OMB 2900-0770

Estimated Burden: 15 minutes

Expiration Date: 8/31/2017

**Department of Veterans Affairs - Clinic Based Telehealth (CBT) Satisfaction Survey**

Dear Veteran Patient,

It is important that we know what you think about the value of our Clinical Video Telehealth and Store and Forward Telehealth service programs. Your comments will help us learn how we can improve care to all Veterans. We would greatly appreciate your taking a few minutes to complete the following survey.

First, we'd like you to know:

1. The information that you provide will be kept private to the extent permitted by law. They will be reviewed by training center staff, not any local personnel.
2. When you finish, please put the survey in the stamped envelope and give it to the clerk to mail. Local staff will not see your responses.
3. Your comments will be combined with comments from other Veteran patients for improvement of services programs within this clinic.

Thank you for your time.

# Date of Appointment

Your Gender:

Was this your first

This session was:

Modality

**1** Male

|  |  |
| --- | --- |
| VISN # | |
|  |  |
| **0** | **0** |
| **1** | **1** |
| **2** | **2** |
| **3** | **3** |
| **4** | **4** |
| **5** | **5** |
| **6** | **6** |
| **7** | **7** |
| **8** | **8** |
| **9** | **9** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Facility # | | | | |
|  |  |  |  |  |
| **A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0**  **1**  **2**  **3**  **4**  **5**  **6**  **7**  **8**  **9** | **A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0**  **1**  **2**  **3**  **4**  **5**  **6**  **7**  **8**  **9** | **A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0**  **1**  **2**  **3**  **4**  **5**  **6**  **7**  **8**  **9** | **A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0**  **1**  **2**  **3**  **4**  **5**  **6**  **7**  **8**  **9** | **A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0**  **1**  **2**  **3**  **4**  **5**  **6**  **7**  **8**  **9** |

|  |  |
| --- | --- |
| Your Age | |
|  |  |
| **0** | **0** |
| **1** | **1** |
| **2** | **2** |
| **3** | **3** |
| **4** | **4** |
| **5** | **5** |
| **6** | **6** |
| **7** | **7** |
| **8** | **8** |
| **9** | **9** |

|  |  |  |
| --- | --- | --- |
| **DATE** | | |
| **MONTH** | **DAY** | **YEAR** |

**2** Female

Telehealth session?

**1** Yes

**2** No

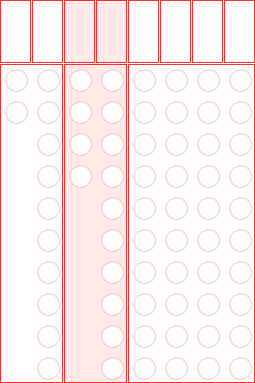
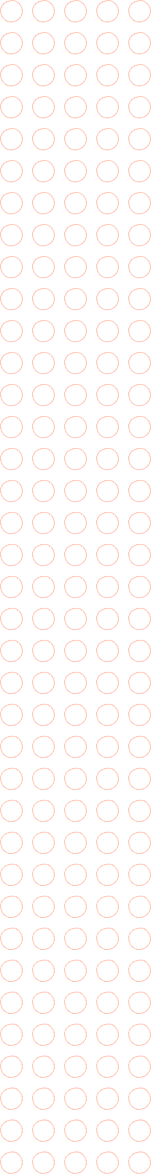
**1** Individual

**2** Group

**1** CVT

**2** SFT

o



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**3 3 3 3 3 3 3**

**4 4 4 4 4 4**

**5 5 5 5 5 5**

**6 6 6 6 6 6**

**7 7 7 7 7 7**

**8 8 8 8 8 8**

**9 9 9 9 9 9**

Program:

**1** Community Living Center

**2** CVT into the Home

**3** Emergency Care

**4** Genomics

**5** Intensive Care Unit

**6** National Telemental Health Center

**7** Non VA Site

**8** Rehabilitation

**9** Spinal Cord Injury

**10** Surgery

**11** Transplant

Tele Specialty Clinic (please check only one of the following): Amputation



**1**

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**53**

Assistive Technology Audiology

Behavioral Pain

Bipolar Disorder Program Blind Rehabilitation Cardiology/Cardiac Chaplain Services Compensation Dermatology

Diabetes

Diabetic Education Endocrine

GI

Hematology Hepatitis/Liver Infectious Disease Insomnia Kinesiotherapy Mental Health MOVE!

