



Consumer Satisfaction Services
4775 Linglestown Road
Harrisburg, PA 17112
(717) 651-1070
www.css-pa.org

Thank you for your participation in our survey. Your voice can make a difference! Consumer Satisfaction Services, Inc. (CSS) gauges and reports on the impact of behavioral health (mental health and/or substance abuse) services which you (your child/adolescent) received under HealthChoices and your health care provider

_____.

Facility Location: _____

Level of Care: _____

The information we gather is used to evaluate the delivery of these services. **Your participation is voluntary; any information you choose to share is kept strictly confidential. You have the option of refusing to answer any question as well as ending the survey at any point. Your choosing or declining to participate will have no effect on any services you are receiving now or may need in the future.**

Do not record your name or any personal information which could identify you anywhere on this survey form. All information which you choose to provide is kept strictly confidential.

Demographic Information

<p>1) Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Self-Identify/Other _____</p> <p>2) Age (Consumer's Age): _____</p> <p>3) County (county where services were received): _____</p>	<p>4) Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Native American / American Indian <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other: _____ <input type="checkbox"/> Did Not Answer</p>
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	Yes	No	Not Sure	NA
Has your provider interviewed you on your satisfaction level with services during the last year?				
Have you completed a survey with Consumer Satisfaction Services during the last year?				

Please indicate your response by placing a check mark or an x in the box which best identifies how you feel for that question.

We invite you to comment on or explain any of your answers in the space that has been provided.

Note: The term "Service Provider" means the person or facility you see for treatment, such as your psychiatrist, psychologist, social worker or case manager.

PERFORMCARE The following questions are intended to evaluate your overall satisfaction with your (your child/adolescents) managed care organization (MCO) PerformCare.		Yes	No	Not Sure	NA
1	Have you received a copy of the Member Handbook from PerformCare? (If no, mark Q1a & Q1b NA) If Does Not Apply, please add comment. Comments:				
1a	Are you satisfied with PERFORMCARE'S s Member handbook, website, and newsletters?				
1b	Do the handbook, website, and newsletters give you useful information?				
2	Are you aware of your right to file a complaint or grievance? If Does Not Apply, please add comment. Comments:				
3	Do you know who to call to file a complaint or grievance? Comments:				
4	In the last twelve months, did you call member services at PERFORMCARE to get information? (Example: help for counseling, treatment or other services) If NO, go to question 5. Comments:				
4a	Were you able to obtain information on treatment and/or services from PerformCare without unnecessary delays? Comments:				
5	Were you given a choice of at least two (2) Providers from PerformCare regarding the type of service you were seeking? Comments:				
6	Were you informed of the time approved for your services? (Example: BHRS hours, treatment sessions) Comments:				
7	When you call PERFORMCARE, do staff treat you courteously and with respect? Comments:				

8	Overall, are you satisfied with the interactions that you have had with PERFORMCARE?				
8a	Have you seen PerformCare (formerly CBHNP) interacting in the community (Conference, Health Fair, Community Event, CSP, Committee). (If they do not attend community events, select Does Not Apply) Comments:				

Additional PERFORMCARE Comments:

I would like to ask you a few questions related to your current Telehealth services.

Telehealth Questions		Yes	No	No Response
Tele 1	Are you currently receiving any of your Mental Health and/or Drug and Alcohol services over the phone or through video conferencing, referred to as Telehealth?			

		Phone Only	Video Conference Only	Both
Tele 2	If yes, which method?			

Tele 3	If yes, which service(s)? (counseling, medication maintenance, psychiatrist visits, etc.)
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		Not at All	Somewhat	Neither	Satisfied	Very Satisfied	NA
Tele 4	If yes, how satisfied have you been using telehealth?						

Tele 5	Why do you say that?
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Tele 6	<p>If you are not satisfied, why?</p> <ul style="list-style-type: none"><input type="checkbox"/> Do not have consistent internet service<input type="checkbox"/> Not comfortable with using a computer or with how the internet works<input type="checkbox"/> Navigation of provider platform (need to download another app)<input type="checkbox"/> Personal private space for sessions in the home<input type="checkbox"/> Child's attention span<input type="checkbox"/> Distractions at the home<input type="checkbox"/> Other (open ended space)
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Tele 7	Other
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Tele 8	<p>If you are not currently receiving telehealth services, why?</p> <ul style="list-style-type: none"><input type="checkbox"/> Do not have consistent internet service<input type="checkbox"/> Cannot afford internet<input type="checkbox"/> Cannot afford computer/tablet<input type="checkbox"/> Not comfortable with using a computer or with how the internet works<input type="checkbox"/> Navigation of provider platform (need to download another app)<input type="checkbox"/> Personal private space for sessions in the home<input type="checkbox"/> Not an option according to provider<input type="checkbox"/> Provider did not inform members of telehealth option<input type="checkbox"/> Child's attention span<input type="checkbox"/> Distractions at the home<input type="checkbox"/> My choice<input type="checkbox"/> Other (open ended space)
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Tele 9	Other
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Tele 10	Please share any comments you have regarding your experience with telehealth that are not captured in the questions above.
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Introduction (If survey for a child/adolescent, questions should be worded as such, i.e. Is your child currently receiving these services...)

		Yes	No	NA
9	Are you currently receiving these services from this provider? If no, skip question 10. Comments:			
		0-6 Months	6-12 Months	12+ Months
10	If so, how long have you been receiving these services? Comments:			
		Yes	No	NA
11	Were there delays before starting these services? If no, skip question 12. Comments:			
		0-6 Months	6-12 Months	12+ Months
12	If so, how long was the delay? Comments:			

SERVICES

The following questions are intended to evaluate your overall satisfaction with the level of treatment and/or services you (your child/adolescent) have received. Remember to answer each question using the scale below. We also urge you to add any additional comments or concerns for each question asked.

The possible answers are Strongly Disagree, Disagree, Neither Agree Nor Disagree, Agree, Strongly Agree or Does Not Apply

		Strongly Disagree	Disagree	Neither	Agree	Strongly Agree	NA
13	When you ask your (your child/adolescent's) provider questions about [specific level of care], your questions are answered to your satisfaction. Comments:						
14	You were given information on how to get additional community resources when you asked for information (example: transportation, childcare, employment training). Note: if not needed select Does Not Apply Comments:						
15	Your provider discussed other services that may benefit you (your child/adolescent) in your (their) treatment/recovery (Example: treatment related services such as peer support, outpatient, medication, etc.). Comments:						
16	You have the option to change your (your child/adolescents) service provider should you choose to. Comments:						
17	You were informed about your rights and responsibilities regarding the treatment you (your child/adolescent) received. Comments:						

		Strongly Disagree	Disagree	Neither	Agree	Strongly Agree	NA
18	You feel comfortable in asking questions regarding your (your child/adolescents) treatment. Comments:						
19	Your service provider spends adequate time with you (your child/adolescent). Comments:						
20	Your provider asks your permission before sharing your (your child/adolescents) personal information. Comments:						
21	Program staff respects your (your child/adolescents) ethnic, cultural, and religious background in your (their) recovery/treatment. Comments:						
22	You trust your (your child/adolescents) service provider. (Facility as a whole) Comments:						
23	You (your child/adolescent) feel(s) safe at this facility. (Only applies if the consumer has been to the facility, NA for community or home based services) Comments:						
24	Your (your child/adolescents) service provider offered you the opportunity to involve family, significant others, or friends into your (their) treatment process. Comments:						

		Strongly Disagree	Disagree	Neither	Agree	Strongly Agree	NA
25	You (your child/adolescent) are (is) included in the development of your (their) treatment/recovery plan and goals for recovery. Comments:						
26	You (your child/adolescent) are (is) an important part of the treatment process. Comments:						
27	Your (your child/adolescents) service provider explained the advantages of therapy or treatment. Comments:						
28	Your (your child/adolescents) service provider explained the limitations of therapy or treatment. Comments:						
29	Overall, you are satisfied with the services you (your child/adolescent) received/are receiving. Comments:						

Outcomes

As a result of your (your child/adolescents) services with this provider, please rate any changes made in the following areas by the response that comes closest to your experience.

		Much Worse	A Little Worse	About the Same	A Little Better	Much Better	NA
30	Managing daily problems. Comments:						
31	Feeling in control of your (their) life. Comments:						
32	Coping with personal crisis (Example: relapse, serious health problems, death or illness of a loved one or friend, job loss, accident, etc.) Comments:						
33	How you (they) feel about yourself (themselves). Comments:						
34	Feeling good (hopeful) about the future. Comments:						

		Much Worse	A Little Worse	About the Same	A Little Better	Much Better	NA
35	Enjoying your (their) free time. Comments:						
36	Strengthening your (their) social support network. Comments:						
37	Being involved in the community or in organizations outside of mental health or substance abuse activities. (example: Boy/Girl Scouts, Sports, Church Activities, Movies) Comments:						
38	Participation in school and/or work activities. Comments:						
39	Interacting with people in social situations. Comments:						
40	Coping with the specific problems or issues that led you (your child/adolescent) to seek services. Comments:						

What is important to you in your (your child/adolescents) treatment?

Treatment Environment These questions are meant to gauge your (your child/adolescents) opinion of the treatment environment. NOTE: 41A and 41B only apply if the consumer has been to the facility. NA for community or home based services

		Poor	Fair	Good	Excellent	NA
41A	Comfort of the facility. (Have not been to facility? Mark NA) Comments:					
41B	Cleanliness of the facility. (Have not been to facility? NA) Comments:					
41C	Friendliness of the staff. Comments:					
41D	Attentiveness of the staff. Comments:					

For the following questions please check the box that comes closest to your (your child/adolescents) experience using one of the following choices:

		Yes	No
42	Did you (your child/adolescent) need emergency mental health or substance abuse service during the past year? If NO go to Question 43 Comments:		

		Not at All	Somewhat	Neither	Satisfied	Very Satisfied	NA
42a	If yes , how satisfied are you with the help you received? Comments:						

42b	If you received emergency services , who was your initial contact to get these emergency services? Be very specific (Lancaster General Hospital, 911, etc...) _____
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The Department of Human Services / Office of Mental Health and Substance Abuse Services have asked us to obtain your responses to the following three questions.

These questions are state mandated and are intended to get your (your child/adolescents) satisfaction with all services, not just the one currently being discussed.

		Much Worse	A Little Worse	About the Same	A Little Better	Much Better	NA
43	What effect has the treatment you received had on the quality of your life? (Child- What effect has the treatment your child received had on the quality of your child's life?) Comments:						
44	Were you given the chance to make treatment decisions? (Child: Were you and your child given the chance to make treatment decisions?) Comments:	[] Yes [] No [] Sometimes					
45	In the last 12 months were you able to get the help you needed. (Child: In the last 12 months did you or your child have problems getting the help he or she needed?) Comments:	[] Yes [] No [] Sometimes					

Q52. For the surveyor: Which of the following resources, if any, were provided to the individual during the survey interaction? (Select all that apply):

- PerformCare phone number/website
- 211
- Information about the current level of care
- Information about alternative levels of care that may be beneficial
- Peer Support Services
- Social determinants of health resources (e.g., food, transportation, housing, etc.)
- Local Community Support Program (CSP) information
- Regional Community Support Program (CSP) information
- Other (please specify):
- No Resources were provided.

53	If other, what resources did you provide? <hr/>
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Interview Information

Name of interviewer(s) _____	Date of interview: _____
Location of interview: <input type="checkbox"/> Home <input type="checkbox"/> Other: _____	
Is the interview for an: <input type="checkbox"/> Adult or <input type="checkbox"/> Child?	
Who was interviewed? <input type="checkbox"/> Self (Consumer) <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Both Parent/Guardian and Self (Consumer)	
Method of interview: <input type="checkbox"/> In-person <input type="checkbox"/> Phone	
Consumer Number: _____	Gift Card Number: _____

<p>FOR SURVEYOR: Is this person's current address different than what is in the phone list? If yes, give County Assistance Office contact information.</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>

Interviewer Comments (Use this space to verbalize any concerns you may have witnessed regarding the consumers situation. Example: physical abuse, which warrants immediate follow-up by CSS staff).