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| <CCC program name> <and/or logo> | | | |
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| **Your feedback is important!** | | | |
| Dear Provider,   1. Please complete this survey as part of our CCC Program continuous quality improvement efforts. 2. The questions correlate with questions your patients who are enrolled in the CCC Program will be asked to address on the CMS Consumer Assessment of Healthcare Providers and Systems annual survey. Consider only this population of patients as you complete the survey. 3. Your responses will be confidential. 4. Mail the survey to the CCC Program office at the address provided below. 5. If you have any questions or comments, please call: <Name> at <xxx-xx-xxxx> | | | |
| Do you know how long it takes for your patients to schedule a check-in or routine appointment with you? | ❑ Yes | ❑ No | ❑ Not sure |
| Do you believe your patients will rate you high on listening carefully to what they want to tell you? | ❑ Yes | ❑ No | ❑ Not sure |
| Do you have enough time to spend with your patients? | ❑ Yes | ❑ No | ❑ Not sure |
| Do you engage your patients in making decisions about changes to any of their prescription medications? | ❑ Yes | ❑ No | ❑ Not sure |
| Does it appear that your patients understand the written instructions or other information you supply them? | ❑ Yes | ❑ No | ❑ Not  applicable |
| Do you or your nurse talk with your patients during routine visits about the exercise or physical activity they get? | ❑ Yes | ❑ No | ❑ Not sure |
| In general, would you rate the overall emotional health of your patients as at least very good? | ❑ Yes | ❑ No | ❑ Not sure |
| In the past year, have you seen many of your CCC Program patients three or more times for the same condition or problem? | ❑ Yes | ❑ No | ❑ Not sure |
| Do you believe your patients would rate you a 5 on a scale of 1 to 5, with 5 being the best provider? | ❑ Yes | ❑ No | ❑ Not sure |
| Do you believe that ninety percent or more of patients you refer to a specialist actually see the specialist within a month? | ❑ Yes | ❑ No | ❑ Not sure |
| Do you always have information you need about your patients from the hospital? | ❑ Yes | ❑ No | ❑ Not sure |
| Do you always have information you need about your patients from providers to whom you referred the patient? | ❑ Yes | ❑ No | ❑ Not sure |
| Do you know to whom to direct your patients if they need help with transportation for their provider appointments? | ❑ Yes | ❑ No | ❑ Not sure |
| Do many of your patients need help with depression? | ❑ Yes | ❑ No | ❑ Not sure |
| Do many of your patients need help with diet and exercise? | ❑ Yes | ❑ No | ❑ Not sure |
| **Questions or comments?** (Responses will be provided to all participants in the community-based care coordination program via our newsletter. If you wish to receive a personal response, please provide your name and telephone number or email address. | | | |
| Thank you! Please mail this survey to: <Name>, <Address>, <City, State, Zip code> | | | |

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