Wisconsin
Department of Health Services

DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Comprehensive Community Services 2013 Annual Program Survey

Report of 2013 CCS Services and Practices

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EXECUTIVE SUMMARY

In 2014, the Division of Mental Health and Substance Abuse Services administered the third annual Comprehensive Community Services (CCS) Program Survey. This program survey asks respondents to report on the services provided to CCS consumers during 2013 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 number of reported consumers continued to grow in 2013, increasing by 15% from 2012. The highest number of discharges continued to be 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 women than men (a reversal from 2012). 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 yet 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 may also be a contributing factor, 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, 11% 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 2013, there were 28 active CCS programs, 27 of which (96%) reported data.[1]

The survey is intended to capture the following areas:

- Consumer demographics
- Diversity of practices between programs
- Consumer discharge patterns and destinations, and
- Use of Evidence-Based Practices (EBPs)

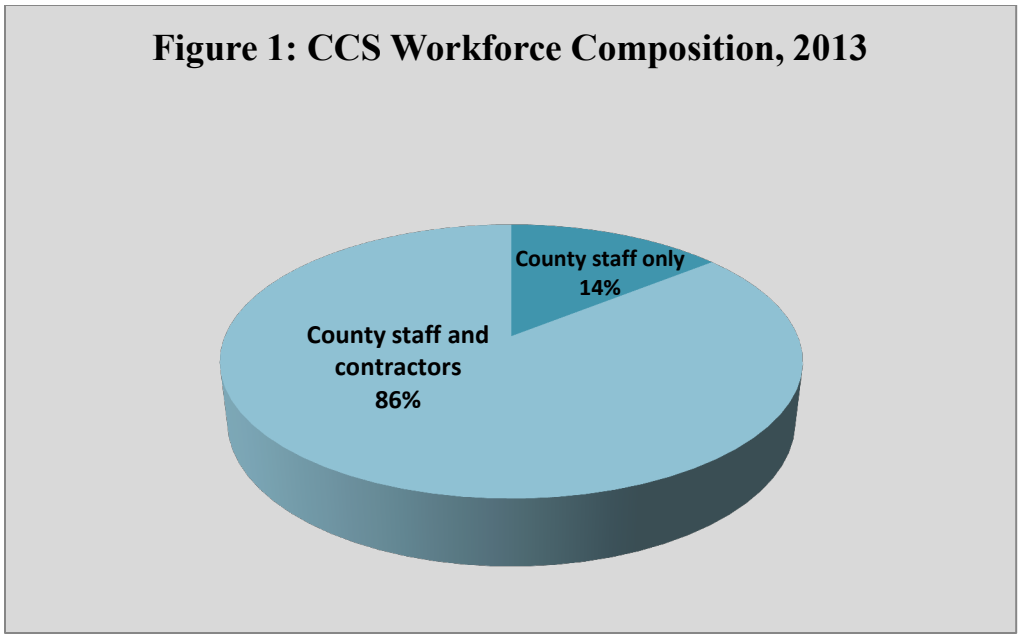
Much of the survey is devoted to questions around the use of EBPs. Programs are asked not only which EBPs they use, but also a series of questions around training, fidelity, and EBP utilization. The utilization questions are designed to track trends and identify potential disparities in EBP usage. In responding to all of the EBP questions, programs are asked to adhere to the strict definitions of the EBP as laid out in a guiding document. Thus, many 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 some variation of an EBP than is presented here.

The CCS Program Survey should be understood in context as a single data source on CCS program trends and performance. With the statewide expansion of PPS beginning in 2014, other standardized data sources will become available to capture a more complete picture of CCS programs' operations, composition, and results. In particular, all CCS programs will complete the same consumer satisfaction surveys (the ROSI[2] for adults and Youth Services Surveys for youth and families). Starting in 2015, data from those surveys, the Functional Screen, and the Division of Mental Health and Substance Abuse's online data system, will all be combined into an annual CCS Outcomes Report. Thus, in the future the information contained in this report will help to supplement additional information on the operation of CCS programs throughout Wisconsin.

PROGRAM STAFFING

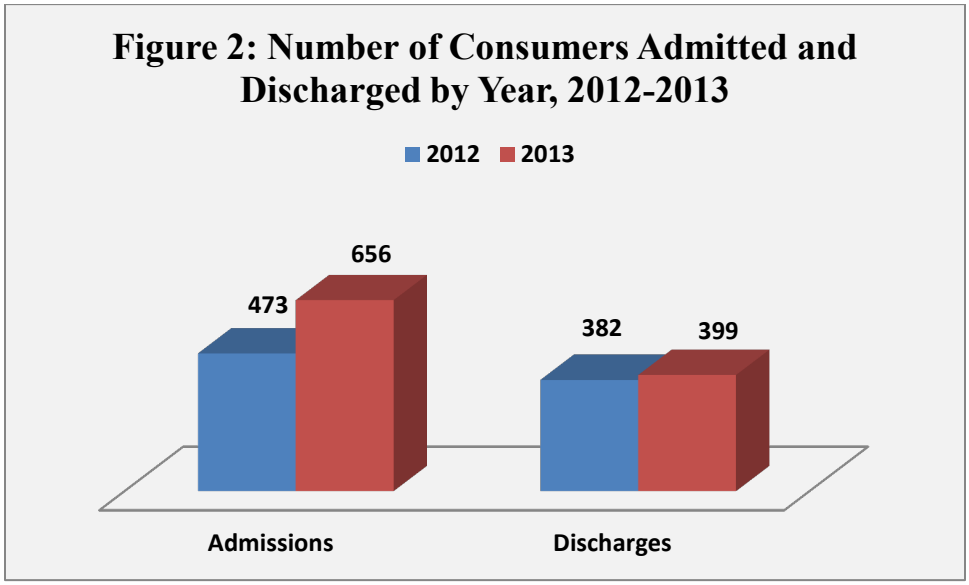
CCS programs may differ in their staff composition. Programs can be staffed either entirely by county employees, or by a mix of county employees and contractors. Figure 1 reveals that the vast majority of programs (86%) fall into the latter category, with a mix of county workers and contractors.

