U.S. Department of Health and Human Services OMB No. xxx-xxxx

Approval Expires: xx/xx/xxxx

**2011 Opioid Treatment Program (OTP) Questionnaire**

**March 31, 2011**

**Sponsored by the Substance Abuse and Mental Health Services Administration**

**(SAMHSA)**

**PLEASE REVIEW THE INFORMATION BELOW.**

**CROSS OUT ANY ERRORS AND ENTER THE CORRECT INFORMATION.**

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| --- |
|  |

**PLEDGE TO RESPONDENTS**

The information you provide will be protected to the fullest extent allowable under the Public Health Service Act, 42 USC Sec 501(n). This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of the information to the purposes for which it was supplied. Facility data will be de-identified such that identifying individual treatment facilities from the published data will not be possible.

|  |  |
| --- | --- |
|  | *PLEASE READ THIS ENTIRE PAGE*  *BEFORE COMPLETING THE QUESTIONNAIRE* |

***INSTRUCTIONS***

* Many of the questions in this survey ask about “this Opioid Treatment Program (OTP).” By “this OTP” we mean the specific opioid treatment program whose name and location are printed on the front cover. If this OTP is part of a larger facility, report only about the services and activities at this OTP. If you have any questions about how “this OTP” applies to your facility, please call 1-888-324-8337
* Return the completed questionnaire in the envelope provided. Please keep a copy for your records.
* For additional information about this survey, please visit **http://info.nssats.com**.
* If you have any questions please contact:

MATHEMATICA POLICY RESEARCH

1-888-324-8337

|  |
| --- |
| SECTION A  **OPIOID TREATMENT PROGRAM SERVICES AND CHARACTERISTICS** |

|  |
| --- |
| Section A asks about services and characteristics of this Opioid Treatment Program (OTP), that is, the OTP at the location listed on the cover of this survey. If this OTP is part of a larger facility, report only about the services and activities at this OTP. |

**A1. Is this OTP, at this location, normally scheduled to be open 365 days a year?**

1 🞎 Yes

0 🞎 No

**A2. Does this OTP have a plan or an agreement with another provider to provide continuity of care for patients during service disruptions, whether due to a major disaster or more routine event, such as a snowstorm?**

1 🞎 Yes

0 🞎 No **SKIP TO A3 (BELOW)**

**A2a. With which of the following providers does this OTP have such a plan or agreement?**

**MARK “YES” OR “NO” FOR EACH**

YES NO

1. A hospital 1 🞎 0 🞎

2. Another OTP 1 🞎 0 🞎

3. A pharmacy 1 🞎 0 🞎

4. Other *(Specify below:* 1 🞎 0 🞎

*)*

**A3. Does this OTP have a formal agreement for medical referral purposes with…**

**MARK “YES” OR “NO” FOR EACH**

YES NO

1. A Federally Qualified Health

Center (FQHC) 1 🞎 0 🞎

2. A hospital 1 🞎 0 🞎

3. A medical clinic 1 🞎 0 🞎

4. Other *(Specify below:* 1 🞎 0 🞎

*)*

**A4. Does this OTP have a written agreement (as provided in 42 CFR Part 2) that permits other health service providers to receive, process, store, or otherwise manage patient records?**

1 🞎 Yes

0 🞎 No

**A5. For each day of the week, record this OTP’s number of scheduled daily hours…**

**Column A** – For dispensing methadone, buprenorphine (Subutex® or generic) or buprenorphine/naloxone (Suboxone®).

**Column B** – For counseling.

* *If not scheduled on a given day, record “0” hours for that activity on that day.*

|  |  |  |
| --- | --- | --- |
|  | **Column A** | **Column B** |
| **Days of Week** | **Total Number of Scheduled Hours for Dispensing**  **Medication** | **Total Number of Scheduled Hours for Counseling** |
| Monday | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| Tuesday | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| Wednesday | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| Thursday | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| Friday | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| Saturday | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| Sunday | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |

**A6. Does the OTP, at this location, provide vaccinations for…**

**MARK “YES” OR “NO” FOR EACH**

YES NO

1. Hepatitis B 1 🞎 0 🞎

2. Influenza 1 🞎 0 🞎

**A7. This question asks about screening and diagnostic tests provided at this OTP.**

**Column A** – For which of these conditions does this OTP routinely screen? Consider all screening performed at intake, assessment or admission.

