



## 2008 Hospital Patient Satisfaction Survey

Dear Member,

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

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

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

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

Thank you in advance for your time.

Sincerely,

Blue Cross and Blue Shield of Illinois  
Quality Improvement Department

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

Discharge Date                      Hospital Name

Who is completing this survey?       Patient       Relative       Other

#### HOSPITAL STAY

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

#### MEDICATIONS

5. Did you receive any medication(s) while in the hospital?       Yes       No      (If No, Skip to Question 7)
- If yes, please rate the education you received about the medication(s).
- |  | Excellent                | Very Good                | Good                     | Fair                     | Poor                     |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Did doctors, nurses or other hospital staff ask if you were allergic to any medicine?       Yes       No
- How frequently did the hospital staff verify your identity (for example: look at your wristband, ask you for your name, etc.) before giving you medication?
- |  | Always                   | Usually                  | Sometimes                | Rarely                   | Never                    |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
6. Did you receive any pain medication(s)?       Yes       No      (If No, Skip to Question 7)
- If yes, were your expectations for pain control met?       Yes       No

#### ADVICE TO QUIT SMOKING

7. Do you smoke every day, some days, or not at all?      Every day      Some days      Not at all      (If Not at all, Skip to Question 9)
- |  |                          |                          |                          |  |  |
|--|--------------------------|--------------------------|--------------------------|--|--|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |  |
|--|--------------------------|--------------------------|--------------------------|--|--|
8. During this hospital admission were you advised to quit smoking by a doctor or other health provider?       Yes       No

**Please complete both sides of this survey. Thank you.**

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### DIAGNOSTIC TESTING/SURGICAL PROCEDURES

9. Did you have any diagnostic tests, such as an x-ray, blood test, or treadmill test, during your hospital stay?  Yes  No (If No, Skip to Question 10)
- If yes, please rate the explanation that you received about what would happen during your tests.
 

Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
  - How frequently did the hospital staff verify your identity before drawing blood or doing other tests (for example: look at your wristband, ask for your name, ask for your date of birth, etc.)?
 

Always	Usually	Sometimes	Rarely	Never
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have a surgical procedure performed while in the hospital?  Yes  No (If No, Skip to Question 11)
- a. If yes, please rate the education you received about the purpose and risks of your surgery.
 

Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
  - b. Did the doctor or other health care staff explain the risks, benefits and alternatives of the procedure to you?  Yes  No (If No, Skip to Question 11)
    - If yes, were you asked to summarize in your own words what was explained to you?  Yes  No  Not Sure  Does Not Apply
    - Were any audiovisual aids (for example: books, brochures, videos, computer, audio tapes, etc.) used to explain the procedure to you?  Yes  No  Not Sure  Does Not Apply
11. Were there any delays in having diagnostic tests or procedures during your hospital stay?  Yes  No (If No, Skip to Question 12)
- If yes, did this delay lengthen your hospital stay by one day or longer?  Yes  No

### DISCHARGE PLANNING

12. Before you left the hospital, were you given:
- a. A complete list of medications?  Yes  No
  - b. Information about any new medications prescribed?  Yes  No  Does Not Apply
  - c. Instructions for a follow-up visit with your physician?  Yes  No
  - d. Written instructions for care after discharge?  
If yes:  Yes  No (If No, Skip to Question 13)
    - Rate your understanding of the written instructions.
 

Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
    - After you left the hospital, were the instructions clear enough to follow?  Yes  No
13. Were you discharged from the hospital on a special diet (fluid restriction, diabetic, low sodium, etc)?  Yes  No (If No, Skip to Question 14)
- If yes, was the diet explained to you in a way that you could understand?  Yes  No

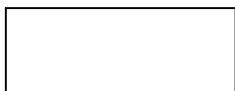
### OVERALL

14. Overall, how would you rate the quality of care you received in the hospital during your stay?
- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Excellent                | Very Good                | Good                     | Fair                     | Poor                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
15. Would you return to this hospital for care in the future?
- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Definitely Yes           | Probably Yes             | Probably Not             | Definitely Not           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
16. How likely would you be to recommend this hospital to a friend or relative?
- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Definitely recommend     | Probably recommend       | Probably not recommend   | Definitely not recommend |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### BLUE STAR<sup>SM</sup> HOSPITAL REPORT

Each year BCBSIL publishes the Blue Star<sup>SM</sup> Hospital report in the member newsletter and on the BCBSIL website.

17. Have you seen the Blue Star<sup>SM</sup> Hospital Report?  Yes  No (If No, Skip Question 18)
18. If yes, was the information useful?  Yes  No



**Thank you for taking the time to complete this survey.**