



Wisconsin
Department of Health Services

DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Comprehensive Community Services 2012 Annual Program Survey

Report of 2012 CCS Services and Practices

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EXECUTIVE SUMMARY

In 2013, the Division of Mental Health and Substance Abuse Services administered the second annual Comprehensive Community Services (CCS) Program Survey. This program survey asks respondents to report on the services provided to CCS consumers during 2012 and mirrors the survey that has long been administered to Community Support Programs (CSPs). In particular, the survey asks programs to report on consumer demographics and health conditions, discharge rates and destinations, and use of Evidence-Based Practices (EBPs). Aside from discharge status, the survey does not ask about consumer outcomes.

There were several notable findings in this year's survey. The response rate for this survey jumped from 75% in 2011 to 96% in 2012, with a corresponding jump in the number of reported consumers served. Just over one-fifth (22%) of consumers were discharged in 2012, with 78% continuing program participation into 2013. The highest number of discharges was due to consumer recovery, and the next highest category was consumers deciding to withdraw because they believed they had recovered, they were dissatisfied with services, or for another reason. Most (90%) of the consumers who were discharged because they moved did not re-enroll in a different CCS program. This is likely due to the fact that CCS was not available in their new area. With a planned statewide expansion of CCS starting in 2014, this problem should be at least partially remedied.

An analysis of consumer demographics revealed that CCS programs are serving consumers across the lifespan, although very few consumers are senior citizens. The gender breakdown of CCS consumers is fairly equitable, with slightly more consumers being men than women. The most notable disparities came from race, ethnicity, and veteran status. CCS programs would have to double their rates of African-Americans and more than triple the rates of Hispanic consumers in order to mirror the state's racial and ethnic breakdown as a whole (although these disparities are likely explained to a large degree by the fact that CCS services are not available in Milwaukee, a county whose population has a much higher percent of minorities than Wisconsin as a whole). The percentage of veterans would have to more than quadruple to achieve parity with the general population.

The survey asked for information on a variety of health-related indicators. While national research indicates that mental health consumers are more likely than the general population to have a variety of co-occurring substance abuse or physical health ailments, results from this survey generally showed a lower incidence of such ailments than the general population. This is most likely due to children being included in the CCS population. Incomplete data collection around a consumer's physical health needs, even though attention to physical health and substance abuse is another important aspect of a consumer's recovery journey.

EBPs are familiar to most CCS programs, but are used to serve only a small fraction of consumers. Two-thirds of CCS programs offer at least one EBP, but when EBPs are offered, they are generally offered to only 5-10% of consumers in that program.

According to the CCS Administrative Rule (DHS 36.08), all programs are required to assess consumer satisfaction. While the majority of CCS programs do report using a consumer satisfaction survey or other tool, 15% admit to not using such a tool. Programs currently have discretion to utilize the tool of their choice, and do not report the outcomes of their survey to the State. This is expected to change in 2014 with the advent of the CCS expansion and the use of a standardized consumer satisfaction instrument.

INTRODUCTION

This report is based on the results of the annual Comprehensive Community Services (CCS) Program Survey. Surveys are provided to all CCS programs at the beginning of a new year, and all programs are asked to return them. In 2012, there were 28 active CCS programs, all but one of which (96%) reported data.

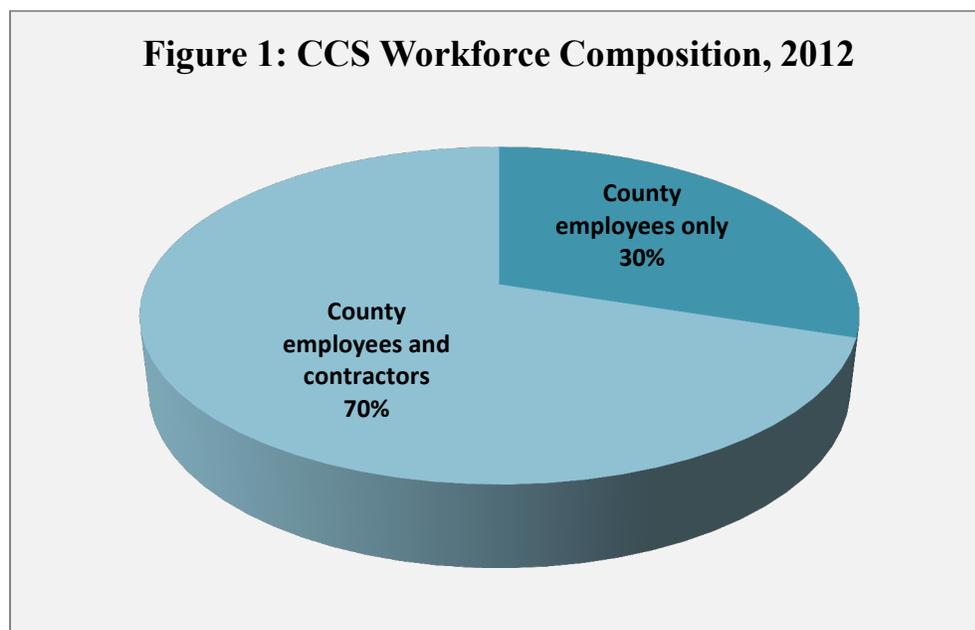
The survey instrument is intended to capture the following areas:

- Program utilization (i.e., number of consumers served, newly enrolled, and discharged)
- Consumer demographics and health status
- Discharge reasons and consumer destinations upon discharge
- Use of Evidence-based practices (EBPs)

Taken together, these areas help paint a picture of how CCS programs are functioning and who they are serving across the State. The survey captures some of the potential challenges that programs face (e.g., handling consumers' co-occurring physical health needs or substance abuse issues) as well as the ways that programs engage their consumers on the path to recovery (e.g., through the use of EBPs). While the survey is not exhaustive, it does help, through self-report, tease out some of the strengths and areas for improvement among CCSs at a given point in time. A copy of the survey appears in Appendix B.

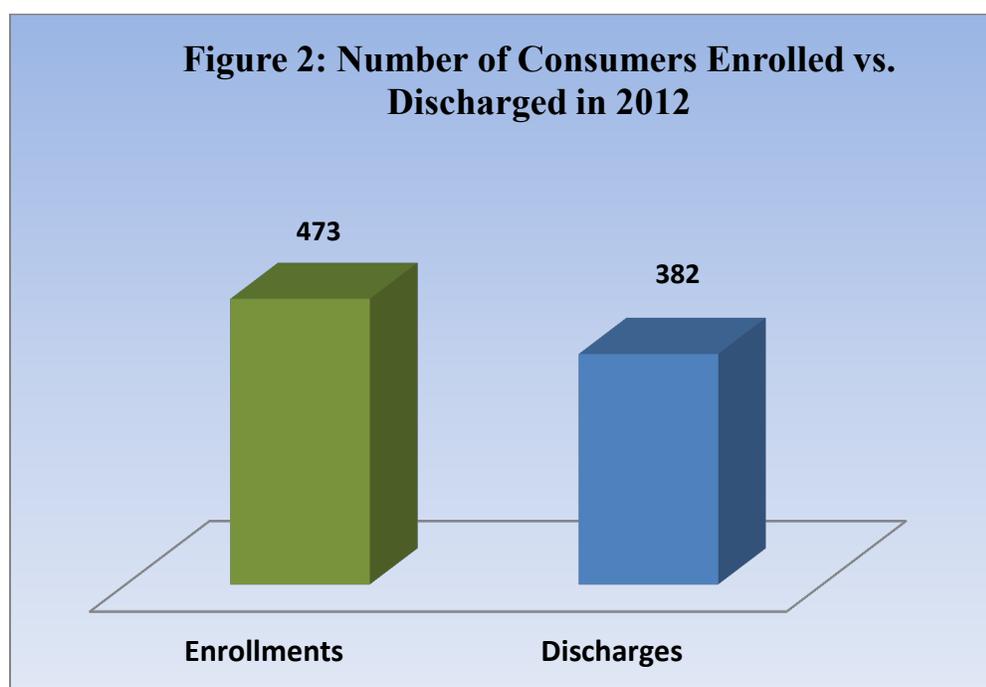
PROGRAM STAFFING

CCS programs may differ in their staff composition. Programs can be staffed either entirely by county employees or by a mix of county employees and contractors. Figure 1 reveals that the majority of programs fall into the latter category, with a mix of county workers and contractors.