**Column B** – For which of these conditions does this OTP perform diagnostic tests? Consider all testing performed as medically appropriate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Column A** | | **Column B** | |
| **Health Condition** | **Routinely Screen** | | **Perform Diagnostic Tests** | |
|  | Yes | No | Yes | No |
| 1. Diabetes | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 2. Hepatitis C | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 3. HIV/AIDS | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 4. Hypertension (high blood pressure) | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 5. Pregnancy | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 6. Heartbeat abnormalities | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 7. Sexually transmitted infections (STIs, including gonorrhea, syphilis) | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 8. Sleep apnea | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 9. Alcohol use | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 10. Tobacco use | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |

**A8. Does this OTP routinely test for any of the following drugs at admission?**

**MARK “YES” OR “NO” FOR EACH**

YES NO

1. Marijuana 1 🞎 0 🞎

2. Cocaine 1 🞎 0 🞎

3. Benzodiazepines 1 🞎 0 🞎

4. Heroin 1 🞎 0 🞎

5. Prescription opioids 1 🞎 0 🞎

6. Methamphetamines 1 🞎 0 🞎

7. Other stimulants *(Please specify:* 1 🞎 0 🞎

*)*

**A9. For each of the listed psychiatric conditions, please indicate if this OTP…**

**Column A** – Routinely screens for the condition.

**Column B** – Provides treatment involving medication.

**Column C** – Provides treatment involving counseling therapy.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Column A** | | **Column B** | | **Column C** | |
| **Psychiatric Condition** | **Routinely Screens** | | **Treatment Involving Medication** | | **Treatment Involving Counseling** | |
|  | Yes | No | Yes | No | Yes | No |
| 1. Anxiety/Panic disorder | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 2. Bipolar disorder | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 3. Depression | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 4. Post traumatic stress disorder | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 5. Schizophrenia | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 6. Other *(Specify below:* | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| *)* | | | | | | |

**A10. This question concerns the clinical staff providing patient services at this OTP in a typical week.**

* *Please count a staff member in one category only.*

**Column A** – Please record total number employed at this OTP.

**Column B** – Please record the sum total hours worked for all staff listed in Column A in a typical week.

|  |  |  |
| --- | --- | --- |
|  | **Column A** | **Column B** |
| **Clinical Staff** | **total number employed at this otp**  **(if none, enter “0”)** | **sum total number of hours worked in typical week** |
| 1. Physician (MD, DO, Psychiatrist, etc.) | \_\_\_\_\_\_ | \_\_\_\_\_\_ |
| 2. Registered Nurse (RN) | \_\_\_\_\_\_ | \_\_\_\_\_\_ |
| 3. Licensed Practical Nurse (LPN) | \_\_\_\_\_\_ | \_\_\_\_\_\_ |
| 4. Mid-level medical personnel (Nurse Practitioner, PA, APRN, etc.) | \_\_\_\_\_\_ | \_\_\_\_\_\_ |
| 5. Pharmacist | \_\_\_\_\_\_ | \_\_\_\_\_\_ |
| 6. Doctoral level counselor (Psychologist, etc.) | \_\_\_\_\_\_ | \_\_\_\_\_\_ |
| 7. Masters level counselor (MSW, etc.) | \_\_\_\_\_\_ | \_\_\_\_\_\_ |
| 8. Other degreed counselor (BA, BS) | \_\_\_\_\_\_ | \_\_\_\_\_\_ |
| 9. Associate degree or non degreed counselor | \_\_\_\_\_\_ | \_\_\_\_\_\_ |

