PERFORMANCE IMPROVEMENT – for CSSNs 2005-06

All CSSNs must operate a performance improvement system. All are required to submit quarterly, performance improvement reports to be reviewed by the Regional Performance Improvement Committee. The formats and instructions for the reporting on these indicators are included in this section.

Following are five sections:

1. A Table of CSSN Performance Improvement Indicators for the 2005/2006 fiscal year. *Pages 2 - 3*
2. Definitions/Descriptions of Indicators. *Pages 4 - 7*
3. Tools for obtaining data (Procedures for Surveys, Surveys to give out, Aggregate Reporting Forms, Co-Occurring Tools) and Reporting Formats for Indicators. *Pages 8 - 19*
4. MDCH QAPIP Program Descriptions for Natural Supports Study and Coordination with Primary Care Physicians Study. *Pages 20 – 27*
5. Supported Employment and Substance Abuse provider information for CSTS only. *Pages 28 – 39*

Note: Also see attachments #1 – 10 for additional information, as referred to in the Table of CSSN Performance Improvement Indicators and the Definitions/Descriptions of Indicators section for each of the indicators in this manual (see pages 2 – 7).

Table of CSSN Performance Improvement Indicators for CSSNs (CSTS - Washtenaw, Livingston CMH, Monroe CMH, Lenawee CMH)			
Area to be reported	***Reporting Requirements***	***Information Source***	***Frequency***
Consumer Satisfaction with services provided	satisfaction on Survey Aggregate Form and response rate (report number of surveys distributed and number of surveys collected); reporting form in provider manual	CSSN Consumer Survey Procedure, CSSN Consumer Survey and CSSN Survey Aggregate Form (in this manual)	annually - due April 30
Goal Attainment	% of cases sampled in which 50% or more of the outcomes are at 3 (on 5 point scale) or better; reporting form in provider manual	Most recent periodic review/status report/progress report from clinical record	quarterly
Person-Centered-Planning (PCP) Facilitation	Number of PCPs completed during the quarter (for all populations combined); reporting from in provider manual	Actual	quarterly
Co-Occurring	COMPASS, Co-Occurring Clinical Assessments, and Workplan based on COMPASS and Co-Occurring Clinical Assessments scores	Instructions and reporting forms in this manual; tools are attachment #1 and attachment #2	annually - due July 30
PCP satisfaction data	Report data quarterly on PCP aggregate data reporting form	Regional PCP Sat Survey Procedure and PCP Sat Survey in this manual; PCP Sat Aggregate reporting form is attachment #3	quarterly
QAPIP studies – Natural Supports	Data due quarterly	Program Description in this manual; reporting form is attachment #4	quarterly
QAPIP studies – Coordination with Primary Care	2nd phase of this study is still being developed	Program Description in this manual; reporting form is attachment #5	will be determined once 2nd phase of study is developed

MDCH Indicators	Report PIHP and CMHSP data as defined in Codebook	See MDCH Codebook attachment #6	quarterly
Network Provider Data	Reported by providers to each CSSN; each CSSN aggregates provider data; WCHO aggregates Washtenaw providers data	See attachment #7 for PI section of Provider Manual (has provider expectations); see attachment #8 for CSSN aggregate reporting form	quarterly
	For Co-Occurring provider data, each CSSN aggregates provider data; WCHO aggregates Washtenaw providers data	See attachment #9 and attachment #10 for aggregated reporting forms for Co-Occurring provider data	annually
Supported Employment	For CSTS only as a SE provider	See pages 28 – 33 of this manual	quarterly
Substance Abuse	For CSTS only as a SA treatment provider	See pages 34-39 of this manual	quarterly

Definitions/Descriptions of Indicators for CSSNs (CSTS – Washtenaw, Livingston CMH, Monroe CMH, Lenawee CMH)

<u>Consumer Satisfaction with Services Provided</u>

This information will be obtained after distributing, collecting, and reviewing the six item ”CSSN Consumer Survey,” a copy of which is included in this manual. The results are reported and submitted annually on April 30, using the “CSSN Consumer Survey Compilation Form,” also included in this manual.

Please refer to this manual for the “CSSN Consumer Survey Procedure” for specific procedures on distributing and reporting the results of the survey. CSSNs are required to submit an explanation for each of the six items falling below 90% agreement on the “CSSN Consumer Survey Compilation Form.” Report data on the “CSSN Quarterly Performance Improvement Indicators Aggregate Reporting Form” in this manual.

<u>Goal Attainment</u>

This indicator reflects the provider’s performance in helping consumers achieve their person-centered planning outcomes. At the time of a Periodic Review/Status Report/Progress Report from the clinical record, the consumer and staff person discuss progress toward each outcome, sharing impressions and reaching consensus on a rating. A five point subjective scale is used to rate and record progress toward each one of the outcomes/goals as follows:

1 = no progress
2 = a little progress
3 = about halfway toward goal achievement
4 = almost there
5 = outcome/goal achieved

A case record review of the most recent Periodic Review/Status Report/Progress Report from the clinical record is conducted quarterly, using a stratified random selection process, annually covering all populations served. A minimum of 10% of cases of each of the three populations (MI, DD, Children) should be reviewed over the course of the year; average 2.5% cases reviewed for each population per quarter. Open cases and cases closed within the last 180 days are to be included. For each chart, review each goal to obtain the rating given (i.e. if a consumer has three goals there should be three ratings, if a consumers has four goals there should be four ratings, etc.).

The following data are reported quarterly on the “CSSN Quarterly Performance Improvement Indicators Aggregate Reporting Form” in this manual:

- The number of cases reviewed
- The number of cases in which a rating of 3 or higher was recorded for half or more of the total outcomes/goals in the PCP

Person-Centered-Planning (PCP) Facilitation

Each CSSN will report the total number of PCPs completed during the quarter (for all populations combined). This data will be used with regional Facilitation data to look at PCP Facilitation. Report data on the "CSSN Quarterly Performance Improvement Indicators Aggregate Reporting Form" in this manual.

Co-Occurring

CSSNs will complete the following assessment tools to determine their level of competence in addressing co-occurring disorders (mental illness and substance abuse). Your score on the tools should be used as an internal guide to develop training and/or staff development activities in your agency.

