

SAPC All Provider Meeting

# Patient Treatment Perceptions Survey (TPS)

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# Outline

- **Purpose of Treatment Perceptions Survey (TPS)**
- **Target Population and Survey Forms**
- **Survey Packet Pickup / Download**
- **TPS Mandatory Training**
- **TPS Webpage**
- **Return of Completed Survey Forms**
- **Q&A**



LAC's Treatment Perceptions Survey is scheduled on:  
**Monday, January 22, 2018 to**  
**Friday, January 26, 2018**



## Purpose of the TPS

- Obtain feedback on patient perceptions of care, which will be used to improve services.
- Fulfill Los Angeles County's External Quality Review Organization (EQRO) requirement to conduct a patient satisfaction survey using a validated tool.
- Address the data collection needs for the Centers for Medicare and Medicaid Services requirement to evaluate the DMC-ODS demonstration pilot.
- Supports DMC-ODS quality improvement efforts by providing key information on the impacts of DMC-ODS and the new continuum of care.



## Who Should Receive a Survey

- **Survey every patient (12+) who receives a face-to-face service during the survey period.**
  - Adult TPS (age 18+; grey form)
  - Youth TPS (age 12-17; blue form)
- **Patient participation is optional, but providers should distribute the TPS to ALL patients.**
- **Each patient should complete ONLY ONE survey for each provider facility where they receive services.**
- **Patients who receive services at more than one treatment facility during the survey period should be given a survey form at each facility.**



# Survey Forms- Adult

**Treatment Perceptions Survey (Adult)** Print PDF as needed.  
Do not photocopy!

**County / Provider Use Only**

Provider ID:

Facility ID:

Treatment Setting:  
 OP    Residential 3.1    WM 1  
 IOP    Residential 3.3    Residential WM 3.2  
 OTP    Residential 3.5    Inpatient WM 3.7/4.0

Please answer these questions about your experience at this program. If the question is about something you have not experienced, fill in the circle for "Not Applicable".  
**DO NOT WRITE YOUR NAME ON THIS FORM.**

Your answers must be able to be read by a computer. Therefore, please use a pen, fill in the circle completely, and choose only one answer for each question.

Today's Date (MM/DD/YYYY)      Correct      Incorrect

/  / 201

Strongly Agree    Agree    I am Neutral    Disagree    Strongly Disagree    Not Applicable

1. The location was convenient (public transportation, distance, parking, etc.).
2. Services were available when I needed them.
3. I chose the treatment goals with my provider's help.
4. Staff gave me enough time in my treatment sessions.
5. Staff treated me with respect.
6. Staff spoke to me in a way I understood.
7. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).
8. Staff here work with my physical health care providers to support my wellness.
9. Staff here work with my mental health care providers to support my wellness.
10. As a direct result of the services I am receiving, I am better able to do things that I want to do.
11. I felt welcomed here.
12. I like the services offered here.
13. I was able to get all the help/services that I needed.
14. I would recommend this agency to a friend or family member.

## Comments

Please do not write any information that may identify you, including but not limited to your name and/or phone number.

## Please answer the following questions

1. How long have you have received services here?  
 First visit/day    2 weeks or less    More than 2 weeks

### 2. Gender Identity (Please mark all that apply):

- Female
- Male
- Transgender
- Additional identity →
- Decline to answer

### 3. Race/Ethnicity (Please mark all that apply):

- American Indian/Alaskan Native
- Asian
- Black/African American
- Latino
- Native Hawaiian/Pacific Islander
- White/Caucasian
- Other
- Unknown

4. Age:

Thank you for taking the time to answer these questions!

# Survey Forms- Youth

**Treatment Perceptions Survey (Youth)** Print PDF as needed.

*County / Provider Use Only*

Provider ID:

Facility ID:

Treatment Setting:

OP       Residential 3.1  
 IOP       Residential 3.5  
 DTP       Inpatient WM 3.7/4.0

Please answer these questions about your experience at this program. If the question is about something you have not experienced, fill in the circle for "Not Applicable". DO NOT WRITE YOUR NAME ON THIS FORM.

Your answers must be able to be read by a computer. Therefore, please use a pen, fill in the circle completely, and choose only one answer for each question.

Today's Date (MM/DD/YYYY)

  /  /

Correct  Incorrect

Strongly Agree  
Agree  
Undecided  
Disagree  
Strongly Disagree  
Not Applicable

1. The location of services was convenient for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Services were available at times that were convenient for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. My admission experience was too long.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. My counselor and I worked on treatment goals together.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I received services that were right for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Staff treated me with respect.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I feel my counselor took the time to listen to what I had to say.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I developed a positive, trusting relationship with my counselor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I feel my counselor was sincerely interested in me and understood me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I liked my counselor here.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. My counselor is capable of helping me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. As a result of the services I received, I am better able to do things I want to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Overall, I am satisfied with the services I received.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I would recommend the services to a friend who is in need of similar help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Let us know your comments – what was most helpful about this program?

Please do not write any information that may identify you, including but not limited to your name and/or phone number.

## What would you change about this program?

## Do you have any further comments or suggestions?

## Please answer the following questions:

- How long have you received services here:
  - First visit/day
  - 1 - 2 months
  - 6 months to 1 year
  - I have received services for less than one month
  - 3 - 5 months
  - More than 1 year
- Gender identity (please mark all that apply):
  - Female
  - Male
  - Transgender
  - Additional identity →
  - Decline to answer
- Race/Ethnicity (please mark all that apply):
  - American Indian/Alaskan Native
  - Asian
  - Black/African American
  - Latino
  - Native Hawaiian/Pacific Islander
  - White/Caucasian
  - Other
  - Unknown
- Age:

Thank you for taking the time to answer these questions!



## Survey Packet Pick up/Download

- **Pick up your survey packet – Available 12/7/17 through 1/19/18**
  - Survey packets are specific to your provider agency and facility locations within your agency
  - **Provider ID**
  - Provider/Patient instructions
  - Envelops
  
- Survey forms will also be available on SAPC website
  - <http://publichealth.lacounty.gov/sapc/TPS/tps.htm>
    - Adult TPS available in 13 languages
    - Youth TPS available in English and Spanish





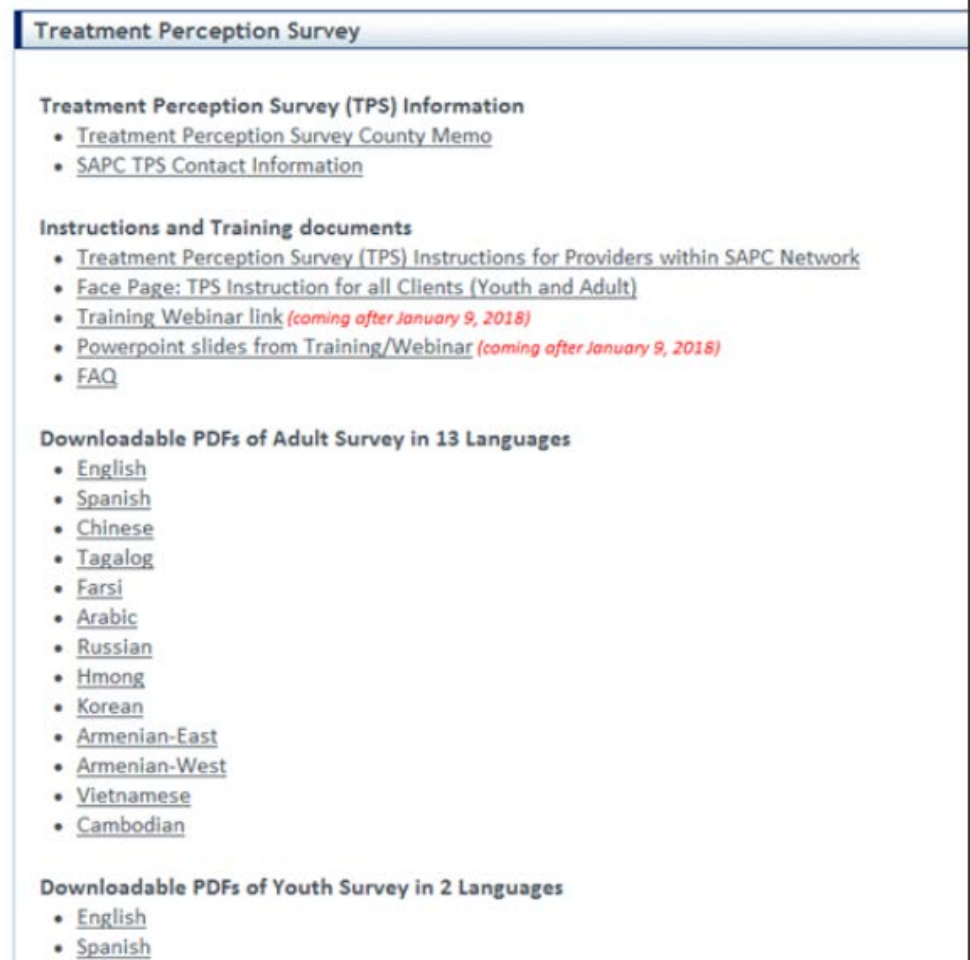
## TPS Mandatory Training

- Scheduled on **January 9, 2018** in G-2 at SAPC:
  - A representative from your agency is required to attend at least **ONE** of the following sessions:
    - Morning Session (10:00-11:30am); OR
    - Afternoon Session (1:00-2:30pm); OR
    - Webinar
  - Detailed information on training and webinar will be sent out via email.
  
- To facilitate the train-the-trainer format, the training session will be recorded and uploaded on SAPC TPS website.



# Treatment Perceptions Survey Webpage

<http://publichealth.lacounty.gov/sapc/TPS/tps.htm>



**Treatment Perception Survey**

**Treatment Perception Survey (TPS) Information**

- [Treatment Perception Survey County Memo](#)
- [SAPC TPS Contact Information](#)

**Instructions and Training documents**

- [Treatment Perception Survey \(TPS\) Instructions for Providers within SAPC Network](#)
- [Face Page: TPS Instruction for all Clients \(Youth and Adult\)](#)
- [Training Webinar link \(coming after January 9, 2018\)](#)
- [Powerpoint slides from Training/Webinar \(coming after January 9, 2018\)](#)
- [FAQ](#)

**Downloadable PDFs of Adult Survey in 13 Languages**

- [English](#)
- [Spanish](#)
- [Chinese](#)
- [Tagalog](#)
- [Farsi](#)
- [Arabic](#)
- [Russian](#)
- [Hmong](#)
- [Korean](#)
- [Armenian-East](#)
- [Armenian-West](#)
- [Vietnamese](#)
- [Cambodian](#)

**Downloadable PDFs of Youth Survey in 2 Languages**

- [English](#)
- [Spanish](#)

## Return Completed Survey Forms

- Compile the completed forms by each facility within your agency.
  - Deliver them to SAPC in-person or by mail (postmarked) by **5 PM February 2, 2018.**
    - Return all unused surveys and envelopes
    - Return surveys marked “Declined”
- \* Analysis and report by County, agency, and facility level (if applicable) will be available.



# Thank you!



For more questions, please contact:

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