey?**

I'm an interviewer from [SURVEY VENDOR NAME], which is an independent research survey organization. *[Agency Name]* has asked our organization to conduct the survey to help them get feedback from their patients.

### **What is the purpose of this survey?**

The purpose of this survey is to learn about your experiences getting home health care. The survey results will help consumers make more informed choices when choosing a home health care provider.

### **What questions will be asked?**

The survey asks questions about your experiences with home health care and your rating of the care you receive.

### **How do I know this is confidential?**

I can assure you that all information you provide will be kept confidential and is protected by the Federal Privacy Act of 1974. All project staff members have signed affidavits of confidentiality and are prohibited by law from using survey information for anything other than this research study.

### **Why do you want to know all this personal stuff about me if this is a survey about my home health care experiences?**

These health and demographic questions are designed to tell our researchers more about the people who answered the survey. They allow the researchers to do analysis by grouping people together.

**I'm on the *Do Not Call* list. Why are you calling me?**

The Do Not Call list stops sales and telemarketing calls. We are conducting survey research on behalf of your home health care agency. We are not calling to sell or market a product or service.

**I'm not going to answer a lot of questions over the phone!**

Your cooperation is very important to us. Your experiences will help your home health care agency and other home health care agencies understand which programs are the most helpful to you and others like you. All of the answers you give in this survey will be kept completely confidential and are protected by the Federal Privacy Act of 1974. Let me start and you can see what the questions are like.

**Why (or how) was I selected for this study?**

We used scientific sampling procedures to select a sample of people who have received health care in their homes. Your opinions are valuable because they represent those of other people like yourself.

**I don't like my home health care agency!**

I understand. Your opinions are very important and will help your home health care agency understand how to improve its programs. Let's start now. [NOTE: DO NOT ARGUE BACK. MAKE SHORT, NEUTRAL COMMENTS TO LET THEM KNOW THAT YOU ARE LISTENING AND IMMEDIATELY ASK THE FIRST QUESTION.]

**How do I know this survey is legitimate? How do I know you really are an interviewer for this survey?**

You can contact [SURVEY VENDOR NAME] at [TELEPHONE NUMBER] for information about the survey.

**How long will this take?**

This survey takes on average about 12 minutes to complete. I'll move through the questions as quickly as possible.

NOTE THAT SURVEY COMPLETION TIME WILL DEPEND ON WHETHER OTHER NON-CAHPS SURVEY ITEMS ARE ADDED TO THE QUESTIONNAIRE.

## PREGUNTAS MÁS FRECUENTES ENCUESTA DE CAHPS SOBRE LOS SERVICIOS DE SALUD EN CASA

### ¿Quién patrocina esta encuesta?

[Agency Name] le ha pedido a nuestra compañía que realice esta encuesta para ayudar a evaluar los servicios que los proveedores de salud le dan en su casa. La encuesta es parte de un estudio nacional que ayudará a que los consumidores estén mejor informados antes de tomar decisiones sobre los proveedores de cuidado de salud en su casa. Los resultados de este estudio se harán públicos en el Internet en <https://www.medicare.gov/care-compare>.

[THE FOLLOWING QUESTIONS AND ANSWERS ARE TO BE USED ONLY WHEN THE INTERVIEWER IS SPEAKING WITH THE SAMPLED PATIENT. IF THE INTERVIEWER IS NOT SPEAKING WITH THE PATIENT, THE INTERVIEWER SHOULD ONLY INDICATE THAT THE STUDY IS ABOUT HEALTH CARE.]

### ¿Quién realiza esta encuesta?

Soy un(a) entrevistador(a) de [SURVEY VENDOR NAME], que es una organización independiente de estudios de encuestas. [Agency Name] le ha pedido a nuestra organización que realice la encuesta para ayudar a obtener las opiniones de sus pacientes.

### ¿Cuál es el objetivo de esta encuesta?

El objetivo de esta encuesta es conocer sus experiencias al obtener cuidado de salud en casa. La encuesta ayudará a que los consumidores estén mejor informados al tomar decisiones cuando elijan un proveedor de cuidado de salud en casa.

### ¿Qué preguntas se van a hacer?

Las preguntas de la encuesta son sobre sus experiencias con los servicios de cuidado de salud en casa y sobre cómo califica los servicios que recibe usted.

### ¿Cómo puedo saber si es confidencial?

Le puedo asegurar que toda la información que usted proporcione se mantendrá en forma confidencial y será protegida por la Ley de privacidad federal de 1974. Todos los miembros del personal del proyecto han firmado declaraciones de confidencialidad y se les prohíbe por ley usar la información de esta encuesta para nada que no esté relacionado con este estudio.

### ¿Por qué desea tener toda esta información personal mía si esta encuesta trata sobre mis experiencias con los servicios de cuidado de salud en casa?

Estas preguntas sobre salud e información demográfica están diseñadas para darles más información a las personas a cargo del estudio sobre las personas que han respondido a nuestra

encuesta. Estas preguntas permiten que los responsables del estudio analicen la información, asignando a los participantes a grupos determinados.

**Yo estoy en el registro ‘no llamar’. ¿Por qué me están llamando?**

Los listados de ‘no llamar’ detienen las llamadas de vendedores o promotores. Nosotros estamos realizando estudios de encuestas a nombre de su agencia de servicios de cuidado de la salud en casa. No estamos llamando para vender o promocionar un producto o servicio.

**¡No voy a contestar muchas preguntas por teléfono!**

Su cooperación es muy importante para nosotros. Sus experiencias ayudarán a su agencia de servicios de cuidado de salud en casa y a otras agencias a entender que programas son los que más lo/la ayudan a usted y a otras personas como usted. Todas las respuestas que usted proporcione en esta encuesta serán completamente confidenciales y serán protegidas por la Ley de privacidad de 1974. Permítame comenzar para que usted vea cómo son las preguntas.

**¿Por qué y cómo fui seleccionado para este estudio?**

Nosotros usamos procedimientos científicos de muestreo para seleccionar un grupo de personas que han recibido servicios de cuidado de salud en casa. Sus opiniones son importantes porque representan las opiniones de otras personas como usted.

**¡No me agrada mi agencia de servicios de cuidado de salud en casa!**

Lo/La entiendo. Sus opiniones son muy importantes y ayudarán a que su agencia de servicios de cuidado de salud mejore su programa. Comencemos ahora. [NOTE: DO NOT ARGUE BACK. MAKE SHORT, NEUTRAL COMMENTS TO LET THEM KNOW THAT YOU ARE LISTENING AND IMMEDIATELY ASK THE FIRST QUESTION.]

**¿Cómo puedo saber si esta encuesta es auténtica o legítima? ¿Cómo sé si usted es realmente es un entrevistador de la encuesta?**

Usted puede comunicarse con [SURVEY VENDOR NAME] llamando al [TELEPHONE NUMBER] para recibir información sobre la encuesta.

**¿Cuánto tiempo tomará?**

En promedio la encuesta se puede completar como en 12 minutos. Yo le haré las preguntas tan rápido como pueda.

NOTE THAT SURVEY COMPLETION TIME WILL DEPEND ON WHETHER OTHER NON-CAHPS SURVEY ITEMS ARE ADDED TO THE QUESTIONNAIRE.



**APPENDIX M:**  
**GENERAL GUIDELINES FOR TELEPHONE INTERVIEWERS**

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# HOME HEALTH CARE CAHPS SURVEY

## GENERAL GUIDELINES FOR TELEPHONE INTERVIEWING

### OVERVIEW

The Home Health Care CAHPS Survey will be administered as an electronic system telephone interview. As a telephone interviewer on the Home Health Care CAHPS Survey, you will use the system to conduct each interview. The questions you ask are programmed into a computer. The phone number is provided by the computer for you to make the call. You will read the questions from the computer screen and enter the answer to each question into the computer. Based on the answer you enter, the computer will automatically take you to a screen with the next applicable question.

You play an extremely important role in the overall success of this study. You are the link to the hundreds of respondents who will provide valuable information to the project team. You are the person who develops rapport with the respondents, assures them that their participation is important, and obtains their full cooperation and informed consent.

As a professional interviewer, your job is to help each respondent feel at ease and comfortable with the interview. Key to accomplishing this goal is to be fully informed about the survey, the interview, and the data collection procedures.

### GENERAL INTERVIEWING TECHNIQUES

The process of asking questions, probing, and entering responses correctly is crucial to obtaining high-quality data for the Home Health Care CAHPS Survey. General techniques and procedures you should follow when conducting the Home Health Care CAHPS Survey interviews are provided below.

#### Administering Survey Questions

- Ask the questions exactly as they are presented. Do not change the wording or condense any question when reading it to the respondent.
- Emphasize all words or phrases that appear in **bold**, are underlined, or appear in *italics*.
- Ask every question specified, even when a respondent has seemingly provided the answer as part of the response to a preceding question. The answer received in the context of one question may not be the same answer that will be received when the other question is asked. If it becomes cumbersome to the respondent, remind him or her gently that you must ask all questions of all respondents.

- If the answer to a question indicates that the respondent did not understand the intent of the question, or if the respondent requests that any part of the question be clarified, even if it is only one word, repeat the question.
- Read the questions slowly, at a pace that allows them to be readily understood. Remember that the respondent has not heard these questions before and will not have had the exposure that you have had to the questionnaire.
- Transition statements are designed to inform the respondent of the nature of an upcoming question or a series of questions, to define a word, or to describe what is being asked for in the question. Read transition statements just as they are presented.
- Give the respondent plenty of time to recall past events.
- Do not suggest answers to the respondent. Your job as an interviewer is to read the questions exactly as they are printed, make sure the respondent understands the question, and then enter the responses. Do not help the respondent answer the questions.
- Ask questions in the exact order in which they are presented.
- Do not read words that appear in ALL CAPITAL LETTERS to the respondent. This includes both questions and response categories.
- Read all questions including those which may appear to be sensitive to the respondent in the same manner with no hesitation or change in inflection.
- Thoroughly familiarize yourself with the Frequently Asked Questions list before you conduct interviews so that you are knowledgeable about the Home Health Care CAHPS Survey.
- At the end of the interview, tell the sample member that the survey is completed and thank him or her for taking part in the survey.

### Introducing the Survey

The introduction is of the utmost importance to successfully completing a telephone interview. Most people hang up in the first few minutes of the interview, so if you can convince the respondent to remain on the line long enough to hear the purpose of the study and begin asking the questions, the chances that your respondent will complete the interview increase dramatically.

- When reading the introduction, sound confident and pronounce the words as clearly as you can.

- *Respondents are typically not expecting survey research calls*, so they may need your help to clarify the nature of the call.
- Practice the introduction until you can present it in such a manner that your presentation sounds **confident**, **sincere**, and **natural**.
- Deliver the introduction at a conversational pace. Rushing through the introduction gives an impression of lack of confidence and may also cause the listener to misunderstand.
- Try not to pause too long before asking the first question in the survey following the introduction. A pause tends to indicate that you are waiting for approval to continue.

### **Avoiding Refusals**

The first and most critical step in avoiding refusals is your effort to establish rapport with reluctant sample members, therefore minimizing the incidence of refusals. Remember, you will not be able to call back and convert a refusal—your initial contact with the sample member is the only chance you will have to create a successful interview. The following are some tips to follow to avoid refusals.