CONSUMERS SERVED

Twenty-seven of 28 CCS programs (96%) responded to the survey in 2012. That was an increase of six programs from 2011. The increased number of programs translated into 473 more consumers being reported: to a total of 1,698. While the increased response rate in 2012 makes it difficult to know whether more consumers were actually served (vs. simply more reported), the data showed signs of program expansion. For instance, in 2012 programs served 63 participants each on average (vs. 54 in 2011), ranging from 5 to 271. Similarly, more consumers were enrolled than discharged in 2012, which may also imply that existing programs were expanding their ranks (see Figure 2). Data from the State's Program Participation System (PPS)¹ database confirms that consumer enrollment increased from 2011 to 2012.

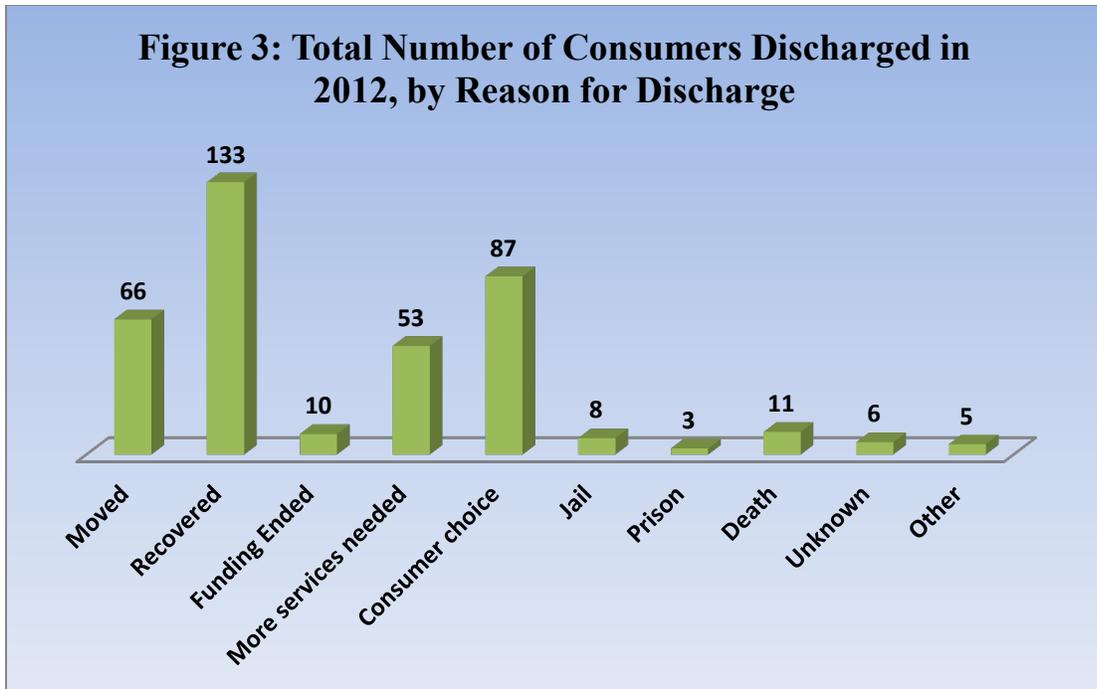


The average program enrolled just over 17 new consumers in 2012 and discharged approximately 14. Enrollments ranged from 0-62 consumers, while discharges ranged from 1-66 consumers. Programs were also asked how many of their consumers were also enrolled in Family Care. In 2012, eighty enrollees were concurrently enrolled in Family Care, and almost half of them (39) were discharged in 2012.

DISCHARGE REASONS AND DESTINATIONS

While the majority of consumers stayed on at the end of the year, approximately 22% of consumers served during 2012 were discharged by the end of the year. Consumers were discharged for many different reasons. However, the leading reason was that the individual recovered to the extent that CCS-level services were no longer needed (35% of discharges).

¹ Formerly Human Services Reporting System (HSRS).



The second leading reason for discharge (23% of discharges, or 87 individuals) was that the consumer decided to withdraw, or what is shown in Figure 3 as “Consumer choice”. Sixty-six individuals (17%) moved out of the geographic service area. Fifty-three individuals (14%) left CCS because they needed more intensive services. Relatively small proportions of consumers left because funding or authorization ended, because they were incarcerated, due to death, or for other or unknown reasons. However, to the extent that CCS programs are intended to help prevent poor consumer outcomes such as incarceration or preventable deaths, these few cases should prompt closer investigation within the individual CCS programs.

Programs were asked to provide the post-discharge destinations for all consumers, by the reason for discharge. The results are displayed in tabular form in Table 1 and in graphical form in Figure 4 (below).

Table 1: Discharge Destinations, by Reason for Discharge, 2012

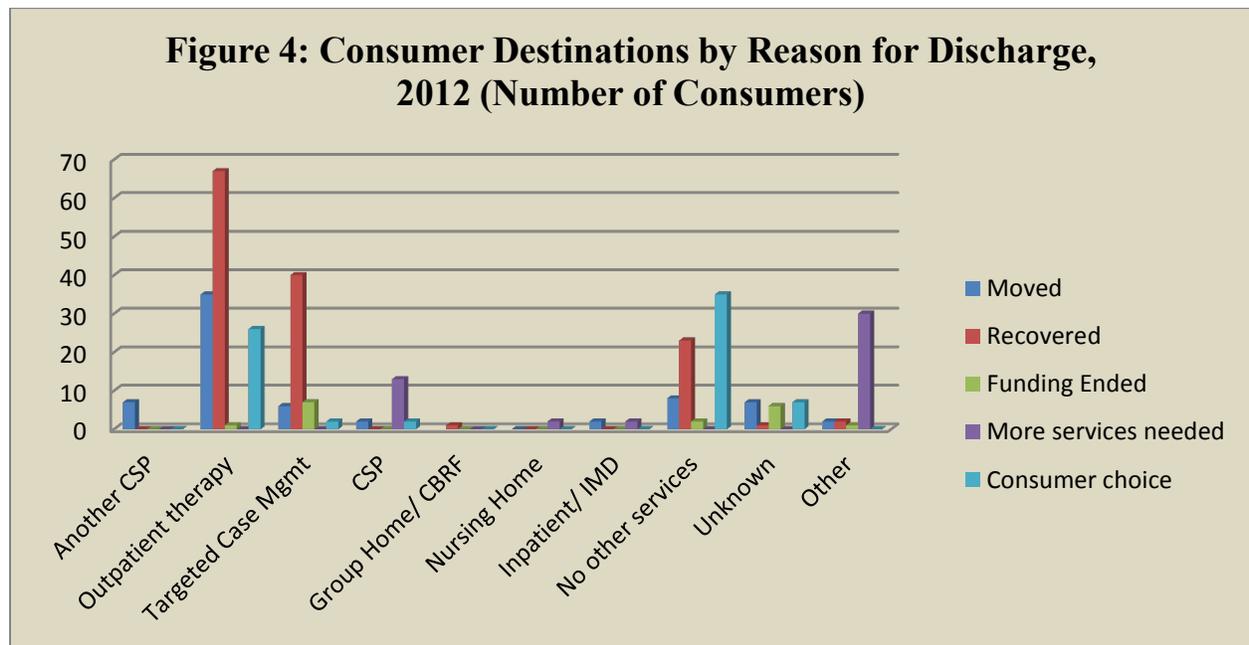
Reason for Discharge	Another CCS	Outpatient Therapy	Targeted Case Mgmt	CSP	Group Home/CBRF	Nursing Home	Inpatient/IMD	No Other Services	Unknown	Other
Moved	10%	51%	9%	3%	0%	0%	3%	12%	10%	3%
Recovered	N/A	50%	30%	N/A	1%	N/A	N/A	17%	1%	1%
Funding Ended	N/A	6%	41%	0%	0%	0%	0%	12%	35%	6%
More Services Needed	N/A	0%	0%	28%	0%	4%	4%	0%	0%	64%
Consumer Choice	N/A	36%	3%	3%	0%	0%	0%	49%	10%	0%

