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Joint Outpatient Experience Surveys - JOES helps us improve your healthcare



The Military Health System sends out the Joint Outpatient Experience Surveys. JOES, replaced the Army Provider Level Satisfaction Survey, as a single survey for all military treatment facilities across the services. It combines and standardizes methods used to learn about beneficiary health care experiences with the goal of making them better.

According to the Defense Health Agency, JOES will have a considerable impact on how the MHS delivers health care. Whichever health care system TRICARE beneficiaries go to, they now receive the same questionnaire, mailed to their homes, to report their experience.

As part of an integrated, multi-service market JOES provides standardized, common patient experience data for all Colorado Springs Army and Air Force medical facilities.

Evans Army Community Hospital's leadership values this feedback from our patients and uses it to identify areas where we can improve and to recognize our outstanding personnel. We encourage all our patients to complete and submit the surveys.

For more information see: <http://www.health.mil/surveys>



Joint
Outpatient
Experience
Survey



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OFFICIAL GOVERNMENT BUSINESS

PRESORTED
FIRST-CLASS MAIL
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PAID
IPSOS

Your TRICARE Is Asking For Your Opinions



[Type text]

[Name]
[Address]
[Address]

Time Sensitive Survey
Please complete and return the enclosed survey as soon as possible. Thanks!

Dear [Patient (Rank) and/or First Name, Middle Initial, Last Name]:

The Department of Defense needs your help. Our goal is to provide the best healthcare possible for you and your family. As a result, we are asking for your candid opinions about your and/or your child's recent outpatient healthcare experience. We are appreciative of your feedback because all healthcare improvement efforts are directly related to feedback received through our patient satisfaction experience surveys.

The enclosed survey asks about your and/or your child's recent visit with [Provider Rank] [Provider Name] at [Facility Name] on [Date of Encounter]. Providers are part of a clinic team that includes nurses, corpsmen and other staff. Please consider all the services provided by the clinic team in your answers. If you were not treated by this provider, please answer only the non-provider specific questions. The survey should take about ten minutes to answer.

Please complete and return the survey by using the enclosed postage-paid envelope. If you misplaced your envelope, you may mail it to the Office of the Assistant Secretary of Defense (Health Affairs) Defense Health Agency, Decision Support Division, c/o Ipsos Survey Processing Center, PO Box 5030, Chicago, Illinois 60680-4138.


For your added convenience, you can also complete this survey online at: www.ipsosresearch.com/joessurvey. Please note that you cannot use a search engine such as Google to locate the website. Once there, please enter your password [XXXXXXXXX].

Your answers will be held in the strictest confidence and you will not be identified in any release of survey data. The results of this survey are compiled and reported in groups only. Any written comments you include will be visible to the Commander of the facility that you visited, but your personal information will be kept confidential unless you provide contact information.

If you have any questions or concerns about this survey, you are welcome to contact the helpdesk. The helpdesk may be reached at 1-800-280-8116, or joes.survey@ipsos-research.com.

Your assistance will vastly improve the quality of healthcare throughout our militancy community.


Thank you!



NADJA Y. WEST
LTG, US Army
The Surgeon General and
Commanding General, USAMEDCOM

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C. FORRE J. A. ISON III
Vice Admiral, Medical Corps
United States Navy
Surgeon General of the Navy

MARK A. EDIGER
Lieutenant General, USAF, MC, CFS
Surgeon General



R.C. BONO
Vice Admiral, Medical Corps
United States Navy



Joint Outpatient Experience Survey



Please use pen or dark pencil to mark an "X" in the answer box:
Example: Correct Incorrect

1. According to our records, you recently had a healthcare visit with **<PROVIDER>** on **<VISIT DATE>** at **<FACILITY NAME>**. Is this correct?
 Yes → Please continue with survey.
 No, saw someone else..... → Please go to **question #12**.
 No, didn't have visit..... → Please return your survey in the pre-paid envelope provided.

