Health Advocate Pilot Project Patient Satisfaction Assessment

OMB No. 2900-0770
Estimated Burden: 5 Minutes
Expiration Date: 9/30/2020

The Paperwork Reduction Act of 1995: This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this survey will average 5 minutes. This includes the time it will take to follow instructions, gather the necessary facts and respond to questions asked. Customer satisfaction is used to gauge customer perceptions of VA services as well as customer expectations and desires. The results of this in-person survey will lead to improvements in the quality of service delivery by helping to achieve primary care services. Participation in this survey is voluntary and failure to respond will have no impact on benefits to which you may be entitled.

Please circle answer that best describes your experience at today's appointment.

1. Compared to your prior primary care visits to this clinic, how would you rate today's appointment?

Much better | Slightly better | Same | Slightly worse | Much worse | n/a

2. Compared to past primary care visits, my primary care provider focused on the computer

Much less | Slightly less | Same | Slightly more | Much more | n/a

3. How comfortable were you with speaking openly to your primary care provider about your health concerns with other staff present during your primary care visit?

Very comfortable | Slightly comfortable | Neutral | Slightly uncomfortable | Very uncomfortable

4. How helpful was the health education you received during your primary care visit?

Very helpful | Somewhat helpful | Neutral | Somewhat unhelpful | Very unhelpful

5. How comfortable were you with staff writing notes in the computer throughout your primary care visit with the primary care provider?

Very comfortable | Slightly comfortable | Neutral | Slightly uncomfortable | Very uncomfortable

For Administrative Purposes Only (*To be completed by clinic staff*)

Date of visit: _____

Time of visit: _____

Provider name: _____

Health Advocate name: _____