Consumers who moved most often transferred to outpatient therapy (51%), rather than enrolling into another CCS (10%). Presumably this was due to the lack of CCS programs in their new area. Twelve percent of consumers, however, had no other services upon moving; a number which may be higher if some of the “unknown” consumers also ended up without services.

Those consumers who recovered to the extent that CCS was no longer needed moved primarily into outpatient therapy (50%) and secondarily into Targeted Case Management (TCM) (30%). A substantial minority (17%) of such consumers, however, wound up with no services whatsoever.

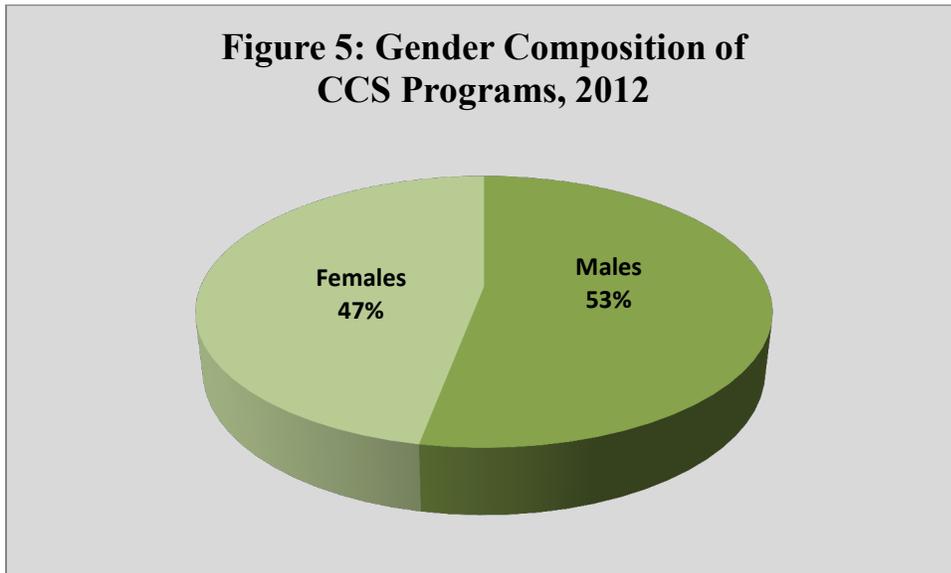
Consumers who lost funding or authorization for their CCS services moved primarily to TCM (41%) or to other, unknown services (35%). Write-in responses imply that, while at least one consumer moved to Family Care, most of these consumers had no known services after leaving CCS. Of those who needed more services, approximately 28% transferred to a CSP, while a few individuals were placed in a nursing home, Institute for Mental Disease (IMD), or other inpatient facility. Almost two-thirds (64%) of those discharged due to extensive service needs had “other” listed as their destination. Write-in responses for this question indicated that most of these individuals went to some form of residential treatment facility or residential services, including foster care. The Family Care program and Children’s Long-Term Services (CLTS) were also listed for this question.

Among consumers who opted out of CCS, almost half (49%) did not enroll in any other services. Another 36% opted for either outpatient therapy or TCM. Perhaps surprisingly, two consumers who decided to withdraw from CCS enrolled in CSPs. Figure 4 (below) presents this information in graphical form.

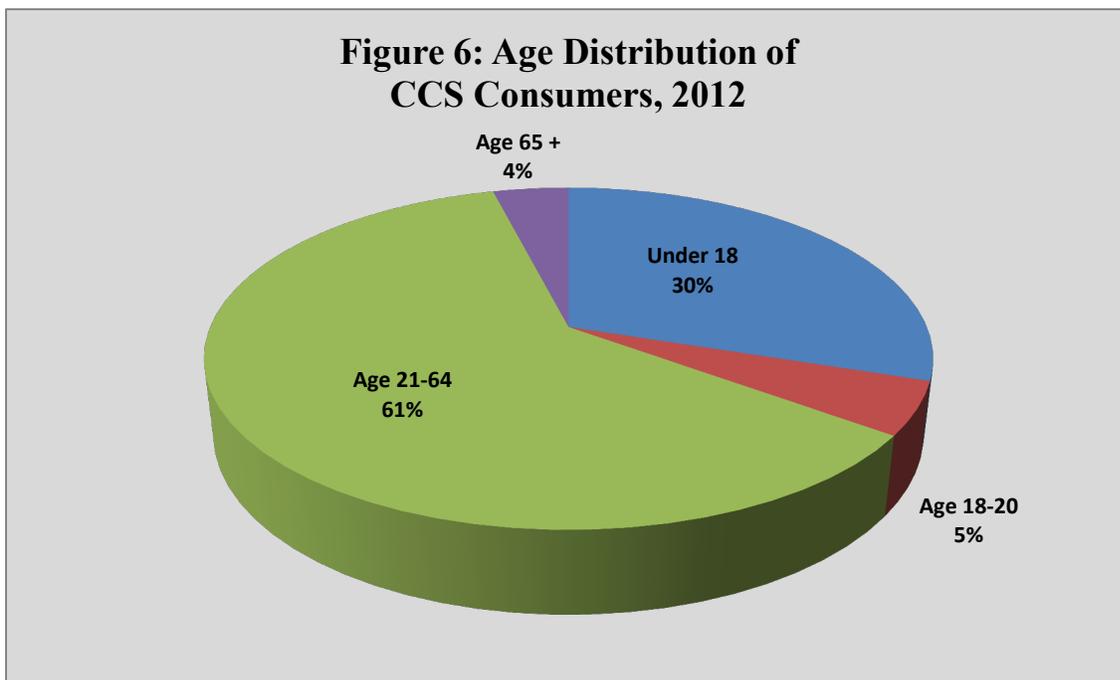


CONSUMER DEMOGRAPHICS

Programs were asked to provide demographic information for all consumers served during 2012. As can be seen from the figures below, the average CCS consumer was a non-Hispanic, White male between the ages of 21-64. Gender differences were only slightly weighted towards males, with 47% of consumers being female.



CCS programs serve children and youth as well as adults, and just under one-third (30%) of CCS consumers were under age 18. An additional 5% were young people between 18-20 years old, and only 4% were seniors.



Race and Ethnicity

Just over 90% of consumers served in 2012 were White. Approximately 1.5% were American Indian, and 3.2% were African American. While American Indians were represented at a rate proportional to their standing in the general population, the rate for African-Americans is approximately half the rate of African-American representation in the state at large: 6.5% (U.S. Census Bureau). Several consumers (42 individuals, or nearly 2.5%) were recorded as belonging to more than one racial group.