Thinking specifically about this visit, please mark an "X" in the box for the answer that applies to you:

2. Do you know who your Primary Care Manager (PCM) is? Yes No → Go to Question #4
3. Did you see your PCM during this visit (Please pick one answer)?
 Yes
 No, I saw another provider on my care team
 No, I saw another provider from a different care team
 No, I saw a specialty provider

For questions 4 through 8, please indicate how much you agree or disagree with the following statements:

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
4. This provider, <PROVIDER> , treated me with courtesy and respect.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. This provider explained things in a way that was easy to understand.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. This provider seemed to know the important information about my medical history.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Based on this visit, I feel confident I have the knowledge to make healthy choices and informed medical decisions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Based on this visit, I am confident I have the ability to influence my health.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For question 9, please indicate how satisfied or dissatisfied you are with the following:

	Completely Dissatisfied	Somewhat Dissatisfied	Neither Satisfied nor Dissatisfied	Somewhat Satisfied	Completely Satisfied
9. Overall, how satisfied are you with your visit <u>with this provider</u> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did this provider review a complete list of your current and new medications with you, including any over-the-counter medications (e.g. aspirin, vitamins)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
11. Please provide any comments about your visit with <PROVIDER> that you would like to share. Please do not provide any personally identifiable information.					

12. If you made an appointment for this visit, how did you make this appointment?
 Phone → 12a. Were you at any time told no appointments were available but to call back when they would be available? Yes No
 TRICARE Online (TOL)
 Secure Messaging
 In Person
 No, did not make appointment → Go to Question #17



For questions 13 through 15, please rate the following aspects of your appointment:

	N/A	Poor	Fair	Good	Very Good	Excellent
13. The ease of making the appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. The amount of time between when you made the appointment until your actual visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. If seen past your scheduled appointment time, the effort made to keep you informed about the delay.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Did your healthcare team begin to address your needs within 30 minutes of your appointment time?						
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A				

For questions 17 and 18, please rate the following aspects of your care and service during THIS visit:

	N/A	Poor	Fair	Good	Very Good	Excellent
17. The courtesy and respectfulness of clerks and receptionists.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. The helpfulness of clerks and receptionists.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you also went to the Pharmacy, Laboratory, or Radiology Department in conjunction with THIS visit, please rate your experience with these services:

	N/A	Poor	Fair	Good	Very Good	Excellent
19. Overall experience with Pharmacy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Overall experience with Radiology.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Overall experience with Laboratory.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

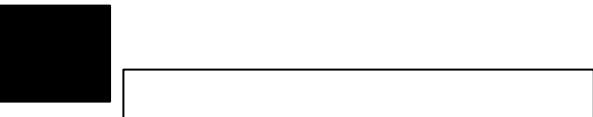
Please indicate how much you agree or disagree with the following statements:

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
22. Overall, I am satisfied with the healthcare I received on this visit....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I would recommend this facility to a TRICARE-eligible family member or friend.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. In general, I am able to see my provider when needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. In general, my provider team considers my values and opinions when we make decisions about my healthcare.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About you:

	Poor	Fair	Good	Very Good	Excellent
26. In general, how would you rate your overall health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. In general, how would you rate your overall mental or emotional health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Please provide any comments about <FACILITY> that you would like to share. Please do not provide any personally identifiable information.					

**Thank you very much for your opinions. Please return your questionnaire in the envelope provided to:
ATTN: MILITARY HEALTH SYSTEM SURVEY CENTER, c/o Ipsos, P.O. BOX 5030, CHICAGO, IL 60680**



Privacy Advisory: Your contact information was used to ask for your participation in this survey about your recent visit. Your responses are voluntary and your decision to participate or not will not affect your opportunity to receive future medical benefits. However, your responses to this survey about your recent experience in our treatment facility will allow us to maintain or improve the quality of the patient care provided to all receiving treatment at your facility.