VISN 1 Outpatient Mental Health Patient Satisfaction Survey

OMB No. 2900-0770
Estimated Burden: 10 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 10 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 telephone/mail survey will lead to improvements in the quality of service delivery by helping to achieve services. Participation in this survey is voluntary and failure to respond will have no impact on benefits to which you may be entitled.

OVERALL ASSESSMENT OF THE CENTER (...continued)	very poor 1	poor 2	fair 3	good 4	very good 5
3. Degree to which you feel that your condition has improved as a result of the service received through this center	○	○	○	○	○
4. Overall rating of care given at this center	○	○	○	○	○
5. Likelihood of recommending this center to others	○	○	○	○	○

Comments (describe good or bad experience):_____

Now think about your experiences with all the services provided by the Department of Veterans Affairs (which include healthcare, benefits programs, or memorial services). Please tell us how you feel about the following statements.

I got the service I needed

○ Strongly Disagree
○ Disagree
○ Neither Agree Nor Disagree
○ Agree
○ Strongly Agree

It was easy to get the service I needed

○ Strongly Disagree
○ Disagree
○ Neither Agree Nor Disagree
○ Agree
○ Strongly Agree

I felt like a valued customer

○ Strongly Disagree
○ Disagree
○ Neither Agree Nor Disagree
○ Agree
○ Strongly Agree

I trust VA to fulfill our country's commitment to veterans

○ Strongly Disagree
○ Disagree
○ Neither Agree Nor Disagree
○ Agree
○ Strongly Agree

Patient's Name: (optional)_____

Telephone Number: (optional)_____

OUTPATIENT BEHAVIORAL HEALTH SATISFACTION SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope or deposit it in the nearby lock box.

BACKGROUND QUESTIONS

1. Referred through an Emergency Department ..... ○ Yes ○ No
2. Referred by your physician ..... ○ Yes ○ No
3. Informed of patients' rights including confidentiality ..... ○ Yes ○ No
4. Patient's first use of this outpatient treatment program ..... ○ Yes ○ No
5. How many visits have you had for this treatment program? ..... ☐☐
6. Date this treatment began: ☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)
7. Date this treatment ended: ☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)
8. Patient's sex ..... ○ Male ○ Female
9. Patient's age ..... ☐☐☐

INSTRUCTIONS: Please rate the services you received from our facility. <u>Select the response</u> that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
Example: ●

REGISTRATION AND SCHEDULING	very poor 1	poor 2	fair 3	good 4	very good 5
1. Speed of the registration process	○	○	○	○	○
2. Courtesy of the person who helped you register	○	○	○	○	○
3. Ease of getting an appointment	○	○	○	○	○
4. Convenience of available appointment times	○	○	○	○	○

Comments (describe good or bad experience):_____

continued...

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OUTPATIENT TREATMENT AREA

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Cheerfulness of treatment area	○	○	○	○	○
2. Cleanliness of treatment area	○	○	○	○	○
3. Convenience of location	○	○	○	○	○
4. Privacy of treatment area	○	○	○	○	○
5. Comfort level in and around the treatment area	○	○	○	○	○

Comments (describe good or bad experience):

OFFICE STAFF

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Helpfulness of the office staff	○	○	○	○	○
2. Degree to which staff kept you adequately informed	○	○	○	○	○
3. Efficiency in handling your requests	○	○	○	○	○

Comments (describe good or bad experience):

YOUR PRIMARY THERAPIST

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Amount of time your therapist spent with you	○	○	○	○	○
2. Competence of therapist	○	○	○	○	○
3. Therapist's concern for your questions and worries	○	○	○	○	○
4. Degree to which therapist understood you and your needs	○	○	○	○	○
5. How well the therapist kept you informed about your treatment	○	○	○	○	○

Comments (describe good or bad experience):

THERAPEUTIC SERVICES - PHYSICIAN OR ADVANCED PRACTICE NURSE

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Time physician spent with you	○	○	○	○	○
2. How well you were informed about your medication	○	○	○	○	○
3. Courtesy of physician	○	○	○	○	○

Comments (describe good or bad experience):

THERAPEUTIC SERVICES

Please rate helpfulness of:

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Individual counseling sessions	○	○	○	○	○

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THERAPEUTIC SERVICES (...continued)

	very poor 1	poor 2	fair 3	good 4	very good 5
2. Group therapy sessions (if you participated)	○	○	○	○	○
3. Family therapy sessions (if you participated)	○	○	○	○	○
4. Couple therapy sessions (if you participated)	○	○	○	○	○

Comments (describe good or bad experience):

SUPPORTIVE SERVICES - PSYCHOLOGICAL TESTING

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ability of person who administered tests	○	○	○	○	○
2. Courtesy of person who administered tests	○	○	○	○	○
3. Adequacy of explanation of tests	○	○	○	○	○

Comments (describe good or bad experience):

COMPLETION OF SERVICES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Extent to which you felt ready to be discharged	○	○	○	○	○
2. Information provided regarding your medication	○	○	○	○	○
3. Information regarding follow up recommendation	○	○	○	○	○
4. Instructions on what to do if experiencing problems related to your condition (when to seek help, who to call, etc.)	○	○	○	○	○

Comments (describe good or bad experience):

SOME PERSONAL ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Staff concern for your privacy	○	○	○	○	○
2. Staff sensitivity for the inconvenience health problems can cause	○	○	○	○	○
3. Degree to which staff addressed your emotional/spiritual needs	○	○	○	○	○
4. Response to concerns/complaints made during your treatment	○	○	○	○	○
5. Staff efforts to include you in decisions about your treatment	○	○	○	○	○

Comments (describe good or bad experience):

OVERALL ASSESSMENT OF THE CENTER

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the staff worked together to care for you	○	○	○	○	○
2. Cheerfulness of the center	○	○	○	○	○

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