- **The COMPASS™ =** is a tool used to assess the provider's level of competence in several areas at a **systems level.** This will allow CSSNs feedback on their ability to meet the needs of co-occurring consumers from an administrative standpoint. CSSNs must complete this entire tool (due July 30). (COMPASS™ instructions in provider manual; COMPASS™ tool is attachment #1).

- **The Co-Occurring Clinical Assessment =** is a revised tool to assess the level of competence in several areas at a **direct clinical level**. It will allow the individual clinician to be provided feedback on areas where they are competent or where there is need for improvement in meeting the needs of co-occurring consumers. CSSNs must complete this tool (due July 30). (Co-Occurring Clinical Assessment instructions in provider manual; Co-Occurring Clinical Assessment tool is attachment #2).

- **Co-Occurring Action Plan:** (To be completed by the 3rd quarter of the fiscal year with submission by July 30th following the end of the quarter)

  The CSSN based on the implementation of a Comprehensive Co-Occurring Service Array will complete an annual action plan. This action plan will address the key areas the CSSN will implement over the next year. CSSNs must complete an Action Plan (due July 30).

  The Action Plan should include the areas identified as a need for improvement based on the scores from completing the COMPASS™.

  An example may be…

  > From the philosophy section of the COMPASS™ the overall score was a 2.5, an action plan item may be to share literature about co-occurring disorders during staff meetings on a regular basis to provide staff a better understanding of what co-occurring disorders are.

Or

Choose one of the specific questions to address from a section that was scored lower. For example in the Treatment Content and Treatment Programming section of the COMPASS™, you could implement question #5 which is, Clients have access to disorder-specific self help recovery programs as well as dual recovery programs.

Or

Identify action plan items that are pertinent to your own agency but fall under the categories of the COMPASS™.

Person-Centered-Planning (PCP) Satisfaction

Person-Centered-Planning Satisfaction data should be gathered by administering the "Person-Centered-Planning Satisfaction Survey" according to the "Regional Person Centered Planning Satisfaction Survey Procedure", both of which are included in this manual. Report data quarterly using attachment #3.

MDCH QAPIP Studies

Natural Supports Study – see Program Description in this manual for information. Natural Supports data is due quarterly; report data using attachment #4.

Coordination with Primary Care Physicians – see Program Description in this manual for information. Baseline data has been gathered from CSSNs; 2nd phase of study being developed including indicators and frequency needed. Reporting form is attachment #5.

MDCH Indicators

Report PIHP and CMHSP data as defined in MDCH Codebook (attachment #6).

Network Provider Data

Network provider data reported by providers to CSSNs (for requirements see attachment #7); CSSNs aggregated this data quarterly using aggregate reporting form which is attached (attachment #8). This does not apply to CSTS as WCHO aggregates Washtenaw network provider data.

CSSNs aggregate Co-Occurring network provider data annually (data due from providers July 30 as referred to in attachment #7). CSSNs aggregated data using Co-Occurring aggregate forms, attachments # 9 and #10).

Supported Employment

For CSTS only, as a Supported Employment provider. Staff retention data due quarterly and satisfaction data due annually using procedure and survey included in this manual. See pages 28 – 33 for instructions, procedure, survey and reporting forms.

Substance Abuse

For CSTS only, as a Substance Abuse Treatment provider. Satisfaction data due quarterly using procedure, survey, and aggregate reporting form included in this manual. See pages 34 -39 of this manual.

CSSNs Reporting Consumers' Satisfaction – Consumer Survey Procedure

Survey Form

- The CSSN Consumer Survey provided in the Provider Manual can either be used as a stand alone survey or the six questions and three open-ended questions (things I like best, things I'd like to see improved, and other comments) can be incorporated into the CSSN's own consumer survey.

- CSSNs should complete the top bolded section of the CSSN Consumer Survey before making copies of the survey to distribute.

Distribution / Collection

- All consumers should be offered a survey. Surveys can be distributed any time during the second quarter – January, February, or March – either by mail or hand delivered.
- CSSNs should keep track of the number of surveys sent (by population) and the number of surveys returned (by population).
- Surveys should be returned in a **sealed envelope** that is addressed to a designated staff at the CSSN agency – preferably an administrative or office staff (most neutral staff). If an administrative or office staff person is not available, then the envelope should be addressed to a staff at the supervisory level.
- Surveys should be returned by mail (CSSN to include self-addressed stamped envelope) or handed to an agency staff (not case manager) in the **sealed envelope**.

Assistance

- Staff working directly with the consumer should not provide assistance with completing the survey.
- If a consumer needs assistance in filling out the survey, a guardian, parent, family member, or friend can assist.

- Customer / Member Services at the CMH can be contacted if help is needed finding someone to assist the consumer in completing the survey.

Reporting

- CSSN Consumer Survey data is **due annually by April 30th** (with 2nd quarter CSSN Performance Improvement Data reports); data should be submitted by each CSSN to Nicole James-Emerick at the WCHO.
- CSSNs shall submit aggregate data when reporting (on the CSSN aggregate form).
- Responses are to be reported using the CSSN Consumer Survey Aggregate form by reporting the number of consumers answering each question for each category (strongly agree / agree / disagree / strongly disagree).
- CSSNs should address any aggregate scores that fall below 90% for each of the survey questions. The explanation shall provide an analysis of the causes of the scores below the 90% benchmark and CSSN agency plans for improvement.

Consumer Survey

*Staff to fill out bolded areas below prior to going to consumer

CSSN AGENCY NAME: ____

- **Population (*check one*):** □Adults with Mental Illness □Children with Mental Illness □Adults with Developmental Disabilities □Children with Developmental Disabilities

Please mark one box for each question that best describes how you feel about [Insert name of CSSN ____________________________________].

	Question	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
1	This agency is helping to achieve my goals.				
2	Given other choices, I would still choose to get services from this agency.				
3	I would recommend this agency to a friend or family member.				
4	Agency staff respect my language, race, religion, ethnic background or culture when providing services.				
5	This agency helps me to feel safe.				
6	Overall, the services that I am receiving from this agency are what I expected or are better than I expected.				