- Make sure you are mentally prepared when you start each call, and have a positive attitude.
- Treat respondents the way you would like to be treated.
- Always use an effective/positive/friendly tone and maintain a professional outlook.
- Pay careful attention to what the respondent says during the interview.
- Listen to the respondent completely rather than assuming you know what he or she is objecting to.
- Listen before evaluating and entering a response code.
- Be accommodating to the respondents' needs.
- Always remain in control of the interaction.
- Understand the reason for reluctance/refusal at the start of the call, or figure it out as quickly as possible.
- Listen as an ally, not an adversary, and do not debate or argue with the respondent.
- Be prepared to address one (or more) reason(s) for reluctance/refusal.

- Focus your comments to sample members on why they specifically are important to the study.
- Paraphrase what you hear and repeat this back to the respondent.
- Remember that you are a professional representative of your survey organization and the home health care organization whose patients you are contacting.

## GENERAL INTERVIEWING GUIDANCE

The following sections provide guidance on the use of neutral feedback, probes, avoiding bias, and entering responses accurately. By following these rules, interviewers will help ensure that the Home Health Care CAHPS Survey interviews are conducted in a standardized manner.

### Providing Neutral Positive Feedback

The use of neutral feedback can help build rapport with sample members, particularly with HHCAHPS sample members, who are generally older and sicker than the general population. Periodically acknowledging the respondent during the interview can help gain and retain cooperation during the interview.

Acceptable neutral acknowledgment words:

- Thank you
- All right
- Okay
- I understand
- Let me repeat the question

### Probing

At times, it will be necessary for you to probe to obtain a more complete or more specific answer from a respondent. To elicit an acceptable response, you will often need to use an appropriate neutral or nondirective probe. The important thing to remember is not to suggest answers or lead the respondent. Some general rules for probing follow.

- Repeat the question if the respondent misunderstood or misinterpreted the question. After hearing the question the second time, the respondent will probably understand what information is expected.

- Use a silent probe, which is pausing or hesitating to indicate to the respondent that you need additional or better information. This is a good probe to use after you have determined the respondent's response pattern.
- Use neutral questions or statements to encourage a respondent to elaborate on an inadequate response. Examples of neutral probes include the following: "What do you mean?" "How do you mean?" "Tell me what you have in mind." "Tell me more about...."
- Use clarification probes when the response is unclear, ambiguous, or contradictory. Be careful not to appear to challenge the respondent when clarifying a statement and always use a neutral probe. Examples of clarification probes are "Can you give me an example?" or "Could you be more specific?"
- Encourage the respondent to give his or her best guess if a respondent gives a "don't know" response. Let the respondent know that this is not a test and there are no right or wrong answers. We are interested in the respondent's opinions and assessment of the home health care that he or she has received.
- If the respondent asks you to answer the question for him or her, let the respondent know that you cannot answer the question for him or her. Instead, ask the respondent if she or he requires clarification on the content or meaning of the question.

## Avoiding Bias

One common pitfall of interviewing is unknowingly introducing bias into an interview. Bias occurs when an interviewer says or does something that affects the answers respondents give in an interview. An interview that has significant bias will not provide accurate data for the research being conducted; such an interview may have to be thrown out.

As a professional interviewer, remaining neutral at all times ensures that bias is not introduced into the interview. There are many things you can do or avoid doing to help ensure that no bias is introduced. You should

- read all statements and questions exactly as they are written,
- use neutral probes that do not suggest answers,
- not provide your own personal opinions or answers in an effort to "help" respondents, and
- not use body language, such as a cough or a yawn to influence the interview.

Taking these steps to monitor your own spoken and unspoken language will go a long way to guarantee that the interviews you conduct are completed correctly and efficiently.

## Entering Responses

The majority of the questions you will ask have precoded responses. To enter a response for these types of questions, you will simply select the appropriate response option and enter the number corresponding to that response.

The conventions presented below must be followed at all times to ensure that the responses you enter accurately reflect the respondents' answers and to ensure that questionnaire data are all collected in the same systematic manner.

- If the answer does not appear to satisfy the objective, repeat the question.
- In entering answers to open-ended questions or "Other (specify)" categories, enter the response verbatim, exactly as it was given by the respondent.
- Enter the response immediately after it is given.
- If a respondent gives a range in response to a question, probe as appropriate for a more specific answer. For example, if a respondent says, "Oh, 2 or 3 times" and you can enter only one number, ask for clarification: "Would that be closer to 2 or to 3?"

## Rules for Successful Telephone Interviewing

Remember, the key to successful interviewing is being prepared for every contact that you make. Have a complete set of the appropriate materials at your work station, organized in such a manner that you do not have to stop and search for required documents. Some general rules that you should follow every time you place a call are provided below.

1. **Be prepared before you place a call.** Be prepared to talk to the sample member. You should be able to explain the purpose of your call to the sample member or his or her family and friends. Do not rely on your memory alone to answer questions. Make sure you review and understand the Frequently Asked Questions (FAQs).
2. **Act professionally.** Convey to sample members that you are a professional who specializes in asking questions and conducting interviews. As a professional interviewer, you have specific tasks to accomplish for this survey.
3. **Make the most of your contact.** Even though you may not be able to obtain an interview on this call, it is important to make the most of the contact to aid in future attempts. For example, if you are trying to contact the sample member and he or she is not available, gain as much information as you can to help reach the sample member the next time he or she is called. Important questions to ask:



- When is the sample member usually home?
  - What is the best time to reach the sample member?
  - Can you schedule an “appointment” to reach the sample member at a later time?
4. **Don’t be too quick to code a sample member as incapable.** Some sample members may be hard of hearing or appear not to fully understand you when you call. Rather than immediately coding these cases as “Incapable,” please attempt to set a call-back for a different time of day and different day of the week. It is possible that reaching the sample member at a different time may result in your being able to conduct the interview with him or her. If, on the second call, you encounter the same situation with the sample member, please attempt to get a proxy respondent. Guidance for obtaining a proxy respondent is provided below.

## CONDUCTING A PROXY INTERVIEW

It is permitted to interview a proxy respondent on the Home Health Care CAHPS Survey if the sample member is not physically or mentally capable of responding to the survey. When an interviewer determines through their interaction with a sample member or someone speaking on behalf of the sample member that the sample member is physically or mentally incapable of participating in a telephone, interviewers should request to speak with a proxy respondent. We provide a sample script below that interviewers can use to identify and request to speak with a proxy respondent. This script is also provided in *Appendixes C, D, G, and H* in English, Spanish, Russian, and Vietnamese languages, along with a copy of the proxy interview script.

Several conditions apply to the use of a proxy respondent:

- The proxy respondent cannot be a home health aide or any type of health care provider from a home health agency.
- The proxy respondent should be familiar with the sample member’s health and health care experiences.
- A family member or friend is an ideal proxy respondent.

When administering the proxy interview, after the interviewer has read the Sample Member’s name three times, it is acceptable for the interviewer to use the relationship of the sample member to the proxy respondent moving forward if it is known. For example, the interviewer may use the words “your wife,” “your brother,” “your mother,” etc. rather than reading the sample member’s name in each question. This may improve the flow of the interview for both the interviewer and the proxy.

If no acceptable proxy respondent is available, the interviewer should code the case as “Ineligible: Mentally or Physically Incapacitated—240.”

**PROXY\_REQ** Is there somebody such as a family member or friend who is familiar with {FILL SAMPLE MEMBER NAME}'s health care experiences?

PROBE TO FIND OUT IF PERSON IS AVAILABLE IN HOUSEHOLD TO DO INTERVIEW NOW.

YES

NO (CODE AS INCAPABLE)

## **APPENDIX N:**

### **XML DATA FILE LAYOUT FOR STANDARD HEADER RECORD**

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## XML DATA FILE LAYOUT HOME HEALTH CARE CAHPS SURVEY

### STANDARD HEADER RECORD

The following section defines the format of the header record.

**Note:** Data element names do not contain any spaces, underscores, or capital letters. Each element must have a closing tag that is the same as the opening tag but with a forward slash.

STANDARD HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Type of Header Record <header-type> This header element should only occur once per file. <b>Example:</b> <header-type>1</header-type>	Type of Header Record	1 = Standard Header Record	Numeric	1	Yes
Provider Name <provider-name> This header element should only occur once per file. <b>Example:</b> <provider-name>Sample Home Health Agency</provider-name>	Name of Home Health Agency	—	Alphanumeric character	100	Yes
Provider ID <provider-id> This header element should only occur once per file. <b>Example:</b> <provider-id>123456</provider-id>	CMS Certification Number (CCN, formerly known as the Medicare Provider ID Number)	No Dashes or spaces Valid 6 digit CMS Certification Number	Alphanumeric character	6	Yes

STANDARD HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
NPI <b>&lt;npi&gt;</b> This header element should only occur once per file. This is an optional data element at this time but may be required in the future. <b>Example: &lt;npi&gt;1234567890&lt;/npi&gt;</b>	National Provider ID Number	No Dashes or spaces Valid 10 digit National Provider Identifier	Alphanumeric character	10	No
Sample Month <b>&lt;sample-month&gt;</b> This header element will occur again as an administration data element in the patient level data record. <b>Example: &lt;sample-month&gt;12&lt;/sample-month&gt;</b>	Home Health Care CAHPS Survey sampling month	MM (1 – 12 = January – December)	Numeric	2	Yes
Sample Year <b>&lt;sample-yr&gt;</b> This header element will occur again as an administration data element in the patient level data record. <b>Example: &lt;sample-yr&gt;2009&lt;/sample-yr&gt;</b>	Year of sample month	YYYY (2009 or greater)	Numeric	4	Yes

STANDARD HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Survey Mode <b>&lt;survey-mode&gt;</b> <b>This header element should only occur once per file. “5-Exception” is not a valid value. Note: The Survey Mode must be the same for all three months within a quarter. The Survey Mode should not be coded as “Exception,” as it is an invalid answer value. Example: &lt;survey-mode&gt;1&lt;/survey-mode&gt;</b>	Mode of Survey Administration.	1 = Mail only 2 = Telephone only 3 = Mixed mode Note: the Survey Mode must be the same for all 3 months in quarter	Numeric	1	Yes
Type of Sampling <b>&lt;sample-type&gt;</b> This header element should only occur once per file. <b>Example: &lt;sample-type&gt;1&lt;/sample-type&gt;</b>	Type of sampling used	1 = Census 2 = Simple random sampling (SRS) 3 = Proportionate Stratified Random sampling (PSRS) Note: Sample Type must be the same for all three months in each quarter.	Numeric	1	Yes
No. of Patients Served <b>&lt;patients-hha&gt;</b> This header element should only occur once per file. <b>Example: &lt;patients-hha&gt;600&lt;/patients-hha&gt;</b>	Total number of Patients the HHA served during the sample Month	0 – 999,999 M = Unknown/Missing	Alphanumeric character	6	Yes

STANDARD HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
No. of Patients on file(s) submitted to Vendor <b>&lt;number-vendor-submitted&gt;</b> This header element should only occur once per file. <b>Example: &lt;number-vendor-submitted&gt;595&lt;/number-vendor-submitted&gt;</b>	Number of patients on the files submitted by the HHA for the sample month Note that HHAs will exclude from the files they submit to survey vendor's patients who are deceased, those who requested that their name not be released to anyone else, patients who received home health visits for routine maternity care, those currently receiving hospice care, and those who have a condition or illness and live in a state that has regulations or laws restricting the release of patient information for patients with those conditions/illnesses.	0 – 999,999	Numeric	6	Yes
Eligible Patients <b>&lt;number-eligible-patients&gt;</b> This header element should only occur once per file. <b>Example: &lt;number-eligible-patients&gt;500&lt;/number-eligible-patients&gt;</b>	Number of patients eligible for survey in the sample month	0 – 999,999	Numeric	6	Yes



STANDARD HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Number of Patients Sampled <number-sampled> This header element should only occur once per file. <b>Example: &lt;number-sampled&gt;450</b> </number-sampled>	Number of patients sampled during this sample month	0 – 999,999	Numeric	6	Yes

# PATIENT ADMINISTRATIVE DATA RECORD

The following section defines the format of the patient level data record.