Just over 91% of consumers were listed as non-Hispanic/Latino. Most of the remainder were listed as “Unknown,” so that only 1.8% of consumers were recorded as being Hispanic or Latino. This stands in contrast to approximately 6.2% representation in Wisconsin as a whole.²

It should be noted that the CCS service area in 2012 did not include all Wisconsin counties; in particular, Milwaukee County was not certified to provide CCS services and so was not included in this analysis. The lower rate of racial and ethnic minorities among CCS consumers is likely at least partially explained by the fact that CCS services were not available in Milwaukee, a county whose population has a much higher percentage of racial and ethnic minorities than Wisconsin as a whole.

Veteran Status

Only 1.6% of those served in CCS in 2012 were recorded as veterans. This number is quite low, given that veterans represent approximately 7% of the state population as a whole. Identified veterans are, however, under-represented in the county mental health system in general, with only 568 total consumers recorded as being veterans in the state’s mental health database (PPS) between 2008-2014. Whether veterans are truly under-represented or merely not identified as such is unknown at this time.

SUBSTANCE USE AND PHYSICAL HEALTH

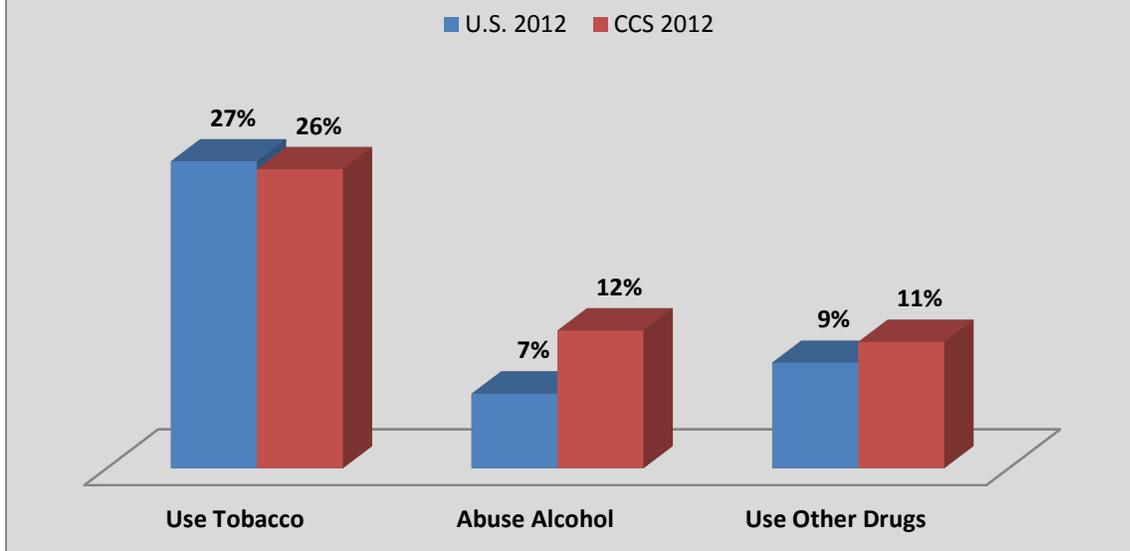
A series of questions in the survey asks about CCS consumers’ substance use and abuse patterns. Respondents are asked to count consumers towards all categories that apply, and so categories include overlap between consumers (i.e., a consumer who smokes and abuses alcohol will appear in both categories in Figure 7, below). National data³ on alcohol abuse is based on the percentage of Americans aged 12 or older who are “heavy drinkers” (drank five or more drinks on the same occasion on each of five or more days in the past 30 days) while rates of tobacco and illicit drug use are based on the percentage of respondents who are current users (reported using such substances within the past month).

While CCS consumers use tobacco at about the same rate as the general U.S. population, they are reportedly more likely to abuse alcohol and use illicit drugs. Even so, the differences in substance use between CCS consumers and the U.S. population are perhaps less pronounced than might be expected, given the focus of CCS on providing psychosocial and substance abuse services. (An explanation for these findings is discussed below.)

² Information on the racial and ethnic breakdown of Wisconsin, as well as veteran status, comes from the U.S. Census Bureau: <http://quickfacts.census.gov/qfd/states/55000.html>.

³ National estimates are taken from Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*. Available online at: <http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#ch4>.

Figure 7: Substance Use and Abuse Among CCS Consumers and U.S. Population, 2012



Another set of questions asked programs to report the rates of a variety of physical health conditions among their consumers. The question is based on research showing that, in general, individuals with mental health issues are more likely to have a variety of co-occurring physical health issues (including asthma & cardiovascular problems).⁴ Surprisingly, physical health for CCS consumers is reported to be better than for the general population.⁵

There are a few possible explanations for these unexpected results. One possibility is that CCS consumers are actually healthier (at least as measured by these substance use and health indicators) than the average American. Another possible explanation is that most CCS programs do not ask consumers about their physical health needs systematically or in this much detail, and therefore the rates for CCS consumers are underreported.

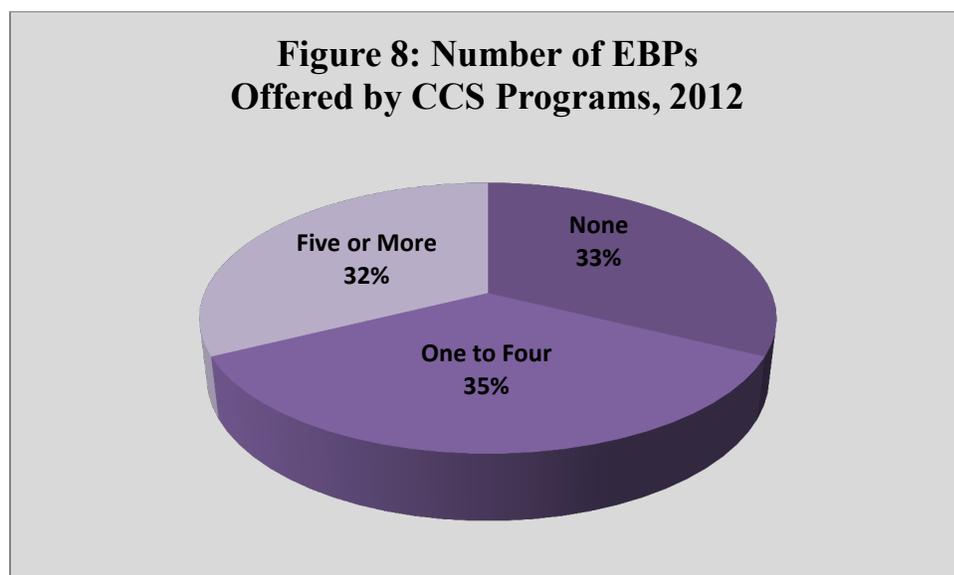
A more likely explanation, however, is that CCS consumers include both more youth (30% age 17 or younger) and fewer elderly (only 4% age 65 or older) than the U.S. study populations (which mostly focus on adult populations). Therefore, it is not unexpected that reported substance use is lower than expected among CCS consumers (given the greater proportion of children than the U.S. in general) and CCS consumers are reported to be healthier than the U.S. population as a whole (given the smaller share of older adults who often experience more health issues). Unfortunately, the CCS survey data is aggregate program information (not individual client records), so it is not possible to make a direct comparison between these CCS and U.S. rates (by controlling for age to adjust for their different age distributions).

⁴ Ziege, Anne and Tim Connor. "Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey." Wisconsin Department of Health Services, Division of Public Health, Bureau of Health Information and Policy, 2009.

⁵ National figures were drawn from a variety of sources. See Appendix A.

EVIDENCE-BASED PRACTICES

A main goal of this survey was to determine the extent to which CCS programs incorporate the use of Evidence-Based Practices (EBPs). Incorporating EBPs is a potentially powerful way for CCS programs to enhance consumers' recovery process. However, CCS programs are not required to use EBPs. Rather, programs are provided with the information and encouraged to incorporate EBPs to the best of their ability. Figure 8 reveals that just over two-thirds of programs offer at least one EBP.