[1] Upon request, one tri-county area program (Lincoln, Langlade, Marathon) completed separate surveys for each county, but each of those counties is not counted towards the response rate here.
[2] Recovery-Oriented System Indicators survey



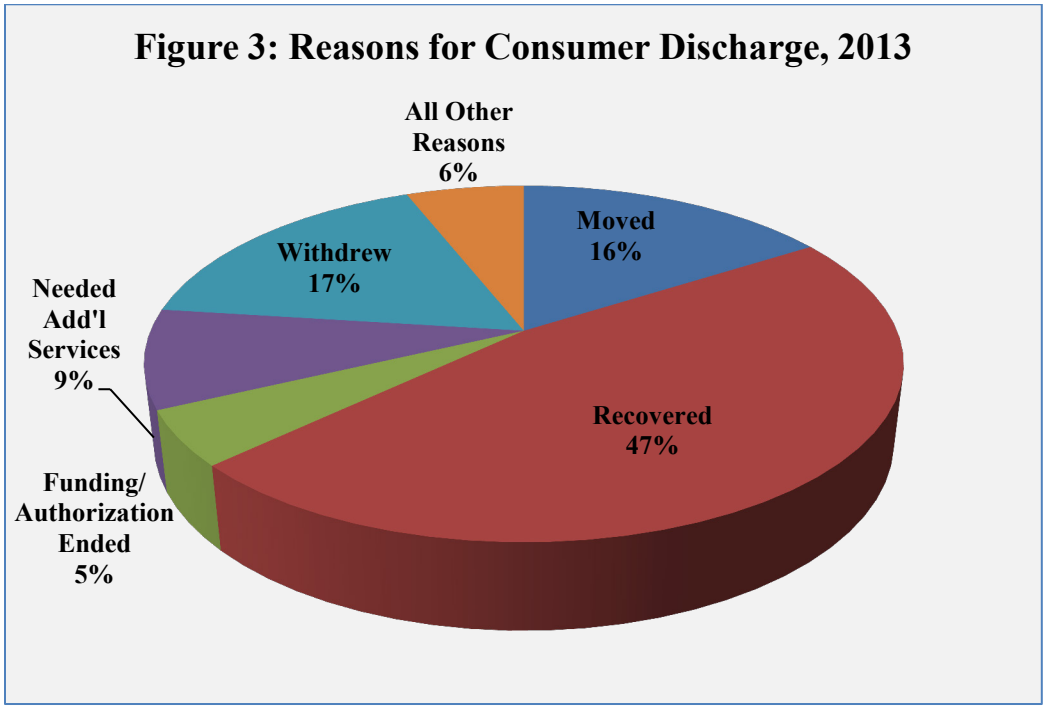
CONSUMERS SERVED

Respondents reported that 1,947 consumers were served in 2013. This was nearly a 15% increase from the 2012 numbers (1,698 consumers). The number of new admissions in 2013 does show some evidence of program expansion, so the increase may be due to more than differences in reporting.



DISCHARGE REASONS AND DESTINATIONS

While the majority of consumers stayed on at the end of the year, approximately 20% of consumers served during 2013 were discharged by the end of the year. Consumers were discharged for many different reasons. However, as can be seen in Figure 3, the leading reason was that the individual recovered to the extent that CCS-level services were no longer needed (47%).[3]



Seventeen percent of discharged clients chose to withdraw from CCS, while approximately 16% moved out of the CCS service area. Approximately 9% of consumers were discharged because they needed additional services. Approximately 5% of consumers lost their funding or authorization, while 2% died during the course of the program. An additional 2% were discharged for "other" reasons, 1% were unknown, and 1% went to jail or prison.

Table 1 (below) provides the service destinations of clients who were discharged for various reasons. Very few of the consumers who moved out of their CCS service area relocated into another CCS (10%). More commonly, they moved to outpatient services (51%). This pattern may change as CCS programs expand beginning in 2014.

[3] The number of consumers reported in the discharge categories totaled more than the total number of consumers listed as discharged in 2013. The percentages for this figure were therefore calculated based on the number reported across discharge categories, so that the total equals 100%.

Table 1: Consumer Destinations by Reason for Discharge, 2013

Reason for Discharge	Another CCS	Outpatient/ Psychiatry	TCM	CSP	Nursing Home	Group Home/ CBRF	Inpatient	No Other Services	Unknown	Other
Moved	10%	**51%**	9%	1%	1%	0%	1%	7%	15%	5%
Recovered	N/A	**67%**	**20%**	0%	0%	0%	0%	11%	1%	1%
Funding/ Auth Ended	N/A	**35%**	**35%**	4%	0%	0%	0%	**22%**	4%	0%
Needed Add'l Services	N/A	0%	0%	**20%**	**27%**	0%	10%	7%	7%	**30%**
Withdrew	0%	**38%**	10%	1%	0%	0%	0%	**30%**	**21%**	0%

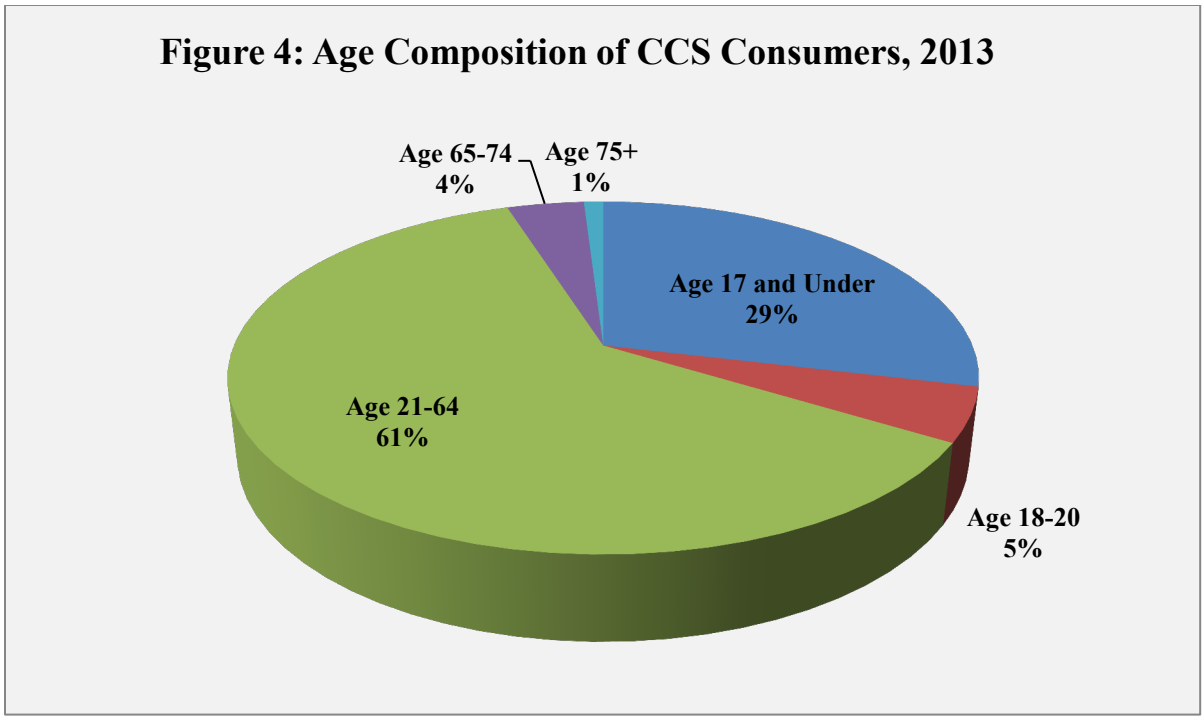
Outpatient therapy and/or Targeted Case Management (TCM) were also the most common destinations for consumers recovered, whose funding ended or who chose to withdraw. A relatively high proportion of consumers who chose to withdraw or whose funding ended did not continue in any other services. Although this may be the most appropriate course for some of these individuals, it is probably not the optimal outcome for all of them, and indicates a need to improve access to post-CCS services.

Unsurprisingly, those with additional needs went to appropriate placements, such as Community Support Programs (CSPs) or nursing homes. Thirty percent of those discharged due to additional needs went to an "other" placement. Write-in comments indicated that these individuals by and large also went on to appropriate placements, including CBRFs and other residential facilities, CSP, Family Care, and day treatment (it is unclear why respondents did not list consumers under CBRF or CSP in the survey). One consumer was involved with the juvenile justice system and another was enrolled at a military training academy. These responses were very similar to responses from 2012.

CONSUMER DEMOGRAPHICS

The gender composition of CCS was fairly evenly divided between males and females, with slightly more consumers being female (51% vs. 49% male). This is a reversal from 2012 numbers (47% female), but still displays a relatively equitable gender breakdown among consumers.

The age distribution of CCS consumers (see Figure 4, below) remains essentially unchanged from 2012. Twenty-nine percent of consumers are minors (under age 18), whereas a very small percentage (5%) are 65 or over. The majority of consumers are working-age adults, age 21-64.



Race and Ethnicity

The racial and ethnic composition of CCS participants remained essentially unchanged from previous years. Approximately 91% of consumers whose race was recorded were White, 4% were Black or African-American (a slight increase from the previous year), 2% were more than one race, 1% were Native American or American Indian, 2% had no recorded race ("Unknown"), and the remaining 1% were distributed between the other racial categories (i.e., Asian and Hawaiian/Pacific Islander). Racial minority groups were under-represented relative to their representation in Wisconsin as a whole. For instance, African Americans make up 6.5% of Wisconsin residents, but 4% of CCS consumers.

The ethnic composition of CCS consumers was also fairly consistent with previous years. Eighty-five percent of consumers were listed as "non-Hispanic or Latino". One difference was a significant increase in consumers whose ethnicity was unknown (from approximately 7% in 2012 to 9% in 2013). The percentage of known Latinos or Hispanics remained fairly stable, at 2%. As noted in previous years, this is approximately one-third the rate of representation of Hispanics or Latinos in Wisconsin as a whole (6.2%).

It should be noted that the CCS service area in 2013 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 2% of those served in CCS in 2013 were recorded as veterans (and additional 10% were listed as "unknown" with regard to veteran status). 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 and 2014. Whether veterans are truly under-represented or merely not identified as such is unknown at this time.

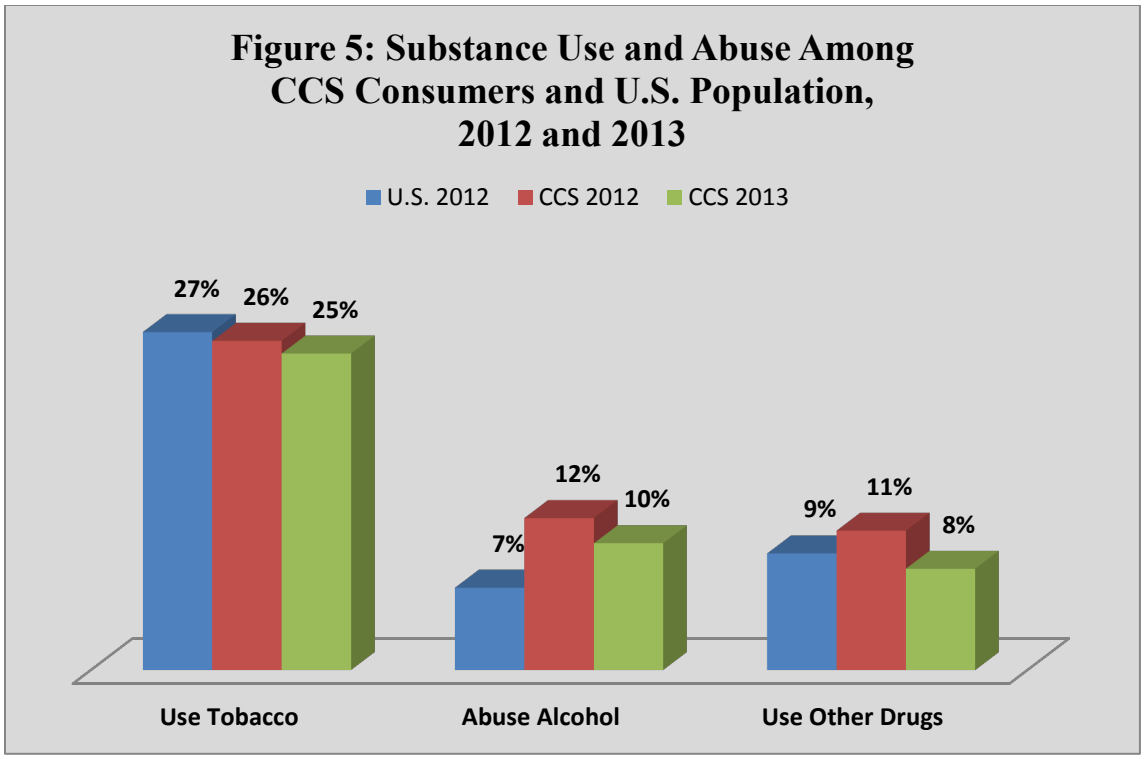
SUBSTANCE USE AND PHYSICAL HEALTH

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 5, below). National data[4] 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).

According to the survey results, CCS consumers' tobacco use is fairly representative of the U.S. population and they are somewhat more likely to abuse alcohol and use illicit drugs. However, the reported differences between CCS consumers and the general population are 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.)

Comparing CCS consumers across time, all reported rates of substance use were lower in 2013 than 2012: tobacco use fell slightly from one year to the next; rates of alcohol abuse dropped (from 12% to 10%); and illicit drug use was substantially lower in 2013 than 2012 (8% vs. 11%).

[4] National estimates are taken from the 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.



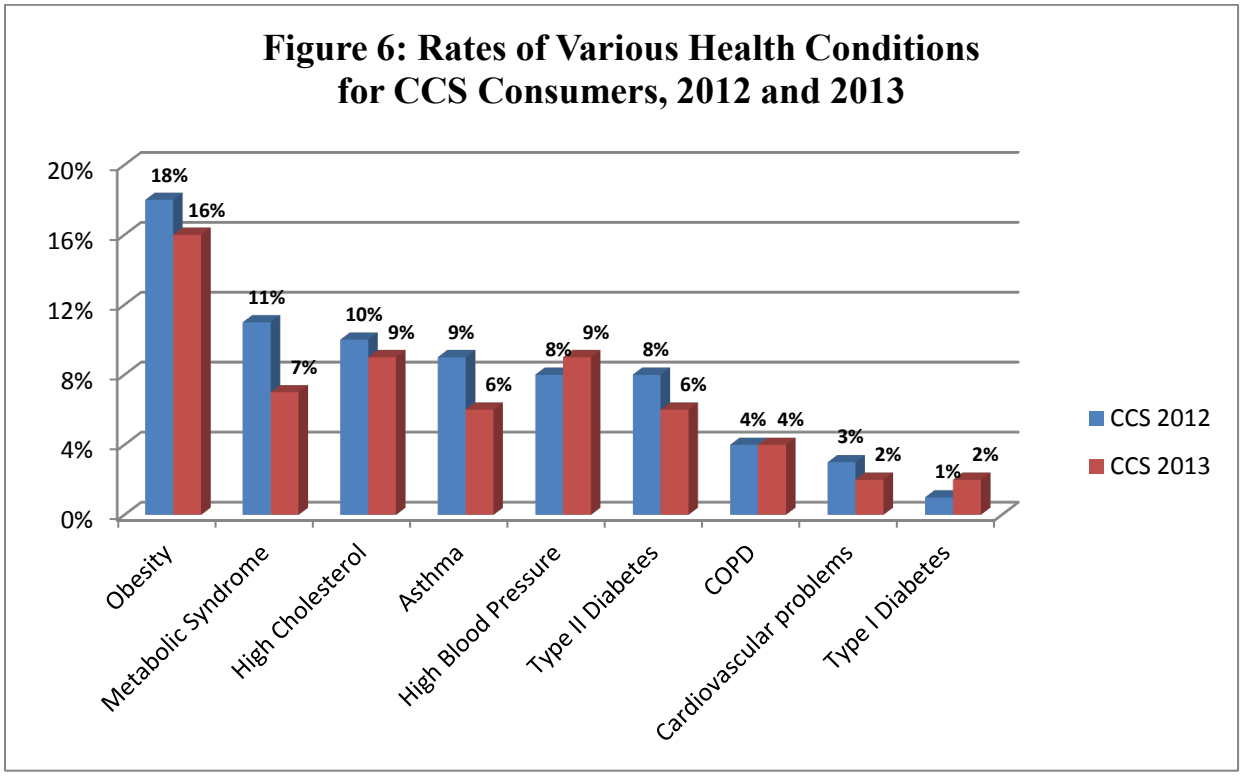
Another set of questions asked programs to report the rates of a variety of health issues among their consumers. The question is based on research showing that, in general, individuals with mental health issues are more likely to have a variety of co-occurring physical health issues (including asthma & cardiovascular problems).[5] As in the previous year, results indicated that CCS consumers had markedly lower rates of physical health issues than the general population.[6]

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, it that CCS consumers include both more youth (29% age 17 or younger) and fewer elderly (only 5% 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).

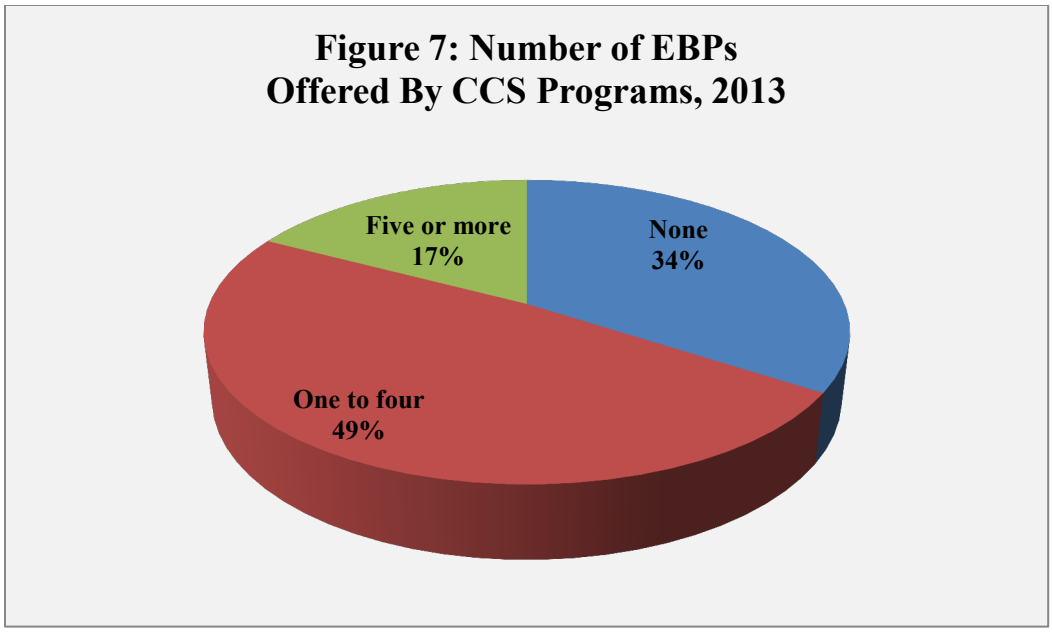
[5] Ziege, Anne and Tim Connor. "Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey." Wisconsin Department of Health Services, Division of Public Health, Bureau of Health Information and Policy, 2009.
[6] National figures were drawn from a variety of sources. See Appendix A.

Instead, an analysis was conducted to compare the rates of health conditions reported among consumers by CCS program in 2012 and 2013 (see Figure 6). Parallel to the lower rates of substance use in 2013, CCS consumers were generally reported to be healthier in 2013 than the previous year, with substantially lower rates of obesity, metabolic syndrome, asthma, and Type II diabetes.



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 7 (below) reveals that approximately two-thirds of programs offer at least one EBP. This is almost identical to the 2012 rate.

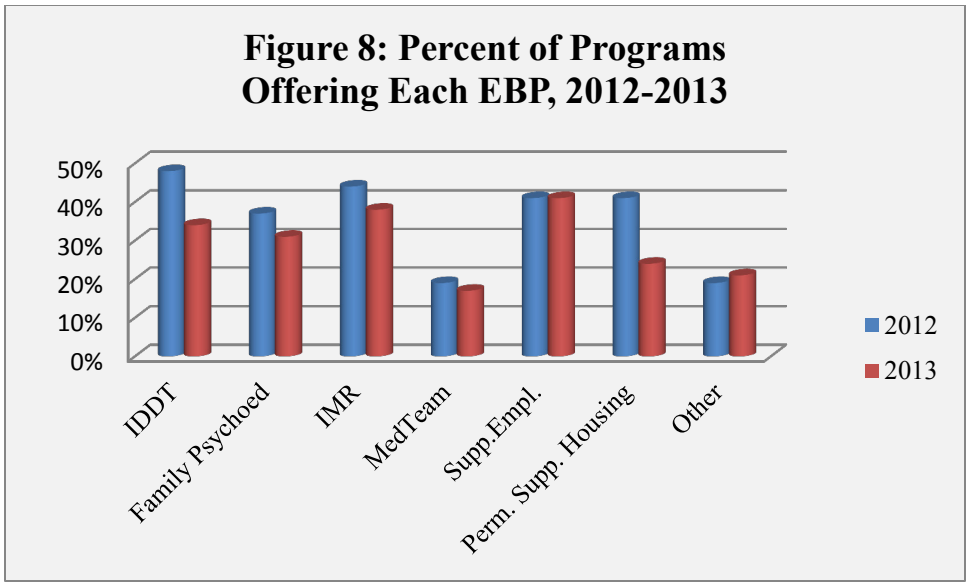


As described in the introduction, programs were asked to adhere to the strict definitions of each EBP as laid out in a guiding document. Thus, the figures reported below may not fully reflect the extent to which some programs incorporate elements of EBPs. Also, the CCS programs were not asked about EBPs oriented specifically for children.

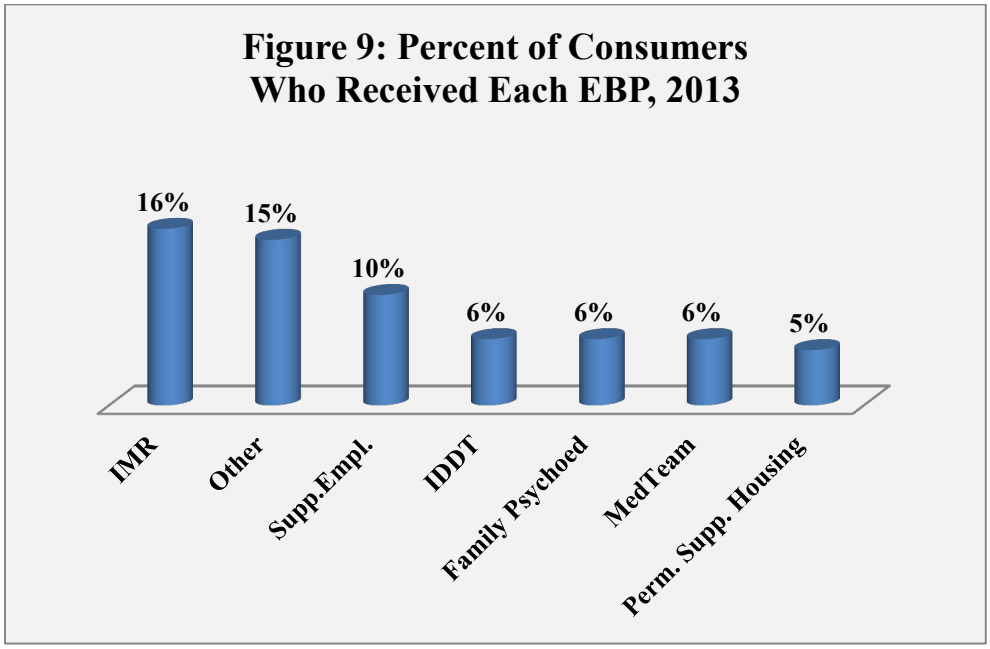
The specific EBPs asked about on the survey include the following:

- 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

The reported percent of programs offering each EBP dropped considerably from 2012 (see Figure 8, below). For instance, the reported use of Permanent Supportive Housing (PSH) dropped by 17% (from 41% to 24%) and IDDT dropped by 14% (from 48% to 34%). Family Psychoeducation, IMR, and MedTeam all decreased by 2%-6%, while Supported Employment remained unchanged. The "Other" category was the only type of EBP to see an increase (2%). A comparison of survey responses from 2012 and 2013 reveals that five CCS programs collectively reported offering 18 fewer EBPs in 2013 than in 2012 (vs. six programs which collectively reported offering ten more EBPs in 2013). Two counties which had offered multiple EBPs in 2012 reported no use of EBPs in 2013, and their data accounted for almost half of the drop-off in 2013. The remaining three programs just reported a reduction in one or two specific EBPs, yet still reported using some EBPs in 2013.



While relatively few programs offered EBPs, even those that did offer EBPs offered them to only a fraction of their consumers. As seen in Figure 9, the most widely available practice was Illness Management and Recovery (IMR), which was offered to only 16% of CCS consumers. With the exception of the "Other" category, all other EBPs specified on the survey were offered to only between 5%-10% of consumers. These proportions are very similar to the 2012 figures (not shown here).



Approximately 15% of consumers received another EBP not specified on the survey. Table 2 (below) shows which EBPs are included in this "Other" category and how many CCSs report using them.

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

Evidence-Based Practice (EBP)	Number of Programs
Cognitive Behavioral Therapy (CBT)	5
Dialectical Behavioral Therapy (DBT)	3
Motivational Interviewing (MI)	3
Assertive Community Treatment (ACT)	1
Clubhouse Model	1
Consumer-Operated Services	1
Person-Centered Planning	1
WRAP	1

Three programs reported using Cognitive Behavioral Therapy (CBT), and two programs reported using "Coping Cat", which is in essence a CBT-based intervention designed for children. Thus, all of these are categorized as "CBT" in the table. Similarly, two programs reported using DBT and one reported using "Mindfulness-based program for Youth"; all three are categorized under "DBT". One other practice not listed in the table was QPR gatekeeper training. QPR ("Question, Persuade, Refer") is a best practice for *providers* when they encounter a consumer who is potentially suicidal. Therefore, it is not included in the table as a treatment EBP.

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

Most of the programs that used an EBP reported that their staff were trained in that method (between 57% and 100%), with Permanent Supportive Housing (PSH) being the EBP with which staff were reportedly least familiar. With the exception of PSH, in the majority of cases programs used a toolkit to guide implementation of their EBPs, although a substantial minority of programs using each EBP did not do so.

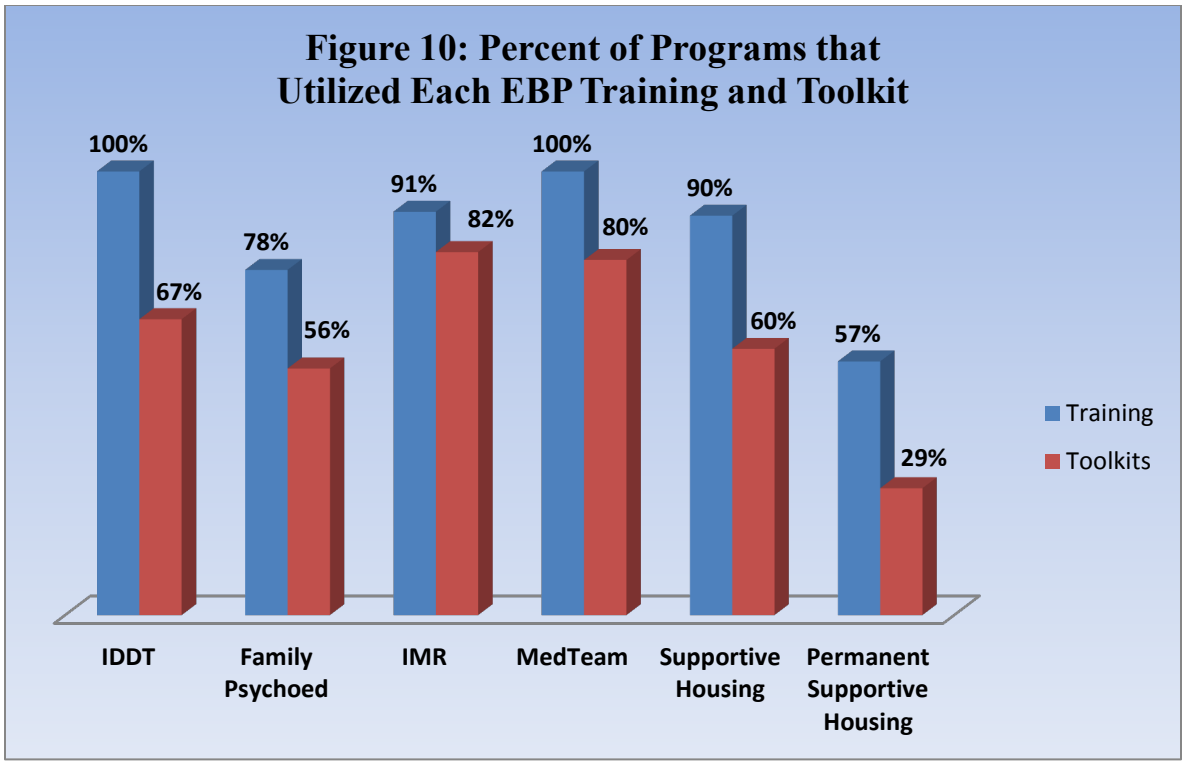


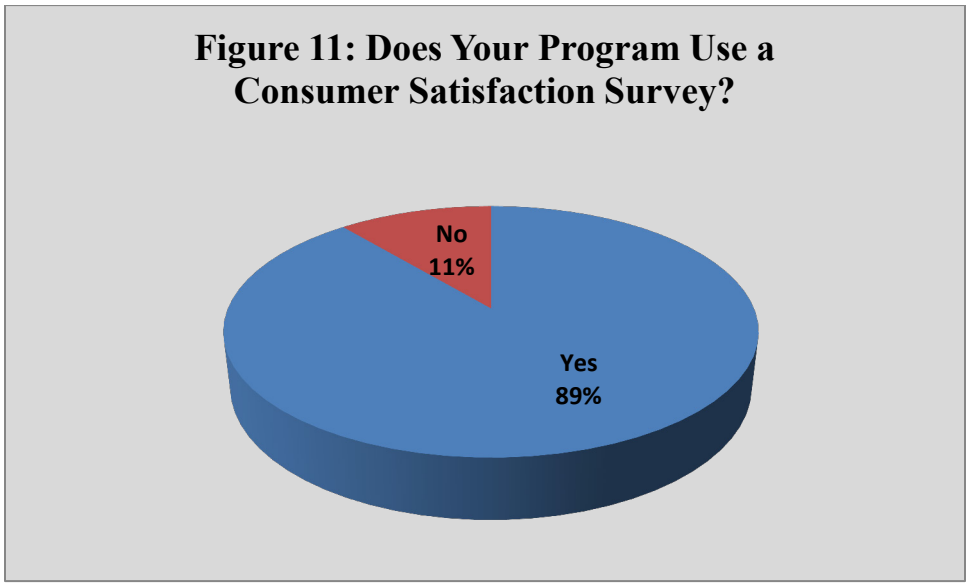
Table 3 shows that Supported Employment is most likely to be monitored for fidelity: this happens in 63% (almost 2/3) of the programs using this EBP. Most of the other practices were monitored in only slightly more than half of the cases, and PSH was rarely monitored. Many of the programs that use EBPs never employ an outside monitor. The exception is Supported Employment, in which over one third (36%) of the programs that use it do utilize an outside monitor.

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
IDDT	10	50%	10%
Family Psychoeducation	9	56%	0%
IMR	11	55%	9%
MedTeam	5	40%	0%
Supported Employment	11	63%	36%
Permanent Supportive Housing (PSH)	7	29%	0%

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 2013. As can be seen in Figure 11, nearly 90% of programs did report the use of a consumer satisfaction survey. This represents an increase from the previous year when 85% of programs reported using a survey to collect data on consumer satisfaction.



Programs were asked to report on the type of survey or tool used. Fifty-three percent of programs (n=15) reported using the ROSI. On a write-in question, an equal number of programs also listed an additional survey tool, which many programs apparently used in combination with the ROSI. Of the 17 programs reporting using a tool beyond either the ROSI or the tool outlined in their EBP toolkit, 58% (n=10) report using an instrument designed by their agency. Other instruments listed included the Quality of Life Satisfaction Survey, Ohio Scales, the Youth Satisfaction Survey, and a modified ROSI.

Beginning in 2014, many CCS programs will be required to administer the ROSI to adults, and appropriate versions of the Youth Satisfaction Survey to youth and parents of young children. With the implementation of standardized survey instruments, future CCS reports will be able to report out responses to consumer satisfaction surveys, and thereby gain additional information on how well CCS programs are serving their consumers.

WAITING LISTS

Most CCS programs did not maintain waitlists in 2013, but approximately 14% did (n=4). Those four programs collectively had 100 consumers on the waitlist at the end of 2012 and added an additional 60 consumers in 2013. They ranged from having a minimum of zero consumers on the waitlist at the end of

2012 to a maximum of 77; the range for 2013 was zero to 54. The average amount of time consumers spent on a waitlist ranged from two to six months. One program wrote in the comments section that they did not maintain an official waitlist and were therefore unable to contribute numbers, but that informally they do have more clients present to their CCS than they are able to serve at a given point in time. Another program clarified that their waitlist is made up primarily of children with Severe Emotional Disorders (SED), and that they are searching for ways to better meet the needs of these children. This issue is not unique to CCS or to any particular part of the state, as there is a known shortage of mental health providers for children.

Respondents were asked whether or not they offered any interim services to those on the CCS wait list. All four of the programs that maintained waitlists reported that they did offer some services to those on the waitlist. The breakdown of particular services offered is listed in Table 4 below.

Table 4: Services Offered to Those on CCS Waitlists, 2013

Service	Number of Programs Offering Service (n=4)
Case Management	2
Outpatient Mental Health Services	4
Psychiatric Care	4
Linkage to Community Resources	4
Medication Management	2
Outpatient Substance Abuse Services	2
Crisis Intervention	4
Clubhouse	0
Drop-In Center	1

Table 4 reveals that programs were more likely to link waitlist clients up with clinical services than with informal or peer-based resources, such as clubhouses and drop-in centers. While the linkages to clinical services are indeed crucial, programs may also want to consider strengthening their ties with clubhouses, drop-in centers, and (in the future) peer-run respites, where such resources are available.

