

**CBHNP Satisfaction Surveys  
2003 Report Summary  
(Submitted to QIC 10/13/04)**

CBHNP conducts surveys annually with both providers and Members to determine how well CBHNP is meeting the needs in managed care. Four different surveys were completed:

1. MHSIP (Mental Health Statistics Improvement Program) Adult Survey, Version 1.1, Feb. 2000 – 28 items.
  - a. The response rate for this survey was 8% (275 of 3655). The mailing sample was the total population of Adult Members who had at least 1 claim in Contract Year 2, 10/1/02-9/30/03.
  
2. MHSIP (Mental Health Statistics Improvement Program) Youth Services Survey (YSS) & Youth Services Survey for Families (YSS-F), June 2001 – 21 items.
  - a. The response rate for this survey was 8% (442 of 5713). The mailing sample was the total population of Youth Members who had at least 1 claim in Contract Year 2, 10/1/02-9/30/03.
  
3. Member Satisfaction with CBHNP Survey – 11 items plus additional Yes-No questions, internally developed.
  - a. The response rate for this survey was 8% (725 of 9368). The mailing sample was the total population of Members who had at least 1 claim in Contract Year 2, 10/1/02-9/30/03.
  
4. CHCS (Center for Health Care Strategies) Clinical and Administrative Provider Satisfaction Survey – 38 items for clinical staff; 15 items for administrative staff. (This is the same Provider Opinion Survey that OMHSAS uses as part of its Early Warning Program).
  - a. The survey was distributed to 277 provider sites, with 65 surveys being returned for a response rate of 23%.

The survey process and reports were completed by CBHNP staff and analyzed in the CBHNP Quality Improvement Committee (QIC) on September 1, 2004 in order to assist in the refinement of the Quality Improvement Program and Work Plan for the upcoming 2004-05 Contract Year. The QIC evaluated all surveys and responses and determined the following 3 areas of relative dissatisfaction were consistent with other aspects of the QI Program and were the recommended priority areas for CBHNP. These priority areas will be stressed in written communications with Members and providers (e.g., newsletters) as well as face-to-face interactions (e.g., community presentations with Members and families; provider trainings and meetings).

## **Psychiatry Access & Medication Education**

Psychiatry access was an identified focus of last year's survey process and analysis. As a result, specific study and monitoring of routine access to psychiatry evaluations was initiated by the QIC. On the survey question, "I was able to see a psychiatrist when I wanted to," last year's Satisfaction Rate was 81%. This improved to 89% this year, but remains a targeted area for improving Member satisfaction. The additional psychiatry-related area of side effect education can also be tied in. The survey question, "Staff told me what side effects to watch out for" had a Satisfaction Rate of 86% last year and improved to only 87% this year. The QIC recommended continued specific monitoring of psychiatry access, intervention in cases as needed by the Clinical Department, and Member education regarding medication side effects and "how to talk to your doctor."

## **Provider Choice**

There are four points of access for HealthChoices members. Members may access services by going directly to a provider, the Base Service Unit (BSU)/Single County Authority (SCA), a crisis intervention unit or emergency room, or by calling CBHNP Capital Area Member Services. Having a choice of providers is a critical aspect of the HealthChoices program regardless of the point of access. On the Member Satisfaction with CBHNP Survey, being offered a choice of providers was an identified focus of last year's survey process and analysis. The Satisfaction Rate improved from 79% last year to 82% this year. The CSS, Inc. Consumer / Family Satisfaction Team surveys have improved substantially in the area of Member awareness of provider choice / alternatives. Nevertheless, continued interventions (e.g., specific member communication; broader distribution of Provider listings) to target Provider Choice are recommended.

## **Emphasis of Recovery and Resiliency Models**

The QIC noted that multiple satisfaction survey items that tended to show lower satisfaction ratings reflected aspects of consumer-oriented and strengths-based models for behavioral health. Resiliency and Recovery models reflect both a treatment philosophy and a process characterized by consumers moving toward participation in age-appropriate roles, including living independently, working, and having less dependence on mental health and substance abuse systems. Most Resiliency and Recovery Models for behavioral health service delivery share common characteristics:

- Consumer-centered
- Empower clients
- Racially and culturally appropriate
- Are flexible
- Focus on strengths
- Normalize and incorporates natural supports
- Meet special needs
- Are accountable
- Are coordinated

It was felt that increase awareness by Members, providers, and CBHNP staff of a resiliency and recovery orientation could potentially improve a number of these recovery-related satisfaction survey items. It was recommended that CBHNP incorporate a resiliency and recovery focus in their training plans and community outreach.

Individual reports of full surveys can be requested from the CBHNP Quality Improvement Department by contacting:

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