*Note: Data element names do not contain any spaces, underscores, or capital letters. Each element must have a closing tag that is the same as the opening tag but with a forward slash.*

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Provider ID <b>&lt;provider-id&gt;</b> This administration element also occurs in the previous header record. <b>Example: &lt;provider-id&gt;123456</b> <b>&lt;/provider-id&gt;</b>	CMS Certification Number (CCN, formerly known as the Medicare Provider ID Number)	No Dashes or spaces. Valid 6 digit CMS Certification Number	Alphanumeric character	6	Yes
NPI <b>&lt;npi&gt;</b> This administration element also occurs in the previous header record. <b>Example: &lt;npi&gt;1234567890&lt;/npi&gt;</b>	National Provider Identifier	No Dashes or spaces. Valid 10 digit National Provider Identifier	Alphanumeric character	10	No
Sample Month <b>&lt;sample-month&gt;</b> This administration element also occurs in the previous header record. <b>Example: &lt;sample-month&gt;12</b> <b>&lt;/sample-month&gt;</b>	Home Health Care CAHPS Survey sampling month	MM (1 – 12 = January – December)	Numeric	2	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Sample Year <sample-yr> Example: <sample-yr>2009</sample-yr>	Year of sample month	YYYY (2009 or greater)	Numeric	4	Yes
Sample ID No. <sample-id> Example: <sample-id>12345</sample-id>	Survey vendors will assign a unique de-identified sample identification number (SID) to each patient. The SID number will be used to track the survey status of the patient throughout the survey administration process and to designate sample patients on the data file submitted to the Data Center.	Maximum of 16 characters	Alphanumeric character	16	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Age <patient-age> Example: <patient-age>07</patient-age>	Patient’s age as of sample month	18–24 ..... 01 25–29 ..... 02 30–34 ..... 03 35–39 ..... 04 40–44 ..... 05 45–49 ..... 06 50–54 ..... 07 55–59 ..... 08 60–64 ..... 09 65–69 ..... 10 70–74 ..... 11 75–79 ..... 12 80–84 ..... 13 85–89 ..... 14 90 or older..... 15 Unknown/Missing....M (Patients must be 18 or older to be eligible for the survey)	Alphanumeric character	2	Yes
Sex <sex> <sup>11</sup> Example: <sex>1</sex>	Patient’s sex	1 = Male 2 = Female M = Unknown/Missing	Alphanumeric character	1	Yes

<sup>11</sup> No programmatic changes have been made at this time to the XML file schema. New HHCAHPS Survey vendors should contact the HHCAHPS Survey Coordination Team ([hhcahps@rti.org](mailto:hhcahps@rti.org)) for guidance on this variable.

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Number of Skilled Visits <number-visits> Example: <number-visits>4 </number-visits>	Number of skilled home health visits patient had in sample month – nurses, PT, OT, SP visits; not nursing aides. Include visits made by PT, OT, and SP assistants.  Used by survey vendor to confirm patient meets survey eligibility requirements	1 – 999 M = Unknown/Missing	Alphanumeric character	3	Yes
Lookback Period Visits <lb-visits> Example: <lb-visits>11</lb-visits>	Total number of skilled home health care visits patient had in the lookback period.  Used by survey vendor to confirm patient meets survey eligibility criteria.	2 – 999 M = Missing/Unknown Patient must have had at least 2 visits in lookback period	Alphanumeric character	3	Yes
Admission Source <admission-source-1> Example: <admission-source-1>1 </admission-source-1>	Source of patient admission for home health care	Inpatient setting: 1 = Hospital (acute or long-term) M = Unknown/Missing	Alphanumeric character	1	Yes
Admission Source <admission-source-2> Example: <admission-source-2>1 </admission-source-2>	Source of patient admission for home health care	Inpatient setting: 1 = Rehabilitation facility (hospital) M = Unknown/Missing	Alphanumeric character	1	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Admission Source <admission-source-3> Example: <admission-source-3>1 </admission-source-3>	Source of patient admission for home health care	Inpatient setting: 1 = Skilled Nursing Facility (or swing bed in hospital) M = Unknown/Missing	Alphanumeric character	1	Yes
Admission Source <admission-source-4> Example: <admission-source-4>1 </admission-source-4>	Source of patient admission for home health care	Inpatient setting: 1 = Other nursing home (long-term care) M = Unknown/Missing	Alphanumeric character	1	Yes
Admission Source <admission-source-5> Example: <admission-source-5>1 </admission-source-5>	Source of patient admission for home health care	Inpatient setting: 1 = Other inpatient facility M = Unknown/Missing	Alphanumeric character	1	Yes
Admission Source <admission-source-6> Example: <admission-source-6>1 </admission-source-6>	Source of patient admission for home health care	Non-inpatient setting: 1 = Directly from community (e.g., private home, assisted living, group home, adult foster care) M = Unknown/Missing	Alphanumeric character	1	Yes
Payer (e.g., Medicare) <payer-medicare> Example: <payer-medicare>1 </payer-medicare>	Source of payment for home health care	1 = Medicare A = Assumed M = Missing	Alphanumeric character	1	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Payer (e.g., Medicaid) <payer-medicaid> Example: <payer-medicaid>1 </payer-medicaid>	Source of payment for home health care	1 = Medicaid A = Assumed M = Missing	Alphanumeric character	1	Yes
Payer (e.g., private insurance) <payer-private> Example: <payer-private>1 </payer-private>	Source of payment for home health care	1 = Private Health Insurance A = Assumed M = Missing	Alphanumeric character	1	Yes
Payer (e.g., Other) <payer-other> Example: <payer-other>1</payer-other>	Source of payment for home health care	1 = Other A = Assumed M = Missing	Alphanumeric character	1	Yes
HMO Indicator <hmo-enrollee> Example: <hmo-enrollee>1</hmo-enrollee>	Is patient in an HMO?	1 = Yes 2 = No M = Unknown/Missing	Alphanumeric character	1	Yes
Dually eligible for Medicare and Medicaid? <dual-eligible> Example: <dual-eligible>1</dual-eligible>	Is patient dually eligible for Medicare and Medicaid coverage?	1 = Yes 2 = No 3 = Not Applicable M = Unknown/Missing	Alphanumeric character	1	Yes
Primary Diagnosis <primary-diagnosis> Example: <primarydiagnosis>A6921 </primarydiagnosis>	Underlying condition/procedure requiring home health care (ICD-10-CM diagnosis code for underlying condition) External cause codes (ICD-10-CM codes beginning with V, W, X, or Y) are not allowed as the primary diagnosis but are allowed for the other diagnoses.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Other diagnosis1 <other-diagnosis-1> Example: <other-diagnosis-1>A6921 </other-diagnosis-1>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Other diagnosis2 <other-diagnosis-2> Example: <other-diagnosis-2>A6921 </other-diagnosis-2>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Other diagnosis3 <other-diagnosis-3> Example: <other-diagnosis-3>A6921 </other-diagnosis-3>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Other diagnosis4 <other-diagnosis-4> Example: <other-diagnosis-4>A6921 </other-diagnosis-4>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Other diagnosis5 <other-diagnosis-5> Example: <other-diagnosis-5>A6921 </other-diagnosis-5>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Surgical Discharge <surgical-discharge> Example: <surgical-discharge>1 </surgical-discharge>	Is care related to surgical discharge?	1 = Yes 2 = No M = Missing	Alphanumeric character	1	Yes



PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
ESRD <esrd> Example: <esrd>2</esrd>	Does patient have end-stage renal disease?	1 = Yes 2 = No M = Missing	Alphanumeric character	1	Yes
You must EITHER enter the total number of ADL Deficits for which the patient is not fully independent OR enter the OASIS value for each of the 5 ADL Levels specified below. You do not need to provide both.					
ADL Deficits <adl-deficits> Example: <adl-deficits>2</adl-deficits>	Number of activities of daily living (ADLs) for which patient is not independent (0-5). Enter the number of OASIS ADL items listed below for which the patient has, or would have, a response code greater than 0.	0 – 5 M = Missing	Alphanumeric character	1	Yes
ADL Dress Upper <adl-du> Example: <adl-du>0</adl-du>	<b>Ability to Dress Upper Body</b> (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps	0, 1, 2, 3 M = Missing 0 = fully independent	Alphanumeric character	1	Yes
ADL Dress Lower <adl-dl> Example: <adl-dl>0</adl-dl>	<b>Ability to Dress Lower Body</b> (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes	0, 1, 2, 3 M = Missing 0 = fully independent	Alphanumeric character	1	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
ADL Bathing <adl-bathing> Example: <adl-bathing>0</adl-bathing>	<b>Bathing:</b> Ability to wash entire body, <b>Excludes grooming (washing face and hands only)</b>	0, 1, 2, 3, 4, 5, 6 M = Missing 0 = fully independent	Alphanumeric character	1	Yes
ADL Toilet Transferring <adl-toilet-transferring> Example: <adl-toilet-transferring>0</adl-toilet-transferring>	<b>Toileting:</b> Ability to get to and from the toilet or bedside commode	0, 1, 2, 3, 4 M = Missing 0 = fully independent	Alphanumeric character	1	Yes
ADL Transferring <adl-transfer> Example: <adl-transfer>0</adl-transfer>	<b>Transferring:</b> Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.	0, 1, 2, 3, 4, 5 M = Missing 0 = fully independent	Alphanumeric character	1	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Final Survey Status <b>&lt;final-status&gt;</b> <b>Example: &lt;final-status&gt;110&lt;/final-status&gt;</b>	Final disposition of survey	110 = Completed Mail Survey 120 = Completed Phone Survey 210 = Ineligible: Deceased 220 = Ineligible: Does not Meet Eligibility criteria (See Section IV in this manual) 230 = Ineligible: Language Barrier 240 = Ineligible: Mentally or Physically Incapacitated, No proxy Respondent available 310 = Breakoff 320 = Refusal 330 = Bad Address/ Undeliverable Mail 340 = Wrong/Disc/No Telephone Number 350 = No response after Maximum attempts	Numeric	3	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Survey Language <b>&lt;language-survey&gt;</b> This administration data element should only occur once per patient. <b>Example:</b> <b>&lt;language-survey&gt;1&lt;/language-survey&gt;</b>	Identify language in which survey completed	1 = English 2 = Spanish 3 = Chinese 4 = Russian 5 = Vietnamese 6 = Armenian M = Missing	Alphanumeric character	1	Yes
Proxy Flag <b>&lt;proxy&gt;</b> This administration data element should only occur once per patient. <b>Example:</b> <b>&lt;proxy&gt;1&lt;/proxy&gt;</b>	Did a proxy complete the interview for the sample member?	1 = Yes 2 = No M = Missing	Alphanumeric character	1	Yes
Number of Supplemental Questions <b>&lt;number-supplemental&gt;</b> This administration data element should only occur once per patient. <b>Example:</b> <b>&lt;number-supplemental&gt;5&lt;/number-supplemental&gt;</b>	Number of supplemental questions HHA added to survey	0 – 99	Numeric	2	Yes

## PATIENT RESPONSE RECORD

A survey results record is defined as the <patient response> and is defined as follows:

(Note: Survey results records are not required for a valid data submission but if survey results are included then all answers must have an entry. Survey results record is required, if the final <final-status> is “110-Completed Mail survey,” “120-Completed Phone survey,” or “310-Nonresponse: Break-off”.)