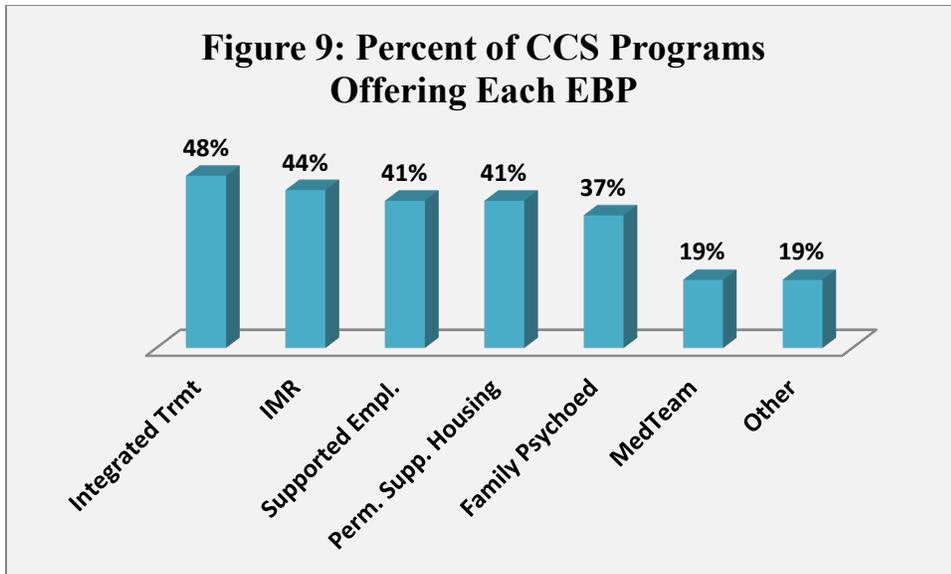


In responding to all of the EBP questions, programs are asked to adhere to the strict definitions of each EBP as laid out in a guiding document. Thus, several CCS programs report that they follow many of the guiding principles or practices of a given EBP, but don't strictly qualify as providing that EBP. For that reason, it can be assumed that more programs utilize a variant of an EBP than is presented here. Also, the CCS programs were not asked about EBPs oriented specifically for children.

The specific EBPs asked about on the survey included:

- Integrated Treatment for Co-Occurring Disorders, or Integrated Dual Disorder Treatment (IDDT)
- Family Psychoeducation
- Illness Management and Recovery (IMR)
- MedTeam
- Supported Employment
- Permanent Supportive Housing

When looking at specific EBPs (see Figure 9, below), Integrated Treatment for Co-Occurring Disorders (IDDT) was the most commonly offered EBP, followed by Illness Management and Recovery (IMR), Supported Employment, Permanent Supportive Housing, and Family Psychoeducation.



Respondents were also permitted to write in additional EBPs that they used that were not specifically listed on the survey. The responses to that question appear in Table 2.

Table 2: Additional Evidence-Based Practices (EBPs) Indicated by Respondents

Evidence-Based Practice (EBP)	Number of Programs
Dialectical Behavioral Therapy (DBT)	2
Motivational Interviewing	2
Cognitive Behavioral Therapy (CBT)	1
Clubhouse Model	1
Person-centered planning	1

In addition to these additional EBPs, one program listed using the Adult Functional Screen, which is used to determine whether or not CCS is an appropriate placement for a consumer. Presumably other CCS programs also use the screen as a placement tool; it is not intended as a treatment practice.

While between one-fifth and one-half of programs offer the various EBPs (see Figure 9), the number of consumers actually served using these practices was considerably smaller (not shown here). The highest percentage of consumers receiving an EBP received Illness Management and Recovery (20%). All other EBPs served less than 10% of consumers (range: 5%-9%).

In terms of the demographic breakdown of those consumers who were offered EBPs, the gender composition of those receiving EBPs was fairly consistent with the overall profile of CCS. Females were slightly over-represented among EBPs based on their representation in CCS overall (47% of overall consumers vs. 49% of those receiving EBPs). In terms of age, youth were slightly under-represented among those consumers receiving EBPs. Whereas youth constitute 35% of those in CCS overall (30%

under age 18 and 5% ages 18-20), they represent only 30% of those receiving EBPs (25% under age 18 and 5% ages 18-20). Similarly, those age 65 and older were also under-represented: while they constituted 4% of those in CCS, they made up only 1.4% of those receiving EBPs. The racial breakdown of those who received EBPs was fairly similar to the general pool of CCS consumers, with the exception that there was slightly lower representation among African Americans (2.8% in EBPs vs. 3.2% of consumers overall) and Whites (87% of EBPs vs. 90% of consumers overall) as opposed to consumers with more than one race (6.6% of those receiving EBPs vs. 2.5% of consumers overall).

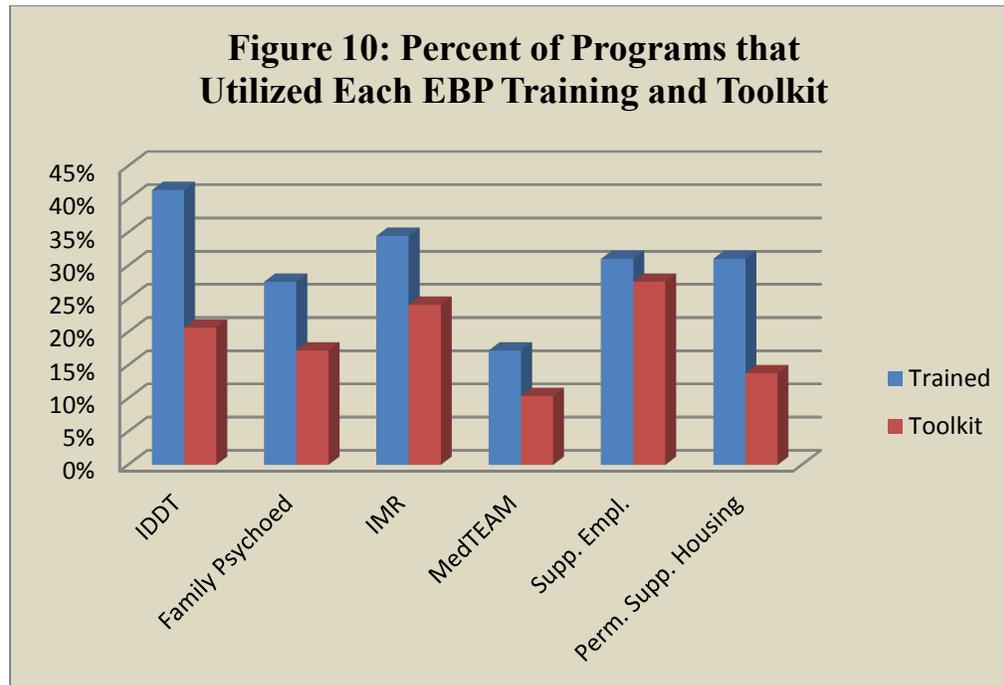
With regard to ethnicity, Hispanic and Latino consumers were better represented among those receiving EBPs than in the general pool of CCS consumers (3% of those receiving EBPs vs. 1.4% of all consumers). Overall however, the vast majority of all consumers and those receiving EBPs were both non-Hispanic Whites.

EBP Training and Monitoring

The survey included a series of questions asking each program whether or not their staff members were trained in particular EBPs, and whether or not the program utilized a toolkit to guide implementation. The questions asked whether:

- Staff had training in that EBP;
- Programs used the EBP toolkits in implementation;
- Programs monitored fidelity; and
- Assuming programs monitored fidelity, whether they used an outside monitor.

Figure 10 displays the responses to the questions about training and toolkit usage, while Table 3 (below) shows the responses to the questions about fidelity monitoring.