Things I like best about this agency are:

____

____

Things that I'd like to see improved are:

____

____

Any other comments:

____

____

Completed by: □Consumer □Guardian / Parent □Other Family / Friend □Staff Assisted

Optional: Gender: □Male □Female Age: □Under 18 □18 – 26 □26 – 35 □36 to 49 □50 – 64 □65 or over

Race: □White □African American □Hispanic □Asian or Pacific Islander □Native American □Other

CSSN
Consumer Survey Compilation Form

CSSN: ____
DATE: ________________

□ MIA □ MIC □ DDA □ DDC □ All pop. combined

1. **Please enter the total number of responses received in each cell. Enter "0" if there were no responses in a particular cell.**
2. **Please fill in the "Totals" column at the end of each row.**

	Question	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1	**Totals**
1	This agency is helping to achieve my outcomes					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
2	Given other choices, I would still choose to get services from this agency.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
3	I would recommend this agency to a friend or family member.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
4	Agency staff respect my language, race, religion, ethnic background and culture when providing services.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
5	This agency helps me feel safe.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
6	Overall, the services that I am receiving from this provider are what I expected or are better than what I expected.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

CSSN QUARTERLY PERFORMANCE IMPROVEMENT INDICATORS
AGGREGATE REPORTING FORM

CSSN: ______________________________

Quarter: ______________________________

Reporting Area: **Satisfaction with Services Provided**
Reporting Requirements: **Please Report Annually – Due April 30:**

Population	# Surveys Distributed	# Surveys Collected	Response Rate (B÷A)	Circle any item (1 – 5) falling below 90% (from on Compilation Form	Overall Satisfaction (from Compilation Form #6,c)
MIA	**A.**	**B.**	**C.** **%**	***D.** **1 2 3 4 5**	***E.** **%**
MIC	**A.**	**B.**	**C.** **%**	***D.** **1 2 3 4 5**	***E.** **%**
DDA	**A.**	**B.**	**C.** **%**	***D.** **1 2 3 4 5**	***E.** **%**
DDC	**A.**	**B.**	**C.** **%**	***D.** **1 2 3 4 5**	***E.** **%**
TOTALS	**A.**	**B.**	**C.** **%**	***D.** **1 2 3 4 5**	***E.** **%**

*If any of the 6 items on the survey fell below 90% , please provide, for each item, your impressions as to why this lower-than-expected result may have occurred. Include the results of your assessment of the need for an improvement plan and, if indicated, what it will be.

____
____
____
____
____
____

(Continued for CSSNs)

Reporting Area: **Consumer Goal Attainment**

Reporting Requirements: **Please Report Quarterly:**

Quarter	A. # Cases reviewed	B. # of Cases with ½ or more outcomes with progress rated 3 or higher	C. % of Cases with ½ or more outcomes with progress rated 3 or higher (B ÷ A)
1st			%
2nd			%
3rd			%
4th			%

Reporting Area: **Person-Centered-Planning (PCP) Facilitation**

Reporting Requirements: **Please Report Quarterly:**

Report the number of PCPs completed during the quarter (all populations combined):

1st	2nd	3rd	4th

Community Mental Health Partnership of Southeast Michigan

Co-Occurring Clinical Assessment

INSTRUCTIONS

The instrument is designed to take a ‘snapshot’ of **each** individual staff person’s readiness to do co-occurring work. It attempts to measure attitudes and values as well as specific knowledge and skills.

A baseline scope will assist the staff person in determining current levels of practice. Additional future ‘snapshots’ will show progress towards achieving competence over time for those staff persons wishing to develop their skill in working with consumers with a co-occurring disorder.

Section One looks at attitudes and values using a five-point agree-disagree scale. Staff should respond as to their current beliefs.

Section Two looks at knowledge and skills, using a five point none to outstanding scale. Staff should respond as to their current knowledge and skills.

On the last page, the name of the rater should be given along with the totals for each survey set. There is a space for comments.

It is common for those that are not currently practicing in a co-occurring model to have very low scores. This will allow for future growth in this area of providing services.

The Co-Occurring Clinical Assessment survey should be scored with the results posted on the reporting page. A photocopy of the survey including the reporting page should be submitted to the PI Department of each county in which you provide services.

- Scoring instructions: Average the scores for each survey set and document this number on the last page of the co-occurring clinical assessment tool. Remember when averaging to add all the items scored for each question and divide only by the number of items responded to **(i.e. items scored as N/A or left blank should not be included in the average)**. For example: Survey Set I Attitudes & Values has fifteen items. If fourteen items have scores and one is left blank or marked N/A then to average this category add the fourteen completed items and divide by fourteen to get the total set score(the number of items with scores).

- Feel free to write comments or notes about discussion(s) related to action plan development on the tool.

- Contact the PI Department of the county in which you provide services with any questions you may have.

Community Mental Health Partnership of Southeast Michigan

Co-Occurring Clinical Assessment

Reporting Form

Use this form to tally the scores of all staff that complete this tool. Average all of the scores together at the bottom of the chart. You may add additional rows to the chart for more staff.

Staff Person's Name or Assigned Number	Survey Set I Averages	Survey Set II Averages
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13. Add more spaces as needed for all staff that complete the tool.		
Total Averages	Add all the scores for this set and divide by the number of scores added together	Add all the scores for this set and divide by the number of scores added together

Guidelines for filling out the COMPASS™:

- Please fill out one COMPASS™ tool as a group **(i.e. one COMPASS™: per agency).**

- Group members should meet together as a group when completing the tool.

- Group members should include a cross section of staff including administrators, clinicians and support staff.

- Some providers serve multiple populations such as adult and youth/adolescents. If this is the case for your agency, please fill out ***one*** COMPASS™ tool for ***each*** population you serve.

- If your program does not provide a particular service (e.g. mental health treatment or substance abuse treatment) and **if your agency *has no plans* to begin providing that service(s) for consumers with co-occurring disorders then rate the item(s) as "N/A".**

- If your program/agency does not provide a particular service (e.g. mental health treatment of substance abuse treatment) but, **if you plan on being trained and plan on working with consumers that have a co-occurring disorder, rate that item as a 1.**

- Scoring instructions: Average the scores for items in a particular category (e.g. Philosophy) and report this number on the COMPASS Reporting Form in the space provided. Remember when averaging to add all the items scored for each question and divide only by the number of items responded to **(i.e. items scored as N/A or left blank should not be included in the average)**. For example the Philosophy Category has five items. If four items have scores and one is left blank or marked N/A then to average this category add the four completed items and divide by four (the number of items with scores).