**Note:** Data element names do not contain any spaces, underscores, or capital letters. Each element must have a closing tag that is the same as the opening tag but with a forward slash.

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q1 <confirm-care> This patient response data element should only occur once per patient. <b>Example:</b> <confirm-care>1</confirm-care>	According to our records, you got care from the home health agency, [AGENCY NAME]. Is that right?	Yes..... 1 No ..... 2 MISSING/DK..... M	Alphanumeric character	1	Yes
Q2 <what-care-get> This patient response data element should only occur once per patient. <b>Example:</b> <what-care-get>1</what-care-get>	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?	Yes..... 1 No ..... 2 Do not Remember ..... 3 MISSING/DK..... M	Alphanumeric character	1	Yes
Q3 <how-set-up-home> This patient response data element should only occur once per patient. <b>Example:</b> <how-set-up-home>1</how-set-up-home>	When you first started getting home health care from this agency, did someone from the agency <b>talk with you</b> about how to set up your home so you can move around safely?	Yes..... 1 No ..... 2 Do not Remember ..... 3 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q4 <b>&lt;talk-about-meds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;talk-about-meds&gt;1</b> <b>&lt;/talk-about-meds&gt;</b>	When you started getting home health care from this agency, did someone from the agency talk with you about all the <b>prescription and over-the-counter medicines</b> you were taking?	Yes..... 1 No .....2 Do not Remember .....3 MISSING/DK..... M	Alphanumeric character	1	Yes
Q5 <b>&lt;see-meds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;see-meds&gt;1&lt;/see-meds&gt;</b>	When you started getting home health care from this agency, did someone from the agency ask to <b>see</b> all the prescription and over-the-counter medicines you were taking?	Yes..... 1 No .....2 Do not Remember .....3 MISSING/DK..... M	Alphanumeric character	1	Yes
Q6 <b>&lt;nurse-provider&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;nurse-provider&gt;1</b> <b>&lt;/nurse-provider&gt;</b>	In the last 2 months of care, was one of your home health providers from this agency a nurse?	Yes..... 1 No .....2 MISSING/DK..... M	Alphanumeric character	1	Yes
Q7 <b>&lt;phys-occ-sp-ther&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;phys-occ-sp-ther&gt;1</b> <b>&lt;/phys-occ-sp-ther&gt;</b>	In the last 2 months of care, was one of your home health providers from this agency a physical, occupational, or speech therapist?	Yes..... 1 No .....2 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q8 <b>&lt;personal-care&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;personal-care&gt;1</b> <b>&lt;/personal-care&gt;</b>	In the last 2 months of care, was one of your home health providers from this agency a home health or personal care aide?	Yes..... 1 No ..... 2 MISSING/DK..... M	Alphanumeric character	1	Yes
Q9 <b>&lt;informed-up-to-date&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;informed-up-to-date&gt;4</b> <b>&lt;/informed-up-to-date&gt;</b>	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?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 I only had one provider in the last 2 months of care ..... 5 MISSING/DK..... M	Alphanumeric character	1	Yes
Q10 <b>&lt;talk-about-pain&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;talk-about-pain&gt;1</b> <b>&lt;/talk-about-pain&gt;</b>	In the last 2 months of care, did you and a home health provider from this agency talk about pain?	Yes..... 1 No ..... 2 MISSING/DK..... M	Alphanumeric character	1	Yes
Q11 <b>&lt;take-newmeds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;take-newmeds&gt;2</b> <b>&lt;/take-newmeds&gt;</b>	In the last 2 months of care, did you take any new prescription medicine or change any of the medicines you were taking?	Yes..... 1 No ..... 2 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q12 <b>&lt;talk-about-newmeds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;talk-about-newmeds&gt;1</b> <b>&lt;/talk-about-newmeds&gt;</b>	In the last 2 months of care, did home health providers from this agency talk with you about the <b>purpose</b> for taking your new or changed prescription medicines?	Yes..... 1 No .....2 I did <b>not</b> take any new prescription medicines or change any medicines .....3 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes
Q13 <b>&lt;when-take-meds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;when-take-meds&gt;1</b> <b>&lt;/when-take-meds&gt;</b>	In the last 2 months of care, did home health providers from this agency talk with you about <b>when</b> to take these medicines?	Yes..... 1 No .....2 I did <b>not</b> take any new prescription medicines or change any medicines .....3 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes
Q14 <b>&lt;med-side-effects&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;med-side-effects&gt;1</b> <b>&lt;/med-side-effects&gt;</b>	In the last 2 months of care, did home health providers from this agency talk with you about the <b>side effects</b> of these medicines?	Yes..... 1 No .....2 I did <b>not</b> take any new prescription medicines or change any medicines .....3 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes



PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q15 <b>&lt;when-arrive&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;when-arrive&gt;4&lt;/when-arrive&gt;</b>	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?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK..... M	Alphanumeric character	1	Yes
Q16 <b>&lt;treat-gently&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;treat-gently&gt;4&lt;/treat-gently&gt;</b>	In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK..... M	Alphanumeric character	1	Yes
Q17 <b>&lt;explain-things&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;explain-things&gt;4&lt;/explain-things&gt;</b>	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?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK..... M	Alphanumeric character	1	Yes
Q18 <b>&lt;listen-carefully&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;listen-carefully&gt;4&lt;/listen-carefully&gt;</b>	In the last 2 months of care, how often did home health providers from this agency listen carefully to you?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK..... M	Alphanumeric character	1	Yes
Q19 <b>&lt;courtesy-respect&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;courtesy-respect&gt;4&lt;/courtesy-respect&gt;</b>	In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q20 <b>&lt;rate-care&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;rate-care&gt;09&lt;rate-care&gt;</b>	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?	Worst home health care possible .....00 1 .....01 2 .....02 3 .....03 4 .....04 5 .....05 6 .....06 7 .....07 8 .....08 9 .....09 Best home health care possible .....10 MISSING/DK..... M	Alphanumeric character	2	Yes
Q21 <b>&lt;contact-office-screener&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;contact-office-screener&gt;1&lt;/contact-office-screener&gt;</b>	In the last 2 months of care, did you contact this agency's <b>office</b> to get help or advice?	Yes..... 1 No .....2 MISSING/DK..... M	Alphanumeric character	1	Yes
Q22 <b>&lt;get-help-needed&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;get-help-needed&gt;1&lt;/get-help-needed&gt;</b>	In the last 2 months of care, when you contacted this agency's office did you get the help or advice you needed?	Yes..... 1 No .....2 I did <b>not</b> contact this agency.....3 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q23 <b>&lt;how-long-help-afterhours&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;how-long-help-afterhours&gt;2</b> <b>&lt;/how-long-help-afterhours&gt;</b>	When you contacted this agency's office, how long did it take for you to get help or advice you needed?	Same day ..... 1 1 to 5 days.....2 6 to 14 days.....3 More than 14 days .....4 I did <b>not</b> contact this agency.....5 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes
Q24 <b>&lt;problems-with-care-screener&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;problems-with-care-screener&gt;2</b> <b>&lt;/problems-with-care-screener&gt;</b>	In the last 2 months of care, did you have any problems with the care you got through this agency?	Yes..... 1 No .....2 MISSING/DK..... M	Alphanumeric character	1	Yes
Q25 <b>&lt;recommend&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;recommend&gt;1&lt;/recommend&gt;</b>	Would you recommend this agency to your family or friends if they needed home health care?	Definitely no..... 1 Probably no.....2 Probably yes .....3 Definitely yes .....4 MISSING/DK..... M	Alphanumeric character	1	Yes
Q26 <b>&lt;overall-health&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;overall-health&gt;1</b> <b>&lt;/overall-health&gt;</b>	In general, how would you rate your overall health?	Excellent..... 1 Very good .....2 Good .....3 Fair .....4 Poor .....5 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q27 <b>&lt;mental-health&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;mental-health&gt;1&lt;/mental-health&gt;</b>	In general, how would you rate your overall mental or emotional health?	Excellent..... 1 Very good.....2 Good.....3 Fair .....4 Poor .....5 MISSING/DK..... M	Alphanumeric character	1	Yes
Q28 <b>&lt;live&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;live&gt;2&lt;/live&gt;</b>	Do you live alone?	Yes..... 1 No .....2 MISSING/DK..... M	Alphanumeric character	1	Yes
Q29 <b>&lt;education&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;education&gt;3&lt;/education&gt;</b>	What is the highest grade or level of school that you have completed?	8th grade or less..... 1 Some high school, but did not graduate...2 High school graduate or GED .....3 Some college or 2-year degree .....4 4-year college graduate .....5 More than 4-year college degree.....6 MISSING/DK..... M	Alphanumeric character	1	Yes
Q30 <b>&lt;ethnicity&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;ethnicity&gt;2&lt;/ethnicity&gt;</b>	Are you Hispanic or Latino/Latina?	Yes..... 1 No .....2 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q31 <race-amer-indian> This patient response data element should only occur once per patient. <b>Example:</b> <race-amer-indian>1</race-amer-indian>	What is your race? Please select one or more.	American Indian or Alaska Native ..... 1 MISSING/DK..... M	Alphanumeric character	1	Yes
Q31 <race-asian> This patient response data element should only occur once per patient. <b>Example:</b> <race-asian>1</race-asian>	What is your race? Please select one or more.	Asian..... 1 MISSING/DK..... M	Alphanumeric character	1	Yes
Q31 <race-african-amer> This patient response data element should only occur once per patient. <b>Example:</b> <race-african-amer>1</race-african-amer>	What is your race? Please select one or more.	Black or African American ..... 1 MISSING/DK..... M	Alphanumeric character	1	Yes
Q31 <race-native-hawaiian> This patient response data element should only occur once per patient. <b>Example:</b> <race-native-hawaiian>1</race-native-hawaiian>	What is your race? Please select one or more.	Native Hawaiian or other Pacific Islander. 1 MISSING/DK..... M	Alphanumeric character	1	Yes
Q31 <race-white> This patient response data element should only occur once per patient. <b>Example:</b> <race-white>1</race-white>	What is your race? Please select one or more.	White ..... 1 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q32 <b>&lt;language-home&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;language-home&gt;1&lt;/language-home&gt;</b>	What language do you mainly speak at home?	English..... 1 Spanish .....2 Some other language .3 MISSING/DK..... M	Alphanumeric character	1	Yes
Q33 <b>&lt;help-you&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-you&gt;1&lt;/help-you&gt;</b>	Did someone help you complete this survey?	Yes..... 1 No .....2 MISSING/DK..... M	Alphanumeric character	1	Yes
Q34 <b>&lt;help-read&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-read&gt;1&lt;/help-read&gt;</b>	How did that person help you? Check all that apply.	Read the questions to me ..... 1 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes
Q34 <b>&lt;help-wrote&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-wrote&gt;1&lt;/help-wrote&gt;</b>	How did that person help you? Check all that apply.	Wrote down the answers I gave ..... 1 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes
Q34 <b>&lt;help-answer&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-answer&gt;1&lt;/help-answer&gt;</b>	How did that person help you? Check all that apply.	Answered the questions for me ..... 1 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q34 <b>&lt;help-translate&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-translate&gt;1</b> <b>&lt;/help-translate&gt;</b>	How did that person help you? Check all that apply.	Translated the questions into my language..... 1 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes
Q34 <b>&lt;help-other&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-other&gt;1&lt;/help-other&gt;</b>	How did that person help you? Check all that apply.	Helped in some other way ..... 1 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes
Q34 <b>&lt;help-none&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-none&gt;1&lt;/help-none&gt;</b>	How did that person help you? Check all that apply.	No one helped me complete this survey.. 1 NOT APPLICABLE..8 MISSING/DK..... M	Alphanumeric character	1	Yes

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**APPENDIX O:**  
**XML DATA FILE LAYOUT FOR DISPROPORTIONATE STRATIFIED**  
**RANDOM SAMPLING**

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## XML DATA FILE LAYOUT FOR DISPROPORTIONATE STRATIFIED RANDOM SAMPLING HOME HEALTH CARE CAHPS SURVEY

### DSRS HEADER RECORD

The following section defines the format of the header record.

