State Of Oregon
Oregon Health Authority
Health Systems Division
Problem Gambling Services Unit

Gambling Participant Monitoring System (GPMS)

User Manual

JANUARY 2016

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Change Transmittals Log

#	Title/Description of Change	Date	Made By

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Chapter 1 INTRODUCTION

The data collection protocol manual was first developed by Herbert & Louis in 1992 and then implemented statewide in July 1995. The manual was reviewed and modified in November of 1998. In the spring of 1999, the gambling treatment providers, under the auspices of the Training Committee, conducted an extensive review of the protocol. These changes were compiled in a version of the protocol dated July 1, 2000; however, this version of the protocol was not authorized for implementation due to the extended nature of the transition of program management to the Office of Alcohol and Drug Abuse Programs (OADAP)[1]. Ongoing discussion and periodic reviews by the gambling treatment providers identified areas for additional revisions to meet the changing needs of the program manager, providers, and to reflect advancements in the knowledge base of problem and pathological gambling. This manual has experienced previous revisions in 2001, 2003, 2006, 2007, 2010, minor text revisions in 2013, and this current version of 2016.

This document is a presentation and discussion of the *data fields* that have been approved for the gambling client and family client *datasets*. All demographic worksheets are to be completed by treatment program staff and abstracted from the client/family record. All data is to be submitted to the contract evaluator via US Postal Service: Herbert & Louis, LLC; Data Center; P.O. Box 304; Wilsonville, OR 97070-0304; facsimile at (503) 783-0665; or, secure electronic data transfer.

Question regarding policy should be directed to the Problem Gambling Services Manager, 500 Summer Street NE E86; Salem, OR 97301-1118; Voice: (503) 945-5763; TTY: 800-375-2863 or Email: amh.web@state.or.us.

Change Transmittals

From time to time the contents of this manual are expected to be changed to meet the dynamic needs of a growing system. The second page of this manual contains a Change Transmittal Log. Each of the changes will be promulgated with a change number and title. When the changes are received by the provider, the changes should be made (pages replaced), and the change noted on the Change Transmittal page to facilitate assurance of updated procedures and forms. This manual will be available electronically from the Evaluator as well as posted on publicly accessible electronic sites such as HSD's web site.

PURPOSE

Although it is not the intent of this implementation guide to provide a complete methodological discussion it may be helpful to briefly outline the purposes of the ongoing evaluation efforts:

[1] This name was later changed to Office Of Mental Health and Addiction Services, then to Addictions and Mental Health Division (AMH), and is now the Health Systems Division HSD.

1. Provide descriptive statistical analysis of the clients utilizing services throughout the State;

2. Determine through inferential statistical models the effectiveness of the services being provided;

3. Identify, as possible, statistical correlations among treatments offered and client demographics as they relate to treatment success; and,

4. Develop a formula with which to measure treatment cost/utilization factors as they apply to treatment success.

5. Track provider contract compliance to performance standards as defined in the Problem Gambling Treatment Services element in the OHA HSD County Financial Assistance Agreement.

6. Use the information collected above to direct policy and practice in the design and implementation of a system of excellence to serve Oregonians with problem gambling treatment needs.

The study design incorporates the collection of data at several points across time from clients and family clients that have enrolled in treatment. Admission data is to be collected from all enrollees at the time of admission and mailed to the Evaluator within 14 days of enrollment. This includes the client written survey. Discharge/termination data is to be collected and submitted to the contractor within 90 days of the last face-to-face contact. Timely submission of data is essential in ensuring effective follow-up. Data submission performance will be tracked based on event date (enrollment or discharge).

The Evaluator will initiate follow-up only with clients that have consented to participate in the system wide evaluation. Follow-up with program non-completers will be accomplished at approximately 180 days post discharge. Follow-up with program completers will be accomplished at six and twelve months post discharge windows. It is critical that treatment program staff ensure that the client locator information form is completed fully and accurately.

In an effort to minimize the amount of staff effort required to collect data within the provider organization, instrumentation has been made as brief as possible. A master form for each instrument and data collection form are enclosed. Providers are authorized to locally reproduce all forms.

POINT OF CONTACT

It is required that each treatment program identify a point of contact to serve as the coordinator of the evaluation effort. This individual will be responsible for ensuring appropriate forms are available for completion by clients, family and staff at admission and discharge. Additionally, this individual should be responsible for assimilating the completed forms for mailing to the

evaluator. This individual should contact the evaluator's office to ensure the evaluator's staff have the correct contact information.

DATA COLLECTION

The successfulness of any evaluation effort is primarily based on the ability to consistently collect data from clients and family clients. Although participation in the follow-up portion of the study is to be considered "voluntary," the collection of admission and discharge data from all participants must be considered a standard element of the admission and discharge process to ensure continuity of evaluation capabilities state-wide.

All clients and family clients should be provided the opportunity to sign an informed consent and participation authorization form which will allow evaluator to follow-up at the designated post discharge intervals. For those rare situations when an individual refuses to sign the authorization, all demographic data should be collected. It is generally expected that a minimum of 80% of clients will volunteer for the follow-up and provide locator information.

This manual contains a discussion of the following forms in order of presentation:

Wave 1: Enrollment

1. Gambling Client Enrollment Record Abstracting Form: Used for abstracting key data from the client's record. (Completed on all clients.)
2. Gambling Client Informed Consent and Authorization for Follow-up: Used to provide the client with a specific overview of the follow-up evaluation efforts and the opportunity to volunteer as a participant. (Completed on all clients - special section for refusal.)
3. Gambling Client Survey (Enrollment): A paper and pencil self-report survey to serve as baseline data for longitudinal comparison. (Completed by all clients.)
4. Gambling Client Locator Form: Provides extended contact information to facilitate long term follow-up of gambling and family clients. Same form is used for all enrollees. (Completed only on those who volunteer for follow-up.)
5. Family Client Enrollment Record Abstracting Form: Used for abstracting key data from the client's record. (Completed on all family enrollees.)
6. Family Client Informed Consent and Authorization for Follow-up: Same as Client Informed Consent.
7. Family Client Survey (Enrollment): A paper and pencil self-report survey to serve as baseline data for longitudinal comparison. (Completed by all family enrollees).
8. Family Client Locator Form: Same as Gambling Client Locator Form. (Completed only on those who volunteer for follow-up.)

Wave 2: Discharge/Termination

9. Gambling Client Termination Record Abstracting Form: Used for abstracting key data from the client's record at the time of termination. (Completed on all clients.)

10. Family Client Termination Record Abstracting Form: Used for abstracting key data from the family client record at the time of termination. (Completed on all family enrollees.)

WAVE 3: Semi-annual Client Satisfaction Survey

11. Every six months, to coincide with the Semi-Annual Quality Improvement Reports, agencies are required to survey a representative sample of their active gambler and family clients. These periods are July 1 through December 31 and January 1 through June 30 of each fiscal year. The survey is anonymous and should be administered in a manner that maintains anonymity. Agencies should contact the evaluation team for individualized strategies.

Wave 4: Follow-up (180-Day)

12. Gambling Client Non-completer Survey (Follow-up): A paper and pencil self-report survey with the same core questions as the discharge version. In addition, this instrument contains special questions in an effort to determine potential reasons for non-completion. Follow-up activity conducted by the contractor with telephone follow-up for non-returned surveys. Data collection window is 180 days post termination.

13. Gambling Client Completer Survey (Follow-up): A paper and pencil self-report survey with the same core questions as the discharge version. In addition, this instrument contains a special set of questions regarding outcomes. Follow-up activity conducted by the contractor with telephone follow-up for non-returned surveys. Data collection window is 180 days post termination.

14. Family Client Completer Survey (Follow-up): A paper and pencil self-report survey with the same core questions as the discharge version. In addition, this instrument contains a special set of questions regarding outcomes. Follow-up activity conducted by the contractor with telephone follow-up for non-returned surveys. Data collection window 180 days post termination.

Wave 5: Follow-up - Completers (12-Month)

15. Gambling Client Completer Survey (Follow-up): Same instrument and procedures as Wave 3 at 12 months post discharge.

16. Family Client Completer Survey (Follow-up): Same instrument and procedures as Wave 3 at 12 months post discharge.

CONFIDENTIALITY

Confidentiality of client (gambler and family) identity must be preserved in accordance with prevailing state and federal guidelines including the emerging requirements and interpretations

for the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Public Law 104-191. *It is critical that a copy of the signed authorization accompany the Enrollment Abstracting Form* to ensure that contact information be appropriately processed. Informed Consent and Authorization forms that have the refusal section signed should not be sent to the evaluator. Nonetheless, a note in the clinical charting should be made to the effect that the client declined to participate in the evaluation.

ENCOUNTER DATA

The processing of encounter data is discussed in separate documentation. It is important that providers have on file with the Evaluator appropriate case enrollment documentation that ensures them the opportunity to submit encounter data for reimbursement as per their contract with HSD or the County.

DATA SUBMISSION REQUIREMENTS

a. Enrollment Packet including the Enrollment Record Abstracting Form (Gambler and Family) and Client Survey must be received by the Evaluator within 14 calendar days of enrollment of the client. All clients are required to complete the Client Survey regardless of whether they volunteer to participate in the follow-up evaluation. For those clients consenting to participate in the follow-up, a completed Locator Form must also be included in the packet.

b. Discharge packet consists of the Discharge Record Abstracting Form (Gambler and Family) and must be received by the Evaluator within 90 days of the last face-to-face contact with the client.

c. Semiannual Client Satisfaction Surveys must be completed every six months and received by the Evaluator no later than January 15 for the first half-year and July 15 for the second half-year.

d. Submission of Forms

All forms must be submitted via US Postal Service to the Evaluator at the address below:

Herbert & Louis LLC
Data Processing Center (GPMS)
P.O. Box 304
Wilsonville, OR 97070-0304
Facsimile submissions to: (503) 783-0665
Electronic Submissions
https://www.careaccord.org to herblou.admin
or
Agency's secure email system

CORRECTED: ☐

Chapter 2 GAMBLING CLIENT ENROLLMENT RECORD ABSTRACTING FORM

Leave No Blank Fields:

UK-Unknown, NA-Does Not Apply, NC-Not Collected, CR-Client Refused

Preferred Language: _____

1

Clinic/Provider ID: ☐☐☐☐☐☐☐☐☐☐☐☐ Client Case ID: ☐☐☐☐☐☐☐☐☐☐

2

CLIENT NAME: Last ☐☐☐☐☐☐☐☐☐☐☐☐ First ☐☐☐☐☐☐☐☐☐☐☐☐ MI

Birth ☐☐☐☐☐☐☐☐ DOB: MMDDYYYY ☐☐☐☐☐☐☐☐ Gender: ☐

Ethnicity: ☐☐ ☐☐ County: ☐☐ Zip Code: ☐☐☐☐☐ Access: ☐☐ Referral: ☐☐ _____ Mandated: ☐☐

3

First Contact Date: ☐☐☐☐☐☐ First Available Date: ☐☐☐☐☐☐ Enrollment Date: ☐☐☐☐☐☐ Reason: ☐☐

4

Education: ☐☐ Marital Status: ☐☐ Dependents: ☐☐ ☐☐ ☐☐ ☐☐ Housing: ☐☐

0 - 5 | 6 – 17 | 18 – 64 | 65 +

5

Health Insurance: ☐☐ Employment: ☐☐ Veteran: ☐☐ Income Source: ☐☐ Monthly Household Income: ☐☐☐☐☐☐