- Submit a copy of your completed tool to **each** county in which you provide services. You should **keep** the original to track the progression of your agency in being able to assist consumers with co-occurring disorders.

- Feel free to write comments or notes about discussion(s) related to action plan development on the tool.

- If you have any questions please contact the PI Department of the County in which you provide service for and they will be able to assist you.

Community Mental Health Partnership of Southeast Michigan

COMPASS™ Reporting Form

Please insert the average scores (i.e. per the example on the guideline page) you compiled from each category of the COMPASS™ next to the category listed below. Submit this document to the Performance Improvement Unit of any county in which you provide services.

1. Philosophy _________
2. Management Structure _________
3. Access _________
4. Identification/Detection of Co-Occurring Disorders _________
5. Assessment & Diagnosis _________
6. Treatment Planning _________
7. Treatment Content/Programming _________
8. Integrated Treatment Relationship _________
9. Treatment Program Policies _________
10. Psychopharmacology _________
11. Discharge Planning _________
12. Integrated External Care Management _________
13. Staff Competency Training _________
14. Specific Competencies _________

Overall Average: _________

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Regional Person Centered Planning Satisfaction Survey Procedure

I. Purpose: To ensure all consumers have an opportunity to provide feedback about their Person Centered Plan (PCP) Meeting and that this feedback is kept confidential and responded to appropriately.

II. Application: This applies to any person facilitating a Person Centered Plan.

III. Procedures:

Distribution of Person Centered Plan Satisfaction Survey:

Who	Does What
Case Manager/Supports Coordinator/Other CMH Staff	Ensures the consumer receives a survey from the Person Centered Planning Facilitator after the PCP meeting.
Person Centered Plan Meeting Facilitator	At the end of the PCP the meeting facilitator gives the consumer a Person Centered Planning Satisfaction Survey and a self-addressed stamped envelope. The envelope clearly states the contents as being confidential and is addressed to the PCP Designee. Encourages the consumer to fill out the survey on their own and to be candid in their responses. Explains to the consumer that their responses are used to improve the PCP process. If the consumer requests assistance in completing the survey, the facilitator will encourage them to use natural supports if available or the facilitator/consumer will notify the front desk support staff to schedule a time to meet with the PCP Designee for that county. The survey must be returned in a sealed envelope that is addressed to the PCP Designee for that county, whether filled out after the PCP meeting or mailed back later. The consumer is instructed to: • Complete the survey • Sign the survey if they wish follow up or they can remain anonymous.

- Put the survey into the envelope and seal it
- Give the sealed envelope only to the front desk support staff or mail it back.

Front Desk Support Staff	The front desk support staff forward the sealed envelope to the PCP Designee for that county at the time of the receipt. If the consumer needs assistance filling out the PCP Satisfaction Survey and a Natural Support is not able to assist the consumer in filling out the survey, the front desk support staff contact the PCP Designee to schedule a time to meet with the consumer.

Compilation of Survey Data:

Who	**Does What**
Person Centered Planning Designee for each county	Enters all PCP Satisfaction Survey data into a computer database. Compiles a quarterly report of PCP Survey data in the approved format and submits this quarterly to the appropriate person gathering this data.

VI. Exhibits:
Person Centered Planning Satisfaction Survey

Person Centered Planning Satisfaction Survey – 2005 - 2006

*Staff to fill out bolded areas below prior to going to consumer

CSSN AGENCY NAME: ____

- **Population** **(*check one*):** ☐ Adults with Mental Illness ☐ Children with Mental Illness ☐ Adults with Developmental Disabilities ☐ Children with Developmental Disabilities

Date: __________ **Clinic:** _________________ **Location:** _________ ☐ **Check if Declined**

Please mark one box for each question that best describes how you feel about [Insert name of CSSN ______________________________________].

	Question	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
1	I am satisfied with my level of involvement with my person-centered plan (such as, where and when the meeting would be held and who I wanted to invite.)				
2	I was given the opportunity to choose the meeting facilitator, including someone who was not a paid staff.				
3	My customs and personal beliefs were respected in making my plan (such as, language, race, and religion).				
4	If there were disagreements during the planning process, please respond to the following: The meeting facilitator or agency staff helped resolve disagreements.				
5	We talked about my strengths.				
6	We talked about how people other than professional helpers might be able to help me achieve my outcomes.				
7	My plan provides me with the amount of services I need				
8	I know what to do if I disagree with my plan.				
9	Overall, I liked the person-centered planning process.				

Things I liked best; things that I'd like to see improved; any other comments:

____

____

____

9-20-05

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROJECT

PROJECT #1: NATURAL SUPPORTS
January 2004

I. Program Description

Project Overview:

This QAPIP project on natural supports is a continuation of a major affiliation-wide performance improvement undertaking, originally developed and coordinated in 2002-2003 by the Regional Performance Improvement Committee consisting of staff and consumers from Lenawee, Livingston, Monroe, and Washtenaw counties.

Data from last year reflected weak performance in case record documentation of natural supports discussions with consumers during the PCP process. Additionally, during the DCH site review, the affiliation's written person-centered plans were cited for lacking detail in describing the specific role of natural support persons in helping consumers achieve their outcomes. As a result, the Regional PI Committee concluded that continued data collection, monitoring, and feedback to staff, focusing on these two areas of weakness, would be necessary to ensure the needed improvement in performance.

As before, through a case record review process, data on the use of natural supports will be collected, analyzed, and used for the possible development and implementation of improvement plans. Analysis of these data will again include a comparison with consumer ratings on natural supports related items within the Person-Centered Planning Evaluation Form which is completed by consumers at the end of each service planning process.

Indicators:

1. Percentage of cases in which the use of natural supports is documented as having been addressed during the initial and annual person-centered planning process.

   Threshold: **100%**
   Data Source: **Initial and Annual Person-Centered Plan of Service**

2. Of those cases in which natural supports are addressed, the percentage of cases in which the consumer expresses a desire for them.

   Threshold: **Not applicable**
   Data Source: **Initial and Annual Person-Centered Plan of Service**

3. Of those cases in which the consumer expresses a desire for natural supports, the percentage of cases in which the specific steps the natural support person will take to help the consumers achieve an outcome are spelled out.

