



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

Department of
Health and Social Services

DIVISION OF BEHAVIORAL HEALTH
Director's Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

March 14, 2014

Dear Behavioral Health Providers¹,

RE: Implementation of the CSR-2014

The Division of Behavioral Health (DBH) announces the release of the 2014 version update of the Client Status Review of Life Domains (CSR) instrument, which is available for immediate use. Included in this letter is a description of the *CSR-2014* changes, the motivating factors influencing those changes, and timelines for transition and implementation of the new instrument.

1. Federal reporting requirements have changed and as a result, modifications to CSR questions have occurred in the following topical areas:
 - “Legal Involvement”- reference CSR questions #11 & #12.
 - “Housing” - reference CSR question #22.
 - “School” - reference CSR question #23.
 - “Employment”- reference CSR question #24.
2. Federal Health Care Reform has initiated systems expansion which includes expectations for increased collaboration between behavioral health and primary care. When behavioral health and medical conditions co-occur, the combination is associated with an elevated symptom burden, compounded functional impairment, decreased length and quality of life, and increased health and treatment costs. The most common comorbid medical conditions for behavioral health clients include diabetes, pulmonary, and cardiovascular disease. Four modifiable health risk behaviors are responsible for much of the high rates of comorbidity, the illness burden, and early deaths associated with chronic diseases.² Changes to the *CSR-2014* include questions that target these “four modifiable health risk behaviors”:
 - Tobacco use - reference CSR questions #13 & #14.
 - Excessive alcohol and illicit drug consumption - reference CSR questions #7, #8, & #9.
 - Lack of physical activity - reference CSR question #15.
 - Poor nutrition - reference CSR questions #16 & #17.
3. National Accreditation requirements include expectations of additional sources of client feedback on quality of care. The addition of CSR question #19 will allow providers to fulfill the requirement of a secondary source of client feedback regarding quality of care and outcomes achieved as a result of treatment.

¹ Division Treatment Grantees, BRS Residential, ASAP Providers, DOC Substance Use Disorder Treatment Providers

² Centers for Disease Control and Prevention. Chronic Diseases and Health Promotion, 2010; www.cdc.gov/chronicdisease/overview/.

4. Timeline and Transition:

- Providers can begin using the CSR-2014 immediately.
- The AKAIMS has been programmed to accept submission of data from the new CSR.
- The Division recognizes that BH provider agencies will require a transition period to make internal changes to their business and clinical practices. Therefore, the AKAIMS application is enabled to allow both the old and new versions of the CSR to be entered during this transition.
- The target date for *full* implementation of the new *CSR-2014* instrument is April 15, 2014.
- After April 15, 2014, the AKAIMS application will only accept data submitted from the *CSR-2014* version.

Agencies using an “Electronic Data Interface” (EDI)

For agencies that use an electronic data interface (EDI), it is recognized that the transition will involve additional planning. For each EDI Agency, the following tasks are necessary:

- Coordinate programming with your EHR vendor to accommodate the new CSR.
- Change data submission transactions to accommodate the new CSR.

Division AKAIMS programmers have completed modifications to the state repository to accept the new information. To access the updated documentation of the new requirements contact Steve Cocroft (AKAIMS Programmer) at (907) 269-7491.

In addition, please note the following:

- Providers are encouraged to use the “Question & Answer” sessions during the bi-weekly Wednesday teleconferences if questions related to the *CSR-2014* emerge.
- The *AST/CSR Clinical Guidance Document*, located on the Division’s website, is in process of being updated to accommodate the new version of the *CSR-2014*.
- The transition from the *CSR-2011* to the *CSR-2014* will have no impact on the current performance measures for Grant Quarterly Reviews and Performance Based Funding.
- The hard-copy version of the *CSR-2014* is attached, and is also available through the AKAIMS application, and the Division webpage entitled “ Performance Management System”, located at <http://dhss.alaska.gov/dbh/Pages/Performance%20Measures/Default.aspx>

Your patience during this transition is appreciated. This effort will continue to help the Division refine its *Performance Management System* in the areas of efficiency, effectiveness, and treatment service outcomes. It will also assist the Division in fulfilling its federal reporting obligations.

Sincerely,


Barbara Henjum
Acting Director

Attachment: CSR – 2014

CLIENT STATUS REVIEW

Case Number:

Type of CSR: Initial 90-135 Day Follow-Up Discharge Administered by: _____

Date Completed: ____/____/____ Name: _____

Are you completing this survey for? (Please check one) I filled this out by myself (age 12 and older)
 I filled this out for a child/youth (Under age 12) Someone helped me fill this out

What best describes the reason you came in for services today? Select all that apply...
 I decided on my own I was encouraged by others (like family, friends, etc.)
 I was required to come (including court order, Office of Children's Services, etc.)

Health and Quality of Life		# of Days
1. How many days during the past 30 days was your physical health (including physical illness and/or injury) not good?	-----	<input type="text"/>
2. How many days during the past 30 days was your mental health (including depression and/or problems with emotions, behavior, or thinking) not good? -----	-----	<input type="text"/>
3. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities, such as taking care of yourself, work, or recreation?-----	-----	<input type="text"/>
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? -----	-----	<input type="text"/>
		# of Times
5. In the past 30 days, how many times have you used emergency medical services such as the hospital, emergency room, or emergency medical technicians/health aides? -----	-----	<input type="text"/>
6. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Substance Use		# of Days
7. How many days during the past 30 days have you had at least one alcoholic beverage? -----	-----	<input type="text"/>
8. How many days during the past 30 days have you had 4 or more alcoholic beverages? -----	-----	<input type="text"/>
9. How many days during the past 30 days have you used marijuana or illegal drugs (including medications not as prescribed or directed)? -----	-----	<input type="text"/>

Legal Involvement		# of Times
10. In the past 30 days, have you had any legal involvement (legal charges, court appearance, arrests, probation or parole) <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. In the past 30 days, how many times have you been arrested? -----	-----	<input type="text"/>
12. In the past 12 months, how many times have you been arrested? -----	-----	<input type="text"/>

Health Behavior		# of Days
13. How many days during the past 30 days have you smoked cigarettes, pipes, or cigars AND/OR used chewing tobacco, snuff, or snus? -----	-----	<input type="text"/>
14. How many days during the past 30 days have you smoked 20 or more cigarettes per day? -----	-----	<input type="text"/>
15. How many days during the past 7 days did you participate in any physical activities or exercise such as running, sports (basketball, baseball etc.), swimming, bicycling or walking for exercise? -----	-----	<input type="text"/>
		# of Times
16. During the past 7 days, how many times did you drink 100% fruit juice or eat fruit? -----	-----	<input type="text"/>
17. During the past 7 days, how many times did you eat vegetables? -----	-----	<input type="text"/>

CLIENT STATUS REVIEW

Case Number:

18. Please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question

How do you (or your child) feel about:	Terrible 	Unhappy 	Dissatisfied 	Mixed 	Satisfied 	Pleased 	Delighted 
Your housing?							
Your ability to support your basic needs of food, housing, etc.?							
Your safety in your home or where you sleep?							
Your safety outside your home?							
How much people in your life support you?							
Your friendships?							
Your family situation?							
Your sense of spirituality, relationship with a higher power, or meaningfulness of life?							
Your life in general?							

Please Answer Questions 19 – 21 if you have received services from this agency.

19. Please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question.

How do you feel about the services you (or your child) received?	Terrible 	Unhappy 	Dissatisfied 	Mixed 	Satisfied 	Pleased 	Delighted 
I was treated with respect.							
I was given information about my rights.							
I helped to choose my treatment goals.							
I felt comfortable asking questions about my treatment.							
I was able to get all the services I needed.							
Because of the services I received:							
I am better able to handle daily life.							
I am getting along better with other people.							
I am better able to cope when things go wrong.							
The quality of my life has improved.							

20. What did you like about the services you received? _____

21. What did you dislike about the services you received? _____

Please Answer Questions 22 – 25 with the assistance of agency staff.

22. Which one of the following best describes your housing situation/living arrangement? (In the past 30 days, where have you been living most of the time?) (please check one)

- | | |
|---|---|
| <input type="checkbox"/> Adult in private residence – <u>independent living</u>
(may live with others, but capable of self-care) | <input type="checkbox"/> Crisis residence (short term stabilization) |
| <input type="checkbox"/> Adult in private residence – <u>dependent living</u> (heavily dependent on others for daily living assistance) | <input type="checkbox"/> Residential care facility (assisted living, halfway house, group homes, board & care) |
| <input type="checkbox"/> Child living in private residence (not in foster home) | <input type="checkbox"/> Residential treatment facility for: |
| <input type="checkbox"/> Foster home/foster care | <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Co-occurring Disorder |
| <input type="checkbox"/> Homeless or shelter | <input type="checkbox"/> Institutional care facility (care provided 24 hours, 7 days/week)
(hospital, other inpatient psychiatric facility, nursing facility/home) |
| <input type="checkbox"/> Jail or correctional facility | <input type="checkbox"/> Other (please describe) _____ |

23. Did you attend school at any time in the past three months? Yes No

If you checked 'Yes,' please indicate below the grade/educational level you attended in the past three months.

If you checked 'No,' please indicate below the highest grade/educational level you have completed.

- | | |
|---|--|
| <input type="checkbox"/> No years of schooling | <input type="checkbox"/> College Undergraduate Freshman (1 st year) |
| <input type="checkbox"/> Nursery School/Pre-School (Including Head Start) | <input type="checkbox"/> College Undergraduate Sophomore (2 nd year) |
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> College Undergraduate Junior (3 rd year) |
| <input type="checkbox"/> Self-Contained Special Education Class (No equivalent grade level) | <input type="checkbox"/> College Undergraduate Senior (4 th year) |
| <input type="checkbox"/> Vocational School | <input type="checkbox"/> Graduate or Professional School
(Master's, Doctoral, Medical, Law) |

24. Which one of the following best describes your employment status during most of the previous **week**? (please check one)

- | | | |
|--|---|--|
| <input type="checkbox"/> Employed full time working for money (30 or more hours per week); includes Supported Employment and Armed Forces | <input type="checkbox"/> Employed part time working for money (less than 30 hours per week); includes Supported Employment and Armed Forces | <input type="checkbox"/> Unemployed - actively looking for employment or laid off from job (and awaiting to be recalled) in the past 30 days |
| <input type="checkbox"/> Not in labor/work force (not employed and not actively looking for employment during the past 30 days); if you checked this box, please check one of the following: | | |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Not Yet School Age | <input type="checkbox"/> In Residential Care Facility |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Student | <input type="checkbox"/> In Residential Treatment Facility |
| <input type="checkbox"/> Disabled | <input type="checkbox"/> Job training program | <input type="checkbox"/> Inpatient of Institutional Care Facility |
| <input type="checkbox"/> Volunteer | <input type="checkbox"/> Engaged in subsistence activities | <input type="checkbox"/> Inmate of Jail or Correctional Facility |
| <input type="checkbox"/> Sheltered/Non-competitive employment | <input type="checkbox"/> Other (please describe) _____ | |

25. Over the past 7 days, which one of the following best describes the number of hours you engaged in productive activities (e.g., school, employment, volunteering in community service, subsistence activities, etc.)? (Please check one of the boxes below)

- less than 10 hours
 10-20 hours
 21-30 hours
 31-40 hours
 41-50 hours
 More than 50 hours