6

Gambling Debt: ☐☐☐☐☐☐ Age 1st Gambled: ☐☐ Age Onset: ☐☐

Primary Gambling Activity: Type: ☐☐ _____ Venue: ☐☐ Jurisdiction: ☐☐

Secondary Gambling Activity: Type: ☐☐ _____ Venue: ☐☐ Jurisdiction: ☐☐

Social Gaming ☐☐

7

Diagnostic Impression:

Primary: [ ][ ] Secondary: [ ][ ]

Substance Abuse: [ ][ ][ ][ ][ ] Specifier: [ ][ ]

DSM-IV Pathological Gambling:

- [ ] 1 Preoccupation
- [ ] 2 Tolerance
- [ ] 3 Stop/Control
- [ ] 4 Restlessness
- [ ] 5 Escape
- [ ] 6 Chasing
- [ ] 7 Lying
- [ ] 8 Committed Illegal Acts for $
- [ ] 9 Risked Losing Relationships
- [ ] 10 Bailouts

Suicide:	Job/School Problems:	Bankruptcy:	Relationship Problems:	Legal:
[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]

8

Treatment History:

	Times:	Last Type Treatment	Concurrently Enrolled:	Self Help 12-Step
Gambling:	[ ][ ]	[ ][ ]		[ ][ ]
Alcohol/Drug:	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]
Mental Health:	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]

9

COMPLETE THIS BOX ONLY WITH RELEASE FOR FOLLOW-UP

Client Primary Contact Information

Mailing Address:

City: State: Zip:

Home Phone:

Release Attached: [ ]

10

Primary Counselor:

11

PRINT Completed By: ______________________ Date: ___________ Phone: ________________________

GAMBLING CLIENT ENROLLMENT ABSTRACTING INSTRUCTIONS

The data to be coded into each of the fields on the Client Enrollment Coding Form is discussed by numerical section identification found on the left side of the form.

LEAVE NO BLANK FIELDS

USE THE FOLLOWING CODES FOR ALL FIELDS WHERE THE INFORMATION IS EITHER UNKNOWN, NOT AVAILABLE, OR THE CLIENT HAS REFUSED TO PROVIDE.

UK – UNKNOWN
NA – DOES NOT APPLY
NC – NOT COLLECTED BY AGENCY
CR – CLIENT REFUSED

CORRECTED: Check this box only if the Form is being resubmitted to correct, or update, previously submitted information. Please make a photocopy of the original form, check the corrected box, and indicate the changes on the form with red ink. Please write clearly.

PREFERRED LANGUAGE: Fill in preferred language if other than English

BLOCK 1: *Provider Identification*

Clinic/ Provider Identification: Facility or Clinic name where services are being provided. State issued clinic ID numbers/codes may be substituted.

Client Case Identification Code: This is the same local, discrete case identification that providers have been utilizing. Each client enrolling in the program must be assigned a discrete, confidential 10-character (maximum) alpha-numeric client case identification code by the providing agency. This identification code will be utilized to track the individual throughout his, or her, care with that agency. Readmissions must utilize the same client case identification (ID). This case identification must match all encounter data.

BLOCK 2: *Client Identification*

Name: In UPPER CASE BLOCK LETTERS, enter the entire last name, first name and middle initial of the client with a space between the names. Then enter the *birth name*. Please write legibly. IN ORDER FOR CLAIMS TO BE REIMBURSED THE STATE MUST HAVE THE CLIENT'S NAME.

Definition: Birth Name is the last name of the person as it would appear on his/her birth certificate.

Notes:

1. Check spelling of names for correctness. This is critical for database integrity.
2. Enter client's full given (or legally changed) name, NOT nickname.
3. It is essential that the following letters be printed with exaggerated clarity: **U, V, I, L, D, and O.**

Example: Example of Client Name**:** Alice Johnson is a client who has never been married. JOHNSON would be the "LAST" and "BIRTH NAME." ALICE, of course, would be the "FIRST" name.

Date of Birth: In American format – MM/DD/YYYY

Gender: M= Male; F=Female; O = Other (please specify)

Primary & Secondary Race/Ethnicity:

01 White (Non-Hispanic)
02 Black (Non-Hispanic)
03 Native American
04 Alaska Native
05 Asian
06 Hispanic (Mexican)
07 Hispanic (Puerto Rican)
08 Hispanic (Cuban)
09 Other Hispanic
10 Southeast Asian
11 Other Race/Ethnicity
12 Native Hawaiian/Other Pacific Islander

County: Clients County of Residence

01 Baker	09 Deschutes	17 Josephine	25 Morrow	33 Wasco
02 Benton	10 Douglas	18 Klamath	26 Multnomah	34 Washington
03 Clackamas	11 Gilliam	19 Lake	27 Polk	35 Wheeler
04 Clatsop	12 Grant	20 Lane	28 Sherman	36 Yamhill
05 Columbia	13 Harney	21 Lincoln	29 Tillamook	90 Washington State
06 Coos	14 Hood River	22 Linn	30 Umatilla	91 Idaho
07 Crook	15 Jackson	23 Malheur	31 Union	92 Nevada
08 Curry	16 Jefferson	24 Marion	32 Wallowa	93 California
				98 Other State

NOTE: IF THIS FIELD IS NOT COMPLETED CLAIMS WILL BE DENIED AS AN OUT OF STATE CLIENT. IF THE CLIENT RESIDES OUT OF STATE A WAIVER MUST BE RECEIVED FROM THE PROBLEM GAMBLING SERVICE OFFICE TO CLAIMS BEING APPROVED. CONTACT THE STATE PROBLEM GAMBLING SERVICES OFFICE FOR CURRENT CRITERIA AND APPROVAL PROCEDURES

Client's Zip Code: The US Postal Service ZIP code assigned to the place of residence of the client.

Access Source: This field is to determine where the client acquired the contact information (including phone number) for your treatment agency.

NOTE: THIS CAN NOT BE "SELF" UNLESS THE CLIENT IS PSYCHIC

Codes For Gambling:

AA Oregon Minimal Intervention Program (GEAR)
BB Oregon Gambling Helpline
CC Oregon Council on Problem Gambling
DD Oregon Gambling Foundation
EE Gamblers Anonymous
FF Inpatient Gambling
GG Other Outpatient Gambling
HH National Council on Problem Gambling
II Lottery Outlet Employee (server, bar tender, etc.)
JJ Previous Client Re-enrolling
NN Direct Referral from Peer Mentor Outreach
81 Consumer Credit Counseling
82 Regional/Local Central Intake
87 Placard/sticker on Video Lottery Machine
88 Placard or Sign in a Casino
89 Other Oregon Lottery Retailer Source
90 Other Oregon Casino Source
91 Yellow Page Ad
92 Newspaper Ad
93 Television Ad or Public Service Announcement
94 Radio Ad or Public Service Announcement
95 Web/Internet
96 TV News program or other programming
97 Radio News program or other programming
98 Newspaper/Other magazine news story or article

Personal Support System:

36 Previous/current client from the program
33 Family/ Friend/ Attorney
34 Employer or EAP
38 Self Help Group (NA, CA, etc.)

Local Or State Agencies:

04 Developmental Disabilities Services
05 School
06 Other Community Agencies
07 Support Programs for Adults (TANF/ Food Stamps)
08 Support System for Children (Child Welfare)
11 Vocational Rehabilitation
35 SENIORS and People with Disabilities
37 Youth/ Child Social Services, Center, or Teams

Criminal Justice System:

21 Court
22 Jail - City or County
23 Parole – County/ State/ Federal-including juveniles
24 Police/Sheriff - Local, State
25 Psychiatric Security Review Board
26 Probation -County, State, Federal
27 Alternatives to Street Crimes (TASC)
71 State Correctional Institution
72 Federal Correctional Institution
78 Integrated Treatment Court (Drug Court or Mental Health Court)

Behavioral Health Providers/Agencies:

83 Community-based Service Providers (Mental Health and/or Addictions Services)
84 Other Mental Health/Addiction Services Providers (Independent or Private Practice, e.g., Psychologist/Psychiatrist)
49 Mental Health Organization (MHO)
85 Acute or Sub-Acute Psychiatric Facility
86 State Psychiatric Facility (i.e., EOPC)

Health Providers:

48 Fully Capitated Health Plan (FCHP)
31 Primary Care Provider, Specialist, or Other Physical Health Provider

Other:

99 Other

Referral Source: Using the same codes as described above, indicate if a person, institution, or agency took deliberate action to get the client to the treatment provider. If no other person took ***deliberate*** action to get the client to contact the treatment provider then a code of 32 for a self-referral may be utilized.

32 Self

NOTE: Respite and residential gambling treatment programs please write in the space provided the name of the outpatient gambling treatment program that made the referral.

Mandated: To track if the client was mandated by the referring agency to attend treatment. This should include any referrals where the program is required to provide periodic reports and where the client is under the threat of legal repercussions for failure to attend. Examples include court order, probation/parole order, employer mandate, etc.

01 = Yes; 02 = No

BLOCK 3: *Enrollment Performance Indicators*

First Contact Date: The date in MM/DD/YY format that the client first contacted the program regarding admission or enrollment.

First Available Date: The date of the first available appointment.

Enrollment Date: The date that the client was first provided services. For treatment as usual programs this would be the first face-to-face contact. For minimal intervention programs with telephone only counseling this should be the date the client verbally agreed to enroll in the program.

Reason for Enrollment: This field is used to distinguish between clients (either gamblers or family clients) being seen for intended full treatment or those who might be seen simply for an assessment or for relapse prevention.

01 Regular Treatment Program
02 Assessment Only
03 Relapse Prevention / Abstinence Maintenance (10 Sessions or Less)
04 Other Brief Therapy
06 Inpatient
07 Respite
05 Other

BLOCK 4: *General Demographics*

Education: Highest number of years education completed (GED = 12)

Marital Status:

01 Never Married
02 Married
03 Widowed
04 Divorced
05 Separated
06 Living as Married

Dependents: Number of individuals, **including self**, who are *dependent on the household income* by age group: Under 6 years of age; between 6 and 17 years old; between 18 and 64 years old; 65 and over years old. Please ensure all of the four boxes are completed with ZEROS if there are no dependents in the age categories.

Housing:

01 Own
02 Rent - no subsidies
03 Rent - with subsidies
04 Institution or Group Home
05 Homeless / Shelter
06 Other - Not paying rent ("Crashing" with friends or acquaintances)
07 A&D Free Housing
08 Incarcerated

BLOCK 5: ***Employment/Veteran Status***

Health Insurance: Type of health care benefits available:

05 Veterans Administration
08 Medicaid/Oregon Health Plan
09 Medicare
11 Private Insurance
12 Other Public Assistance Programs
13 None
14 Other

Employment Status:

01 Full Time (35 or more hours / week)
02 Part Time (17 - 34 hours / week)
03 Irregular (Less than 17 hours / week)
04 Not Employed (Employment Sought)
05 Not Employed (Not Looking)
06 Retired
07 Disabled
08 Home Maker/Stay at Home Parent
09 Full Time Student not working

Veterans Status:

01 On Active Duty never deployed to a combat zone
02 On Active Duty previously deployed to a combat zone
03 Veteran never deployed to a combat zone
04 Veteran previously deployed to a combat zone
05 Disabled Veteran never deployed to a combat zone
06 Disabled Veteran previously deployed to a combat zone
07 No military experience

(Combat zone includes formal zones such as Iraq, Afghanistan, Persian Gulf, Viet Nam, SE Asia, Korea, WWII. Also included are other zones such as Somalia, Bosnia, etc. where combat occurred. Chicago does not count.)