   Threshold: **95%**
   Data Source: **Initial and Annual Person-Centered Plan of Service**

Sampling Methodology: Stratified Random Sampling

Population and Programs to be Sampled:

1. Adults with severe and persistent mental illness receiving ACT, Specialized Residential, Supported Independent Housing, Day Program, Community Integration and/or Psycho-Social Rehabilitation services.

2. Children with serious emotional disturbance receiving Case Management, Home-Based, and/or Wraparound services.

3. Individuals with developmental disabilities receiving Specialized Residential, Supported Independent Housing, Day Program and/or Community Integration services.

Consumers with and without Medicaid will be included in the sample, but data will be reported and aggregated separately.

Sample Size: 10% of all active eligible cases

Data to be Collected:

Results of the case record reviews/file audits. Affiliates have added the above indicators to their ongoing clinical record review. Results of compiled responses on item #12 of the PCP evaluation tool will also be collected.

Date Collection and Reporting Intervals: Quarterly

Protection and Privacy of Information:

Each board will conduct its own case record review. Only aggregated data without consumer names will be submitted to the Regional Performance Improvement Committee for review.

Data Analysis and Interpretation Methods:

1. Aggregated regional performance on the indicators will be compared to the designated threshold/standard.

2. Each board's performance will be compared to the threshold/standard.

3. Each board's performance will be compared to the region's performance and to each of the other board's performance.

4. Each board's performance will be compared to its own results from the pertinent section (natural supports) of the PCP evaluation.

5. Weak performance by a board or the region will lead to an analysis of causes and possible development and implementation of performance improvement plans.

6. Significant gaps between local board performance will lead to inter-board networking and discussion of best practices.

7. Regional and individual board performance will be tracked over time to discern patterns and trends.

Procedures for Feedback to Internal & External Stakeholders:

The Regional Performance Committee will provide feedback via reports to the WCHO Regional Board Subcommittee, the Affiliation Executive Committee, the Regional Consumer Advisory Council, the local QI Committees and other interested stakeholders.

Process for Assessing the Burden and Benefit of the Projects:

With consumer and staff involvement, an annual assessment of the project will weigh all benefits, current and potential, to the consumers against the expenditure of time and other associated costs.

II. Consumer/Stakeholder Involvement

Representing the four local boards in the affiliation, the consumer members of the Regional Performance Improvement Committee and the Regional Consumer Advisory Council have provided feedback and approval of the design of the project, as is the case with all PI projects.

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROJECT

PROJECT #2: COORDINATION WITH PRIMARY CARE
February 2004

I. Program Description

Project Overview:

Improving the coordination of services with primary care physicians is and has been a high priority issue for our affiliation since the leadership of the four local boards began its planning discussions four years ago. Because the Washtenaw Community Health Organization, in partnership with the University of Michigan Hospital, had led the state in the integration of mental health and physical health care, the Lenawee, Livingston, and Monroe Community Mental Health Authorities are eager to continue to utilize the Washtenaw model as a their beacon

The Community Mental Health Partnership of Southeast Michigan views the required DCH performance improvement project on care coordination as an opportunity to pursue an important new initiative. The affiliation has identified two areas which invite closer scrutiny and improvement efforts:

- The level of actual mental health-primary care coordination activity and its documentation in the clinical case record for CMH consumers with a primary care physician, especially those whose need for this kind of collaboration is high
- For those consumers who do not have a primary care physician, the effectiveness of CMH in connecting them with one.

The above two areas will be the focus of the affiliation's second Quality Assessment and Performance Improvement Project for 2004. Data will be systematically collected from a random sample of the case records of adults with severe and persistent mental illness and those with developmental disabilities receiving supported living services, as well as children receiving home-based, wraparound, or case management services. Consumers both with and without Medicaid will be included in the study but will be separated in the performance indicator reports.

To ensure the use of best practices and to ensure improvement over time, the Regional Performance Improvement will develop three sets of guidelines for use by case managers and supports coordinators before data collection begins:

- A list of events occurring during the course of CMH service provision which should initiate communication/coordination with the primary care physician.

- A set of procedures for documenting the communication/coordination with primary care physicians
- A set of guidelines/strategies for use by staff to assist consumers in connecting with a primary care physician

Indicators:

1. Percentage of cases in which the consumer has a primary care physician

   Threshold: **90%**
   Data Source: **Consumer case record – Demographic data or Periodic survey of case managers/supports coordinators**

2. Percentage of cases in which there is documentation that an effort was made by CMH to obtain consumer authorization at the start of CMH services to coordinate/communicate with the primary care physician among consumers with a primary care physician

   Threshold: **95%**
   Data Source: **Consumer case record – Release of Information section**

3. Percentage of cases in which there is documentation that coordination/communication activity occurred with the primary care physician at the start of CMH services among consumers who have a primary care physician and who have authorized CMH to do so

   Threshold: **90%**
   Data Source: **Consumer case record – Contact note or correspondence section**

4. Number and percentage of cases in which there is documentation that coordination/communication activity occurred at designated service provision events (to be determined) among consumers with a primary care physician and who have authorized CMH to do so

   For each designated event:

   Threshold: **90%**
   Data Source: **Consumer case record – Contact note or correspondence section**

Sampling Methodology: Stratified random sampling

Population and Programs to be Sampled:

1. Adults with severe and persistent mental illness receiving Community Living Support services

2. Adults with developmental disabilities receiving Community Living Support services

3. Children with serious emotional disturbance receiving Home-Based, Wraparound, or Case Management services

Sample Size:

1. **Study of consumers with no primary care physician:** 100%
2. **Study of consumers with a primary care physician:** 20%

Data to be Collected:

1. **Study of consumers with no primary care physician:**

   Data will reflect change over time in the percentage of consumers who do not have but desire a primary care physician; the data will, thus, measure the effectiveness of CMH in helping these consumers secure a primary care physician. Case record reviews and/or periodic polling of case managers/supports coordinators, utilizing a "yes-no" approach will serve as the data collection method

2. **Study of consumers with a primary care physician:**

   Various data sets will be involved in the random sample review of 20% of eligible consumers' clinical case records:

   - Documented evidence that an effort was made to obtain consumer authorization to share information with the primary care physician: Yes or No
   - For consumers who provided appropriate authorization, documented evidence that some type of notification and offer of further collaboration/consultation/coordination was provided to the primary care physician at the start of CMH services: Yes or No
   - For consumers who provided appropriate authorization, documented evidence that notification/consultation/coordination occurred with the primary care physician for each of several important designated behavioral health related events: Yes or No

Data Collection and Reporting Intervals:

1. **Study of consumers with no primary care physician:** Onset of study and every 6 months

2. **Study of consumers who have a primary care physician:** Quarterly

Protection and Privacy of Information:

Each board will conduct its own case record review. Only aggregated data without consumer names will be submitted to the Regional Performance Improvement Committee for review.