Nephrology/Renal Neurology/Neuro Non-Epileptic Seizure Nutrition

Obstetrics/Family Planning Occupational Therapy

**Please turn the form over**

Oncology Orthopedics Pain

Patient Education Pharmacy Physical Therapy Podiatry Polytrauma

Preventative Medicine Primary Care Prosthetics

PTSD

Pulmonary/Thoracic Recreational Therapy Retinal Screening

Schizophrenia/Psychotic Disorders Speech Therapy

Spirometry Substance Abuse Tai Chi/Yoga Tobacco Cessation

Traumatic Brain Injury Urology

Women's Health/GYN Wound Care

Other

# We want to know what you thought about today's telehealth session.

**Your honest answers will help us improve the system.**

**Please fill in the number that is closest to your own opinion for each of the following statements.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | **Telehealth Survey Questions**  I felt comfortable with the equipment used. | **Strongly Agree** | **Agree** | **Do not agree or disagree** | **Disagree** | **Strongly disagree** | **NA** |
|  |  |
|  |  |  |
| **5** | **4** | **3** | **2** | **1** |  |
| 2. | The location of the telehealth clinic is convenient | **5** | **4** | **3** | **2** | **1** |  |
|  | for me. |  |  |  |  |  |  |
| 3. | Overall, I am satisfied with the telehealth visit. | **5** | **4** | **3** | **2** | **1** |  |
| 4. | I would recommend this type of session to other | **5** | **4** | **3** | **2** | **1** |  |
|  | veterans. |  |  |  |  |  |  |
| 5. | I would rather use telehealth to receive this service | **5** | **4** | **3** | **2** | **1** |  |
|  | than travel long distance to see my provider. |  |  |  |  |  |  |
| 6. | Information given to me today about my visit was | **5** | **4** | **3** | **2** | **1** |  |
|  | clear and adequate. |  |  |  |  |  |  |
| 7. | The staff gave me opportunities to ask questions. | **5** | **4** | **3** | **2** | **1** |  |

Only complete the following questions if your visit today was conducted by video

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 8. | I was able to see the clinician clearly by video. | **5** | **4** | **3** |  | **1** |  |
| 9. | There was enough technical assistance for my  visit |  |  |  |  |  |  |
| 10. | The telehealth clinic provided the care I expected. |  |  |  |  |  |  |
| 11. | I was able to hear the clinician clearly by video. | **5** | **4** | **3** | **2** | **1** |  |
| 12. | My Relationship with the clinician was the same by video session as it is in person |  |  |  |  |  |  |

I CARE Survey Questions-This are your overall opinion regarding the VA

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 13. | I got the service I needed |  |  |  |  |  |
| 14. | It was easy to get what I needed |  |  |  |  |  |
| 15. | I felt like a valued customer |  |  |  |  |  |
| 16. | I trust VA to fulfill our country’s commitment to Veterans |  |  |  |  |  |

**The Paperwork Reduction Act of 1995** requires us to notify you that this in formation collection is in accordance with the clearance requirements of section 3507 of the

Paperwork Reduction Act of 1995. The public reporting burden for this collection of information is estimated to average 15 minutes, including the time for reviewing instructions, and completing and reviewing the collection of information. No person shall be subject to any penalty for fail ing to comply with a collection of information if it does not display a currently valid OMB control number. Customer satisfaction surveys are used to gauge customer perceptions of VA services as well as customer expectations and

desires. The results of th is survey will lead to improvements in the quality of service delivery by helping to shape the direction and focus of specific, programs and services. Submission of this form is voluntary and failure to respond will have no impact on benefits to which you may be entitled.

VA Form 10-0481a

August 2015