Income Source: Primary source of household income:

00 None (no income)
01 Wages, Salary
05 Public Assistance
06 Dividends or Interest
07 Retirement, Pension, Social Security
08 Disability Insurance, SSD, etc.
09 Other

Estimated Income: Estimated ***MONTHLY*** gross household income (in dollars).

BLOCK 6: *Current Gambling Characteristics*

Gambling Debt: Total estimate current unpaid debt related to gambling (in dollars). If no debt, fill with zeros. Debt includes money owed on credit cards; Pay Day Loans; personal loans from friends, family, or bookies; bank loans used to cover gambling expenditures, etc. **It does not include money "borrowed" from self such money from savings or retirement accounts of self or family member. This is not a debt.**

Age First Gambled: Age, in years, at which the client first ever gambled for money.

Age of Problem Onset: Age, in years, at which first repeated problems associated with gambling were first experienced.

Primary Gambling Activity:

Type: This field should be coded with the client's primary gambling activity.

01 Video Poker
11 Slot Machines/Mechanical Reel
21 Video Line Games
04 Cards
14 Scratch Tickets/Pull Tabs/Breakopens
09 Bingo
12 Keno
05 Horses/Dogs/Other Animals
06 Dice
10 Stocks/Commodities/Bonds
02 Sports-Other than lottery Sports Action
08 Numbers
13 Bowling, pool, golf or other skill games
16 Roulette
17 Power Ball/Daily Four/Mega Bucks
19 Lottery Sports Action
20 Charitable games other than bingo (including raffles)
22 Sweepstakes where a product was purchased to enter
24 Dominoes
25 "Fast Race" Electronic Horse or Dog racing "slot" type machines
26 Fantasy Sports
15 Other (please specify on form)
99 No preference of one type over another

Venue: Location or environment where the client engages in the primary gambling activity.

01 Oregon Video Lottery Retailer (Bar/Pub/Restaurant)
02 Indian Gaming Center or Casino
04 Bingo Hall (Use only - other than Indian Gaming Center/Indian Casino)
05 Food Store or Convenience Store - (Such as - purchase Oregon Lottery games)
06 Restaurant/Pub/Bar (Use only - where no State Video Poker/Line Machines are present)
07 Card Room - Public (Not IGC or Casino)
08 Private Club/Lodge
09 Horse or Dog Race Track/Off Track Betting Facility
10 Home (For other than Internet gambling can include Stocks/Commodities)
11 Internet Gambling - e.g. On-line Casinos, Lotteries - Not stocks or commodities
12 Family member or friend's home
13 Work
14 School
16 Day Trading Facility or Brokerage House
15 Other

Jurisdiction: State in which the primary gambling occurs.

01 Oregon	03 Idaho	05 Washington
02 California	04 Nevada	10 Other

Secondary Gambling Activity: These fields are to be utilized to record the client's secondary gambling activity.

Type: Same coding as for primary gambling type.

Venue: Same coding as for primary gambling venue.

Jurisdiction: Same coding as for primary gambling venue.

Gaming: "Social" gaming in the past 12 months, other than making bets on typical gambling activities. Any type of games on a computer, tablet, game console, mobile phone, portable gaming device or other similar device alone or with others. This includes games such as word games, puzzle games, traditional board games, card games, sports games, trivia/quiz/game show games, strategy games, shooter/action adventure games, driving/motorsports, brain training games, retro games, Anime games, hidden object games, casino style games but not betting money, or social games.

01. Daily
02. Weekly
03. Monthly
04. Less than monthly
05. Never in the last 12 months

BLOCK 7: *DSM-IV Diagnostic Impressions*

Primary: Primary diagnostic impression. (This is a preliminary diagnostic impression and is to be finalized at discharge.)

01 Not Mentally Ill/Diagnosis Deferred
02 Delirium, Dementia, Amnesic and Other Cognitive Disorders
03 Substance-related Disorders (also complete substance abuse diagnostic code & specifier)
04 Disorders due to General Medical Condition
05 Schizophrenia and Other Psychotic Disorders
06 Mood Disorders
09 Anxiety Disorders
10 Adjustment Disorders
11 Personality Disorders
12 Sexual and Gender Identity Disorders
14 Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence
15 Impulse-Control Disorders (NOT PATHOLOGICAL GAMBLING)
16 Eating Disorders
19 Dissociative Disorders
20 **PATHOLOGICAL GAMBLING**
21 **PROBLEM GAMBLING**
22 RELATIONAL PROBLEM RELATED TO PROBLEM OR PATH. GAMBLING
23 Gaming/Social Gaming – not gambling
25 Other

Secondary: Indicated what is the secondary diagnostic impression.
(Use same codes as above)

Substance Abuse: The Axis I diagnostic code for substance abuse/dependence if ever, or currently, diagnosed. For lifetime substance disorders the following "specifier" field should be completed.

Specifier: This field is to distinguish the status of the substance abuse/dependence disorder if in remission. (See DSM-IV-TR)

01 Early Full Remission
02 Early Partial Remission
03 Sustained Full Remission
04 Sustained Partial Remission
05 In a Controlled Environment

DSM-IV Score: *(In order to be consistent with over 20 years of data this section has not been updated.)* Check each corresponding box for the criterion that was endorsed by the client (in order of presentation in the DSM-IV-TR , p. 671 - preoccupation, increasing tolerance, continuation with attempts to stop or control, restlessness or irritability, escape gambling, chasing losses, lying, antisocial behavior to get money, jeopardized or lost relationships, bailout behavior) **DURING THE PAST 12 MONTHS**.

Suicide: During the past six months.

01 Thoughts
02 Threat
03 Plan
04 Action/Behavior
08 None of the Above

Job/School Problems: During the past six months, has the client lost a job, been expelled from school, or received formal disciplinary action at work or school in relation to gambling.

01 Yes 02 No

Bankruptcy: Filed or planning to file bankruptcy due to gambling losses in the past six months.

01 Yes 02 No

Relationship Problems: During the past six months, has the client become divorced, separated, or lost a significant relationship with another family member or close friend due to gambling.

01 Yes 02 No

Legal: Does client currently have pending charges, was incarcerated within the past six months, or on probation for gambling related activities.

01 Yes 02 No

BLOCK 8: *Treatment History*

Treatment History: Complete each set of fields for each of the general types of treatment (**gambling**, **alcohol and drug**, and **mental health**).

Times: Total number of distinct treatment episodes including outpatient and inpatient EXCLUDING this episode - do not include self-help as "treatment."

00 None

Last Type Treatment:

00 None
01 Oregon state-funded outpatient
02 Oregon state-funded residential (inpatient)
03 Oregon state-funded minimal intervention
04 Private outpatient
05 Private residential/inpatient
06 Oregon state-funded respite
09 Other

Concurrently Enrolled: Use this field for Alcohol and Drug and Mental Health only for coding of concurrent treatment being received by the client.

00 Not currently enrolled
01 Same agency as that providing gambling treatment
02 Other state or publicly-funded agency
03 Other private insurance or self pay agency/therapist

Self Help:

00 Not participated in Self help
01 Previously attended - not in the past 30 days
02 Currently attending self-help for this category of problem (gambling, A&D, mental health).

BLOCK 9: *Client Primary Contact Data*

Complete the contact information fields only with a signed release for follow-up. Check the box "Release Attached" and staple the signed release authorization to the form. Print this information clearly. Also ensure a completed locator form is included.

BLOCK 10: *Primary counselor*

Print the primary counselor's name LAST NAME, FIRST NAME.

BLOCK 11: COMPLETE THIS BLOCK TO FACILITATE CONTACT IF THERE ARE ANY QUESTIONS REGARDING THE CODES UTILIZED.

Chapter 3 INFORMED CONSENT & PARTICIPATION AUTHORIZATION

In order for clients (gambler and family enrollees) to be followed for the longitudinal evaluation, a copy of the signed informed consent must be on file with the Evaluator. Participation in the follow-up is completely voluntary. In order to assure that clients are provided with the opportunity to participate in the follow-up evaluation, and to ensure a consistent explanation of the involvement is provided to each client, the following Informed Consent Form should be read to the client with a copy of the Form available to the client to follow along. Clients who choose to volunteer for the follow-up should sign the Form and a copy should be given to them for their personal records. A copy of the signed Form must accompany the Enrollment Record Abstracting Form if the client has consented to participate.

Some clients may choose to not volunteer for the follow-up. These individuals should be requested to sign the last part of the Form titled "Consent Withheld." **Follow-up authorization forms for clients that elect to not participate in the program evaluation <u>should not</u> be sent to the evaluator,** but should be maintained in the client's confidential file with a copy going to the client.

The following form is provided as an example. The informed consent authorization form that is used by your agency should be reviewed by your agency's HIPAA Compliance Officer and/or agency legal counsel.

PLEASE NOTE: In order to be reimbursed for services, agencies will be required to provide the client's name on the enrollment form. This is the same procedure that is being used to reimburse for mental health benefits through OHA/HSD. Your agency's standard consent to treat and release documentation should contain a statement regarding the necessity to collect the client's full name, the protections that are in place and specifically name Herbert & Louis, LLC as the claims processor. Herbert & Louis, LLC is a formal Business Partner by contract with HSD, Problem Gambling Services Unit for HIPAA compliance purposes.

GAMBLING TREATMENT PROGRAM EVALUATION
INFORMED CONSENT AND PARTICIPATION AUTHORIZATION
(EXAMPLE)

Thank you for volunteering to participate in the evaluation of the gambling treatment program. Your participation is very important and your views are highly valued. **The purpose of the evaluation is to determine the effectiveness of the treatment you receive and to improve the delivery of services for future clients**. All the information that you provide will be held in the strictest confidence in accordance with the Federal Confidentiality Law of the United States Code. All reports will only include information from groups of individuals so that no one individual's comments can be identified.

This quality improvement effort is being conducted by Herbert & Louis, LLC (the evaluator) for the Health Systems Division (HSD), Oregon Health Authority under contract. HSD/OHA is allowed to ask for the information on the various forms and questionnaires for program evaluation. HSD will not receive any information that could be used to reveal your identity.

CLIENT AUTHORIZATION

I understand that my participation in this quality improvement effort and my providing information for the forms and questionnaires is strictly voluntary. Any questions that I do not wish to answer will be skipped, and I will not be penalized for not providing any part or all of the information requested. I can refuse to participate at any point in the study and will suffer no penalty and will not be denied any services.

My involvement in the quality improvement effort will consist of participating in one 5 to 15 minute written survey at enrollment and again when I complete the program. If I choose to complete the entire treatment program offered I will be contacted again at 6, and 12 months from the time I leave the program to complete a similar follow-up survey that will take 5 to 15 minutes. If I choose not to complete the treatment program offered, I will be contacted only at six months for follow-up. These surveys will include questions about my housing, employment, physical and mental health, social relationships, gambling, and satisfaction with the program. I understand that I may be telephoned to complete the follow-up surveys if the mailed survey does not reach me. I further understand that the contact persons I provide may be called in order to reach me in case I have changed my mailing address or telephone. The contact persons I provide will not be given any information regarding my participation in treatment nor in the study. They will only be informed that I am participating in a consumer study and that they were given as a contact only if we could not reach you directly by mail or phone. Time permitting, we may attempt to contact you while you are still in treatment to introduce ourselves, answer any questions you may have regarding the follow-up, and verify the contact information we have. This call will only take about 5 minutes.

I authorize _____ (Treatment Provider) to provide Dr. Moore with additional information that will be used to evaluate the program. This information will consist of general admission and demographic information, treatment program attendance, and discharge information including discharge status only. This is general information only that is collected on

Client Initials of 1st Page: _____

all participants in an anonymous manner and does not include any information regarding what occurs in my individual or group counseling sessions.

