

COVER LETTER TEMPLATE

(Date) _____

Dear _____ (Patient, Family Member, Professional)

_____ Health System is a member of a group of Catholic health care organizations across the United States. The goal of this Coalition is to improve care for persons who may be affected by a life-threatening illness.

We are inviting you to take part in a project to pilot test a new questionnaire. In the future, this questionnaire (form) will help Health Systems and health services collect information about how well they are providing care. Your answers on the forms will help us refine them for future use. It will also help us know if there is a need for more focused change in health care or services for people affected by life-threatening illnesses.

The questionnaire that follows is designed to have health care professionals provide feedback on the following:

- Perception and report of personal and professional experiences and outcomes
- System issues that affect care for those with life-threatening illness
- Personal assessment of competency
- Professional perception of patient and family outcomes

The forms take about **20 - 30** minutes to complete. Please complete and return them within a week of receiving them. You will also be sent another copy of the same form in about 2 weeks. We also need you to complete this copy and return it within a week or as soon as possible. Answer the questions on each form from your experience **at that time**. Do not worry about your answers on the first form when completing the second one.

You will not directly benefit from filling out the forms. Your information will be kept confidential. Your answers will be combined with those from other people. Your name will not be used in any written project report or presentation. However, you may receive follow-up contact from _____ Health System or _____ health service project staff.

Completing and returning these forms is voluntary and will qualify as your consent to take part in this project. You will not be paid to take part in this project.

If you have questions about this project, you may call _____ Health System or _____ health service. The contact person is:

(Name and title)

(address)

(phone number)

****Modified City of Hope Professional Questionnaire**

June 1999

PERSONAL /PROFESSIONAL EXPERIENCES

Please answer the following questions **based on your perception at this time.**

Rate the following items from your **personal** perspective

1. Feel satisfied with my work

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

2. Work schedule is unrealistic and high stress

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

3. Have adequate budget and staffing to perform my job

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

4. Feel I work as a member of a strong care team

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

5. Can influence system to improve care

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

6. Receive appropriate recognition for my work

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

7. Have an opportunity to grieve the loss of patients

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

8. Feel not enough time to meet needs

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

Please comment on very low or very high scores:

Please share other comments about your experience

Place of Care Environment (Health Care Experience)

Work place structures, procedures, and policies can influence our care. To what extent are the following an issue as you provide care in your workplace. Please mark NA if you have no information about the item.

1. Effective and timely pain management support is present

NA No problem 0 1 2 3 4 5 6 7 8 9 10
Severe problem

2. Effective and timely symptom relief, e.g. difficulty breathing, nausea, constipation, support is present

NA No problem 0 1 2 3 4 5 6 7 8 9 10
Severe problem

3. Resources adequate for obtaining help to meet physical needs at home

NA No problem 0 1 2 3 4 5 6 7 8 9 10
Severe problem

4. When a conflict over care occurs, adequate support for patient/family in resolving issues and carrying out their care wishes

NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal

5. Providing appropriate control and freedom to refuse care or treatments

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Completely

6. Making family feel welcomed 24 hours a day and with each appointment

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Completely

7. Accessibility to support groups or others who have similar experiences

NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal

8. Access to and opportunity to talk with professional counselors

NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal

9. Availability of chaplains or others to pray with and for patients

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Completely

10. Understanding of illness, treatment, and care wishes by all of the health care team

- NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 11. Getting enough help finding needed resources and support, e.g. transportation or homemaker assistance**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 12. Extent to which communication with healthcare personnel has assisted to maintain hope**
NA None 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 13. Doctors listen and convey caring, respect, and genuine presence**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 14. Doctors' communication easy to understand and conveys a consistent message**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 15. Doctors supportive of seeking second opinions and other care choices**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 16. If "alternative therapies" desired as part of care, doctors answer questions to the satisfaction of patient and families**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 17. Doctors provide opportunity to discuss possible death**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 18. Nurses and other health care providers listen, and convey caring, respect, and genuine presence**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 19. Nurses and other health care providers' communication is easy to understand and conveys a consistent message**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 20. Nurses / other health care providers provide the opportunity to discuss possible death**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 21. DNR orders written in a timely manner**

- NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
22. **"Being with" patient/family in addition to "doing for" patient is valued**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
23. **Professional education in providing excellent end-of-life care is supported**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
24. **Bereavement and follow-up services are accessible and sufficient**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
25. **Appropriate patients are referred to hospice in a timely manner**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
26. **There is support for ethical discussions and consultations**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal

Please comment on very low or very high scores:

EFFECTIVENESS OF CARE

Please answer the following questions **based on your perception at this time.**

Circle the number from 0 - 10 that best describes your perception and experience. If the item is not applicable for your practice, circle NA.

