Agenda Item # 6a

Administrative Use Only

☐ Ascension ☐ FHC
☐ HOPE CC ☐ Options/Koinonia
☐ FCP AODA ☐ Price Co
☐ Iron Co ☐ Sokaogon Comm
☐ LDF FRC ☐ HSC

PATIENT SATISFACTION SURVEY

Please rate your level of agreement with the following statements about the treatment and support services you received at this facility. Select "Does Not Apply" if the statement does not apply to you or if you received the service somewhere else.

Statement	Agree	Neutral / Uncertain	Disagree	Does Not Apply
1. I am satisfied with…				
The overall treatment program.	☐	☐	☐	☐
Individual counseling.	☐	☐	☐	☐
Group counseling.	☐	☐	☐	☐
Medication-assisted treatment (MAT), such as Suboxone or Vivitrol. *Please indicate where MAT received or select "Does Not Apply"* ☐Family Health Center ☐Ascension ☐Other	☐	☐	☐	☐
Care coordination services. *Please indicate who provided services or select "Does Not Apply" May select more than one* ☐HOPE ☐Family Health Center ☐Other	☐	☐	☐	☐
2. Appointments were offered at times that worked well for me.	☐	☐	☐	☐
3. Information about my treatment was clearly explained.	☐	☐	☐	☐
4. I understood expectations of the treatment program.	☐	☐	☐	☐
5. I was actively involved in developing my treatment and/or service plan.	☐	☐	☐	☐
6. Treatment/services I received helped me to understand and manage my substance use disorder.	☐	☐	☐	☐
7. I felt safe while receiving treatment/services.	☐	☐	☐	☐
8. Providers and staff were professional and welcoming.	☐	☐	☐	☐
9. Providers and staff listened to me.	☐	☐	☐	☐
10. I felt motivated and encouraged by providers and staff.	☐	☐	☐	☐
11. Please provide the name of anyone who was particularly helpful to you:				
12. Services were available to help me deal with financial concerns.	☐	☐	☐	☐
13. The facility felt welcoming and safe.	☐	☐	☐	☐

14. What part of treatment or which services made the biggest difference for you?
15. If you could change one thing to improve your experience, what would it be?

Thank you for taking the time to complete this survey.

If you would like to share additional comments, you may:

1. Contact the Marshfield Clinic Health System – Center for Community Health Advancement by phone at 715-221-8400 or email at communityhealth@marshfieldclinic.org

   OR

2. Provide your name and phone number and/or email address below and someone from the HOPE Consortium will contact you. Sharing this information is **optional**.

   Name: ____

   Phone number and/or email address: ________________________