In general, slightly more programs utilized a given EBP than reported that staff were explicitly trained in that method. For instance, while Figure 9 shows that 48% of CCS programs reported that they offer Integrated Treatment for Co-Occurring Disorders (IDDT), 41% reported that their staff had been trained in IDDT (see Figure 10). Even smaller percentages reported using toolkits as part of EBP implementation, with Supported Employment (28%) and Illness Management and Recovery (24%) being the most likely to report using a toolkit.

Table 3 shows approximately one quarter to two-thirds (27%-64%) of programs that use EBPs monitor the fidelity of their practice. The most monitored EBP is Supported Employment (64%) and the least monitored is Permanent Supportive Housing (27%). Most of the programs that monitor fidelity appear to do so themselves, without the use of an outside monitor: only 8%-36% of those programs that use an EBP deploy an outside monitor. When asked how they monitor for fidelity, programs listed a variety of curriculum and approaches, from their own internally developed measures to those laid out in the Substance Abuse and Mental Health Services Administration (SAMHSA) EBP toolkit.

Table 3: Fidelity Monitoring Practices among Programs Offering Each EBP

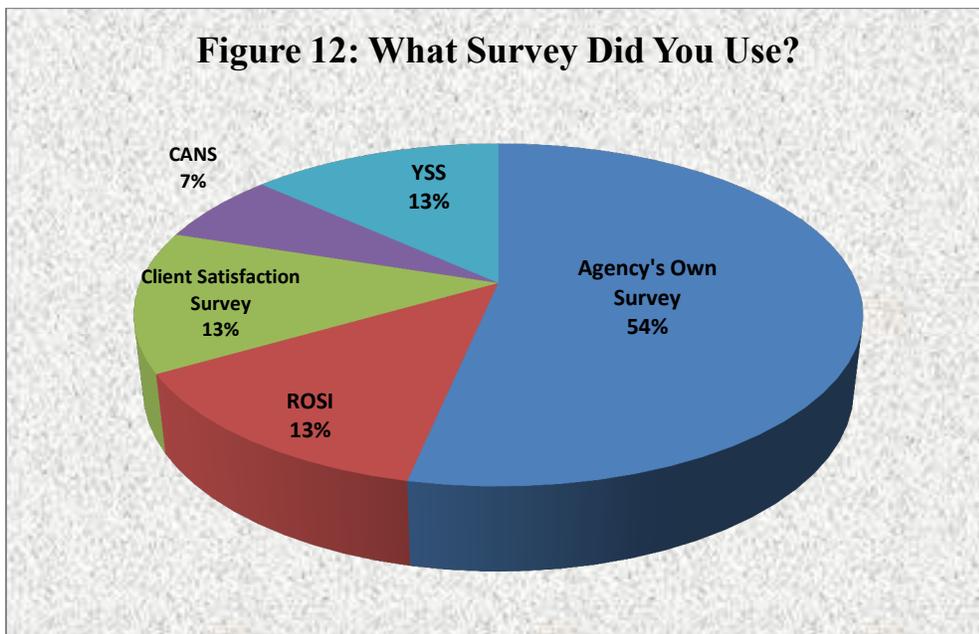
Evidence-Based Practice (EBP)	Number of Programs Using EBP	Percent of Programs Using EBP that Monitor Fidelity	Percent of Programs Using EBP that Use Outside Monitor	Fidelity Tools Used
IDDT	13	38%	8%	IDDT toolkit, objectives met from recovery plan, pre-/post-test
Family Psycho-education	10	40%	10%	EBP toolkit, NAMI Family-to-Family, Functional Family Therapy Measures, Pre-/Post-test, CANS Assessment
IMR	12	50%	17%	Independent Living Resources Wellness Curriculum, EBP toolkit, Internal Quality Assurance Measure, Internally developed measure, pre-/post-test
MedTeam	5	60%	20%	EBP toolkit, Internal Quality Assurance Measure
Supported Employment	11	64%	36%	Dartmouth Model Fidelity Scale, IPS Model, EBP toolkit, Contractor-provided model (unspecified)
Permanent Supportive Housing	11	27%	18%	Tenant-Based Rent Assistance (TBRA); EBP toolkit

CONSUMER SATISFACTION SURVEYS

The CCS Administrative Rule prescribes that programs have some way of gauging consumer satisfaction. Specifically, DHS 36.08 states that “The CCS shall develop and implement a quality improvement plan to assess consumer satisfaction and progress toward desired outcomes identified through the assessment process.” For this survey, programs were asked to report on whether or not they used a survey or other tool to measure consumer satisfaction in 2012. As can be seen in Figure 11, the vast majority of programs (23 out of 27) did report the use of a consumer satisfaction survey.



Programs were asked to report the type of tool used. Not all of the programs that reported using a survey revealed which tool they used. Of the 15 programs that did reveal what survey they used, the most common response (54%) was the use of an agency’s own unique survey. An equal number of programs (13% each) utilized the ROSI, the “Client Satisfaction Survey” (presumably the same one administered by the state to a random sample of mental health consumers) and the Youth Satisfaction Survey.



CONCLUSION

Although more information would be needed to perform a detailed evaluation of CCS programs, several points emerge from the 2012 survey. First, CCS programs have expanded to accommodate more consumers. Second, most programs offer proven treatment methods. Even though CCS programs are not required to implement Evidence-Based Practices (EBP), over two-thirds of the programs surveyed (67%) offer at least one EBP. Almost half of this group offers five or more distinct EBPs, which displays their flexibility and openness to using such practices. Third, the most common reason for a consumer to discontinue CCS participation is that she or he has recovered to the extent that such services are no longer needed. This is a promising reflection on the work of CCS programs.

The survey also revealed some areas in need of improvement, technical assistance, or at least further exploration. While most programs report that they offer EBPs, the actual percent of consumers served through those treatment approaches remains quite small: in many cases, less than 10%. In addition, levels of staff training and fidelity monitoring vary considerably among those programs that do offer EBPs.

The transition out of CCS programs is an important turning point for many consumers. In general, most consumers who leave CCS transition to outpatient therapy and/or targeted case management. However, a substantial minority discontinue services altogether or their service status remains unknown. This might point to an opportunity for programs to work more intensively on transition planning for those leaving CCS.

APPENDIX A: Sources for National Health Estimates

National rates of various health issues (for the analysis of physical health conditions) were drawn from the following sources:

Asthma: Asthma and Allergy Foundation of America, “Asthma Facts and Figures”
<http://www.aafa.org/display.cfm?id=9&sub=42>.

Cardiovascular Problems: Centers for Disease Control, “FastStats: Heart Disease”,
<http://www.cdc.gov/nchs/fastats/heart.htm>.

Chronic Obstructive Pulmonary Disease (COPD): Centers for Disease Control, “CDC Features: 6.3% of Adults Report Having COPD”, <http://www.cdc.gov/Features/copdadults/index.html>.

Diabetes, Type I: National Diabetes Education Program. “The Facts About Diabetes: A Leading Cause of Death in the U.S.” <http://ndep.nih.gov/diabetes-facts/>. Note that the prevalence rate was calculated based on the fact that diabetes overall affects 8% of the adult population, and Type I makes up 5% of those cases.

Diabetes, Type II: Gardner, Amanda. “One in eight Americans diagnosed with Type II Diabetes: Poll.” *Health Day*, February 20, 2013. <http://health.usnews.com/health-news/news/articles/2013/02/20/1-in-8-americans-diagnosed-with-type-2-diabetes-poll>.

High Blood Pressure: Centers for Disease Control, “High Blood Pressure Facts”
<http://www.cdc.gov/bloodpressure/facts.htm>

High Cholesterol: Centers for Disease Control, “Cholesterol” <http://www.cdc.gov/cholesterol/facts.htm>.

