

## Frontier Community Health Care Network Coordination Evaluation Client Satisfaction Survey

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People who live in rural areas often face unique challenges obtaining health care. In an attempt to improve access to high-quality health care for rural citizens, the Health Resources and Services Administration Office of Rural Health Policy has undertaken several initiatives. One such initiative is a new pilot program from Montana's Department of Public Health and Health Services, Frontier Community Health Care Network Coordination Grant. This program is designed to improve quality of health care by connecting people with a community health worker. We need your help to find out how the program is meeting the needs of those who have participated in the program.

As someone who has participated in the Frontier Community Health Care Network Coordination program, you have been selected to complete the brief Client Satisfaction Survey. The survey should only take about 10 minutes.

**Your Privacy is protected.** All information that would let someone identify you or your family will be kept private to the extent allowed by law. We will not share your personal information you provide in this survey with anyone without your OK. Your responses to this survey are also completely **confidential**. You may notice a number on the cover of the survey. This number is used **only** to let us know if you returned your survey so we don't have to send you reminders.

- **Your Participation is Voluntary.** You may choose to answer this survey or not. If you choose not to, this will not affect the health care you get in any way.
- **What To Do When You're Done.** Once you complete the survey, place it in the envelope that was provided, seal the envelope, and return the pre-printed envelope to [ enter address here]
- If you want to know more about this study, please call Dora Hunter, one of the study researchers, at 202.776.5184 or via e-mail: [dora.hunter@altarum.org](mailto:dora.hunter@altarum.org)

Estimated Burden: 10 minutes

## INSTRUCTIONS

Answer each question by marking 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 #1 on page 1**  
 No

According to records shared with us by the Montana Department of Public Health and Human Services you recently participated in a program to improve your health. We'd like to know a little bit more about your experiences with this program.

## PROGRAM ACTIVITY

1. In the last 12 months do you recall having been helped by a community health worker?
  - Yes, I was helped by a community health worker **(If Yes, continue to Question 2)**
  - No, I did not receive any of this type of assistance **(If No, go to Question 6 on page 5)**

2. How much did you interact with the CHW from this program?
  - Every day
  - A few times a week
  - A few times a month
  - Only once
  - Never

3. In which of the following areas have you received assistance from program staff? Check the appropriate boxes below to identify all the best answers for each type of assistance you might have received.

Activity	A community health worker helped with this	Someone else helped with this	I didn't receive any help with this	This doesn't apply to me
Making sure you had transportation to and from your doctor visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting a home health nurse to help with changing bandages, administering insulin or other medical tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Updated your personal health record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting help from a home health aide with normal household activities such as taking a shower, getting dressed or housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making a written plan for your health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting help with meals (arranging for Meals on Wheels or another similar service)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teaching you how to better manage your own health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helping you make or remember appointments with your health care provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other:

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4. Please tell us a little bit about your participation in the Community Health Worker program. Do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I was enthusiastic about participating in this program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My family and/or friends supported my participation in this program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in this program helped me learn more about my health condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in this program was easy for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in this program helped me accomplish normal activities more easily (eating, bathing, dressing, walking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in this program helped improve my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in this program helped me avoid needing to go to the emergency room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand what this program is about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Community Health Worker I worked was knowledgeable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had a positive, productive relationship with the Community Health Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This program improved my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Is there anything else you would like to tell us about your experiences with this program?

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### ABOUT YOURSELF

6. In general, how would you rate your overall **physical** health?

- Excellent
- Very Good
- Good
- Fair
- Poor

8. What is your age?

- 18 to 44
- 45 to 64
- 65 to 74
- 75 to 84
- 85 to 94
- 95 or older

7. In general, how would you rate your overall **mental or emotional** health?

- Excellent
- Very Good
- Good
- Fair
- Poor

9. Are you male or female?

- Male
- Female

10. What is the highest grade or level of school that you have completed?

- 8th grade or less
- Some high school, did not graduate
- High school graduate or GED
- Some college or 2-year degree
- 4-year college graduate
  
- More than 4-year college degree

11. Are you of Hispanic or Latino origin or descent?

- Yes, Hispanic or Latino
- No, not Hispanic or Latino

12. What is your race? Please mark one or more.

- White
- Black or African American
- Asian
  
- American Indian or Alaskan Native

- Native Hawaiian or Other Pacific Islander

13. Did someone help you complete this survey?

- Yes
- No → **Thank you. Please return the completed survey in the postage-paid envelope.**

14. How did that person help you? Mark one or more.

- 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

If so, please print how:

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**THANK YOU**

Please return the completed survey in the postage-paid envelope to the following address:

[Location ]  
C/o Frontier Community Health Care Network Coordination Program  
[address]