**NOTE:** Data element names do not contain any spaces, underscores, or capital letters. Each element must have a closing tag that is the same as the opening tag but with a forward slash.

DSRS HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
<b>Type of Header Record</b> <header-type> This header element should only occur once per file. <b>Example:</b> <header-type>2</header-type>	Type of Header Record	2 = DSRS Header Record	Numeric	1	Yes
<b>Provider Name</b> <provider-name> This header element should only occur once per file. <b>Example:</b> <provider-name>Sample Home Health Agency</provider-name>	Name of Home Health Agency		Alphanumeric character	100	Yes
<b>Provider ID</b> <provider-id> This header element should only occur once per file. <b>Example:</b> <provider-id>123456</provider-id>	CMS Certification Number (CCN, formerly known as the Medicare Provider ID Number)	No Dashes or spaces Valid 6 digit CMS Certification Number	Alphanumeric character	6	Yes

DSRS HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
NPI <b>&lt;npi&gt;</b> This header element should only occur once per file. This is an optional data element at this time but may be required in the future. <b>Example: &lt;npi&gt;1234567890&lt;/npi&gt;</b>	National Provider ID Number	No Dashes or spaces Valid 10 digit National Provider Identifier	Alphanumeric character	10	No
Sample Month <b>&lt;sample-month&gt;</b> This header element will occur again as an administration data element in the patient level data record. <b>Example: &lt;sample-month&gt;12&lt;/sample-month&gt;</b>	Home Health Care CAHPS Survey sampling month	MM (1 – 12 = January – December)	Numeric	2	Yes
Sample Year <b>&lt;sample-yr&gt;</b> This header element will occur again as an administration data element in the patient level data record. <b>Example: &lt;sample-yr&gt;2009&lt;/sample-yr&gt;</b>	Year of sample month	YYYY (2009 or greater)	Numeric	4	Yes
Survey Mode <b>&lt;survey-mode&gt;</b> <b>This header element should only occur once per file. “5-Exception” is not a valid value. Note: The Survey Mode must be the same for all three months within a quarter. The Survey Mode should not be coded as “Exception,” as it is an invalid answer value.</b> <b>Example: &lt;survey-mode&gt;1&lt;/survey-mode&gt;</b>	Mode of Survey Administration.	1 – Mail only 2 – Telephone only 3 – Mixed mode  Note: the Survey Mode must be the same for all 3 months in quarter	Numeric	1	Yes

DSRS HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Type of Sampling <b>&lt;sample-type&gt;</b> This header element should only occur once per file. <b>Example: &lt;sample-type&gt;4&lt;/sample-type&gt;</b>	Type of sampling used	4=Disproportionate sampling (DSRS)  Note: Sample Type must be the same for all three months in each quarter.	Numeric	1	Yes
DSRS Strata <b>&lt;dsrs-strata&gt;</b> This header element should occur once per stratum. <b>Example:</b> <b>&lt;dsrs-strata&gt;</b> <stratum-name>Eastern Branch </stratum-name> <patients-hha>50</patients-hha> <dsrs-vendor-submitted>40 </dsrs-vendor-submitted> <dsrs-eligible>30</dsrs-eligible> <dsrs-samplesize>20</dsrs-samplesize> <b>&lt;/dsrs-strata&gt;</b>	The DSRS Strata <u>subsection</u> should occur once per stratum. There is a minimum of two Stratum required. Each DSRS-Strata element must contain the following five data elements: Stratum Name # Patients Served # Patients on File # Eligible Patients # Sampled Patients	n/a	n/a	n/a	Yes
DSRS Stratum Name <b>&lt;stratum-name&gt;</b> This header element should occur once per stratum. <b>This element should only be included in the XML file if the sampling type utilized is DSRS.</b> <b>Example: &lt;stratum-name&gt;Eastern Branch&lt;/stratum-name&gt;</b>	Stratum Name	If DSRS, then at least 2 strata must be defined. Strata names must be the same within a quarter. Names or numbers may be used.	Alphanumeric characters	45	Yes, if DSRS

DSRS HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
No. of Patients Served for the Stratum <b>&lt;patients-hha&gt;</b> This header element should only occur once per stratum. <b>Example: &lt;patients-hha&gt;600</b> <b>&lt;/patients-hha&gt;</b>	Total Number of Patients the HHA Served during the sample month for this stratum	0 – 999,999 M = Unknown/Missing	Alphanumeric characters	6	Yes
DSRS No. of Patients on file submitted to Vendor <b>&lt;dsrs-vendor-submitted&gt;</b> This header element should only occur once per stratum. <b>Example: &lt;dsrs-vendor-submitted&gt;595</b> <b>&lt;/dsrs-vendor-submitted&gt;</b>	Include the total number of patients on the file(s) submitted by the HHA for this stratum.  Note that HHAs will exclude from the files they submit to survey vendors patients who are deceased, those who requested that their name not be released to anyone else, patients who received home health visits for routine maternity care, those currently receiving hospice care, and patients who have certain conditions or diseases and live in states with regulations or laws that restrict the release of patient information for patients with those conditions and diseases.	0 – 999,999	Numeric	6	Yes
DSRS No. of Patients Eligible <b>&lt;dsrs-eligible&gt;</b> This header element should only occur once per stratum. <b>Example: &lt;dsrs-eligible&gt;500&lt;/dsrs-eligible&gt;</b>	Number of patients <u>eligible</u> within the stratum	0 – 999,999	Numeric	6	Yes

DSRS HEADER RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
DSRS No. of Patients Sampled <dsrs-samplesize> This header element should only occur once per stratum. <b>Example: &lt;dsrs-samplesize&gt;450</b> </dsrs-samplesize>	This is the number of <u>sampl</u> ed patients within the stratum. This variable will be used to weight the data.	10 – 999,999 Must be a minimum of 10 sampled patients in every stratum in every month.	Numeric	6	Yes

**PATIENT ADMINISTRATIVE DATA RECORD**

The following section defines the format of the patient level data record.

**NOTE:** Data element names do not contain any spaces, underscores, or capital letters. Each element must have a closing tag that is the same as the opening tag but with a forward slash.

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Provider ID <provider-id> This administration element also occurs in the previous header record. <b>Example:</b> <provider-id>123456</provider-id>	CMS Certification Number (CCN, formerly known as the Medicare Provider ID Number)	No Dashes or spaces. Valid 6 digit CMS Certification Number	Alphanumeric character	6	Yes
NPI <npi> This administration element also occurs in the previous header record. <b>Example:</b> <npi>1234567890</npi>	National Provider Identifier	No Dashes or spaces. Valid 10 digit National Provider Identifier	Alphanumeric character	10	No
Sample Month <sample-month> This administration element also occurs in the previous header record. <b>Example:</b> <sample-month>12</sample-month>	Home Health Care CAHPS Survey sampling month	MM (1 – 12 = January – December)	Numeric	2	Yes
Sample Year <sample-year> <b>Example:</b> <sample-yr>2009</sample-yr>	Year of sample month	YYYY (2009 or greater)	Numeric	4	Yes



PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
DSRS Stratum Name <stratum-name> <b>Example: &lt;stratum-name&gt;Eastern Branch&lt;/stratum-name&gt;</b>	If DSRS is used, this field is required. This is the name of the stratum the patient was assigned to and should match one of the stratum names provided in the header record.		Alphanumeric character	45	Yes, if DSRS
Sample ID No. <sample-id> <b>Example: &lt;sample-id&gt;12345&lt;/sample-id&gt;</b>	Survey vendors will assign a unique de-identified sample identification number (SID) to each patient. The SID number will be used to track the survey status of the patient throughout the survey administration process and to designate sample patients on the data file submitted to the Data Center.	Maximum of 16 characters	Alphanumeric character	16	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Age <patient-age> Example: <patient-age>07</patient-age>	Patient's age as of sample month	18–24 ..... 01 25–29 ..... 02 30–34 ..... 03 35–39 ..... 04 40–44 ..... 05 45–49 ..... 06 50–54 ..... 07 55–59 ..... 08 60–64 ..... 09 65–69 ..... 10 70–74 ..... 11 75–79 ..... 12 80–84 ..... 13 85–89 ..... 14 90 or older ..... 15 Unknown/Missing ... M  (Patients must be 18 or older to be eligible for the survey)	Alphanumeric character	2	Yes
Sex <sex> <sup>12</sup> Example: <sex>1</sex>	Patient's sex	1 = Male 2 = Female M = Unknown/Missing	Alphanumeric character	1	Yes

<sup>12</sup> No programmatic changes have been made at this time to the XML file schema. New HHCAHPS Survey vendors should contact the HHCAHPS Survey Coordination Team ([hhcahps@rti.org](mailto:hhcahps@rti.org)) for guidance on this variable.

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Number of Skilled Visits <number-visits> Example: <number-visits>4 </number-visits>	Number of skilled home health visits patient had in sample month—nurses, PT, OT, SP visits; not nursing aides.  Used by survey vendor to confirm patient meets survey eligibility requirements	1 – 999 M = Unknown/ Missing	Alphanumeric character	3	Yes
Lookback Period Visits <lb-visits> Example: <lb-visits>11</lb-visits>	Total number of skilled home health care visits patient had in the lookback period.  Used by survey vendor to confirm patient meets survey eligibility criteria.	2 – 999 M = Missing/ Unknown  Patient must have had at least 2 visits in lookback period	Alphanumeric character	3	Yes
Admission Source <admission-source-1> Example: <admission-source-1>1 </admission-source-1>	Source of patient admission for home health care	Inpatient setting: 1 = Hospital (acute or long-term) M = Unknown/ Missing	Alphanumeric character	1	Yes
Admission Source <admission-source-2> Example: <admission-source-2>1 </admission-source-2>	Source of patient admission for home health care	Inpatient setting: 1 = Rehabilitation facility (hospital) M = Unknown/ Missing	Alphanumeric character	1	Yes
Admission Source <admission-source-3> Example: <admission-source-3>1 </admission-source-3>	Source of patient admission for home health care	Inpatient setting: 1 = Skilled Nursing Facility (or swing bed in hospital) M = Unknown/Missing	Alphanumeric character	1	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Admission Source <admission-source-4> Example: <admission-source-4>1 </admission-source-4>	Source of patient admission for home health care	Inpatient setting: 1 = Other nursing home (long-term care) M = Unknown/Missing	Alphanumeric character	1	Yes
Admission Source <admission-source-5> Example: <admission-source-5>1 </admission-source-5>	Source of patient admission for home health care	Inpatient setting: 1 = Other inpatient facility M = Unknown/Missing	Alphanumeric character	1	Yes
Admission Source <admission-source-6> Example: <admission-source-6>1 </admission-source-6>	Source of patient admission for home health care	Non-inpatient setting: 1 = Directly from community (e.g., private home, assisted living, group home, adult foster care) M = Unknown/Missing	Alphanumeric character	1	Yes
Payer (e.g., Medicare) <payer-medicare> Example: <payer-medicare>1 </payer-medicare>	Source of payment for home health care	1 = Medicare A = Assumed M = Missing	Alphanumeric character	1	Yes
Payer (e.g., Medicaid) <payer-medicaid> Example: <payer-medicaid>1 </payer-medicaid>	Source of payment for home health care	1 = Medicaid A = Assumed M = Missing	Alphanumeric character	1	Yes
Payer (e.g., private insurance) <payer-private> Example: <payer-private>1 </payer-private>	Source of payment for home health care	1 = Private Health Insurance A = Assumed M = Missing	Alphanumeric character	1	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Payer (e.g., Other) <payer-other> Example: <payer-other>1</payer-other>	Source of payment for home health care	1 = Other A = Assumed M = Missing	Alphanumeric character	1	Yes
HMO Indicator <hmo-enrollee> Example: <hmo-enrollee>1</hmo-enrollee>	Is patient in an HMO?	1 = Yes 2 = No M = Unknown/Missing	Alphanumeric character	1	Yes
Dually eligible for Medicare and Medicaid? <dual-eligible> Example: <dual-eligible>1</dual-eligible>	Is patient dually eligible for Medicare and Medicaid coverage?	1 = Yes 2 = No 3 = Not Applicable M = Unknown/Missing	Alphanumeric character	1	Yes
Primary Diagnosis <primarydiagnosis> Example: <primarydiagnosis> A6921 </primarydiagnosis>	Underlying condition/procedure requiring home health care (ICD-10-CM diagnosis code for underlying condition) External cause codes (ICD-10-CM codes beginning with V, W, X, or Y) are not allowed as the primary diagnosis but are allowed for the other diagnoses.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	Yes
Other diagnosis1 <other-diagnosis-1> Example: <other-diagnosis-1>A6921 </other-diagnosis-1>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Other diagnosis2 <other-diagnosis-2> Example: <other-diagnosis-2>A6921 </other-diagnosis-2>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Other diagnosis3 <other-diagnosis-3> Example: <other-diagnosis-3>A6921 </other-diagnosis-3>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Other diagnosis4 <other-diagnosis-4> Sub-element of patientleveldata: administration Example: <other-diagnosis-4>A6921 </other-diagnosis-4>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Other diagnosis5 <other-diagnosis-5> Example: <other-diagnosis-5>A6921 </other-diagnosis-5>	Other conditions/diagnosis requiring home health care. The relevant comorbidities should be ICD-10-CM diagnosis codes.	Left justify and retain all leading zeros and no decimal M = Missing	Alphanumeric character	7	No
Surgical Discharge <surgical-discharge> Example: <surgical-discharge>1 </surgical-discharge>	Is care related to surgical discharge?	1 = Yes 2 = No M = Missing	Alphanumeric character	1	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
ESRD <esrd> Example: <esrd>2</esrd>	Does patient have end-stage renal disease?	1 = Yes 2 = No M = Missing	Alphanumeric character	1	Yes
ADL Deficits <adl-deficits> Example: <adl-deficits>2</adl-deficits>	Number of activities of daily living (ADLs) for which patient is not independent (0-5). Enter the number of OASIS ADL items listed below for which the patient has, or would have, a response code greater than 0.	0 – 5 M = Missing	Alphanumeric character	1	Yes
ADL Dress Upper<adl-du> Example: <adl-du>0</adl-du>	<b>Ability to Dress Upper Body</b> (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps	0, 1, 2, 3 M = Missing 0 = fully independent	Alphanumeric character	1	Yes
ADL Dress Lower <adl-dl> Example: <adl-dl>0</adl-dl>	<b>Ability to Dress Lower Body</b> (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes	0, 1, 2, 3 M = Missing 0 = fully independent	Alphanumeric character	1	Yes
ADL Bathing <adl-bathing> Example: <adl-bathing>0</adl-bathing>	<b>Bathing:</b> Ability to wash entire body, <b>Excludes grooming (washing face and hands only)</b>	0, 1, 2, 3, 4, 5, 6 M = Missing 0 = fully independent	Alphanumeric character	1	Yes
ADL Toilet Transferring <adl-toilet-transferring> Example: <adl-toilet-transferring>0</adl-toilet-transferring>	<b>Toileting:</b> Ability to get to and from the toilet or bedside commode	0, 1, 2, 3, 4 M = Missing 0 = fully independent	Alphanumeric character	1	Yes

PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
ADL Transferring <adl-transfer> Example: <adl-transfer>0</adl-transfer>	<b>Transferring:</b> Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.	0, 1, 2, 3, 4, 5 M = Missing 0 = fully independent	Alphanumeric character	1	Yes
Final Survey Status <final-status> Example: <final-status>110</final-status>	Final disposition of survey	110 = Completed Mail Survey 120 = Completed Phone Survey 210 = Ineligible: Deceased 220 = Ineligible: Does not Meet Eligibility criteria (See Section IV in this manual) 230 = Ineligible: Language Barrier 240 = Ineligible: Mentally or Physically Incapacitated, No proxy Respondent available 310 = Breakoff 320 = Refusal 330 = Bad Address/ Undeliverable Mail 340 = Wrong/Disc/No Telephone Number 350 = No response after Maximum attempts	Numeric	3	Yes



PATIENT ADMINISTRATIVE DATA RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Survey Language <b>&lt;language-survey&gt;</b> This administration data element should only occur once per patient. <b>Example: &lt;language-survey&gt;1&lt;/language-survey&gt;</b>	Identify language in which survey completed	1 = English 2 = Spanish 3 = Chinese 4 = Russian 5 = Vietnamese 6 = Armenian M = Missing	Alphanumeric character	1	Yes
Proxy Flag <b>&lt;proxy&gt;</b> This administration data element should only occur once per patient. <b>Example: &lt;proxy&gt;1&lt;/proxy&gt;</b>	Did a proxy complete the interview for the sample member?	1 = Yes 2 = No M = Missing	Alphanumeric character	1	Yes
Number of Supplemental Questions <b>&lt;number-supplemental&gt;</b> This administration data element should only occur once per patient. <b>Example: &lt;number-supplemental&gt;5&lt;/number-supplemental&gt;</b>	Number of supplemental questions HHA added to survey	0 – 99	Numeric	2	Yes

**PATIENT RESPONSE RECORD**

A survey results record is defined as the <patient response> and is defined as follows:

(Note: Survey results records are not required for a valid data submission but if survey results are included then all answers must have an entry. Survey results record is required, if the final <final-status> is “110-Completed Mail survey,” “120-Completed Phone survey,” or “310-Nonresponse: Break-off”.)

**NOTE:** Data element names do not contain any spaces, underscores, or capital letters. Each element must have a closing tag that is the same as the opening tag but with a forward slash.

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q1 <confirm-care> This patient response data element should only occur once per patient. <b>Example:</b> <confirm-care>1 </confirm-care>	According to our records, you got care from the home health agency, [AGENCY NAME]. Is that right?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes
Q2 <what-care-get> This patient response data element should only occur once per patient. <b>Example:</b> <what-care-get>1 </what-care-get>	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?	Yes..... 1 No ..... 2 Do not Remember ..... 3 MISSING/DK.....M	Alphanumeric character	1	Yes
Q3 <how-set-up-home> This patient response data element should only occur once per patient. <b>Example:</b> <how-set-up-home>1 </how-set-up-home>	When you first started getting home health care from this agency, did someone from the agency <b>talk with you</b> about how to set up your home so you can move around safely?	Yes..... 1 No ..... 2 Do not Remember ..... 3 MISSING/DK.....M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q4 <b>&lt;talk-about-meds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;talk-about-meds&gt;1&lt;/talk-about-meds&gt;</b>	When you started getting home health care from this agency, did someone from the agency talk with you about all the <b>prescription and over-the-counter medicines</b> you were taking?	Yes..... 1 No ..... 2 Do not Remember ..... 3 MISSING/DK.....M	Alphanumeric character	1	Yes
Q5 <b>&lt;see-meds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;see-meds&gt;1&lt;/see-meds&gt;</b>	When you started getting home health care from this agency, did someone from the agency ask to <b>see</b> all the prescription and over-the-counter medicines you were taking?	Yes..... 1 No ..... 2 Do not Remember ..... 3 MISSING/DK.....M	Alphanumeric character	1	Yes
Q6 <b>&lt;nurse-provider&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;nurse-provider&gt;1&lt;/nurse-provider&gt;</b>	In the last 2 months of care, was one of your home health providers from this agency a nurse?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes
Q7 <b>&lt;phys-occ-sp-ther&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;phys-occ-sp-ther&gt;1&lt;/phys-occ-sp-ther&gt;</b>	In the last 2 months of care, was one of your home health providers from this agency a physical, occupational, or speech therapist?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q8 <personal-care> This patient response data element should only occur once per patient. Example: <personal-care>1 </personal-care>	In the last 2 months of care, was one of your home health providers from this agency a home health or personal care aide?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes
Q9 <informed-up-to-date> This patient response data element should only occur once per patient. Example: <informed-up-to-date>4 </informed-up-to-date>	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?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 I only had one provider in the last 2 months of care ..... 5 MISSING/DK.....M	Alphanumeric character	1	Yes
Q10 <talk-about-pain> This patient response data element should only occur once per patient. Example: <talk-about-pain>1 </talk-about-pain>	In the last 2 months of care, did you and a home health provider from this agency talk about pain?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes
Q11 <take-newmeds> This patient response data element should only occur once per patient. Example: <take-newmeds>2 </take-newmeds>	In the last 2 months of care, did you take any new prescription medicine or change any of the medicines you were taking?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q12 <b>&lt;talk-about-newmeds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;talk-about-newmeds&gt;1</b> <b>&lt;/talk-about-newmeds&gt;</b>	In the last 2 months of care, did home health providers from this agency talk with you about the <b>purpose</b> for taking your new or changed prescription medicines?	Yes..... 1 No ..... 2 I did <b>not</b> take any new prescription medicines or change any medicines..... 3 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes
Q13 <b>&lt;when-take-meds&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;when-take-meds&gt;1</b> <b>&lt;/when-take-meds&gt;</b>	In the last 2 months of care, did home health providers from this agency talk with you about <b>when</b> to take these medicines?	Yes..... 1 No ..... 2 I did <b>not</b> take any new prescription medicines or change any medicines..... 3 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes
Q14 <b>&lt;med-side-effects&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;med-side-effects&gt;1</b> <b>&lt;/med-side-effects&gt;</b>	In the last 2 months of care, did home health providers from this agency talk with you about the <b>side effects</b> of these medicines?	Yes..... 1 No ..... 2 I did <b>not</b> take any new prescription medicines or change any medicines..... 3 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes
Q15 <b>&lt;when-arrive&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;when-arrive&gt;4&lt;/when-arrive&gt;</b>	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?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK.....M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q16 <treat-gently> This patient response data element should only occur once per patient. <b>Example:</b> <treat-gently>4</treat-gently>	In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK.....M	Alphanumeric character	1	Yes
Q17 <explain-things> This patient response data element should only occur once per patient. <b>Example:</b> <explain-things>4</explain-things>	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?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK.....M	Alphanumeric character	1	Yes
Q18 <listen-carefully> This patient response data element should only occur once per patient. <b>Example:</b> <listen-carefully>4</listen-carefully>	In the last 2 months of care, how often did home health providers from this agency listen carefully to you?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK.....M	Alphanumeric character	1	Yes
Q19 <courtesy-respect> This patient response data element should only occur once per patient. <b>Example:</b> <courtesy-respect>4</courtesy-respect>	In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?	Never ..... 1 Sometimes ..... 2 Usually..... 3 Always..... 4 MISSING/DK.....M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q20 <b>&lt;rate-care&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;rate-care&gt;09&lt;rate-care&gt;</b>	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?	Worst home health care possible ..... 00 1 ..... 01 2 ..... 02 3 ..... 03 4 ..... 04 5 ..... 05 6 ..... 06 7 ..... 07 8 ..... 08 9 ..... 09 Best home health care possible ..... 10 MISSING/DK ..... M	Alphanumeric character	2	Yes
Q21 <b>&lt;contact-office-screener&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;contact-office-screener&gt;1&lt;/contact-office-screener&gt;</b>	In the last 2 months of care, did you contact this agency's <b>office</b> to get help or advice?	Yes ..... 1 No ..... 2 MISSING/DK ..... M	Alphanumeric character	1	Yes
Q22 <b>&lt;get-help-needed&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;get-help-needed&gt;1&lt;/get-help-needed&gt;</b>	In the last 2 months of care, when you contacted this agency's office did you get the help or advice you needed?	Yes ..... 1 No ..... 2 I did <b>not</b> contact this agency ..... 3 NOT APPLICABLE... 8 MISSING/DK ..... M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q23 <b>&lt;how-long-help-afterhours&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;how-long-help-afterhours&gt;2</b> <b>&lt;/how-long-help-afterhours&gt;</b>	When you contacted this agency's office, how long did it take for you to get help or advice you needed?	Same day ..... 1 1 to 5 days..... 2 6 to 14 days..... 3 More than 14 days ..... 4 I did <b>not</b> contact this agency..... 5 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes
Q24 <b>&lt;problems-with-care-screener&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;problems-with-care-screener&gt;2</b> <b>&lt;/problems-with-care-screener&gt;</b>	In the last 2 months of care, did you have any problems with the care you got through this agency?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes
Q25 <b>&lt;recommend&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;recommend&gt;1&lt;/recommend&gt;</b>	Would you recommend this agency to your family or friends if they needed home health care?	Definitely no..... 1 Probably no..... 2 Probably yes ..... 3 Definitely yes ..... 4 MISSING/DK.....M	Alphanumeric character	1	Yes
Q26 <b>&lt;overall-health&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;overall-health&gt;1</b> <b>&lt;/overall-health&gt;</b>	In general, how would you rate your overall health?	Excellent..... 1 Very good..... 2 Good ..... 3 Fair ..... 4 Poor ..... 5 MISSING/DK.....M	Alphanumeric character	1	Yes



PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q27 <b>&lt;mental-health&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;mental-health&gt;1&lt;/mental-health&gt;</b>	In general, how would you rate your overall mental or emotional health?	Excellent..... 1 Very good..... 2 Good..... 3 Fair ..... 4 Poor ..... 5 MISSING/DK.....M	Alphanumeric character	1	Yes
Q28 <b>&lt;live&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;live&gt;2&lt;/live&gt;</b>	Do you live alone?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes
Q29 <b>&lt;education&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;education&gt;3&lt;/education&gt;</b>	What is the highest grade or level of school that you have completed?	8th grade or less..... 1 Some high school, but did not graduate..... 2 High school graduate or GED ..... 3 Some college or 2-year degree ..... 4 4-year college graduate ..... 5 More than 4-year college degree..... 6 MISSING/DK.....M	Alphanumeric character	1	Yes
Q30 <b>&lt;ethnicity&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;ethnicity&gt;2&lt;/ethnicity&gt;</b>	Are you Hispanic or Latino/Latina?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q31 <race-amer-indian> This patient response data element should only occur once per patient. <b>Example:</b> <race-amer-indian>1 </race-amer-indian>	What is your race? Please select one or more.	American Indian or Alaska Native ..... 1 MISSING/DK.....M	Alphanumeric character	1	Yes
Q31 <race-asian> This patient response data element should only occur once per patient. <b>Example:</b> <race-asian>1</race-asian>	What is your race? Please select one or more.	Asian..... 1 MISSING/DK.....M	Alphanumeric character	1	Yes
Q31 <race-african-amer> This patient response data element should only occur once per patient. <b>Example:</b> <race-african-amer>1 </race-african-amer>	What is your race? Please select one or more.	Black or African American ..... 1 MISSING/DK.....M	Alphanumeric character	1	Yes
Q31 <race-native-hawaiian> This patient response data element should only occur once per patient. <b>Example:</b> <race-native-hawaiian>1 </race-native-hawaiian>	What is your race? Please select one or more.	Native Hawaiian or other Pacific Islander.. 1 MISSING/DK.....M	Alphanumeric character	1	Yes
Q31 <race-white> This patient response data element should only occur once per patient. <b>Example:</b> <race-white>1</race-white>	What is your race? Please select one or more.	White ..... 1 MISSING/DK.....M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q32 <b>&lt;language-home&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;language-home&gt;1&lt;/language-home&gt;</b>	What language do you mainly speak at home?	English..... 1 Spanish ..... 2 Some other language .. 3 MISSING/DK.....M	Alphanumeric character	1	Yes
Q33 <b>&lt;help-you&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-you&gt;1&lt;/help-you&gt;</b>	Did someone help you complete this survey?	Yes..... 1 No ..... 2 MISSING/DK.....M	Alphanumeric character	1	Yes
Q34 <b>&lt;help-read&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-read&gt;1&lt;/help-read&gt;</b>	How did that person help you? Check all that apply.	Read the questions to me ..... 1 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes
Q34 <b>&lt;help-wrote&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-wrote&gt;1&lt;/help-wrote&gt;</b>	How did that person help you? Check all that apply.	Wrote down the answers I gave ..... 1 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes
Q34 <b>&lt;help-answer&gt;</b> This patient response data element should only occur once per patient. <b>Example: &lt;help-answer&gt;1&lt;/help-answer&gt;</b>	How did that person help you? Check all that apply.	Answered the questions for me ..... 1 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes

PATIENT RESPONSE RECORD					
XML Element	Description	Valid Values	Data Type	Field Size	Data Element Required
Q34 <help-translate> This patient response data element should only occur once per patient. <b>Example:</b> <help-translate>1</help-translate>	How did that person help you? Check all that apply.	Translated the questions into my language..... 1 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes
Q34 <help-other> This patient response data element should only occur once per patient. <b>Example:</b> <help-other>1</help-other>	How did that person help you? Check all that apply.	Helped in some other way ..... 1 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes
Q34 <help-none> This patient response data element should only occur once per patient. <b>Example:</b> <help-none>1</help-none>	How did that person help you? Check all that apply.	No one helped me complete this survey... 1 NOT APPLICABLE... 8 MISSING/DK.....M	Alphanumeric character	1	Yes

**APPENDIX P:**  
**MODEL QUALITY ASSURANCE PLAN**

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## HOME HEALTH CARE CAHPS SURVEY MODEL QUALITY ASSURANCE PLAN

Survey vendors that meet the necessary business requirements to become an approved Home Health Care CAHPS (HHCAHPS) Survey vendor will receive interim approval as an HHCAHPS Survey vendor once they have participated in the Introduction to the HHCAHPS Survey training session and successfully completed a written Training Certification Form. The final step in the approval process is the submission of an acceptable Quality Assurance Plan (QAP). This model QAP is intended to serve as a guide for survey vendors to help them develop a similar document that describes their implementation of and compliance with all guidelines required to implement the HHCAHPS Survey.

Each vendor must complete and submit a QAP to the HHCAHPS Survey Coordination Team within 6 weeks after the vendor's first quarterly submission of HHCAHPS Survey data. In addition, each vendor will be required to update and resubmit its QAP on or before April 30 of each year thereafter, and whenever it makes key staff or protocol changes. Each vendor will receive final approval as an HHCAHPS Survey vendor after its QAP has been reviewed and accepted by the HHCAHPS Survey Coordination Team.

### **CMS-approved Modes of Survey Administration and Active Administration**

QAPs must include a clear description of the HHCAHPS implementation for *ALL* of the survey mode(s) the vendor is approved for by CMS, and indicate which of the CMS-approved survey mode(s) are actively being administered for current home health agency clients.

Throughout the QAP, vendors should:

- ❖ focus on the modes they are actively administering when providing detailed descriptions, documentation, and timelines in Sections III. Sampling Plan, IV. Survey Implementation Plan and V. Data Security, Confidentiality, and Privacy Plan, and
- ❖ include copies of actively-administered HHCAHPS Survey materials in VI. Questionnaire and Materials Attachments.

The vendor's QAP should include the sections listed below. The specific requirements for these sections are described in the pages that follow.

- I. Organization Background and Staff Experience
- II. Work Plan
- III. Sampling Plan
- IV. Survey Implementation Plan

## V. Data Security, Confidentiality, and Privacy Plan

## VI. Questionnaire and Materials Attachments

To facilitate review of the QAP, each vendor should use the outline format noted above.

### I. ORGANIZATION BACKGROUND AND STAFF EXPERIENCE

In this section of the QAP, each HHCAHPS Survey vendor must provide the following information.

- Your organization's name, address, and telephone number. If your organization has multiple locations, include the address of both the main location and the address of the locations at which the primary operations, including sampling, data collection and data processing activities, are being conducted.
- Describe the history and affiliation with any other organization (e.g., other company or university affiliation). Include the scope of business, number of years in business, and number of years of survey experience.
- Describe your organization's survey experience conducting person-level surveys using each approved data collection mode for the HHCAHPS Survey. You must discuss each data collection mode for which you have received approval, regardless of whether you have any home health agency (HHA) clients who are using that mode.
- Provide an organizational chart that shows the names and titles of staff members, including subcontractors, who are responsible for each of the following tasks:
  - Overall project management, including tracking and supervision of all tasks below.
  - Sampling procedures, including creation of the sample frame, selection of the sample, and assignment of a unique identification number to each sampled patient.
  - Data collection procedures, including overseeing implementation of the data collection mode for which your organization has been approved.
  - Data receipt and data entry/scanning procedures.
  - File development and submission processes.

The organizational chart should also clearly specify all staff reporting relationships, including those staff who are responsible for managing subcontractors. It should designate any individuals who have quality assurance oversight responsibility and indicate which tasks they are responsible for.



- Summarize the background and experience of the individuals who are responsible for the tasks listed in the organizational chart above, including a description of any subcontractors serving in these roles. The description of each individual's experience should include a discussion of how the person's qualifications are relevant to the HHCAHPS Survey tasks that he or she is expected to perform. Resumes should be available upon request.