I understand that I can call Dr. Thomas Moore at (503) 685-6100 (email tlmoore@herblou.com) if I have any questions or concerns or I can also call the State Problem Gambling Services Unit Manager, Health Systems Division, Oregon Health Authority (503) 945-5763 if I have any questions or concerns. My signature below indicates that the purposes and procedures for this study have been fully explained to me and that I consent to participate. It does not, however, obligate me to participate. I understand that I can withdraw from the follow-up at any time by informing Dr. Moore or his staff.

Name _____ Client ID _____
(please print)
Signature _____ Date _____

Witnessed _____ Date _____

##########

Client Consent Withheld

The Informed Consent and Participation Authorization has been read to me and I choose to not participate in the evaluation follow-up. Please ask the counselor to put the word "Declined" in the signature line above and sign below to ensure that you are not contacted for follow-up.

Signature _____ Date _____

##########

☐ Copy provided to client.

Chapter 4 LOCATOR INFORMATION

The information necessary to ensure satisfactory retention rates is to be collected by the programs shortly following the assessment and enrollment process. This information should only be collected from individuals who have consented to participate in the follow-up. The Informed Consent Form contains a discussion of how this information is to be used by the evaluator. It must be stressed to the client that this information will only be used to maintain contact and will not be given to anyone else and will not be disclosed in any manner to anyone. **This includes the procedure that the evaluator will not disclose the current location of the client to friends, family members, or others listed on the form.**

Please reassure the client that their participation and their opinions and feedback are of great importance to the quality improvement efforts of the programs.

The client may skip over items for which they do not have information or for which they do not want to provide. It is very important that we have at least three potential family kin keepers, (usually senior family females such as mother, grandmother, sister, or aunt) that will have a high likelihood of knowing how to leave a message for your client.

The Evaluator will follow up with you to get additional information if incomplete locator forms are received.

This form should <u>not</u> be administered as a handout.

Participant Locator Form [2]

This information should be collected during an interview and completed by the counselor.

This is not a handout for clients to complete.

Date: _____ Interviewer Name: _____
Case #: _____ Interviewer Phone: _____

Suggested introductions: We would like to again thank you for volunteering to help us with the quality improvement effort. Over the next several months you may move and not remember to let us know your new mailing address. In order to assist us in contacting you, we would like to have several different avenues to use to get a message to you when it is time for the follow-up. The only information we will provide to individuals you list as contacts is that you are participating in a longitudinal customer survey and that you gave use permission to contact them to get updated contact information. If you choose, you may omit answering any of these questions.

PLEASE PRINT LEGIBLY.

1. Your full name:
_____(_____)
First Middle (or NMN) Last (Maiden)

2. Date of Birth: ___/____/_____

3. Other names, nicknames, street names, or aliases: _____

4. Justice System State Identification Number (SID): _____

5. Residence Address: _____
(Street Address) (Apt. # or P.O. Box #)

_____
(City, State, and Zip)

6. Do you plan to move anytime soon? _____

(If yes) Where to? _____

7. Home phone: (___)____-_____ 8. Cell phone: (___) ___ - _____.

[2] Adapted from the Locator Form found in the publication Staying In Touch: A fieldwork manual of tracking procedures for locating substance abusers for follow-up studies, Center for Substance Abuse Treatment, 1996.

9. Email address: _____

10. Facebook or Other Social Media Contact: _____

11. Mailing address - if different from residence address:

_____
(Street) (Apt. # or P.O. Box #)

_____
(City, State, Zip)

12. Work Phone? (____) ____-_____ Employer: _____

Address: _____

Pager? (___) ____-_____ (Okay to Leave Message Y __ N__)

13. Who should be contacted in case of an emergency if you were to move? Other than someone who would be moving with you?

Full Name: _____ _____
(First) (Middle) (Last) (Relationship)
Address: _____
Phone: (____) ____-_____
Email _____

14. Who would be the second person that would know how to get a message to you if you moved, other than someone who would be moving with you?

Full Name: _____ _____
(First) (Middle) (Last) (Relationship)
Address: _____
Phone: (____) ____-_____
Email _____

15. Is there a caseworker, probation officer, or other community agency or clinic that you see regularly?

Agency Name: _____

Full Name: _____ _____
(First) (Middle) (Last) (Relationship)
Address: _____
Phone: (____) ____-_____

Chapter 5 GAMBLING CLIENT SURVEY - ENROLLMENT

The following Client Enrollment Survey, is a self-report, paper and pencil survey that should be administered to the client during the enrollment process, or soon afterward. The information collected at enrollment will be used as a baseline and will be recollected at each of the follow-up windows.

PLEASE ENSURE THE CLIENT'S CASE IDENTIFICATION CODE, YOUR PROGRAM NAME, AND THE DATE THE SURVEY WAS COMPLETED APPEAR ON THE FORM THAT IS RETURNED TO THE EVALUATOR.

The information provided by the client on this form is critical to the overall management of the problem gambling services. The record abstracting form has been shortened to reduce duplication of information collected from the client. Due to this, approval of encounter data may be delayed if this survey is not submitted in a timely manner.

Gambling Client Survey - Enrollment

Case No. _____

Program: _____

Today's Date: _____

Herbert & Louis, LLC
PO Box 304
Wilsonville, OR 97070-0304
(503) 685-6100
admin@herblou.com

Thank you for completing this survey. The information you provide is confidential and very important in helping us to evaluate the usefulness of the services that have been provided to you. The information you provide will be combined with information from a large number of other consumers into reports in a manner that your individual identity cannot be identified.

The survey should take between 10 and 15 minutes to complete. Once completed, please return the survey to the counselor.

If you have any questions regarding this survey, or the evaluation of the state funded treatment programs please feel free to contact me directly. You may remove this page from the survey packet and keep it for your records

Thomas L. Moore, PhD
CEO
Herbert & Louis LLC
PO Box 304
Wilsonville, OR 97070-0304
(503) 685-6100
tlmoore@herblou.com

PLEASE DO NOT PUT YOUR NAME ON THIS FORM

Gambling Client Survey - Enrollment

SECTION 1: General Demographics

Today's Date: _____

1. Marital Status

1	Never Married
2	Married
3	Widowed
4	Divorced
5	Separated
6	Living as Married

2. Employment Status

1	Full Time (35 or more hrs/wk)
2	Part Time (17 - 34 hrs / wk)
3	Irregular (Less than 17 hrs/wk
4	Looking for Work
6	Unemployed - Not looking
7	Retired
8	Disabled
9	Homemaker Stay at Home Parent
10	Full Time Student
5	Other

3. Estimated total monthly household income before taxes? $ _____

4. Primary Source of Household Income? *(Check only one.)*

1	Wages, Salary
5	Public Assistance
7	Pension/Retirement
8	Disability Income
9	Other
0	None

5. Health Insurance?

05	Veterans Administration
08	MEDICAID / OHP
09	MEDICARE
11	Other Private Insurance
12	Other Public Assistance
13	None

6. Total number of dependents living with you including yourself? _____

7. Highest number of years of school completed? (GED = 12) _____

8. Total estimated debt related to gambling? $_____

1	Never
2	Rarely
3	Sometimes
4	Often
5	Always
?	Don't Know/ Doesn't Apply

INSTRUCTIONS

Please use the scale to the left to score your responses. Use a pen or pencil to mark your choice. Place an "X" over the number that most closely matches your answer.

SECTION 2: General Satisfaction

During the PAST 6 MONTHS, how frequently were you satisfied with each of the following?

9.	1	2	3	4	5	?	Life in general ?
10.	1	2	3	4	5	?	Overall physical health?
11.	1	2	3	4	5	?	Overall emotional wellbeing?
12.	1	2	3	4	5	?	Relationship with my spouse or significant other?
13.	1	2	3	4	5	?	Relationship with my children?
14.	1	2	3	4	5	?	Relationship with my friends?
15.	1	2	3	4	5	?	Relationship with other family members?
16.	1	2	3	4	5	?	Job?
17.	1	2	3	4	5	?	School (only answer if you are enrolled as a student)?
18.	1	2	3	4	5	?	Spiritual wellbeing?

SECTION 3: General Activities

During the PAST 6 MONTHS, how frequently did you ...?

19.	1	2	3	4	5	?	Accomplish responsibilities at home?
20.	1	2	3	4	5	?	Accomplish responsibilities at work?
21.	1	2	3	4	5	?	Pay bills on time?
22.	1	2	3	4	5	?	Have thoughts of suicide?
23.	1	2	3	4	5	?	Attempt to commit suicide?
24.	1	2	3	4	5	?	Drink alcohol?
25.	1	2	3	4	5	?	Have problems associated with my use of alcohol?
26.	1	2	3	4	5	?	Use illegal drugs?
27.	1	2	3	4	5	?	Have problems associated with my use of illegal drugs?
28.	1	2	3	4	5	?	Use tobacco - smoked or chewed?
29.	1	2	3	4	5	?	Commit illegal acts to get money to gamble with?
30.	1	2	3	4	5	?	Maintain a supportive network of family and/or friends?
31.	1	2	3	4	5	?	Take time off to relax and rest?
32.	1	2	3	4	5	?	Eat healthy foods?
33.	1	2	3	4	5	?	Exercise?
34.	1	2	3	4	5	?	Attend community support (GA, NA AA, etc)?

1	Never
2	Rarely
3	Sometimes
4	Often
5	Always
?	Don't Know/ Doesn't Apply

SECTION 4: Gambling

During the PAST 6 MONTHS, how frequently did you ...?

35.	1	2	3	4	5	?	Often find yourself thinking about gambling, for example reliving past gambling experiences, planning the next time you would play or thinking of ways to get money for gambling?
36.	1	2	3	4	5	?	Need to gamble with more and more money to get the amount of excitement you were looking for?
37.	1	2	3	4	5	?	Make repeated unsuccessful attempts to control, cut back or stop gambling?
38.	1	2	3	4	5	?	Become restless or irritable when trying to cut down or stop gambling?
39.	1	2	3	4	5	?	Gamble to escape from problems or when you were feeling depressed, anxious, or bad about yourself?
40.	1	2	3	4	5	?	After losing money gambling, return another day in order to get even?
41.	1	2	3	4	5	?	Lie to your family or others to hide the extent of your gambling?
42.	1	2	3	4	5	?	Go beyond what is strictly legal to in order to finance gambling or to pay gambling debts?
43.	1	2	3	4	5	?	Risk or lose a significant relationship, job, educational or career opportunity because of gambling?
44.	1	2	3	4	5	?	Seek help from others to provide money to relieve a desperate financial situation caused by gambling?

SECTION 5: Gambling Activities

45.	Number of days gambled during the last 30 days? Days_____
46.	Average amount gambled for each day that you gambled during the past 30 days? (Actual amount of money that came out of your pocket each day gambled.) $_____
47.	What was the primary gambling activity (game) played during the past 30 days? _____
48.	Where did you primarily gamble in the past 30 days? (Bingo hall, card room, bar, casino, home, internet, convenience store, track, restaurant, etc.) _____

SECTION 6: Other Services in the PAST 6 MONTHS

49.	Number of times in the PAST 6 MONTHS that you went to an Emergency Room or Urgent Care Center? Times_____
50.	In the PAST 6 MONTHS, did you enroll in a treatment program for the treatment of alcohol and/or drug abuse problems? Inpatient A&D Program ___Yes ___No Outpatient A&D Program __Yes __No
51.	In the PAST 6 MONTHS, did you enroll in a treatment program for mental health problems (other than the gambling program you attended)? Inpatient Program ___Yes ___No Outpatient Program __Yes __No
52.	In the PAST 6 MONTHS, did you enroll in another gambling treatment program, or see another therapist or doctor outside the staff of the gambling program you attended? Inpatient Program ___Yes ___No Outpatient Program __Yes __No
53.	In the PAST 6 MONTHS, have you filed for bankruptcy? __Yes ___No
54.	In the PAST 6 MONTHS, have you been convicted of any gambling related crime? __Yes __No
55.	In the PAST 6 MONTHS, have you experienced physical violence in a relationship? __Yes __No
56.	In the PAST 6 MONTHS, have you experienced verbal, emotional, or psychological abuse in a relationship? __Yes __No
57.	In the PAST 6 MONTHS, have you felt controlled, trapped, or manipulated by a significant other? __ Yes __No

Thank you for completing this survey. Your assistance is greatly appreciated.