Physical Area

How **effective** do you think you are as a provider in addressing **patient and family concerns** regarding or treating physical symptoms of:

1. Fatigue

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Extremely effective

2. Sleep changes

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Extremely effective

3. Problems with dry mouth, change in food tastes, drooling or appetite changes

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Extremely effective

4. Intestinal problems of constipation or diarrhea

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Extremely effective

5. Nausea

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Extremely effective

6. Shortness of breath or difficulty breathing

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Extremely effective

7. Aches or pain

NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Extremely effective

List by **number** the items where you feel that you do **NOT** have sufficient **knowledge and skills** to counsel or treat **patients and families**:

Please comment on very low or very high scores:

Emotional / Relationship Area

How **effective** do you think you are as a provider in addressing **patient and family concerns** regarding or treating symptoms of:

8. Finding sources of satisfaction / meaning in life
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

9. Anxiety
NA None at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

10. Expressing feelings of sadness, grief, and anger
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

11. Finding opportunity to talk about illness, experiences, and possible death
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

12. Feeling like a burden for the family

- NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 13. Worry about family and friends not being there**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 14. Worry about physicians and other professionals not being there**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 15. Having family / friends give specific support without asking**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal
- 16. Amount of support required to meet needs**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10
Completely
- 17. Isolation from others felt to be caused by illness or treatment**
NA None at all 0 1 2 3 4 5 6 7 8 9 10
A great deal
- 18. How much of treatment wishes and goals family / friends know**
NA None at all 0 1 2 3 4 5 6 7 8 9 10
Completely
- 19. Discussing approach of the last days and importance for family members of relationship, emotional, or spiritual gifts**
NA None at all 0 1 2 3 4 5 6 7 8 9 10
A great deal
- 20. Physical signs and symptoms of approaching death**
NA None at all 0 1 2 3 4 5 6 7 8 9 10
A great deal
- 21. Work place support**
NA Not at all 0 1 2 3 4 5 6 7 8 9 10 A
great deal

List by **number** the items where you feel that you do **NOT** have sufficient **knowledge and skills** to counsel or treat **patients and families**:

Please comment on very low or very high scores:

Spiritual Area

How **effective** do you think you are as a provider in addressing **patient and family** concerns regarding

22. Participation in spiritual or religious experiences (e.g. meditation, spiritual traditions or rituals, praying, or going to a place of worship)

NA None 0 1 2 3 4 5 6 7 8 9 10 A *great deal*

23. Extent to which illness has made a positive change in life

NA None 0 1 2 3 4 5 6 7 8 9 10 A *great deal*

24. Sense of a purpose / mission for life or a reason for being alive

NA None 0 1 2 3 4 5 6 7 8 9 10 A *great deal*

25. Hopefulness

NA None 0 1 2 3 4 5 6 7 8 9 10 A *great deal*

26. Opportunity to reflect on life

NA None 0 1 2 3 4 5 6 7 8 9 10 A *great deal*

27. Viewing time as precious and valuing each minute of life

NA None 0 1 2 3 4 5 6 7 8 9 10 A *great deal*

28. Experience of healing in spiritual, emotional, relational areas of life

NA None 0 1 2 3 4 5 6 7 8 9 10 A *great deal*

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**Modified by Supportive Care of the Dying: A Coalition for Compassionate Care

Information About You

Please complete the following questions about you. This information will be kept strictly confidential.

Primary Practice Areas: (May select more than one)

- Home Health Hospice Hospital
 Long Term Care Outpatient Services Dr's Office / Clinic
 Other *(please specify)* _____

Age _____ **Gender:** Male Female
Years in Practice _____ **Highest Level of Professional Education** _____
Professional Discipline _____

Your Race/Ethnicity Your Religion

- White/Caucasian Jewish Muslim
 Black/African American Catholic Buddhist
 Asian or Pacific Islander Jehovah's Witness Bahia
 Hispanic Christian Scientist No religion
 Native American Seventh Day Adventist Other *(specify)*: _____
 Other Protestant
 Native American _____

Health Services that you facilitate referrals to or refer patients to:

- Home Health Church based ministries, e.g. Stephen Ministries
 Hospice Visiting Nurse

___Parish Nurse

___Other or none

(specify): _____

Primary diagnosis or illness that seem to be life - threatening for the patients you care for. List all that apply:

Approximate number of patients with life-threatening illness you have cared for in the past 3 months _____

Number of your patients who have died during past year

Date Questionnaires completed _____ I.D.
number _____

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