Breakthrough Award Submission Form

Patient Experience [ HCAHPS ]

* Please enter your Top Box Percentages as outlined in the form below.
* Each score will need to be validated by your Survey Vendor Report.
* Vendor reports must have the scores either highlighted or circled when submitted.

|  |  |  |  |
| --- | --- | --- | --- |
| **HCAHPS  DOMAIN** | **Your Top Box Percentage**  ***July 2020 – June 2021***  *(Rolling Year to Date/Average)* | **Your Top Box Percentage**  ***July 2021 – June 2022***  *(Rolling Year to Date/Average)* | **Top Box Percentage**  **National Average**  ***July 2021 – June 2022*** |
| Communication with Nurses |  |  |  |
| Communication with Doctors |  |  |  |
| Response of Hospital Staff |  |  |  |
| Communication about Medicines |  |  |  |
| Hospital Environment - Clean |  |  |  |
| Hospital Environment - Quiet |  |  |  |
| Discharge Information |  |  |  |
| Transition of Care |  |  |  |
| Rate Hospital (9-10) |  |  |  |
| Recommend the Hospital |  |  |  |

**Submitted by:**

Organization:

Contact Person:  Title:

Phone:

Email:

**Validated by:** (Attach a copy of your survey vendor’s report for each submission)

Survey Vendor:

Contact Person:  Title:

Phone:

Email: