

Appendix L. GUIDELINES FOR MEMBER/FAMILY SATISFACTION TEAMS AND MEMBER SATISFACTION SURVEYS

Introduction

The Department of Public Welfare (DPW) values and encourages the input of members and their families in all aspects of the HealthChoices Program and expects that such input will be incorporated in quality improvement. In addition the Office of Mental Health and Substance Abuse Services (OMHSAS), encourages input from members and their families regarding the services and support received in the mental health and drug and alcohol service system. Member and family feedback helps inform Providers, Counties and Behavioral Health Managed Care Organizations (BH-MCO) about how services can support and promote recovery for adults, resilience in children and adolescents and be more effective. Members and families have specialized knowledge and sensitivity about how respect, dignity and responsiveness of services can affect the process of recovery and preserve resilience. Members are more likely to feel safe in describing their experience with someone who is their peer. This requires Primary Contractors to implement a comprehensive approach for the measurement of consumer/family satisfaction, including but not limited to:

- ❖ A Member/Family Satisfaction Team (M/FST) responsible for surveying:
 - a sample of members using the Recovery Oriented Systems Indicators (ROSI) Self-Report Survey Measure
 - an on-going survey of members focusing on satisfaction, recovery and resiliency indicators to include statewide mandated measures
- ❖ An Annual Member Satisfaction survey by BH-MCO

A. Member and Family Satisfaction Team(M/FST) Program

1. Purpose

The purpose of the Member and Family Satisfaction Team (M/FST) Program is to:

- (i) determine whether behavioral health service recipients and their families are satisfied with services
- (ii) provide service delivery that is recovery and resiliency oriented to help ensure that challenges related to service access, delivery and outcome are identified in a timely manner

The M/FST process moves the system towards outcomes and service delivery that are recovery and resiliency oriented. Soliciting feedback on satisfaction with services empowers consumers and families and allows them to have a greater role in determining the quality of behavioral health care and recommending system improvements to DPW.

2. M/FST Components

(i) Organizational Requirements

In order to determine whether or not behavioral health services are meeting the needs and expectations of members and their families, the Primary Contractor will ensure that the M/FST Program is organized and operates in compliance with the following:

(1) Primary Contractor-M/FST Contract Elements

- (a)* The Primary Contractor either directly, or via a Behavioral Health Managed care Company (BH-MCO) or other sub-contractor, must have systems and procedures to routinely assess service Recipient satisfaction. The M/FST Program may be either a single or a multi-county program based upon the nature of the contract between DPW and the Primary Contractors.

- 1 (b) It is the responsibility of the Primary Contractor (the Primary Contractor refers to the
2 responsible party that holds the HealthChoices contract or agreement with DPW) to
3 provide the support, encouragement, and resources necessary to build a strong,
4 independent, conflict free M/FST Program. In a recovery oriented service system
5 support and encouragement would be evidenced by a Primary Contractor that:
- 6 (i) Communicates the importance of listening to and acting upon the results of
7 satisfaction feedback from M/FSTs
- 8 (ii) Supports and encourages M/FSTs so that they are considered a respected and
9 valuable service
- 10 (iii) Requires timely Provider action in response to survey results;
- 11 (iv) Requires a Provider network that works in partnership with M/FSTs to
12 continuously improve service responsiveness and to use M/FST findings in their
13 internal quality management program
- 14 (v) Identifies system improvement needed based on survey results
- 15 (vi) Actively provides direction and feedback to M/FSTs about how to improve their
16 program and acquire the skills needed to move toward the independent operation
17 of a satisfaction survey program
- 18 (vii) Provides the resources necessary to accomplish the requirements outlined in this
19 document
- 20 (c) If the M/FST Program identifies barriers to accessing Members to be surveyed; **such as**
21 **language or other issues impeding communication**, the Primary Contractor will assist to
22 resolve the issue.
- 23
- 24 (d) The Primary Contractor for HealthChoices and/or the BH-MCO must have a contract or a
25 written and signed agreement with each M/FST Program and fiduciary, if applicable.
26 The purchase of service agreement delineates roles and responsibilities of all parties
27 and must contain language consistent with the requirements of HIPPA Privacy and
28 Protected Health Information (PHI) including 45 CFR § 160.103 and CFR § 160.164.501
29 and 164.5029(g) or contain a properly constructed Business Associate Agreement (BAA)
30 as an attachment. Designation of who holds the responsibility for advocacy and follow-
31 up on behalf of members should also be included.
- 32 i. The Primary Contractor for HealthChoices and/or the BH-MCO will include the
33 M/FST in the process for any member who has asked for the M/FST to address an
34 issue on their behalf outside the formal BH-MCO complaint process.
- 35 (e) Under the contract or written agreement, and consistent with the requirements of the
36 Mental Health Procedures Act (Chapter 5100), the M/FST members will act as agents of
37 the Primary Contractor, and are, therefore, to have the same access to members and
38 family members as the Primary Contractor and service Providers, insofar as it is
39 necessary to perform their responsibilities.
- 40 (f) The Primary Contractor will ensure that the M/FST Program has adequate financial
41 resources, training, support, and necessary equipment for the program to achieve the
42 Annual Plan and produce high quality quarterly reports.

43 (2) M/FST Impartiality

44 M/FSTs must be independent from any Provider of behavioral health services or any other
45 agency that might create a conflict of interest. M/FSTs that do not have accounting
46 capabilities may contract with a provider as its fiduciary provided the contract safeguards
47 the independence of the M/FST for program direction including budget priorities,
48 satisfaction surveys, findings and recommendations. M/FSTs and M/FSTs whose parent

- 1 organization or fiduciary provides billable services will include policies and procedures to
2 demonstrate impartiality and to avoid the appearance of conflict of interest.
- 3 (3) Adult v. Family Teams
- 4 The family satisfaction component may be accomplished either as a separate administrative
5 entity or as a component of the M/FST Program that is specifically responsible for family
6 satisfaction activities.
- 7
- 8 (4) Annual Planning and Goal Setting
- 9 The Primary Contractor shall work with the M/FST to establish an annual plan. The plan
10 will outline survey sampling and methodology, and the goals for survey completion.
11 Examples of goals would include; the number and type of interviews (face-to-face,
12 telephonic or other) to be completed, the levels of care to be surveyed and special focus
13 surveys to address specifically identified special populations.
- 14
- 15 (ii) Workforce Requirements
- 16 (1) CFST Program Management/Accountability
- 17 Each M/FST Program must have a **Director** responsible for oversight and everyday
18 operations. The person responsible must be a person who self-identifies as a consumer,
19 person in recovery, or family member as of January 1, 2005.
- 20
- 21 (2) Competitive Wage
- 22 M/FST members must be paid at least as much as other persons in the general workforce
23 doing similar work in the same community.
- 24
- 25 (3) Team Makeup
- 26 (a) Persons performing adult satisfaction activities must be, or have been, consumers of
27 behavioral health services, persons in recovery, or family members.
- 28 (b) Persons performing family satisfaction activities must include family members of
29 children and adolescents with serious emotional disturbance and/or substance abuse
30 disorders who are receiving or have received behavioral health services in the publicly
31 funded system, and may also include older adolescents and/or young adults who are
32 receiving or have received behavioral health services as a child or adolescent in the
33 publicly funded system.
- 34 (c) The family satisfaction component may be a separate and distinct administrative entity,
35 or may be at least one team of an M/FST Program or one member of a team dedicated to
36 family satisfaction activities.
- 37
- 38 (4) Personnel Vetting
- 39 (a) **Team** members must have child abuse and criminal history clearances in accordance
40 with the Child Protective Services Law, Chapter 63, Sections 6303 and 6344, and are
41 mandated reporters for child abuse.
- 42
- 43
- 44 (b) Training for Team Members
- 45 The Primary Contractor will ensure that M/FST members have both an initial
46 orientation to and on-going training in the following areas:
- 47 (i) M/FST members must have basic knowledge of mental illness and addictive
48 diseases and an understanding of the concept of recovery and resilience in relation
49 to older adults, adults and children and adolescents. Persons performing Family
50 Satisfaction activities must also have an understanding of serious emotional
51 disturbance and substance abuse disorders in children and adolescents. M/FS
52 teams must have an understanding of the impact of aging as it relates to mental
53 illness and the older adults.

- (ii) Training for M/FST members must include confidentiality regulations for mental health and substance abuse services. Family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services. Training must include an understanding of responsibilities, as applicable, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- (iii) M/FST members must also have an understanding of the cultural diversity of the individual and community being served in order to ensure culturally sensitive interactions. Training shall include the basic concepts of recovery and resilience.
- (iv) Family satisfaction team members must have training in the responsibilities of being mandated reporters for child abuse.
- (v) The Primary Contractor shall arrange a minimum of two (2) hours orientation/training on the BH-MCO operations, policies and procedures for satisfaction team members.
- (vi) Training on the ROSI Survey and survey methods.

3. Confidentiality

All employees of M/FST Programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of behavioral health service recipients. The contract or written agreement will address confidentiality requirements including the following:

- (i) All M/FST members must receive training in confidentiality regulations for mental health and substance abuse services. All family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services.
- (ii) All M/FST members must sign a confidentiality agreement, and personnel policies must address disciplinary procedures relevant to violation of the signed confidentiality agreement.
- (iii) Mental Health Confidentiality: For purposes of the HealthChoices program, M/FSTs are agents of the Primary Contractor, and have the delegated authority to collect and disseminate the needed information. M/FST team members must be considered as equal to all other mental health professionals with regard to access to HealthChoices members, children and adolescents with serious emotional disturbances and their families. There should be no written permission required to engage members and families receiving mental health services, whether in the state hospitals or community programs.
- (iv) Mental Health Confidentiality: If the Recipient of mental health services is a child (up to 14 years of age), he or she may be interviewed but only in the presence of a responsible family member or authorized caregiver, and the family member or caregiver must also be interviewed. If the Recipient of mental health services is an adolescent (14 to 18 years of age), the adolescent should be interviewed independently and responsible family members or an authorized caregiver could also be offered the opportunity to be interviewed. It is preferable but not necessary to receive the adolescent's consent before interviewing family members or caregivers.
- (v) Drug and Alcohol Confidentiality: A service agreement between the M/FST Program and each Drug and Alcohol Provider outlining Drug and Alcohol confidentiality rules, rights, regulations and laws that govern Drug and Alcohol Providers in Pennsylvania is also required. This is consistent with the current practice of Drug and Alcohol Providers to require such an agreement be signed by representatives of the Departments of Health and Public Welfare, Joint Commission on Accreditation of

1 Healthcare Organizations, and Single County Authorities for Drug and Alcohol
2 services.
3

4 (vi) Drug and Alcohol Confidentiality: Prior to a drug and alcohol service Provider
5 contacting a M/FST Program to provide the name of a person who wishes to be
6 surveyed, a consent to release information form must be signed by the Member
7 requesting their name, address and telephone number be provided to the M/FST
8 Program. A copy of the signed consent to release information form must be retained
9 in the Member's treatment file and a copy given to the Member and the M/FST.
10 Consent to release information forms for Members receiving drug and alcohol
11 treatment services are not required when the M/FST conducts surveys without
12 receiving the person's name and reports data in the aggregate.
13

14 (vii) Drug and Alcohol Confidentiality: Recipients of drug and alcohol treatment
15 services, regardless of age, must give their written consent for a parent or other
16 family member to be interviewed, or to be present while the Recipient of services is
17 being interviewed.
18

19 (viii) M/FSTs must be afforded the opportunity to meet with recipients of mental health
20 and substance abuse services and the family members of child and adolescent
21 service Recipients to describe and explain the purpose and function of M/FSTs.
22

23 **4. Conducting Satisfaction Surveys**

24 Member and family satisfaction interviews serve as a means for early identification and resolution of
25 problems related to service access, and timeliness of service delivery, appropriateness of services
26 and recovery and resilience orientation and outcomes. Interviews afford Members the opportunity
27 to communicate openly with peers on an on-going basis. Additionally, satisfaction surveys assist in
28 determining the level of satisfaction with respect, dignity and hopefulness as integral components of
29 the entire service delivery system. These activities also provide a further check to ensure that the
30 service system is consistent with the principles of recovery in adults, resilience in children and
31 adolescents, of the Community Support Program (CSP), the Child and Adolescent Service System
32 Program (CASSP), cultural competence, and Drug and Alcohol (D&A) Treatment Principles. The
33 Primary Contractor shall ensure:
34

35 (i) Obtaining Member Contact Information: The Primary Contractor shall establish mechanisms
36 to inform all newly enrolled Members receiving mental health and/or drug and alcohol services
37 about the M/FST Program. M/FST surveyors are encouraged to work directly with providers to
38 obtain member information and offer the opportunity to participate in a face-to-face survey
39 when the surveyor is on-site.

40 (1) A mechanism must be established to provide an opportunity to be interviewed at least
41 annually for Members that remain enrolled in mental health and drug and alcohol services.
42 The Primary Contractor will provide the M/FST the contact information of Members (names,
43 telephone numbers, and age group) whom have received mental health services within the
44 past 12 months.
45

46 (2) Members receiving drug and/or alcohol services must sign a release of information with
47 their provider to release the name, address and telephone number to the M/FST. Other
48 Members receiving D&A services may self-disclose that information, sign a release
49 agreement and participate in a face-to-face survey when an M/FST surveyor is on-site.
50

51 (ii) Sampling Procedure

52 (1) On receipt of the Member List of HealthChoices participants for the previous year, the M/FST
53 will randomly identify and interview a minimum of 30 members who have received services
54 in the past year. These members will be interviewed in person, using the ROSI.
55

- 1 (2) The remaining Members from the List of HealthChoices participants must be surveyed in
2 representative proportions of the members served by the primary contractor's behavioral
3 health program; i.e. by provider/service, in the adult priority groups, older adult group,
4 family members of child and adolescent service recipients and special needs population.
5 (iii) Mode of Survey (in person, telephone, etc.)
6 (1) The selected members surveyed using the ROSI will be interviewed face to face.
7
8 (2) Survey formats should be face-to-face, mailed, telephonic and other approved methodologies
9 as required by the annual plan, with deference to member preference and life circumstances.
10 (a) Face to face interviews are preferred when feasible.

11
12 (iv) Environment of Face to Face Surveys

13 Service Providers must provide M/FSTs with comfortable private space for interviews to ensure
14 an environment in which behavioral health members and their families feel free to express any
15 concerns they may have.

- 16
17 (v) Young adults (18-22) may be interviewed by either consumer or family satisfaction team
18 members, as appropriate.
19

20 **5. Satisfaction Survey Content**

21 Members and their families shall have input into the questions asked in
22 satisfaction/recovery/resiliency surveys. The survey tool should allow identification of the
23 Provider(s) and the service(s) provided as well as general satisfaction with the service system.
24

25 Surveys will include but not be limited to the following areas:
26

27 (i) BHMCO Related Issues

- 28 (1) Knowledge of and satisfaction with member services
29
30 (2) Knowledge of benefits and treatment options
31
32 (3) Awareness of complaint and grievance process (and satisfaction with outcome if process
33 was used)
34
35 (4) Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff
36
37 (5) Interagency Team Process for children and adolescents and their families Choice of
38 Providers
39
40 (6) Satisfaction with timeliness and convenience of the service delivery system
41
42
43 (7) Perception of accessibility and acceptability of services (i.e., denial of preferred services,
44 geographic, language/culture, problems resulting in discontinuation of services by
45 Recipient)
46
47 (8) Some of the M/FST survey questions should address satisfaction with the Provider(s) and
48 the mental health and drug and alcohol service(s) the member is receiving.

49 (ii) Provider related issues:

- 50 (1) The findings of the M/FST shall be organized to identify the Provider, or special population
51 in the case of a focused survey for four purposes:
52 (a) to allow the managed care organization to include M/FST information in Provider
53 profiling.

- 1 (b) to provide feedback to the individual Provider about their program.
2 (c) to allow the Primary Contractor (County and/or Managed Care Organization) to direct
3 the Provider to take corrective action to address a Member concern or concerns about
4 the Provider operation or program.
5 (d) Surveys should identify member and family member satisfaction with the services of a
6 specific Provider as well as the level of satisfaction with the behavioral health system
7 and all of the treatment, services and supports each member is receiving. This is
8 primarily accomplished by gathering information through discussions with members of
9 behavioral health services and the families of child and adolescent service members,
10 with follow-up reports, dialogue, and problem resolution feedback with the Primary
11 Contractor.
12
13 (2) The Primary Contractor will identify and request the M/FST to conduct outreach efforts to
14 under-served or un-served groups of members and families as outlined in Appendix Q, in
15 order to conduct satisfaction surveys and identify system improvements that will increase
16 the access, engagement and retention of these individuals in needed behavioral health
17 services.
18
19 (iii) Service Delivery issues:
20 (1) Both the on-going surveys and the annual survey described in Section B can be used to
21 identify trends that may require system improvement.
22
23 (2) M/FSTs solicit input from Recipients of behavioral health services and their families in order
24 that satisfaction and areas of concern can be identified, recovery & resiliency oriented
25 service delivery can be assessed and recommendations for systems improvement can be
26 developed. This can be accomplished through individual and/or group discussions, upon
27 discharge from a service, and as focus groups with behavioral health consumers, persons in
28 recovery, children and adolescents with serious emotional disturbance and/or substance
29 abuse disorders and their families, including visits to programs where members receive
30 their services or to their homes.
31 (a) Family members may be more easily accessed when interviews are conducted by
32 telephone. Information about the M/FST Program is best shared in face-to-face
33 presentation with individuals or groups, however, such methods as videotapes,
34 telephone or written material may also be used.
35 (b) New technologies for survey administration will be considered by OMHSAS after piloting
36 results are available to show that the technology does not decrease reliability or security
37 of the responses by members.
38
39 (iv) Treatment issues
40 (1) Service Recipient involvement in treatment planning and decisions
41 (2) Child or adolescent and their family members involvement in treatment planning and
42 decisions
43 (3) Interagency Team Process for children and adolescents and their families
44 (4) Perception of effectiveness/outcomes of treatment
45 (5) Perception of changes in quality of life as a result of treatment
46 (6) Satisfaction with dignity, respect and hopefulness offered during treatment
47 (7) Satisfaction with physical health care
48
49 (v) Overall Satisfaction
50 (1) Degree to which services were consistent with CSP, CASSP and D&A principles, and facilitate
recovery and resilience

- 1 (2) Freedom from sense of coercion or fear of retribution for Recipients of mental health
- 2 services
- 3 (3) Satisfaction and comfort level with physical environment of facility or site where services
- 4 were provided.
- 5 (4) Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.
- 6
- 7 (vi) Indicators of personal recovery
- 8 (1) Health concerns are met; behavioral and medical
- 9 (2) Living conditions foster recovery
- 10 (3) Personal time is meaningful
- 11 (4) There is connection to the community
- 12 (5) Spiritual needs are met
- 13 (6) Friendship/companion needs are met
- 14 (7) Education and meaningful employment
- 15
- 16 **6. Problem Identification and Response**
- 17 (i) Process for Problem Identification
- 18 M/FSTs must provide feedback to the Primary Contractor through written quarterly reports and
- 19 periodic problem resolution meetings that allow for dialogue and review of findings.
- 20
- 21 (ii) Process for Problem Response and Resolution
- 22 (1) The problem resolution process must include how often problem resolution meetings will
- 23 occur, with whom, and the responsibilities of all parties (County, M/FST, managed care
- 24 organization, and Providers). This process will identify actions to be taken by the Primary
- 25 Contactor if resolution is not reached.
- 26 (a) There must also be a process in place for responding to urgent matters identified by
- 27 Members.
- 28 (b) The Process for problem identification and resolution includes the M/FST Program,
- 29 members, persons in recovery, parents, adolescents, children, designated county staff,
- 30 staff of the managed care organization, and advocates as appropriate to the problem
- 31 identified.
- 32
- 33 (2) Primary Contractor Responsibilities
- 34 The contract or written agreement shall identify the process the Primary Contractor will use
- 35 to resolve problems and address suggestions identified by the M/FST including the
- 36 following:
- 37 (a) The Primary Contractor will ensure that timely reports are provided to the M/FST on
- 38 specific actions and problem resolution resulting from identified issues, concerns and
- 39 problems. The contract or written agreement shall identify the process the Primary
- 40 Contractor will use to resolve problems and address suggestions identified by the
- 41 M/FST including the following.
- 42 (b) This process will identify actions to be taken by the Primary Contactor if resolution is
- 43 not reached. There must also be a process in place for responding to urgent matters
- 44 identified by Members.
- 45 (c) The Primary Contractor will ensure a timely response to the M/FST on actions taken in
- 46 response to reported problems and concerns resulting from service Recipient
- 47 interviews for inclusion in the next quarterly report.

1 (d) Mechanisms must be in place to address identified trends or system changes that may
2 require the Primary Contractor to study in more depth to understand the issue and
3 resolve. This may include focus meetings on specific topics or collaboration with other
4 involved service systems. The results of these focus studies will be provided to the
5 M/FST for inclusion in their reports.
6

7 (3) Provider Responsibilities

8 The Managed Care Organization sub-contracts with Providers of behavioral health services
9 in their network shall include the timeframe in which the Provider must respond to the
10 recommendations made by the M/FST as directed by the County, Managed Care
11 Organization or the M/FST. Providers of behavioral health services are expected to use
12 M/FST feedback in their quality management program.
13

14
15 **7. Formal Reporting**

16 (i) Formal reporting and Review

17 (1) The ROSI data will be reported on a prescribed timeline to be determined by DPW using the
18 approved template.

19 (a) The ROSI survey data are the earliest results reported by the Primary Contractor to
20 DPW.
21

22 (2) The Primary Contractor submits to DPW the ROSI survey data and the M/FST state-wide
23 questions using the approved template on a quarterly basis.
24

25 (3) The Primary Contractor shall provide OMHSAS and the M/FST with the M/FST Program's
26 **quarterly report for the first three quarters of the measurement year, and a yearly report**
27 **summarizing member and family satisfaction findings, as well as improvement actions and**
28 **system changes implemented by the Primary Contractor in response to those findings during**
29 **that year.**
30

31 (4) The Primary Contractor shall provide support and direction to the M/FST to ensure the
32 report contains not only the numeric results of surveys conducted but also information
33 about the actions taken, trends observed, and other relevant information that can be used to
34 improve treatment ad supports.
35

36 (ii) DPW will periodically review the M/FST programs.

37 (1) The review will include:

38 (a) Results of the surveys;

39 (i) Review how M/FST information is used for Quality Management;
40

41 (ii) Actions taken to resolve identified individual issues:
42

43 (iii) M/FST information is incorporated into quality initiatives by the primary
44 contractor.
45

46 (iii) Actions taken to resolve identified individual issues:

47 (1) Role and effectiveness of the Primary Contractor in problem resolution and direction to the
48 M/FST program;
49

50 (2) Role of the fiduciary, if applicable, in supporting the program and financial priorities
51 established by the M/FST program; and
52

53 (3) Progress on gaining skills and abilities of the M/FST program to move toward operating as
54 an independent, conflict free, satisfaction program, as applicable; and
55

1 (4) DPW will provide the Primary Contractor, Managed Care Organization and M/FST feedback
2 on their findings regarding the review on a periodic basis.
3

4 (a) DPW may from time to time require specific questions to be added to M/FST surveys in
5 order to conduct statewide quality assurance activities.
6

7 **B. Annual Member Satisfaction Survey by the BH-MCO**

8 The purpose of the Annual Member Satisfaction Survey is to determine the extent to which the BH-MCO
9 adult Members and family members of children and adolescents are satisfied with overall BH-MCO
10 operations and services, and to identify areas which need improvement. Surveys are developed and used
11 by the BH-MCO to gather information to determine whether the BH-MCO adult Members and family
12 members of children and adolescents are knowledgeable about and satisfied with the behavioral health
13 program including core functions such as member services as well as to assess whether service
14 availability, service access, trained staff and services provision and effectiveness are meeting the
15 Member's needs and expectations.
16

17 (i) General Requirements

18 (1) Surveys of Recipients of substance abuse services, regardless of age, must be distributed by
19 Providers at service delivery sites in order to protect the confidentiality of persons being
20 surveyed.

21 (2) A separate survey instrument must be developed for children and adolescent service
22 Recipients and their families.

23 (3) Findings and resulting recommendations from the survey and consumer/family satisfaction
24 activities are to be incorporated into the Primary Contractor's ongoing quality management
25 and improvement program.

26 (4) The County may directly conduct the annual survey or direct the managed care organization,
27 M/FST Program, or another entity that would be conflict free, to conduct the annual survey.
28

29 (ii) Conducting Annual Satisfaction Surveys

30 (1) Frequency

31 (a) An Annual Member Satisfaction Survey will be conducted.

32 (2) Party Conducting Survey

33 The Primary Contractor is responsible for ensuring that the BH-MCO conducts an annual
34 satisfaction survey.

35 (3) Mode of Survey- conducted by mail or telephonically

36 (a) Sampling Procedure

37 The Annual Member Satisfaction Survey must be conducted with a representative
38 sample of behavioral health service recipients with a statistically valid sampling of
39 members in the adult priority and older adult population groups, family members of
40 child and adolescent service recipients, and special needs populations, as well as a
41 sampling of Members who filed complaints and grievances. The survey of members
42 receiving drug and alcohol services must be anonymously distributed through service
43 Providers.
44

45 (b) Annual Member Satisfaction Survey Content

- 1 (i) Consumers, persons in recovery, and families of children and adolescents shall
- 2 have input into the questions asked in satisfaction surveys. Satisfaction surveys
- 3 shall include but not be limited to the following areas:
- 4 1. BHMCO Related Issues
- 5 a. Knowledge of and satisfaction with member services
- 6 b. Knowledge of benefits and treatment options
- 7 c. Awareness of complaint and grievance process (and satisfaction with
- 8 outcome if process was used)
- 9 d. Satisfaction with level of dignity and respect conveyed to Members by the
- 10 BH-MCO staff
- 11 (iii) Service Delivery
- 12 1. Interagency Team Process for children and adolescents and their families
- 13 2. Choice of Providers and knowledge of procedure to access out of network
- 14 Providers
- 15 3. Satisfaction with timeliness and convenience of the service delivery system
- 16 4. Perception of accessibility and acceptability of services (i.e., denial of preferred
- 17 services, geographic, language/culture, problems resulting in discontinuation of
- 18 services by Recipient)
- 19 (iv) Treatment
- 20 1. Service Recipient involvement in treatment planning and decisions
- 21 2. Child or adolescent and their family Members involvement in treatment
- 22 planning and decisions
- 23 3. Interagency Team Process for children and adolescents and their families
- 24 4. Perception of effectiveness/outcomes of treatment
- 25 5. Perception of changes in quality of life as a result of treatment
- 26 6. Satisfaction with dignity, respect and hopefulness offered during treatment
- 27 7. Satisfaction with physical health care
- 28 8. Satisfaction with discharge planning
- 29 (v) Overall Satisfaction
- 30 1. Degree to which services were consistent with CSP, CASSP and D&A principles,
- 31 and facilitate recovery and resilience
- 32 2. Freedom from sense of coercion or fear of retribution for Recipients of mental
- 33 health services
- 34 3. Satisfaction and comfort level with physical environment of facility or site
- 35 where services were provided
- 36 4. Satisfaction with dignity, respect and hopefulness offered by all levels of the
- 37 service system
- 38 (vi) Miscellaneous
- 39 1. Items required by DPW as a result of the DPW's ongoing monitoring and
- 40 program evaluation

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2. Knowledge of and satisfaction with the Medical Assistance Transportation Program
 3. Satisfaction of consumers with special needs e.g. deaf and hard of hearing, older adults, people who are homeless, etc.
 4. Suggestions for improvement
- (b) Utilization of Annual Member Satisfaction survey results
- (i) Primary Contractor Quality Management
Findings and resulting recommendations from the Annual Member Satisfaction survey and member/family satisfaction activities are to be incorporated into the Primary Contractor's ongoing quality management and improvement program.
 - (ii) Identification of Opportunities for System Improvement
A report of the survey findings and resulting recommendations for quality improvement must be submitted to the Department as part of the annual quality management summary report, quality management plan for the upcoming year.
- (c) Reporting (Annual)
A report of the survey findings and resulting recommendations for quality improvement must be submitted to the Department as part of the annual quality management summary report, quality management plan for the upcoming year.