Metabolic Syndrome: Norton, Amy. “Metabolic Syndrome Continues to Climb in U.S.”, *Reuters*, October 15, 2010. <http://www.reuters.com/article/2010/10/15/us-metabolic-syndrome-idUSTRE69E5FL20101015>

Obesity: Centers for Disease Control, “Overweight and Obesity”:
<http://www.cdc.gov/obesity/data/adult.html>

APPENDIX B: 2012 CCS PROGRAM SURVEY WORKSHEET

This worksheet is provided to assist you in completing the annual survey. You can collect the information you need and record your answers on this worksheet first, then use it to enter your answers into the web survey. If you manage more than one CCS, please complete a separate survey for each program.

When you enter information into the web survey, do not leave the web survey screen idle for more than 15 minutes, or the survey will close and you may lose all of the information you've recorded. Questions with asterisks are required to complete the survey. Dashed lines indicate a page break in the online survey.

Please do not submit copies of this worksheet with your responses. You will still need to complete the web survey.

Please complete the survey by April 5th. If you have any questions or difficulties with the survey, please contact Amy Owen at 608-267-7164 or Amy.Owen@wisconsin.gov. Thank you.

1. Please enter the name of the county certified to offer a CCS program.* *(If you are part of a multi-county behavioral health collaboration, please fill out a separate survey for each county individually.)*

2. Please enter the formal name of the county agency or the contracted private agency that operates your CCS.*

3. Does your CCS employ county employees only or a mixture of county employees and contractors?*

_____ County employees only
_____ County employees and contractors

4. Please enter the DQA program certification number for the CCS.*

5. Please enter the name of the person responsible for completing this survey.*

6. How many active CCS consumers did you have on 12/31/2011?*

7. How many new admissions to your CCS did you have in 2012?*

8. *[Total number of clients served in 2012:
calculated automatically by the survey as the sum of #6 + #7]*

9. How many discharges from your CCS did you have in 2012?*

10. *[Number of active CCS consumers you had on 12/31/2012:
calculated automatically by the survey.]*

11. How many of the continuing 2011 enrollees plus the new 2012 enrollees served were concurrently enrolled in Family Care?*

12. How many of the total 2012 CCS discharges were in Family Care?*

Discharge Reasons

In this section, please provide information on the reasons why consumers were discharged in 2012, and where they went after discharge. When answering the following questions, if there was more than one reason for a consumer's discharge, please choose the most primary reason. In Question 14, please enter the number of consumers discharged for each reason. If you had zero consumers discharged for a particular reason, please enter 0 for your answer to that reason for discharge in Question 14. Your total number of discharges in Question 14 must match the total number of discharges reported in Question 9.

13. Were consumers discharged from your program in 2012 because ...*
 ["No" answers allow you to skip further questions about a reason for discharge you didn't use on the next pages of the online survey.]

	YES	NO
they moved from your geographic service area?	<input type="radio"/>	<input type="radio"/>
they recovered to the extent that CCS-level services were no longer needed?	<input type="radio"/>	<input type="radio"/>
funding or authorization ended for the consumer?	<input type="radio"/>	<input type="radio"/>
the consumer needed services beyond what CCS can offer (inpatient, etc.)?	<input type="radio"/>	<input type="radio"/>
the consumer decided to withdraw?	<input type="radio"/>	<input type="radio"/>
they were sent to jail?	<input type="radio"/>	<input type="radio"/>
they were sent to prison?	<input type="radio"/>	<input type="radio"/>
of death?	<input type="radio"/>	<input type="radio"/>
of unknown reasons?	<input type="radio"/>	<input type="radio"/>
of reasons not listed above (other)?	<input type="radio"/>	<input type="radio"/>

14. **How many** 2012 consumers were discharged because ...*

[The sum of the numbers entered for this question must equal the number of total 2012 discharges reported in Question 9.]

	# of Consumers
they moved from your geographic service area?	
they recovered to the extent that CCS-level services were no longer needed?	
funding or authorization ended for the consumer?	
the consumer needed services beyond what CCS can offer (inpatient, etc.)?	
the consumer decided to withdraw?	
they were sent to jail?	
they were sent to prison?	
of death?	
of unknown reasons?	
of reasons not listed above (other)?	

Discharge Destinations

For all consumers discharged for the reasons listed in this section, please list the number of consumers who transitioned to each of the following services. Please double check that your total for this question matches the number of consumers discharged for this reason you provided in Question 14.

[The following questions on Discharge transition destinations will be on separate pages of the online survey. If you reported that no consumers were discharged for a particular reason in Question 13, you will not see further questions about that discharge reason.]

15. For all 2012 consumers discharged because they moved from your geographic service area, how many went to each of the following:*

[The total number of consumers across each transition destination will automatically appear in the final row in the online survey. Please double-check that this number matches the total number of consumers reported as being discharged for this reason in Question 14.]

	# of Consumers
Another CCS	
Outpatient therapy / psychiatry	
Targeted Case Management or other CM program	
Community Support Program (CSP)	
Nursing Home	
Inpatient / IMD	
Consumer did not transfer to other services	
Unknown	
Other	

16. If answering "Other" in the question above about consumers who moved from your geographic service area, please describe where these consumers went.

17. How many of the consumers discharged because they recovered to the extent that CCS-level services were no longer needed went to each of the following:*

	# of Consumers
Outpatient therapy / psychiatry	
Targeted Case Management or other CM program	
Group Home / CBRF	
Consumer did not transfer to other services	
Unknown	
Other	

18. If answering "Other" in the question above about consumers who recovered to the extent that CCS-level services were no longer needed, please describe where these consumers went.

19. How many of the consumers discharged because funding or authorization ended for the consumer went to each of the following:*

	# of Consumers
Outpatient therapy / psychiatry	
Targeted Case Management or other CM program	
Community Support Program (CSP)	
Group Home / CBRF	
Consumer did not transfer to other services	
Unknown	
Other	

20. If answering "Other" in the question above about consumers for whom funding or authorization ended, please describe where these consumers went.

21. How many of the consumers discharged because the consumer needed services beyond what CCS can offer went to each of the following:*

	# of Consumers
Nursing Home	
Community Support Program (CSP)	
Inpatient / IMD	
Consumer did not transfer to other services	
Unknown	
Other	

22. If answering "Other" in the question above about consumers who needed services beyond what CCS can offer, please describe where these consumers went.

23. How many 2012 consumers were discharged because of consumer decision to withdraw went to each of the following:*

	# of Consumers
Outpatient therapy / psychiatry	
Targeted Case Management or other CM program	
Community Support Program (CSP)	
Group Home / CBRF	
Consumer did not transfer to other services	
Unknown	
Other	

24. If answering "Other" in the question above about consumers who were discharged because of consumer decision to withdraw, please describe where these consumers went.

25. For consumers who were reported as discharged for reasons not listed ("Other") in Question 13, please describe the reasons these consumers were discharged.

Other Reason 1:

Other Reason 2:

Other Reason 3:

Demographic Information

In this section, please provide information about the full group of CCS consumers you served in 2012.

[The totals for each of the questions in this section must equal the number of consumers you reported serving in 2012 (as calculated in #8).]