SUICIDE RISK ASSESSMENT

For the first time on this survey, programs were asked to report whether or not they assess suicide risk and, if so, what tools they use. Nineteen of the twenty-eight programs (68%) indicated that they either currently assess for suicide (n=18) or will in 2014 (n=1). Most of those who assess for suicide also incorporate suicide prevention into their consumers' treatment plans. Six programs (31% of those assessing for suicide; 21% of all CCS programs) specifically mentioned that they work closely with Crisis Intervention services or Mobile Crisis Teams in assessing and managing suicide risks. Several programs shared the specific instrument they use to assess suicide. The instruments are listed in Table 5 (below). With the exceptions of the Mental Health Status Observations Checklist and the SAD Person Scale (n=2), each assessment was listed by only a single agency.

Table 5: Suicide Risk Assessment Tools Listed By Respondents

Suicide Assessment Tools
Northwest Connections Tool
Columbia Suicide Severity Rating Scale (C-SSRS)
CANS
ASIST
Assessment on Tier system (Part of electronic health record)
Mental Status Observations Checklist
Suicide and Homicide Checklists
SAD Person Scale
IS PATH WARM
Protective Factors Checklist
SAC Brief Mental Status Scale
SPS Suicide Assessment Checklist

Many of the programs that answered this question implied that suicide risk assessment and management is an integral and ongoing part of their work as CCS programs. It is hoped that the nine programs which did not indicate the use of any suicide risk assessment will move in that direction in the future.

CONCLUSION

A few respondents indicated that they would like to expand their use of evidence-based practices (EBPs) and that the survey is helpful in presenting ideas of which EBPs to use.

Although more information would be needed to perform a detailed evaluation of CCS programs, several points emerge from the 2013 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, two-thirds of the programs surveyed (66%) 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 finding, virtually unchanged from 2012, 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 offering 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 vary considerably among those programs that do offer EBPs, and in most cases, there is very little in the way of fidelity monitoring.

The transition out of CCS 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: 2013 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 March 28th. If you have any questions or difficulties with the survey, please contact Kate McCoy at 608-267-9391 or Katherine.mccoy@dhs.wisconsin.gov. Thank you.

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1. Please enter the name of the county contracting for or directly operating your CCS.*
(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 12/31/2012?*

7. How many new admissions to your CCS did you have in 2013?*

8. *[Total number of clients served in 2013: calculated automatically by the survey as the sum of #6 + #7]*

9. How many discharges from your CCS did you have in 2013?*

10. *[Number of active CCS consumers you had on 12/31/2013: calculated automatically by the survey.]*

11. How many of the continuing 2012 enrollees plus the new 2013 enrollees served were concurrently enrolled in Family Care?*

12. How many of the total 2013 CCS discharges were in Family Care?*

Discharge Reasons

In this section, please provide information on the reasons why consumers were discharged in 2013, 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 2013 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?	●	●
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)?	●	●

14. **How many** 2013 consumers were discharged because ...*

[The sum of the numbers entered for this question must equal the number of total 2013 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 2013 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 (CCS)	
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 2013 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.

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19. How many of the 2013 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 2013 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 2013 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 2013.

[The totals for each of the questions in this section must equal the number of consumers you reported serving in 2013 (as calculated in #8).]

26. Please enter the number of 2013 consumers of each gender.*

	# of Consumers
Female	
Male	
Unknown	

27. Please enter the number of 2013 consumers in each age group.*

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

28. Please enter the number of 2013 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 2013 consumers with each ethnicity.*

	# of Consumers
Hispanic / Latino	
Not Hispanic / Latino	
Unknown	

30. Please enter the number of 2013 consumers who are veterans and non-veterans.*

	# of Consumers
Veterans	
Non-Veterans	
Unknown	

Medical Conditions & Substance Use

31. Please enter the number of 2013 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 2013 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 2013, instead of leaving it blank.]

33. Did you use the following Evidence-Based Practices (EBPs) in 2013? 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	●	●
Family Psychoeducation	●	●
Illness Management and Recovery (IMR)	●	●
MedTEAM	●	●
Supported Employment	●	●
Permanent Supportive Housing	●	●
Other EBP not listed (but is found on the SAMHSA website)	●	●

34. Please enter the number of 2013 consumers who received the following evidence-based practices. Please count a consumer multiple times if they received more than one evidence-based practice in 2013.*

	# 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 2013 of each gender. Please count a consumer multiple times if they received more than one EBP in 2013.*

[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 2013 in each age group. Please count a consumer multiple times if they received more than one EBP in 2013. *

[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 2013 in each racial / ethnic group. Please count a consumer multiple times if they received more than one EBP in 2013.*

[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 2013 with each ethnicity. Please count a consumer multiple times if they received more than one EBP in 2013.*

[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? _____

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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?

_____

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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?

_____

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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 2013?

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 2013?*

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

____Yes ____ No

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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 *(please describe)*: _____	

CCS Waiting List Information

54. Were there times during 2013 when there was a waiting list for CCS services?*

[In the online survey, further questions about waiting lists will not appear if you choose no.]

____Yes ____ No

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55. How many consumers were on the CCS waiting list on 12/31/2012?*

_____

56. How many additional consumers were placed on the CCS waiting list during 2013?*

_____

57. How long was the average wait in months in 2013 before consumers on your waiting list received CCS services?*

(Please provide an average number of months, not a range of months) _____

58. Please report which of the following interim services consumers received while on your CCS waiting list.* *(Please mark all that apply)*	
None	
Case management services	
Outpatient mental health services	
Psychiatric services	
Assistance with locating community resources	
Medication management services	
Outpatient substance abuse services	
Crisis intervention services	
Clubhouse	
Drop-in center	
Other services *(please describe)*: _____	

59. Does your CCS have a specific policy or standard practice for assessing and managing suicide risk? Is the program using any particular tools? If so, please list them here.

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

61. *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.**