CORRECTED: ☐

Chapter 6 GAMBLING CLIENT TERMINATION ABSTRACTING FORM

LEAVE NO BLANK FIELDS – REFER TO MANUAL
UK-Unknown, NA-Does Not Apply, NC-Not Collected, CR-Client Refused

1 Clinic/Provider ID: ☐☐☐☐☐☐☐☐☐☐☐☐ Client Case ID: ☐☐☐☐☐☐☐☐☐☐

2 Enrollment Date: ☐☐ ☐☐ ☐☐ DOB: ☐☐ ☐☐ ☐☐ Gender: ☐

3 Last Service Date: ☐☐ ☐☐ ☐☐ Termination Type: ☐☐ Treatment Type: ☐☐ Referral Type: ☐☐ Follow-up Appointment Date: _____Time:_____ _____

4 Suicide ☐☐ Bankruptcy: ☐☐ Legal: ☐☐ Abuse: ☐☐ Reported: ☐☐

5 If gambled in last 30 days. Primary Gambling Activity: Type: ☐☐ Venue: ☐☐ Jurisdiction: ☐☐

6 Diagnostic Impression:
Primary: ☐☐ Secondary: ☐☐

7 Ancillary Support Services Received (Check All That Apply)

01	___ Physical Health	07	___ Employment
02	___ Mental Health	08	___ Housing
03	___ Other Addictions	09	___ Emergency Clothing
04	___ Dental	10	___ Food Stamps
05	___ Vision	11	___ Insurance Enrollment
06	___ Education	12	___ Other

8 PRINT Completed By: _____ Date: _____ Phone: _____

Gambling Client Termination Record Abstracting Form-Instructions

The data to be coded into each of the fields on the Client Discharge/Termination Coding Form is discussed by numerical section identification found on the left side of the form. This form does not need to be completed if the individual was enrolled as an assessment only AND there were NO changes to the enrollment form.

LEAVE NO BLANK FIELDS

USE THE FOLLOWING CODES FOR ALL FIELDS WHERE THE INFORMATION IS EITHER UNKNOWN, NOT AVAILABLE, OR THE CLIENT HAS REFUSED TO PROVIDE.

UK – UNKNOWN
NA – DOES NOT APPLY
NC – NOT COLLECTED BY AGENCY
CR – CLIENT REFUSED

CORRECTED: Check this box only if the form is being resubmitted to correct, or update, previously submitted information. Please make a photocopy of the original form, check the corrected box, and indicate the changes on the form with red ink. Please write clearly.

BLOCK 1: ***Identification***

Clinic/ Provider Identification: Facility or Clinic name where services were provided. State issued clinic ID numbers/codes may be substituted. This should be the same code as that on the Enrollment Form.

Client Case Identification Code: This is the same local, discrete case identification code that providers have been utilizing. Each client enrolling in the program must be assigned a discrete, confidential 10-character (maximum) alpha-numeric client case identification code by the providing agency. This identification code will be utilized to track the individual throughout his, or her, care with that agency. Readmissions must utilize the same case code - please do not reassign client case codes for readmissions. This case identification code must match that submitted for the client with all encounter data.

BLOCK 2: ***Client ID Verification Information***

Enrollment Date: Date the client was enrolled in treatment for this episode of care. This field is used for confirmation of the case identification.

Date of Birth: In American format - DD/MM/YYYY. This field is used for confirmation in the database in the case that the Client Case ID provided is not legible.

Gender: M for Male; F for Female. This field is utilized for secondary confirmation along with the Date of Birth field if the Client Case ID provided is not legible or has been duplicated by the provider.

BLOCK 3: *Termination Data* All client records must be closed within the time prescribed by the prevailing contract with AMH. Clients being transferred from agency to agency must be closed at the first agency and then reopened at the accepting agency. Clients being transferred from residential gambling treatment should be opened and closed for that treatment modality and then reopened for outpatient treatment. Similarly, clients enrolled in minimal intervention projects should be closed in that level of care and re-opened in a new level of care as appropriate.

Last Service Date: Date in American format (MM/DD/YY) that the client was last seen at the clinic/provider agency.

Termination Type:

02 Stopped coming – against staff advice – cap not reached
03 Treatment completed successfully **
04 Further treatment not appropriate at this program
05 Non-compliance with rules and regulations
06 Client refused services
07 Moved from Catchment Area
08 No transportation
09 Conflicting hours
10 Evaluation services only
11 Incarcerated
12 Deceased
13 Parent/legal guardian withdrew client
14 Program cuts or program closure (other than standard treatment session cap)
15 Physical/Mental illness
16 Treatment subsidy ran out, client unwilling to pay, left against staff advice

*** The definition for treatment completed successfully can be found in the prevailing contract with AMH.*

Treatment Type: Primary mode of treatment received by the client at this agency during this episode of care. (Based on ASAM levels of service.)

01 Outpatient
02 Intensive Outpatient/Partial Hospitalization
03 Residential/Inpatient
04 Medically-managed intensive inpatient
05 Long term residential (more than 30 days)
06 Evaluation or Assessment Only
07 Minimal - home-based intervention
08 Respite Care

Referral Type: Principle type of treatment referred to following this treatment.

00 None
01 Minimal - home-based intervention
02 Traditional Outpatient Structure Program with individual, group, and psychoeducational session for the client (and the family).
03 Outpatient – Individual therapist not with an organized program.
04 Residential - short-term crisis stabilization (less than 5 days)
05 Residential - mid-term care (5 to 30 days)
06 Medically Managed Residential Care - (Patient under direct supervision of an MD)
07 Residential - long-term (more than 30 days)
08 Gamblers' Anonymous
09 Other

NOTE: Respite and residential treatment providers must write in the outpatient program name the client was referred to following treatment as well as the date and time of the follow-up appointment.

BLOCK 4:

Suicide: During the past six months.

01 Thoughts
02 Threat
03 Plan
04 Action/Behavior
08 None of the Above

Bankruptcy: Filed or planning to file bankruptcy due to gambling losses during the past six months.

01 Yes 02 No

Legal: Does client currently have pending charges, was incarcerated within the past six months, or on probation for gambling related activities.

01 Yes 02 No

Abuse: Since Enrollment has there been any child, spouse, partner, or elderly abuse in the household reported to the program including physical, emotional or sexual abuse, neglect or abandonment?

01 Yes 02 No

Reported: Was the abuse required to be reported by the program to a cognizant authority?

01 Yes 02 No

BLOCK 5: *Current Gambling Characteristics*

Primary Gambling Activity:

Type: This field should be coded with the client's primary gambling activity – IF GAMBLED IN PAST 30 DAYS.

01 Video Poker
11 Slot Machines/Mechanical Reel
21 Video Line Games
04 Cards
14 Scratch Tickets/Pull Tabs/Breakopens
09 Bingo
12 Keno
05 Horses/Dogs/Other Animals
06 Dice
10 Stocks/Commodities/Bonds
02 Sports-Other than lottery Sports Action
08 Numbers
13 Bowling, pool, golf or other skill games
16 Roulette
17 Power Ball/Daily Four/Mega Bucks
19 Lottery Sports Action
20 Charitable games other than bingo (including raffles)
22 Sweepstakes where a product was purchased to enter
24 Dominoes
25 "Fast Race" Electronic Horse or Dog racing "slot" type machines
26 Fantasy Sports
15 Other (please specify on form)
99 No preference of one type over another

Venue: Location or environment where the client engages in the primary gambling activity. – IF GAMBLED IN THE PAST 30 DAYS.

01 Oregon Video Poker Lottery Retailer (Bar/Pub/Restaurant)
02 Indian Gaming Center or Casino
04 Bingo Hall (Use only - other than Indian Gaming Center/Indian Casino)
05 Food Store or Convenience Store - (Such as - purchase Oregon Lottery games)
06 Restaurant/Pub/Bar (Use only - where no State Video Poker/Line Machines are present)
07 Card Room - Public (Not IGC or Casino)
08 Private Club/Lodge
09 Horse or Dog Race Track/Off Track Betting Facility
10 Home (For other than Internet gambling can include Stocks/Commodities)
11 Internet Gambling - e.g. On-line Casinos, Lotteries - Not stocks or commodities
12 Family member or friend's home
13 Work
14 School
16 Day Trading Facility or Brokerage House
15 Other
90 No gambling since entering treatment

Jurisdiction: State in which the primary gambling occurs – IF GAMBLED IN THE PAST 30 DAYS.

01 Oregon
02 California
03 Idaho
04 Nevada
05 Washington
10 Other Jurisdiction

BLOCK 6: *Diagnostic Impressions*

Primary: Indicate the final primary diagnostic impression. (Reason for treatment)

01 Not Mentally Ill/Diagnosis Deferred
02 Delirium, Dementia, Amnesic and Other Cognitive Disorders
03 Substance-related Disorders (also complete substance abuse diagnostic code & specifier)
04 Disorders due to General Medical Condition
05 Schizophrenia and Other Psychotic Disorders
06 Mood Disorders
09 Anxiety Disorders
10 Adjustment Disorders
11 Personality Disorders
12 Sexual and Gender Identity Disorders
14 Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence
15 Impulse-Control Disorders (NOT PATHOLOGICAL GAMBLING)
16 Eating Disorders
19 Dissociative Disorders
20 **PATHOLOGICAL GAMBLING**
21 **PROBLEM GAMBLING**
22 RELATIONAL PROBLEM RELATED TO PROBLEM OR PATH. GAMBLING
23 Gaming – not gambling
25 Other

Secondary: Indicated the secondary diagnostic impression if present.

(Use same codes as above)

BLOCK 7: Ancillary Services. Check all boxes for additional services that were provided to the client and paid for by any funding source.

BLOCK 8: COMPLETE THIS BLOCK TO FACILITATE CONTACT IF THERE ARE ANY QUESTIONS REGARDING THE CODES UTILIZED.

CORRECTED: ☐

Chapter 7 FAMILY CLIENT ENROLLMENT ABSTRACTING FORM

Leave No Blank Fields"

UK-Unknown, NA-Does Not Apply, NC-Not Collected, CR-Client Refused

Preferred Language: _____

1

Clinic/Provider ID: ☐☐☐☐☐☐☐☐☐☐☐☐

Family Client ID: ☐☐☐☐☐☐☐☐☐☐

2

CLIENT NAME: Last ☐☐☐☐☐☐☐☐☐☐☐☐ First ☐☐☐☐☐☐☐☐☐☐ MI ☐

Birth: ☐☐☐☐☐☐☐☐ DOB: ☐☐ ☐☐ ☐☐ Gender: ☐ Ethnicity: ☐☐

County: ☐☐ Zip Code: ☐☐☐☐☐ Access Source: ☐☐ Referral Source: ☐☐ _____ Mandated: ☐☐

3

First Contact Date: ☐☐ ☐☐ ☐☐ First Available Date: ☐☐ ☐☐ ☐☐ Enrollment Date: ☐☐ ☐☐ ☐☐ Reason: ☐☐

4

Education: ☐☐ Marital Status: ☐☐ Dependents: ☐☐ ☐☐ ☐☐ ☐☐ Housing: ☐☐

0 - 5 6 – 17 18 – 64 65 +

5

Health Insurance: ☐☐ Employment: ☐☐ Veteran: ☐☐ Income Source: ☐☐ Monthly Household Income: ☐☐☐☐☐☐

6

Diagnostic Impression:

Primary: ☐☐ Secondary: ☐☐ Substance Abuse: ☐☐☐☐☐ Specifier: ☐☐

Suicide: ☐☐ Bankruptcy: ☐☐

FAMILY ENROLLMENT FORM Page 2

7

Treatment History:		Last Type Treatment	Concurrently Enrolled:	Self Help 12-Step
Gambling:				
Alcohol/Drug:				
Mental Health:				

8

Gambler Case ID: DOB: Gender: Relationship:

9

COMPLETE THIS BOX ONLY WITH RELEASE FOR FOLLOW-UP

Mailing Address:

City: State: Zip:

Home Phone:

Release Attached:

10

Primary Counselor:

11

PRINT Completed By: _____ Date: _____ Phone: _____

Family Enrollment Record Abstracting Instructions

Each family member that is to receive treatment and the state is to be billed for that treatment must be enrolled as a family client. The family client should be invited to participate in the follow-up and if they accept a release and locator form must be submitted.

The fields contained on this form are essentially the same as those for the gambling client. All fields are to be completed in relation to the family member that is receiving treatment except for BLOCK 8 which contains information regarding the gambler - if the gambler is in treatment.

LEAVE NO BLANK FIELDS

USE THE FOLLOWING CODES FOR ALL FIELDS WHERE THE INFORMATION IS EITHER UNKNOWN, NOT AVAILABLE, OR THE CLIENT HAS REFUSED TO PROVIDE.

UK – UNKNOWN
NA – DOES NOT APPLY
NC – NOT COLLECTED BY AGENCY
CR – CLIENT REFUSED

CORRECTED: Check this box only if the Form is being resubmitted to correct, or update, previously submitted information. Please make a photocopy of the original form, check the corrected box, and indicate the changes on the form with red ink. Please write clearly.

PREFERRED LANGUAGE: Fill in preferred language if other than English

BLOCK 1: *Provider Identification*

Clinic/ Provider Identification: Facility or Clinic name where services are being provided. State issued clinic ID numbers/codes may be substituted.

Family Client Case Identification Code: This is the same local, discrete case identification code that providers have been utilizing. Each family client enrolling in the program must be assigned a discrete, confidential 10-character (maximum) alpha-numeric client case identification code by the providing agency. This identification code will be utilized to track the individual throughout his, or her, care with that agency. Readmissions must utilize the same case code - please do not reassign client case codes for readmissions. This case identification code must match the case code submitted with all encounter data.

BLOCK 2: *Client Identification*

Name: In UPPER CASE BLOCK LETTERS, enter the entire last name, first name, and initial of client with a space between the names. Then enter the *birth name*. Please write legibly.

Definition: Birth Name is the last name of the person as it would appear on his/her birth certificate.

Notes:

1. Check spelling of names for correctness. This is critical for database integrity.
2. Enter client's full given (or legally changed) name, NOT nickname.
3. It is essential that the following letters be printed with exaggerated clarity: **U, V, I, L, D, and O.**

Example: Example of Client Name**:** Alice Johnson is a residential client who has never been married. JOHNSON would be the "LAST" and "BIRTH NAME." ALICE, of course, would be the "FIRST" name.

Date of Birth: In American format - MM/DD/YYYY

Gender: M=Male; F=Female; O = Other (please specify)

Ethnicity/Race: (Primary and Secondary)

01 White (Non-Hispanic)
02 Black (Non-Hispanic)
03 Native American
04 Alaska Native
05 Asian
06 Hispanic (Mexican)
07 Hispanic (Puerto Rican)
08 Hispanic (Cuban)
09 Other Hispanic
10 Southeast Asian
11 Other Race/Ethnicity
12 Native Hawaiian/Other Pacific Islander

County: Family member county of residence

01 Baker	09 Deschutes	17 Josephine	25 Morrow	33 Wasco
02 Benton	10 Douglas	18 Klamath	26 Multnomah	34 Washington
03 Clackamas	11 Gilliam	19 Lake	27 Polk	35 Wheeler
04 Clatsop	12 Grant	20 Lane	28 Sherman	36 Yamhill
05 Columbia	13 Harney	21 Lincoln	29 Tillamook	90 Washington State
06 Coos	14 Hood River	22 Linn	30 Umatilla	91 Idaho
07 Crook	15 Jackson	23 Malheur	31 Union	92 Nevada
08 Curry	16 Jefferson	24 Marion	32 Wallowa	93 California
				98 Other State

NOTE: IF THIS FIELD IS NOT COMPLETED CLAIMS WILL BE DENIED AS AN OUT OF STATE CLIENT. IF THE CLIENT RESIDES OUT OF STATE A WAIVER MUST BE RECEIVED FROM THE PROBLEM GAMBLING SERVICE OFFICE TO CLAIMS BEING APPROVED. CONTACT THE STATE PROBLEM GAMBLING SERVICES OFFICE FOR CURRENT CRITERIA AND APPROVAL PROCEDURES

Family Client's Zip Code: The US Postal Service ZIP code assigned to the place of residence of the family client.

Access Source: This field is to determine where the family client acquired the contact information (including phone number) for your treatment agency. **THIS CAN NOT BE CODED AS "SELF."**

Codes For Gambling:

AA Oregon Minimal Intervention Program (GEAR)
BB Oregon Gambling Helpline
CC Oregon Council on Problem Gambling
DD Oregon Gambling Foundation
EE Gamblers Anonymous
FF Inpatient Gambling
GG Other Outpatient Gambling
HH National Council on Problem Gambling
II Lottery Outlet Employee (server, bar tender, etc.)
JJ Previous Client Re-enrolling
NN Direct Referral from Peer Mentor Outreach
81 Consumer Credit Counseling
82 Regional/Local Central Intake
87 Placard/sticker on Video Lottery Machine
88 Placard or Sign in a Casino
89 Other Oregon Lottery Retailer Source
90 Other Oregon Casino Source
91 Yellow Page Ad
92 Newspaper Ad
93 Television Ad or Public Service Announcement
94 Radio Ad or Public Service Announcement
95 Web/Internet
96 TV News program or other programming
97 Radio News program or other programming
98 Newspaper/Other magazine news story or article

Personal Support System:

36 Previous/current client from the program
33 Family/ Friend/ Attorney
34 Employer or EAP
38 Self Help Group (NA, CA, etc.)

Local Or State Agencies:

04 Developmental Disabilities Services
05 School
06 Other Community Agencies
07 Support Programs for Adults (TANF/ Food Stamps)
08 Support System for Children (Child Welfare)
11 Vocational Rehabilitation
35 SENIORS and People with Disabilities
37 Youth/ Child Social Services, Center, or Teams

Criminal Justice System:

21 Court
22 Jail - City or County
23 Parole County/ State/ Federal-including juveniles
24 Police/Sheriff - Local, State
25 Psychiatric Security Review Board
26 Probation -County, State, Federal
27 Alternatives to Street Crimes (TASC)
71 State Correctional Institution
72 Federal Correctional Institution
78 Integrated Treatment Court (Drug Court or Mental Health Court)

Behavioral Health Providers/Agencies:

83 Community-based Service Providers (Mental Health and/or Addictions Services)
84 Other Mental Health/Addiction Services Providers (Independent or Private Practice, e.g., Psychologist/Psychiatrist)
49 Mental Health Organization (MHO)
85 Acute or Sub-Acute Psychiatric Facility
86 State Psychiatric Facility (i.e., EOPC)

Health Providers:

48 Fully Capitated Health Plan (FCHP)
31 Primary Care Provider, Specialist, or Other Physical Health Provider

Other:

99 Other

Referral Source: Using the same codes as described above, indicate if a person, institution, or agency took deliberate action to get the client to the treatment provider. If no other person took ***deliberate*** action to get the client to contact the treatment provider then a code of 32 for a self-referral may be utilized.

32 Self

NOTE: Respite and residential treatment programs please write in the name of the outpatient gambling program that made the referral.

Mandated: To track if the client was mandated by the referring agency to attend treatment. This should include any referrals where the program is required to provide periodic reports and where the client is under the threat of legal repercussions for failure to attend. (Court, parole/probation, employer (for continued employment), for example.)

01 = Yes; 02 = No

BLOCK 3: *Enrollment Performance Indicators*

First Contact Date: The date in MM/DD/YY format that the family client first contacted the program regarding admission or enrollment.

First Available Date: The date of the first available appointment.

Enrollment Date: The date that the family client was first provided services. For treatment as usual programs this would be the first face-to-face contact. For minimal intervention programs with telephone only counseling this should be the date the client verbally agreed to enroll in the program.

Reason for Enrollment: This field is used to distinguish between clients (either gamblers or family clients) being seen for intended full treatment or those who might be seen simply for an assessment or for relapse prevention.

01 Regular Treatment Program
02 Assessment Only
03 Relapse Prevention / Abstinence Maintenance (Short term)
04 Other Brief Therapy
06 Inpatient
07 Respite
05 Other

BLOCK 4: *General Demographics*

Education: Highest grade completed (GED = 12)

Marital Status:

01 Never Married
02 Married
03 Widowed
04 Divorced
05 Separated
06 Living as Married

Dependents: Number of dependents, **<u>including self</u>**, who are *dependent on the household income* by age group: Under 6 years of age; between 6 and 17 years old; between 18 and 64 years old; 65 and over years old. Please ensure all of the four boxes are completed with ZEROS if there are no dependents in that age categories.

Housing:

01 Own
02 Rent - no subsidies
03 Rent - with subsidies
04 Institution or Group Home
05 Homeless / Shelter
06 Other - Not paying rent ("Crashing" with friends or acquaintances)
07 A&D Free Housing
08 Incarcerated

BLOCK 5: ***<u>Employment /Veteran Status</u>***

Health Insurance: Type of health care benefits available: (AMH CPMS)

05 Veterans Administration
08 Medicaid/Oregon Health Plan
09 Medicare
11 Private Insurance
12 Other Public Assistance Programs
13 None
14 Other

Employment Status:

01 Full Time (35 or more hours / week)
02 Part Time (17 - 34 hours / week)
03 Irregular (Less than 17 hours / week)
04 Not Employed (Employment Sought)
05 Not Employed (Not Looking)
06 Retired
07 Disabled
08 Home Maker/Stay at Home Parent
09 Full Time Student not working

Veterans Status:

01 On Active Duty never deployed to a combat zone
02 On Active Duty previously deployed to a combat zone
03 Veteran never deployed to a combat zone
04 Veteran previously deployed to a combat zone
05 Disabled Veteran never deployed to a combat zone
06 Disabled Veteran previously deployed to a combat zone
07 No military experience

(Combat zone includes formal zones such as Iraq, Afghanistan, Persian Gulf, Viet Nam, SE Asia, Korea, WWII. Also included are other zones such as Somalia, Bosnia, etc. where combat occurred..)