26. Please enter the number of 2012 consumers of each gender.*

	# of Consumers
Female	
Male	
Unknown	

27. Please enter the number of 2012 consumers in each age group.*

	# of Consumers
17 and under	
18-20	
21-64	
65-74	
75+	
Unknown	

28. Please enter the number of 2012 consumers in each racial / ethnic group.*

	# of Consumers
American Indian / Alaskan Native	
Asian	
Black / African American	
Hawaiian / Pacific Islander	
White	
More Than One Race	
Unknown	

29. Please enter the number of 2012 consumers with each ethnicity.*

	# of Consumers
Hispanic / Latino	
Not Hispanic / Latino	
Unknown	

30. Please enter the number of 2012 consumers who are veterans and non-veterans.*

	# of Consumers
Veterans	
Non-Veterans	
Unknown	

Medical Conditions & Substance Use

31. Please enter the number of 2012 consumers with the following substance use patterns. Please count a consumer multiple times if they qualify for more than one category on the list.*

	# of Consumers
Use Tobacco	
Abuse Alcohol	
Abuse Other Drugs	

32. Please enter the number of 2012 consumers with the following medical conditions. Please count a consumer multiple times if they have more than one medical condition on the list.*

	# of Consumers
Metabolic Syndrome (consumer has all of the following: high blood pressure / hypertension, high cholesterol, and obesity around the midsection)	
High blood pressure / Hypertension (exclude those with metabolic syndrome)	
High cholesterol (exclude those with metabolic syndrome)	
Obesity (exclude those with metabolic syndrome)	
Type I Diabetes	
Type II Diabetes	
Asthma	
COPD (Chronic Obstructive Pulmonary Disease)	
Cardiovascular problems (angina or coronary artery disease, heart attack, or stroke)	

Evidence-Based Practices

In this section, please report how many CCS consumers received any of the listed evidence-based practices (EBP). The EBP used must match the EBP definitions in the SAMHSA Resource Toolkits as described in the “EBP Definitions” document sent with the email invitation for this survey. Please review the “EBP Definitions” document before answering the questions in this section.

["No" answers in Question 33 will allow you to skip additional questions about that EBP on the next pages. Please report a 0 for questions related to an EBP if you used that EBP with zero clients in 2012, instead of leaving it blank.]

33. Did you use the following Evidence-Based Practices (EBPs) in 2012? Please answer "Yes" or "No" for each EBP.*

["No" answers allow you to skip questions about an EBP you didn't use on the next pages of the online survey.]

	YES	NO
Integrated Treatment for Co-Occurring Disorders	<input type="radio"/>	<input type="radio"/>
Family Psychoeducation	<input type="radio"/>	<input type="radio"/>
Illness Management and Recovery (IMR)	<input type="radio"/>	<input type="radio"/>
MedTEAM	<input type="radio"/>	<input type="radio"/>
Supported Employment	<input type="radio"/>	<input type="radio"/>
Permanent Supportive Housing	<input type="radio"/>	<input type="radio"/>
Other EBP not listed (but is found on the SAMHSA website)	<input type="radio"/>	<input type="radio"/>

34. Please enter the number of 2012 consumers who received the following evidence-based practices. Please count a consumer multiple times if they received more than one evidence-based practice in 2012.*

	# of Consumers
Integrated Treatment for Co-Occurring Disorders	
Family Psychoeducation	
Illness Management and Recovery (IMR)	
MedTEAM	
Supported Employment	
Permanent Supportive Housing	
Other EBP not listed (but is found on the SAMHA website)	

35. Please enter the number of consumers who received an EBP in 2012 of each gender. Please count a consumer multiple times if they received more than one EBP in 2012.*

[On the online survey, the total number of consumers receiving each EBP across genders will automatically appear in the final column for each EBP listed. Please check that this number matches the total number of consumers reported as receiving that EBP in Question 34, not including those listed as "other EBP".]

	Female	Male	Unknown
Integrated Treatment for Co-Occurring Disorders			
Family Psychoeducation			
Illness Management and Recovery (IMR)			
MedTEAM			
Supported Employment			
Permanent Supportive Housing			

36. Please enter the number of consumers who received an EBP in 2012 in each age group. Please count a consumer multiple times if they received more than one EBP in 2012. *

[On the online survey, the total number of consumers receiving each EBP across all age groups will automatically appear in the final column for each EBP listed. Please check that this number matches the total number of consumers reported as receiving that EBP in Question 34, not including those listed as "other EBP".]

	17 and under	18-20	21-64	65-74	75+	Un-known
Integrated Treatment for Co-Occurring Disorders						
Family Psychoeducation						
Illness Management and Recovery (IMR)						
MedTEAM						
Supported Employment						
Permanent Supportive Housing						

37. Please enter the number of consumers who received an EBP in 2012 in each racial / ethnic group. Please count a consumer multiple times if they received more than one EBP in 2012.*

[On the online survey, the total number of consumers receiving each EBP across all racial / ethnic groups will automatically appear in the final column for each EBP listed. Please check that this number matches the total number of consumers reported as receiving that EBP in Question 34, not including those listed as "other EBP".]

	Amer. Indian/ Alaskan Native	Asian	Black/ African American	Hawaiian/ Pacific Islander	White	More than One Race	Un- known
Integrated Treatment for Co-Occurring Disorders							
Family Psychoeducation							
Illness Management and Recovery (IMR)							
MedTEAM							
Supported Employment							
Permanent Supportive Housing							

38. Please enter the number of consumers who received an EBP in 2012 with each ethnicity. Please count a consumer multiple times if they received more than one EBP in 2012.*

[On the online survey, the total number of consumers receiving each EBP with each ethnicity will automatically appear in the final column for each EBP listed. Please check that this number matches the total number of consumers reported as receiving that EBP in Question 34, not including those listed as "other EBP".]

	Hispanic/ Latino	Not Hispanic/ Latino	Unknown
Integrated Treatment for Co-Occurring Disorders			
Family Psychoeducation			
Illness Management and Recovery (IMR)			
MedTEAM			
Supported Employment			
Permanent Supportive Housing			

Evidence-Based Practices, Continued

In this section, please answer the following questions on your use of evidence-based practices (EBP). Please check that you have answered "Yes" or "No" for all questions. Refer to the "EBP Definitions" document to guide your answers to these questions.

[The following questions on EBPs will be on separate pages of the online survey. If you reported that you did not use an EBP in Question 33, you will not see further questions about that EBP.]

39. Integrated Treatment for Co-Occurring Disorders*

	Yes	No
Have CCS staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the "EBP Definition" document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

40. If you monitored fidelity for Integrated Treatment for Co-Occurring Disorders, what fidelity measure did you use? _____

41. Family Psychoeducation*

	Yes	No
Have CCS staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

42. If you monitored fidelity for Family Psychoeducation, what fidelity measure did you use?

43. Illness Management and Recovery (IMR)*

	Yes	No
Have CCS staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

44. If you monitored fidelity for Illness Management and Recovery (IMR), what fidelity measure did you use?

45. MedTEAM*

	Yes	No
Have CCS staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the "EBP Definition" document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

46. If you monitored fidelity for MedTEAM, what fidelity measure did you use?

47. Supported Employment*

	Yes	No
Have CCS staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the "EBP Definition" document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

48. If you monitored fidelity for Supported Employment, what fidelity measure did you use?

49. Permanent Supportive Housing*

	Yes	No
Have CCS staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the "EBP Definition" document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

50. If you monitored fidelity for Permanent Supportive Housing, what fidelity measure did you use?

51. What EBPs not listed previously (but is found on the SAMHSA website) did you use in 2012?

Other EBP 1:

Other EBP 2:

Other EBP 3:

Consumer Satisfaction

52. Did you use a survey or other tool to measure consumer satisfaction in 2012?*

[In the online survey, further questions about consumer satisfaction tools will not appear if you choose no.]

Yes No

53. Which survey or tool did you use to measure consumer satisfaction?*

(Please mark all that apply)

The instrument in my Evidence-Based Practice toolkit	
Recovery-Oriented Systems Inventory (ROSI)	
Other tool <i>(please describe)</i> : <hr/>	

54. Do you have any clarifications about your answers, additional comments, or suggestions about this survey?

55. Please record **your email address** below to ensure that we have received your survey, and to receive an email confirmation of your survey completion and a copy of your responses for your records. If you do not receive an email confirmation after you complete the survey, it means that we have not received your survey and you may need to submit it again.*