Data Analysis and Interpretation Method:

1. Aggregated regional performance on each indicator will be compared to the designated threshold

2. Each board's performance will be compared to the threshold

3. Each board's performance will be compared to the region's performance and to each of the other board's performance

4. Weak performance by a board or the region will lead to an analysis of causes and possible development and implementation of performance plans.

5. Significant gaps between local board performance will lead to inter-board networking and discussion of best practices.

6. Regional and individual board performance will be tracked over time to discern patterns and trends.

Procedures for Feedback to Internal & External Stakeholders:

The Regional Performance Improvement Committee will provide feedback via reports to the:

- WCHO Board Regional Sub-committee
- Affiliation Executive Committee
- Regional Consumer Advisory Council
- four local QI Committees
- participating Medicaid HMO administrators
- interested primary care physicians who serve CMH consumers.

Process for Assessing the Burden & Benefit of the Project:

On a twice-yearly basis consumer and staff members of the Regional Performance Improvement Committee will weigh all current and potential benefits of the study to the consumer against the expenditure of time and other associated costs. Input will also be solicited from the primary care physicians who have expressed an interest in the project

II. Consumer/Stakeholder Involvement

As has been the case with all past regional performance improvement projects, there will be significant CMH consumer involvement. They will be involved in the design of the project, development of performance indicators, review of data reports, the development of recommendations for methodological improvements, making recommendations for performance improvement, generating conclusions regarding findings and other important aspects project follow-up. This involvement is ensured and is continuous via their membership on the Regional Performance Improvement Committee.

To provide a physical health perspective on coordination with behavior health care, representatives from the various Medicaid HMOs operating in the four counties will be involved throughout the study. After the Regional PI Committee initially provides these representatives with the background and purpose of the project, input will be sought initially regarding the design of the study. Data reports will be shared periodically and discussion of their reactions, needs, and suggestions for improvements will be encouraged.

SUPPORTED EMPLOYMENT – THIS SECTION FOR CSTS ONLY

Consumer Satisfaction with Services Provided

This information will be obtained after distributing, collecting, and reviewing the eight item "Consumer Survey," a copy of which is included in the Provider Manual. The results are reported and submitted annually on April 30, using the "Consumer Survey Compilation Form," also included in the Manual.

Please refer to the Manual for the "Consumer Survey Procedure" for specific procedures on distributing and reporting the results of the survey. Providers are required to submit an explanation for each of the eight items falling below 90% agreement on the "Consumer Survey Compilation Form."

Please note that copies of individual completed surveys must be included in the April 30 submission.

Staff Retention

This indicator reflects the ability of the provider to retain direct care workers and supervisors, thus minimizing the kind of disruption experienced by consumers when there is staff turnover.

The Staff Retention Rate is reported quarterly. It is calculated by dividing the number of staff on the payroll on the last day of the reporting quarter who had been employed for a designated amount of time (see categories below), divided by the total number of staff. Include all direct care staff working in the specific provider setting including supervisors who have regular direct contact with consumers.

Three Staff Retention Rates are required:

1. Percentage of employees working at least 6 months
2. Percentage of staff working at least 12 months
3. Percentage of staff working 24 months (2 years) or more

The provider is required to provide an explanation on the quarterly reporting form whenever #1 above falls below 50%.

Co-Occurring

Providers will complete the following assessment tool to determine their level of competence in addressing co-occurring disorders (mental illness and substance abuse). Your score on the tool should be used as an internal guide to develop training and/or staff development activities in your agency.

The COMPASS™ - Philosophy section only = is a tool used to assess the provider's level of competence in several areas at a **systems level.** This will

allow providers feedback on their ability to meet the needs of co-occurring consumers from an administrative standpoint. Supported Employment Providers must complete the **Philosophy section only** (due July 30). (COMPASS™ Tool in provider manual).

Reporting Consumers' Satisfaction – Mental Health Providers
Consumer Survey Procedure

Survey Form

- The Consumer Survey provided in the Provider Manual can either be used as a stand alone survey or the eight questions and three open-ended questions (things I like best, things I'd like to see improved, and other comments) can be incorporated into the provider's own consumer survey. **Providers serving less than 5 consumers per contract type do not need to complete these Consumer Surveys.**
- Providers should complete the top of the Consumer Survey with the provider agency name, type of service provided, population served, and provider / program name in the instruction section before distributing the surveys. Providers may want to fill this in once for each contract type before making copies to distribute.

Distribution / Collection

- All consumers should be offered a survey. Surveys can be distributed any time during the second quarter – January, February, or March – either by mail or hand delivered.
- Providers should keep track of the number of surveys sent (by contract type) and the number of surveys returned (by contract type).
- Surveys should be returned in a **sealed envelope** that is addressed to a designated staff at the provider agency – preferably an administrative or office staff (most neutral staff). If an administrative or office staff person is not available, then the envelope should be addressed to a staff at the supervisory level.
- Surveys should be returned by mail (provider to include self-addressed stamped envelope) or handed to an agency staff (not direct care staff) in the **sealed envelope**.

Assistance

- Staff working directly with the consumer should not provide assistance with completing the survey.
- If a consumer needs assistance in filling out the survey, a guardian, parent, family member, or friend can assist. If none of these choices are available, a case manager, provider administrative staff, or provider supervisor can assist.
- Customer / Member Services at the CMH can be contacted if help is needed finding someone to assist the consumer in completing the survey.