## II. WORK PLAN

- Describe how your organization is implementing the HHCAHPS Survey for each mode for which your organization has been approved. This section of your QAP must describe the entire process that your organization is following, including:
  - a. how you are obtaining the sample frame and selecting the sample;
    - how you are fielding the survey, receiving and processing the data;
    - the procedures that you are following to prepare and submit final files; and
    - the type of quality control procedures you are following at each stage to ensure data quality.

For each step above, you must specify the name of the individual who is responsible for conducting and providing oversight of the activity.

- Include a copy of a schedule or timeline that you are following to ensure that you are able to conduct all activities within the timeframes specified in the HHCAHPS Survey protocols. The timeline must describe when that activity will be completed (for example, *x weeks* after sample selection, or *y weeks* after mailing the first questionnaire). The timeline must include receipt of files from HHAs, sample selection, each step of the mailout or telephone implementation, data file cleaning, and data file preparation and submission.

## III. SAMPLING PLAN

- Describe how you are working with your client HHAs to ensure that the HHAs understand patient survey eligibility criteria and the measures you take to ensure that all patient information needed for sample selection is included on the file that is submitted and that the monthly patient files are submitted in time for you to select the sample and initiate the survey within 21 days after the sample month ends.
- Describe how HHAs submit the monthly patient files to your organization and how you check those files. That is, describe the steps that you take to ensure that the HHA has included all required data on the monthly patient files and the checks you make to ensure that

the same patient information is not included more than once on the monthly patient information file.

- Describe how you create the sample frame. This section should describe the process you are using to develop a sampling frame that complies with the HHCAHPS Survey protocol. Specifically, you must explain how you are creating the frame, what patient survey eligibility criteria you are using, and the types of patients who are being excluded and how those cases are being identified. Please make sure your QAP addresses each of the following questions:
  - b. How do you check monthly patient information files for complete information?
- What do you do if information is missing from the monthly patient information files?
- What are the eligibility and exclusion criteria that you use to determine which patients are eligible and which patients should be excluded from the sample frame? How do you know whether your client HHAs have included all eligible patients on the monthly patient files? Do you obtain and retain documentation from the HHAs about who was excluded and the reasons those patients were excluded from the monthly patient information files?
- Do you check the monthly patient information files to ensure that patients are only listed once on the file? If so, what information and process do you use to identify and remove patients who may have been listed on the monthly patient information file more than once?
- What do you do if information needed for determining patient eligibility is missing from the monthly patient information file?
- If the source of payment is missing, are patients included or excluded from the sample frame?
- What process (system or procedures) do you use to identify and remove patients who have been included in the survey sample in the last 5 months?
- HHCAHPS Survey vendors are expected to calculate and use a sample rate for each HHA client to ensure that an even distribution of patients is sampled over a 12-month period. How do you determine a sample rate for each HHA?
- How is the sample selected? What software program do you use to generate the seed number and assign random numbers used for sampling?
- What documentation about sample frame creation do you retain and for how long?
- What software do you use to assign a unique sample identification number to each sample patient?

- Which staff member conducts the activities above and which staff member performs quality control of that person's work to ensure that the sample frame was created correctly and the sample selected is correct?
- Describe the quality control checks that you are performing on the sampling activities, how frequently those checks are being performed, and by whom. Indicate what percentage of the sample frame or sample file is being checked, and describe the documentation that you maintain to verify that the quality control procedures have taken place. Note that this documentation may be requested by the HHCAHPS Survey Coordination Team at any time.
- If applicable, describe any sampling exceptions that you have requested or been approved for. Explain the exceptions request and the specific procedures you are or will be following to implement the approved exception.

#### **IV. SURVEY IMPLEMENTATION PLAN**

- Describe the system resources that you are using to implement your approved survey mode(s). This includes a description of the relevant hardware or software. For example, describe the electronic telephone interviewing systems, mailing equipment, scanning or data entry equipment, and case management system that you are using.
- For all approved modes of administration, describe training that is being given to all staff working on the HHCAHPS Survey project, including telephone interviewers (if applicable), mail survey production staff, and data receipt/data processing/data entry staffs. If you are using any subcontractors for any roles, describe how the subcontractor's staff are being trained. Include a discussion of quality control procedures that you are implementing during training to ensure compliance with HHCAHPS Survey protocols, and describe documentation that is being kept to provide evidence of this quality control.
- Describe the toll-free customer support telephone line that you are offering, including the actual telephone number, how customer support staff are being trained, and who is responsible for training and responding to questions related to the HHCAHPS Survey. Also include information on the days of the week and times of the day that you are staffing the customer support line and how you are handling after-hours contacts, and include text of any recordings that are being used. Include a discussion of quality control procedures that are being implemented to ensure compliance with HHCAHPS Survey protocols and describe documentation that is being kept to provide evidence of this quality control.
- Describe the production and mailout process for mail surveys, if applicable, including who is responsible for the process, and what quality control checks are being implemented at each stage (for example, monitoring the quality and content of mail survey packages, use of seeded mailings, and frequency of checks). Describe all quality control checks that are being

implemented and documented to ensure that the HHCAHPS Survey protocols are being followed.

- Describe the receipt and data entry or scanning process for mail surveys, if applicable, including who is responsible for the process and what quality control checks are being implemented at the questionnaire receipt, data entry, or scanning phase, and how frequently those checks are being made. Describe all quality control checks that are being implemented and documented to ensure that the HHCAHPS Survey protocols are being followed.
- Describe the process for implementing the telephone survey, if applicable, including who is responsible for training and monitoring interviewer performance, how training and monitoring are being documented, and what systems and procedures are being used to ensure that all interviewing is conducted according to the HHCAHPS Survey protocols (for example, varying times of day that calls are attempted and tracking the status of call attempts). If you are using a telephone survey subcontractor, describe oversight activities you are conducting to ensure that the subcontractor is in compliance with HHCAHPS Survey protocols.
- If you are approved for Mixed Mode administration, you must address all of the paragraphs above regarding both Mail and Telephone processes. In addition, you must include a discussion of the control system used to monitor case status as the case transitions from the mail phase of the survey to the telephone follow-up phase. Describe how you keep track of surveys that are returned while the telephone follow-up phase is in effect. Describe the processes that you have in place to ensure that sample members who have returned a completed survey are not called after the completed survey is received. How do you determine which completed survey to retain (mail or telephone interview data) if the sample member returns a completed survey and participates in a telephone interview?
- Describe the processes you are using to create data files and submit them to the HHCAHPS Survey Data Center through the HHCAHPS Survey Web site. Discuss quality control checks that are being implemented during file creation, including how these checks are being documented.

## **V. DATA SECURITY, CONFIDENTIALITY, AND PRIVACY PLAN**

- Describe the measures that you are taking to ensure data security, including a discussion of the use of passwords, file encryption, backup systems, and any other measures to ensure the security of HHCAHPS Survey data. Describe how often passwords are changed. For both hard-copy questionnaires and electronic data files, describe how and for how long these materials will be stored and when and how they will be destroyed.

- Describe how confidentiality agreements are being implemented among vendor staff and any subcontractor staff, including how affidavits of confidentiality are being documented. Include a copy of the confidentiality agreement that is being used as an appendix in your QAP.
- Describe the measures that are being taken to protect respondent privacy and ensure compliance with Health Insurance Portability and Accountability Act requirements.
- If you are approved for telephone surveys, include a screenshot or text indicating the voluntary nature of the sample member's participation.

## **VI. QUESTIONNAIRE AND MATERIALS ATTACHMENTS**

- For all approved modes you are actively administering, attach a copy of your formatted materials. Include English and Spanish versions of the requested materials, if your organization administers both languages.
- If you are approved for Mail Only or Mixed Mode administration, attach a copy of your cover letters and mail survey questionnaire, including the cover page and back page.
- If you are approved for Telephone Only or Mixed Mode administration, attach all screen shots from your telephone interview program—beginning with the introductory screens and ending with the last question in the interview. If your interview includes the Consent to Share Responses question, please include a screen shot of this question as well.

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**APPENDIX Q:**  
**EXCEPTIONS REQUEST FORM**

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## HOME HEALTH CARE CAHPS SURVEY EXCEPTIONS REQUEST FORM

*To submit this form online, please go to <https://homehealthcahps.org/>.*

**Date Submitted:**

### **I. GENERAL INFORMATION**

The following general information should be filled out about the survey vendor organization.

#### **1. Survey Vendor Organization Information**

Organization Name:

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP Code:

(Area Code) Telephone number:

(Area Code) Fax number:

Website address:

#### **2. Survey Vendor Contact Person**

First Name, Middle Initial, Last Name:

Title:

Degree/License (e.g., BA, PhD, MBA, PMA):

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP Code:

(Area Code) Telephone number:

(Area Code) Fax number:

E-mail address:

**II. EXCEPTIONS REQUEST INFORMATION**

Please complete Items 1 and 2 below.

**1. Exception Request**

1a. Exception Request Classification (Check one)

- ☐ New Exception
- ☐ Update List of Applicable Home Health Agencies
- ☐ Appeal of Exception Denial

1b. Exception Request for (Check one)

- ☐ Using a Different Sampling Method
- ☐ Other (specify)

**2. Description of Exception Request**

2a. Purpose of requested exception (e.g., sampling, data issues)

2b. How the exception will be implemented

2c. Evidence that exception will not affect survey results

**III. LIST OF HOME HEALTH AGENCIES IMPACTED BY THIS EXCEPTION REQUEST**

Vendor should submit a New Exception Request if additional agencies are added after this form is submitted.

1. Home Health Agency Name:  
CMS Certification Number:
2. Home Health Agency Name:  
CMS Certification Number:
3. Home Health Agency Name:  
CMS Certification Number:
4. Home Health Agency Name:  
CMS Certification Number:
5. Home Health Agency Name:  
CMS Certification Number:

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**APPENDIX R:**  
**DISCREPANCY NOTIFICATION REPORT**

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## HOME HEALTH CARE CAHPS SURVEY DISCREPANCY REPORT

*To submit this form online, please go to <https://homehealthcahps.org/>.*

**Date Submitted:**

### **I. GENERAL INFORMATION**

The following general information should be filled out about the survey vendor organization.

#### **1. Survey Vendor Organization Information**

Organization Name:

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP Code:

(Area Code) Telephone number:

(Area Code) Fax number:

Website address:

#### **2. Survey Vendor Contact Person**

First Name, Middle Initial, Last Name:

Title:

Degree/License (e.g., BA, PhD, MBA, PMA):

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP Code:

(Area Code) Telephone number:

(Area Code) Fax number:

E-mail address:

**II. DISCREPANCY INFORMATION**

Please complete the items below in detail.

1. Description of discrepancy, how it was discovered, and the affected timeframe
  
2. Number of eligible patients affected by the discrepancy
  
3. Description of corrective action to be taken to address discrepancy, along with proposed timeline
  
4. Additional information not provided above which will help the Coordination Team understand the discrepancy

**III. LIST OF HOME HEALTH AGENCIES IMPACTED BY THIS DISCREPANCY REPORT**

Vendor should submit a New Discrepancy Report if additional agencies are added after this form is submitted.

1. Home Health Agency Name:  
CMS Certification Number:
2. Home Health Agency Name:  
CMS Certification Number:
3. Home Health Agency Name:  
CMS Certification Number:
4. Home Health Agency Name:  
CMS Certification Number:
5. Home Health Agency Name:  
CMS Certification Number: