Consumer Satisfaction Services
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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

1) Gender: ☐ Female ☐ Male ☐ Self-Identify/Other ___________________________ **2) Age (Consumer's Age):** _____ **3) County (county where services were received):** ________________	**4) Race:** ☐ African American ☐ Asian / Pacific Islander ☐ Hispanic / Latino ☐ Native American / American Indian ☐ White / Caucasian ☐ Multi-racial ☐ Other:__________________________ ☐ Did Not Answer

	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.)

		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?

Tele 6	If you are not satisfied, why? ☐ Do not have consistent internet service ☐ Not comfortable with using a computer or with how the internet works ☐ Navigation of provider platform (need to download another app) ☐ Personal private space for sessions in the home ☐ Child's attention span ☐ Distractions at the home ☐ Other (open ended space)

Tele 7	Other

Tele 8	If you are not currently receiving telehealth services, why? ☐ Do not have consistent internet service ☐ Cannot afford internet ☐ Cannot afford computer/tablet ☐ Not comfortable with using a computer or with how the internet works ☐ Navigation of provider platform (need to download another app) ☐ Personal private space for sessions in the home ☐ Not an option according to provider ☐ Provider did not inform members of telehealth option ☐ Child's attention span ☐ Distractions at the home ☐ My choice ☐ Other (open ended space)

Tele 9	Other

Tele 10	Please share any comments you have regarding your experience with telehealth that are not captured in the questions above.

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	Your provider informed you who to call if you have questions about your (your child/adolescents) mental health or substance abuse services. 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**	**Neither**	**Agree**	**Strongly**	**NA**

		Disagree				Agree	
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…) ____

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

Interview Information

Name of interviewer(s) ____ Date of interview: _______________
Location of interview: ☐Home ☐Other: _______________________
Is the interview for an: ☐Adult or ☐Child? Who was interviewed? ☐Self (Consumer) ☐ Parent/Guardian ☐Both Parent/Guardian and Self (Consumer)
Method of interview: ☐In-person ☐Phone
Consumer Number:______________ Gift Card Number:_______________

FOR SURVEYOR: Is this person's current address different than what is in the phone list? If yes, give County Assistance Office contact information.

☐ Yes
☐ No

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).