Reporting

- Consumer Survey data is **due annually by April 30th** (with 2nd quarter Performance Improvement Data reports).
- Providers shall submit aggregate data **and** copies of the completed surveys when reporting this data.
- Responses are to be reported using the Consumer Survey Aggregate form by reporting the number of consumers answering each question for each category (strongly agree / agree / disagree / strongly disagree).
- Providers should address any aggregate scores that fall below 90% for each of the survey questions. The explanation shall provide an analysis of the causes of the scores below the 90% benchmark and provider agency plans for improvement.

Consumer Survey

MENTAL HEALTH PROVIDER AGENCY NAME: ______________________________

- Service Provided (*check one*): ☐ Licensed Setting ☐ Child Waiver – direct care ☐ Supported Employment ☐ Child Waiver - professional ☐ Case Management / Outpatient ☐ Clubhouse ☐ Supported Living ☐ Day Program

- Population: ☐ Persons with Mental Illness ☐ Persons with Developmental Disabilities

Please mark one box for each question that best describes how you feel about [Insert name of Provider / Name of Program]_______________________________________

Question		Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
1	This provider is helping to achieve my goals.				
2	Given other choices, I would still choose to get services from this provider.				
3	I would recommend this provider to a friend or family member.				
4	Provider staff respect my language, race, religion, ethnic background or culture when providing services.				
5	This provider helps me to feel safe.				
6	I am satisfied with the number of times that I go out in the community.				
7	I am satisfied with the kinds of activities that I get to go on.				
8	Overall, the services that I am receiving from this provider are what I expected or are better than what I expected.				

Things I like best about this provider are:

____

____

Things that I'd like to see improved are:

____

____

Any other comments:

____

____

Completed by: ☐Consumer ☐Guardian / Parent ☐Other Family / Friend ☐Staff Assisted

Network Provider
Mental Health Providers - Consumer Survey Compilation Form

PROVIDER AGENCY NAME: ____
DATE: _________________

Service Provided (*check one*):
- ☐ Licensed Setting
- ☐ Child Waiver – direct care
- ☐ Supported Employment
- ☐ Child Waiver - professional
- ☐ Case Management / Outpatient
- ☐ Clubhouse
- ☐ Supported Living
- ☐ Day Program

1. Please enter the total number of responses received in each cell. Enter "0" if there were no responses in a particular cell.
2. Please fill in the "Totals" column at the end of each row.
3. Please attach copies of all completed surveys for submission along with this Compilation Form

	Question	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1	**Totals**
1	This provider is helping to achieve my goals.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
2	Given other choices, I would still choose to get services from this provider.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
3	I would recommend this provider to a friend or family member.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
4	Provider staff respects my language, race, religion, ethnic background or culture when providing services.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
5	This provider helps me feel safe.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
6	I am satisfied with the number of times that I go out in the community.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
7	I am satisfied with the kinds of activities that I get to go on.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
8	Overall, the services that I am receiving from this provider are what I expected or are better than what I expected.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%

LN 8-02-04

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
QUARTERLY PERFORMANCE IMPROVEMENT NETWORK INDICATORS
AGGREGATE REPORTING FORM

For Supported Employment Providers

Reporting Area: **Satisfaction with Services Provided**

Reporting Requirements: **Please Report Annually – Due April 30:**

# Surveys Distributed	# Surveys Collected	Response Rate (B÷A)	Circle any item (1 – 7) falling below 90% on the compilation form	Overall Satisfaction (from Compilation Form #8, c)
A.	B.	C. %	*D. 1 2 3 4 5 6 7	*E. %

*If any of the 8 items on the survey fell below 90% on the Compilation Form, please provide, for each item, your impressions as to why this lower-than-expected result may have occurred. Include the results of your assessment of the need for an improvement plan and, if indicated, what it will be.

____

____

____

____

Reporting Area: **Staff Retention**

Reporting Requirements: **Please Report Quarterly:**

Quarter	A. Total Staff	B. No. on last day of ¼ who have worked 6 months or more	C.* Staff Retention Rate (B ÷ A)	D. No. on last day of ¼ who have worked 12 months or more	E. No. on last day of ¼ who have worked 24 months or more
1st					
2nd					
3rd					
4th					

*If C. is 50% or below, please provide the results of your evaluation as to the reason for this low rate:

____

____

____

____

SUBSTANCE ABUSE TREATMENT PROVIDERS – Washtenaw and Livingston Providers – THIS SECTION FOR CSTS ONLY

Satisfaction with Services Provided

Use the Substance Abuse Consumers' Satisfaction Procedure form, and the SA Consumer Survey to obtain satisfaction data and submit aggregate data quarterly on Encompass (on the SA Provider Consumer Survey Compilation Form).

Co-Occurring

Providers will complete the following assessment tools to determine their level of competence in addressing co-occurring disorders (mental illness and substance abuse). Your score on the tools should be used as an internal guide to develop training and/or staff development activities in your agency.

- **The COMPASS™ =** is a tool used to assess the provider's level of competence in several areas at a **systems level.** This will allow providers feedback on their ability to meet the needs of co-occurring consumers from an administrative standpoint. Hospital Providers must complete this entire tool (due July 30). (COMPASS™ Tool in provider manual).

- **The Co-Occurring Clinical Assessment =** is a revised tool to assess the level of competence in several areas at a **direct clinical level**. It will allow the individual clinician to be provided feedback on areas where they are competent or where there is need for improvement in meeting the needs of co-occurring consumers. Hospital Providers must complete this tool (due July 30). (Co-Occurring Clinical Assessment Tool in provider manual).

- **Co-Occurring Action Plan:** (To be completed by the 3rd quarter of the fiscal year with submission by July 30th following the end of the quarter)

  The Contracted Network Provider based on the implementation of a Comprehensive Co-Occurring Service Array will complete an annual action plan. This action plan will address the key areas the contracted network provider will implement over the next year. Hospital Providers must complete an Action Plan (due July 30).

  The Action Plan should include the areas identified as a need for improvement based on the scores from completing the COMPASS™.

  An example may be…

  From the philosophy section of the COMPASS™ the overall score was a 2.5, an action plan item may be to share literature about co-

occurring disorders during staff meetings on a regular basis to provide staff a better understanding of what co-occurring disorders are.