Income Source: Primary source of household income:

00 None (no income)
01 Wages, Salary
05 Public Assistance
06 Dividends or Interest
07 Retirement, Pension, Social Security
08 Disability Insurance, SSD, etc.
09 Other

Estimated Income: Estimated **MONTHLY** gross household income (in dollars).

BLOCK 6: *Diagnostic Impressions*

Primary: Preliminary primary diagnostic impression. (This is a preliminary diagnostic impression and is to be finalized at discharge.)

01 Not Mentally Ill/Diagnosis Deferred
02 Delirium, Dementia, Amnesic and Other Cognitive Disorders
03 Substance-related Disorders (also complete substance abuse diagnostic code & specifier)
04 Disorders due to General Medical Condition
05 Schizophrenia and Other Psychotic Disorders
06 Mood Disorders
09 Anxiety Disorders
10 Adjustment Disorders
11 Personality Disorders
12 Sexual and Gender Identity Disorders
14 Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence
15 Impulse-Control Disorders (NOT PATHOLOGICAL GAMBLING)
16 Eating Disorders
19 Dissociative Disorders
20 PATHOLOGICAL GAMBLING
21 PROBLEM GAMBLING
22 FAMILY ISSUES RELATED TO PROBLEM GAMBLING
23 Gaming – Not Gambling
25 Other

Secondary: Indicated the secondary diagnostic impression if present.
(Use same codes as above)

Substance Abuse: The Axis I diagnostic code for substance abuse/dependence if ever, or currently, diagnosed. For lifetime substance disorders the following "specifier" field should be completed.

Specifier: This field is to distinguish the status of the substance abuse/dependence disorder if in remission. (See DSM-IV-TR)

01 Early Full Remission
02 Early Partial Remission
03 Sustained Full Remission
04 Sustained Partial Remission
05 In a Controlled Environment

Suicide: Within the past six months.

01 Thoughts
02 Threat
03 Plan
04 Action/Behavior
08 None of the Above

Bankruptcy: Filed or planning to file bankruptcy due to gambling losses in the past six months.

01 Yes 02 No

BLOCK 7: *Treatment History*

Treatment History: Complete each set of fields for each of the general types of treatment (**gambling**, **alcohol and drug**, and **mental health**) for the family client.

Times: Total number of distinct treatment episodes including outpatient and inpatient EXCLUDING this episode - do not include self help.

00 None

Last Type Treatment:

00 None
01 Oregon state-funded outpatient
02 Oregon state-funded residential (inpatient)
03 Oregon state-funded minimal intervention
04 Private outpatient
05 Private residential/inpatient
06 Oregon state-funded respite
09 Other

Concurrently Enrolled: Use this field for Alcohol and Drug and Mental Health only for coding of concurrent treatment being received by the client.

00 Not currently enrolled
01 Same agency as that providing gambling treatment
02 Other state or publicly-funded agency
03 Other private insurance or self pay agency/therapist

Self Help:

00 Not participating in Self Help
01 Previously attended - not in the past 30 days
02 Currently attending self-help for this category of problem (Gamanon, Alanon, etc.)

BLOCK 8: *Gambler*

Complete these fields ONLY if the gambler is enrolled. ***IF THE GAMBLER EVENTUALLY ENROLLS, PLEASE ENSURE THIS INFORMATION IS CORRECTED WITH THE EVALUATOR.***

Gambler Case Identification Code: This is the discrete client case identification for the gambler *if enrolled* in the program.

Gambler Date of Birth: This date of birth field is for the gambler client and is used for confirmation in case the Gambler Case Identification field is not legible. Use MM/DD/YYYY format

Gambler Gender: This field is used for secondary confirmation in case the gambler Case Identification field is not legible.

Relationship: The relationship of the family client to the gambler.

01 Spouse or Significant Other
02 Parent (Step Parent/Guardian)
03 Child (Step Child)
04 Sibling
05 Other Family Relationship
06 Friend or Co-worker
07 Employee or Employer
08 Other

BLOCK 9: *Family Client Primary Contact Data*

Complete the contacts fields only with a signed release for follow-up. Check the box "Release Attached" and staple the signed release authorization to the form. Also ensure a completed locator form is included.

BLOCK 10: *Primary counselor*

Print the primary counselor's name LAST NAME, FIRST NAME.

BLOCK 11: COMPLETE THIS BLOCK TO FACILITATE CONTACT IF THERE ARE ANY QUESTIONS REGARDING THE CODES UTILIZED.

Chapter 8 FAMILY CLIENT INFORMED CONSENT FOR PARTICIPATION

The form and the procedures for the family client informed consent and participation authorization are the same as for the gambling client. The same form should be utilized as discussed and presented earlier in this manual.

Chapter 9 FAMILY CLIENT LOCATOR INFORMATION

The form and the procedures for the family client locator information for follow-up are the same as for the gambling client. Again, this form should only be completed and forwarded to the evaluator with a signed informed consent and participation authorization. The same form should be utilized as discussed and presented earlier in this manual.

Chapter 10 FAMILY CLIENT SURVEY - ENROLLMENT

Family Client Enrollment Self-Report Survey

This instrument is similar to the gambling client instrument. The instrument should be completed by all family member clients enrolling for treatment.

PLEASE ENSURE THE CLIENT'S CASE IDENTIFICATION CODE, YOUR PROGRAM NAME, AND THE DATE THE SURVEY WAS COMPLETED APPEAR ON THE FORM THAT IS RETURNED TO THE EVALUATOR.

Case No. _____

Program: _____

Today's Date: _____

Herbert & Louis, LLC
PO Box 304
Wilsonville, OR 97070-0304
(503) 685-6100
admin@herblou.com

Thank you for completing this survey. The information you provide is confidential and very important in helping us to evaluate the usefulness of the services that have been provided to you. The information you provide will be combined with information from a large number of other consumers into reports in a manner that your individual identity cannot be identified.

The survey should take between 10 and 15 minutes to complete. Once completed, please return the survey to the counselor.

If you have any questions regarding this survey, or the evaluation of the state funded treatment programs please feel free to contact me directly. You make keep this page for your records.

Thomas L. Moore, PhD
CEO
Herbert & Louis LLC
PO Box 304
Wilsonville, OR 97070-0304
(503) 685-6100
tlmoore@herblou.com

PLEASE DO NOT PUT YOUR NAME ON THIS FORM

Family Client Survey – Enrollment

SECTION 1: General Demographics

Today's Date: _____

1. Marital Status

1	Never Married
2	Married
3	Widowed
4	Divorced
5	Separated
6	Living as Married

2. Employment Status

1	Full Time (35 or more hrs/wk)
2	Part Time (17 - 34 hrs / wk)
3	Irregular (Less than 17 hrs/wk
4	Looking for Work
6	Unemployed - Not looking
7	Retired
8	Disabled
5	Other

3. Estimated total monthly household income before taxes? $ _____

4. Primary Source of Household Income? *(Check only one.)*

1	Wages, Salary
5	Public Assistance
7	Pension
9	Other
0	None

5. Health Insurance?

05	Veterans Administration
08	MEDICAID / OHP
09	MEDICARE
11	Other Private Insurance
12	Other Public Assistance
13	None

6. Total number of dependents living with you including yourself? _____

7. Highest number of years school completed? (GED = 12) _____

8. Total estimated family debt related to gambling? $_____

FAMILY MEMBER ENROLLMENT – PAGE 2

1	Never
2	Rarely
3	Sometimes
4	Often
5	Always
?	Don't Know/ Doesn't Apply

INSTRUCTIONS

Please use the scale to the left to score your responses. Use a pen or pencil to mark your choice. Place an "X" over the number that most closely matches your answer.

SECTION 2: General Satisfaction

During the past six months, how frequently were you satisfied with each of the following?

9.	1	2	3	4	5	?	Life in general?
10.	1	2	3	4	5	?	Overall physical health?
11.	1	2	3	4	5	?	Overall emotional wellbeing?
12.	1	2	3	4	5	?	Relationship with my spouse or significant other?
13.	1	2	3	4	5	?	Relationship with my children?
14.	1	2	3	4	5	?	Relationship with my friends?
15.	1	2	3	4	5	?	Relationship with other family members?
16.	1	2	3	4	5	?	Job?
17.	1	2	3	4	5	?	School (only answer if you are enrolled as a student)?
18.	1	2	3	4	5	?	Spiritual wellbeing?

SECTION 3: General Activities

During the past six months, how frequently did you ...?

19.	1	2	3	4	5	?	Accomplish responsibilities at home?
20.	1	2	3	4	5	?	Accomplish responsibilities at work?
21.	1	2	3	4	5	?	Pay bills on time?
22.	1	2	3	4	5	?	Have thoughts of suicide?
23.	1	2	3	4	5	?	Attempt to commit suicide?
24.	1	2	3	4	5	?	Drink alcohol?
25.	1	2	3	4	5	?	Have problems associated with my use of alcohol?
26.	1	2	3	4	5	?	Use illegal drugs?
27.	1	2	3	4	5	?	Have problems associated with my use of illegal drugs?
28.	1	2	3	4	5	?	Use tobacco - smoked or chewed?
29.	1	2	3	4	5	?	Commit illegal acts to get money to pay gambling debts?
30.	1	2	3	4	5	?	Maintain a supportive network of family and/or friends?
31.	1	2	3	4	5	?	Take time off to relax and rest?
32.	1	2	3	4	5	?	Eat healthy foods?
33.	1	2	3	4	5	?	Exercise?
34.	1	2	3	4	5	?	Attend community support (GA, NA AA, etc.)?

FAMILY MEMBER ENROLLMENT – PAGE 3

SECTION 4: Other Services in the PAST 6 MONTHS

35.	Number of times in the PAST 6 MONTHS that you went to an Emergency Room or Urgent Care Center? Times_____
36.	In the PAST 6 MONTHS, did you enroll in a treatment program for the treatment of alcohol and/or drug abuse problems? Inpatient A&D Program ___Yes ___No Outpatient A&D Program __Yes __No
37.	In the PAST 6 MONTHS, did your enroll in a treatment program for mental health problems (other than the gambling program you attended? Inpatient Program ___Yes ___No Outpatient Program __Yes __No
38.	In the PAST 6 MONTHS, did you enroll in another gambling treatment program, or see another therapist or doctor outside the staff of the gambling program you attended? Inpatient Program ___Yes ___No Outpatient Program __Yes __No
39.	In the PAST 6 MONTHS, have you filed for bankruptcy? __Yes __No
40.	In the PAST 6 MONTHS, have you been convicted of any crime? __Yes __No
41.	In the PAST 6 MONTHS, have you experienced physical violence in a relationship? __Yes __No
42.	In the PAST 6 MONTHS, have you experienced verbal, emotional, or psychological abuse in a relationship? __Yes __No
43.	In the PAST 6 MONTHS, have you felt controlled, trapped, or manipulated by a significant other? __ Yes __No

Thank you for completing this survey. Your assistance is greatly appreciated.

CORRECTED: ☐

Chapter 11 FAMILY CLIENT TERMINATION ABSTRACTING FORM

REFER TO DATA COLLECTION PROTOCOL BEFORE COMPLETING

LEAVE NO BLANK FIELDS – REFER TO MANUAL:
UK-Unknown, NA-Does Not Apply, NC-Not Collected, CR-Client Refused

1 Clinic/Provider ID: ☐☐☐☐☐☐☐☐☐☐☐☐ Family Client Case ID: ☐☐☐☐☐☐☐☐☐☐

2 Enrollment Date: ☐☐☐☐☐☐ DOB: ☐☐☐☐☐☐ Gender: ☐

3 Last Service Date: ☐☐☐☐☐☐ Termination Type: ☐☐ Treatment Type: ☐☐ Referral Type: ☐☐ _____

4 Gambler Case ID: ☐☐☐☐☐☐☐☐☐☐ DOB: ☐☐☐☐☐☐ Gender: ☐ Relationship: ☐

5 Suicide: ☐☐ Bankruptcy: ☐☐ Abuse: ☐☐ Reported: ☐☐

6 Diagnostic Impression:
Primary: ☐☐ Secondary: ☐☐

7 Ancillary Support Services Received (Check All That Apply)

01	___ Physical Health	07	___ Employment
02	___ Mental Health	08	___ Housing
03	___ Other Addictions	09	___ Emergency Clothing
04	___ Dental	10	___ Food Stamps
05	___ Vision	11	___ Insurance Enrollment
06	___ Education	12	___ Other

8 PRINT Completed By: _____ Date: _____

Family Client Termination Abstracting Form - Instructions

The data to be coded into each of the fields on the Client Discharge/Termination Coding Form is discussed by numerical section identification found on the left side of the form. This form does not need to be completed if the individual was an assessment only AND there were NO changes to the enrollment form.

LEAVE NO BLANK FIELDS

USE THE FOLLOWING CODES FOR ALL FIELDS WHERE THE INFORMATION IS EITHER UNKNOWN, NOT AVAILABLE, OR THE CLIENT HAS REFUSED TO PROVIDE.

UK – UNKNOWN
NA – DOES NOT APPLY
NC – NOT COLLECTED BY AGENCY
CR – CLIENT REFUSED

CORRECTED: Check this box only if the Form is being resubmitted to correct, or update, previously submitted information. Please make a photocopy of the original form, check the corrected box, and indicate the changes on the form with red ink. Please write clearly.

BLOCK 1: ***Provider Identification***

Clinic/ Provider Identification: Facility or Clinic name where services are being provided. State issued clinic ID numbers/codes may be substituted. This should be the same as that on the Enrollment Form.

Family Client Case Identification Code: Each family client enrolling in the program must be assigned a discrete, confidential 10-character alpha-numeric (maximum) client case identification code by the providing agency. This code will be utilized to track the individual throughout his, or her, care with that agency. This code must be the same as that used for the family member's enrollment.

BLOCK 2: ***Client Identification***

Enrollment Date: Date the family client was enrolled for the current episode of care using the MM/DD/YY format.

Date of Birth: In American format - MM/DD/YYYY. This field is used for confirmation in the database in the case that the family client Case ID provided is not legible.

Gender: M for Male; F for Female. This field is utilized for secondary confirmation along with the Date of Birth field if the family client Case ID provided is not legible or has been duplicated by the provider.

BLOCK 3: *Termination Data* All family client records must be closed within the time prescribed by the prevailing contract with AMH. Family clients being transferred from agency to agency must be closed at the first agency and then reopened at the accepting agency. Family clients being transferred from residential gambling treatment should be opened and closed for that treatment model and then reopened for outpatient treatment. Similarly, clients enrolled in minimal intervention projects should be closed in that level of care and re-opened in a new level of care as appropriate.

Last Service Date: Date in American format (MM/DD/YY) that the family client was last seen at the clinic/provider agency.

Termination Type:

02 Stopped coming – against staff advice – cap not reached
03 Treatment completed successfully **
04 Further treatment not appropriate at this program
05 Non-compliance with rules and regulations
06 Client refused services
07 Moved from Catchment Area
08 No transportation
09 Conflicting hours
10 Evaluation services only
11 Incarcerated
12 Deceased
13 Parent/legal guardian withdrew client
14 Program cuts or program closure (other than standard treatment session cap)
15 Physical/Mental illness
16 Treatment subsidy ran out, client unwilling to pay, left against staff advice

*** The definition for treatment completed successfully can be found in the prevailing contract with AMH.*

Treatment Type: Primary mode of treatment received by the family client at this agency during this episode of care. (Based on ASAM levels of service.)

01 Outpatient
02 Intensive Outpatient/Partial Hospitalization
03 Residential/Inpatient
04 Medically-managed intensive inpatient
05 Long term residential (more than 30 days)
06 Evaluation or Assessment Only
07 Minimal - home-based intervention
08 State funded respite care

Referral Type: Principle type of treatment family client referred to following this treatment.

00 None
01 Minimal - home-based intervention
02 Traditional Outpatient Structure Program with individual, group, and psychoeducational session for the client (and the family).
03 Outpatient – Individual therapist not with an organized program.
04 Residential - short-term crisis stabilization (less than 5 days)
05 Residential - mid-term care (5 to 30 days)
06 Medically Managed Residential Care - (Patient under direct supervision of an MD)
07 Residential - long-term (more than 30 days)
08 GamAnon
09 Other

NOTE: Respite and residential treatment programs please write in the name of the outpatient gambling treatment program the client was referred to.

BLOCK 4: *Gambler Identification if enrolled.*

Gambler Case Identification Code: This is the discrete client case identification for the gambler *if enrolled* in the program.

Gambler Date of Birth: This date of birth field is for the gambler client and is used for confirmation in case the Gambler Case Identification field is not legible. Use MM/DD/YYYY format

Gambler Gender: This field is used for secondary confirmation in case the gambler Case Identification field is not legible.

Relationship: The relationship of the <u>family client to the gambler</u>.

01 Spouse or Significant Other
02 Parent (Step Parent/Guardian)
03 Child (Step Child)
04 Sibling
05 Other Family Relationship
06 Friend or Co-worker
07 Employee or Employer
08 Other

BLOCK 5:

Suicide: In the past six months.

01 Thoughts
02 Threat
03 Plan
04 Action/Behavior
08 None of the Above

Bankruptcy: Filed, or planning to file, bankruptcy due to gambling losses in the past six months.

01 Yes 02 No

Abuse: Since enrolling in treatment has there been any child, spouse, partner, or elderly abuse in the household reported to the agency including physical, emotional or sexual abuse, neglect or abandonment?

01 Yes
02 No

Reported: Was the abuse required to be reported by the program to cognizant authorities.

01 Yes
02 No

BLOCK 6: *Diagnostic Impressions*

Primary: Indicate final primary diagnostic impression. (Reason for Treatment)

01 Not Mentally Ill/Diagnosis Deferred
02 Delirium, Dementia, Amnesic and Other Cognitive Disorders
03 Substance-related Disorders (also complete substance abuse diagnostic code & specifier)
04 Disorders due to General Medical Condition
05 Schizophrenia and Other Psychotic Disorders
06 Mood Disorders
09 Anxiety Disorders
10 Adjustment Disorders
11 Personality Disorders
12 Sexual and Gender Identity Disorders
14 Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence
15 Impulse-Control Disorders (NOT PATHOLOGICAL GAMBLING)
16 Eating Disorders
19 Dissociative Disorders
20 **PATHOLOGICAL GAMBLING**
21 **PROBLEM GAMBLING**
22 **FAMILY ISSUES RELATED TO PROBLEM GAMBLING**
23 Gaming – not gambling
25 Other

Secondary: Indicated what is the secondary diagnostic impression.

(Use same codes as above)

BLOCK 7: Ancillary Services. Check all boxes for additional services that were provided to the client and paid for by any funding source.

BLOCK 8: COMPLETE THIS BLOCK TO FACILITATE CONTACT IF THERE ARE ANY QUESTIONS REGARDING THE CODES UTILIZED.

Chapter 12 SEMIANNUAL CLIENT SATISFACTION SURVEY

Agencies are required to conduct semi-annual consumer satisfaction surveys of gambling and family clients. The surveys are anonymous and the data collections periods are July 1 through December 31 and January 1 through June 30 must be submitted to the Evaluator by July 15 and December 15 each year to be included in the semiannual Quality Improvement Reports ("Report Cards").

It is expected that agencies will survey at least 50% of their active case load during the survey period or a representative sample as determined in conjunction with the program evaluator. The survey period and local strategy will vary from agency to agency according to size and program format. Generally, consumers will be asked to complete the survey in a manner that ensures complete anonymity. This can be accomplished by having them put their completed surveys in a sealed box at the end of group or individual sessions for example.

Agencies are strongly encouraged to contact the evaluator when developing strategies and protocol for collecting this semiannual consumer satisfaction data. Agencies do receive feedback from these surveys with their semiannual quality improvement reports.

OREGON PROBLEM GAMBLING SERVICES - SEMI-ANNUAL SATISFACTION SURVEY 010116

Thank you for completing this survey. The information you provide is anonymous and very important in helping us to evaluate the usefulness of the services that are being provided to you. The information you provide will be combined with information from a large number of other consumers into reports in a manner that your individual identity can not be identified.

1. **Date:** _____ 2. **Age:** _____ 3. **Gender:** 01 ___ Male 02___ Female 03__Other

4. **Race/Ethnicity:** (Check all that apply)

01 __ White (Non-Hispanic)
02 __ Black (Non-Hispanic)
03 __ Native American
04 __ Alaska Native
05 __ Asian
06 __ Hispanic (Mexican)
07 __ Hispanic (Puerto Rican)
08 __ Hispanic (Cuban)
09 __ Other Hispanic
10 __ Southeast Asian
11 __ Native Hawaiian/Other Pacific Islander
12 __ Other Race/Ethnicity

5. How long have you been enrolled in this program? 01 __ One month or less 02 __ Two to six months 03 __ More than six months

6. Are you a family member of a problem gambler? 01 __ Yes 02 __ No

		To what extent is this a barrier to recovery?						To what extent is this improving with treatment/peer mentoring?				
		Very Little/No	Little	Some	Great	Very Great		Very Little/No	Little	Some	Great	Very Great
7.	Housing	1	2	3	4	5		1	2	3	4	5
8.	Relationships with Spouse or Significant Other	1	2	3	4	5		1	2	3	4	5
9.	Relationships with other Family Members	1	2	3	4	5		1	2	3	4	5
10.	Relationships with Friends	1	2	3	4	5		1	2	3	4	5
11.	Employment or Income	1	2	3	4	5		1	2	3	4	5
12.	Physical Health	1	2	3	4	5		1	2	3	4	5
13.	Overall Well Being	1	2	3	4	5		1	2	3	4	5
14.	Education	1	2	3	4	5		1	2	3	4	5

Please complete page two of this survey.

rev 020216

Satisfaction

To what extent do you agree with the following statements?		Very Little/No	Little	Some	Great	Very Great	Don't Know/NA
15.	Services received from the program are helpful.	1	2	3	4	5	?
16.	The location where the services are provided is convenient.	1	2	3	4	5	?
17.	The facility is appropriate for the services provided.	1	2	3	4	5	?
18.	The times that the services are available are convenient.	1	2	3	4	5	?
19.	I am treated with dignity and respect.	1	2	3	4	5	?
20.	My aftercare plan will be helpful.	1	2	3	4	5	?
21.	I feel that we are working on issues that I want to work on.	1	2	3	4	5	?
22.	I feel my counselor's approach is a good fit for me.	1	2	3	4	5	?
23.	I feel the counseling I'm receiving is right for me.	1	2	3	4	5	?
24.	The problems that brought me to the program are improving.	1	2	3	4	5	?
25.	I would recommend the program services to others.	1	2	3	4	5	?

If you have received support or services from a peer specialist working for the program please answer questions 26 & 27

26.	The peer support specialist is helpful in my recovery.	1	2	3	4	5	?
27.	The peer support specialist provides help beyond what the counselors are able to do.	1	2	3	4	5	?

28.	What has been the most helpful part of treatment/peer mentoring so far?
29.	What has been the least helpful part of treatment/peer mentoring so far?
30.	Other Comments and Recommendations?