Or

Choose one of the specific questions to address from a section that was scored lower. For example in the Treatment Content and Treatment Programming section of the COMPASS™, you could implement question #5 which is, Clients have access to disorder-specific self help recovery programs as well as dual recovery programs.

Or

Identify action plan items that are pertinent to your own agency but fall under the categories of the COMPASS™.

Timeliness

Non-Urgent:

- Must receive face-to-face assessment within 14 days of a non-emergency request for service.
- Must be offered an appointment for treatment admission within 14 days of a non-emergent assessment.
- Must be seen for follow-up care within 7 days of discharge from SA Detox Unit.

PLEASE NOTE: These timeliness indicators will be pulled directly from Encompass but SA providers must still adhere to the DCH requirements above.

Reporting Consumers' Satisfaction – Substance Abuse Providers
Consumer Survey Procedure

Survey Form

- The Consumer Survey provided in the Provider Manual can either be used as a stand alone survey or the six questions and three open-ended questions (things I like best, things I'd like to see improved, and other comments) can be incorporated into the provider's own consumer survey.
-
- Providers should complete the top of the Consumer Survey with the provider agency name, type of service provided, population served, and provider / program name in the instruction section before distributing the surveys. Providers may want to fill this in once for each contract type before making copies to distribute.

Distribution / Collection

- All consumers should be offered a survey and scores reported on quarterly. Surveys can be distributed either by mail or hand delivered.
- Providers should keep track of the number of surveys sent (by contract type) and the number of surveys returned (by contract type).
- Surveys should be returned in a **sealed envelope** that is addressed to a designated staff at the provider agency – preferably an administrative or office staff (most neutral staff). If an administrative or office staff person is not available, then the envelope should be addressed to a staff at the supervisory level.
- Surveys should be returned by mail (provider to include self-addressed stamped envelope) or handed to an agency staff (not direct care staff) in the **sealed envelope**.

Assistance

- Staff working directly with the consumer should not provide assistance with completing the survey.
- If a consumer needs assistance in filling out the survey, a guardian, parent, family member, or friend can assist. If none of these choices are available, a case manager, provider administrative staff, or provider supervisor can assist.
- Customer / Member Services at the CMH can be contacted if help is needed finding someone to assist the consumer in completing the survey.

Reporting

- Consumer Survey data is **due quarterly – January 15 2006 (for Oct – Dec 2005), April 15 2006 (for Jan – March 2006), July 15 2006 (for April – June 2006), and October 15 2006 (for July – Sept 2006).**
- Providers shall submit aggregate data when reporting this data on a quarterly basis.
- Responses are to be reported using the Substance Abuse Consumer Survey Aggregate form by reporting the number of consumers answering each question for each category (strongly agree / agree / disagree / strongly disagree).
- Providers should address any aggregate scores that fall below 90% for each of the survey questions. The explanation shall provide an analysis of the causes of the scores below the 90% benchmark and provider agency plans for improvement.

WCHO SUBSTANCE ABUSE SATISFACTION SURVEY

PROVIDER AGENCY NAME: ____

- Service Provided
  (*check one*): ☐ Detoxification ☐ Outpatient
  ☐ Residential ☐ Intensive Outpatient
  ☐ Methadone
- Age (check one): ☐ Under age 18 ☐ Age 18 or over
- Gender (*check one*): ☐ Male ☐ Female

Please mark one box for each question that best describes how you feel about [Insert name of Provider / Name of Program]____

Question		Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
1	This provider is helping to achieve my goals.				
2	Given other choices, I would still choose to get services from this provider.				
3	I would recommend this provider to a friend or family member.				
4	Provider staff respect my language, race, religion, ethnic background or culture when providing services.				
5	This provider helps me to feel safe.				
6	Overall, the services that I am receiving from this provider are what I expected or are better than what I expected.				

Things I like best about this provider are:
____
____

Things that I'd like to see improved are:
____
____

Any other comments:
____
____

Completed by: ☐Consumer ☐Guardian / Parent ☐Other Family / Friend ☐Staff Assisted
Date Completed:____

Substance Abuse Providers - Consumer Survey Compilation Form
(report quarterly)

PROVIDER AGENCY NAME: ____
DATE: _________________

Service Provided (*check one*):
- ☐ Detoxification
- ☐ Residential
- ☐ Methadone
- ☐ Outpatient
- ☐ Intensive Outpatient

1. **Please enter the total number of responses received in each cell; separate total # for under 18 and for 18 and over. Enter "0" if there were no responses in a particular cell.**
2. **Please fill in the "Totals" column at the end of each row.**
3. **Please fill in other boxes below (over/under 18, M/F, and response rate).**
4. **Please address any items that fell below 90%.**

Aggregate scores for UNDER 18						
	Question	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1	**Totals**
1	This provider is helping to achieve my goals.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
2	Given other choices, I would still choose to get services from this provider.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
3	I would recommend this provider to a friend or family member.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
4	Provider staff respects my language, race, religion, ethnic background or culture when providing services.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
5	This provider helps me feel safe.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
6	Overall, the services that I am receiving from this provider are what I expected or are better than what I expected.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%

Substance Abuse Providers - Consumer Survey Compilation Form (continued) (report quarterly)

Aggregate scores for 18 and OVER

	Question	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1	Totals
1	This provider is helping to achieve my goals.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
2	Given other choices, I would still choose to get services from this provider.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
3	I would recommend this provider to a friend or family member.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
4	Provider staff respects my language, race, religion, ethnic background or culture when providing services.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
5	This provider helps me feel safe.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%
6	Overall, the services that I am receiving from this provider are what I expected or are better than what I expected.					a. Total 4+3 = _____ b. Total 4+3+2+1= _____ c. a. divided by b= _____%

Number Surveyed **Under** Age 18 ______ Number Surveyed Age 18 or over _______

Number of Respondents **Under** Age 18 ____ Number of Respondents Age 18 or over _____

Number of Female Respondents **Under** Age 18 _____

Number of Female Respondents Age 18 or over _____

Number of Male Respondents **Under** Age 18 _____

Number of Male Respondents Age 18 or over _____

*If any of the 6 items on the survey fell below 90% on the Compilation Form for Under 18 and//or 18 and Over, please provide, for each item, your impressions as to why this lower-than-expected result may have occurred. Include the results of your assessment of the need for an improvement plan and, if indicated, what it will be.