**A11. For clinical management, does this OTP…**

**MARK “YES” OR “NO” FOR EACH**

YES NO

1. Use in-house or proprietary software

(software that was created for, or

modified specifically for, this OTP

or facility)? 1 🞎 0 🞎

2 . Use commercially-available software

that has not been modified specifically

for this OTP or facility? 1 🞎 0 🞎

3. Use a paper system only (no computer/

electronic clinical management)? 1 🞎 0 🞎

**A12. For each of the following activities, please indicate if staff members routinely use computer or electronic resources, paper only, or a combination of both to accomplish their work…**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **MARK ONE METHOD FOR EACH ACTIVITY** | | |
| **Work Activity** | **Computer/ Electronic Only** | **Paper Only** | **Both Electronic and Paper** |
| 1. Intake | 1 🞎 | 2 🞎 | 3 🞎 |
| 2. Assessment | 1 🞎 | 2 🞎 | 3 🞎 |
| 3. Treatment plan | 1 🞎 | 2 🞎 | 3 🞎 |
| 4. Discharge | 1 🞎 | 2 🞎 | 3 🞎 |
| 5. Referrals | 1 🞎 | 2 🞎 | 3 🞎 |
| 6. Issue/Receive lab results | 1 🞎 | 2 🞎 | 3 🞎 |
| 7. Billing | 1 🞎 | 2 🞎 | 3 🞎 |
| 8. Outcomes management | 1 🞎 | 2 🞎 | 3 🞎 |
| 9. Medication dispensing | 1 🞎 | 2 🞎 | 3 🞎 |

**A13. Do computers at this OTP have the capability to access the Internet?**

1 🞎 Yes

0 🞎 No **SKIP TO A14**

**A13a. Does this OTP primarily access the Internet using…**

1 🞎 A regular “dial-up” telephone line

2 🞎 DSL, cable modem, fiber optics, satellite,

wireless (such as Wi-Fi) or some other

broadband Internet connection?

3 🞎 Something else? *(Specify below:*

*)*

**A14. Do any outpatients travel an hour or more, each way, to be treated at this OTP?**

1 🞎 Yes

0 🞎 No

n 🞎 Not applicable, no outpatient OTP patients

|  |
| --- |
| SECTION B: OTP PATIENT CHARACTERISTICS  For this survey, an OTP patient is a person who has been admitted to this OTP and who receives methadone or buprenorphine. |

|  |
| --- |
| **QUESTION B1** REFERS ONLY TO NEW PATIENTS ADMITTED TO THIS OTP IN 2010. |

**B1. During the 2010 calendar year, how many new patients were admitted to this OTP?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ENTER A NUMBER**  **(IF NONE, ENTER “0”)** | | |
| **2010 CALENDAR YEAR**  **TOTAL BOX** |  |  |  |

|  |
| --- |
| **Questions B2 – B6 ask about ALL patients in treatment at this OTP on March 31, 2011.** |

**B2. On March 31, 2011, how many patients were in treatment at this OTP?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ENTER A NUMBER**  **(IF NONE, ENTER “0”)** | | |
| **MARCH 31, 2011**  **TOTAL BOX** |  |  |  |

**B3. On March 31, 2011, how many of these OTP patients were…**

* *Each category total should equal the number reported in the TOTAL BOX in B2.*

|  |  |
| --- | --- |
| **ENTER THE NUMBER OF PATIENTS IN EACHCATEGORY**  **(IF NONE, ENTER “0”)** | |
| **GENDER** |  |
| Male |  |
| Female |  |
| Other, unknown or not collected |  |
| **GENDER TOTAL:** *(Should=B2)* |  |
| **AGE** |  |
| Under 18 |  |
| 18-34 |  |
| 35-54 |  |
| 55 and over |  |
| Unknown or not collected |  |
| **AGE TOTAL:** *(Should=B2)* |  |
| **RACE & ETHNICITY** |  |
| White |  |
| Black |  |
| Hispanic |  |
| Asian |  |
| American Indian or Alaska Native |  |
| Native Hawaiian or Other Pacific Islander |  |
| Two or more races |  |
| Unknown or not collected |  |
| **RACE & ETHNICITY TOTAL:** *(Should=B2)* |  |
| **VETERAN STATUS** |  |
| Veteran |  |
| Non Veteran |  |
| Unknown or not collected |  |
| **VETERAN TOTAL:** *(Should=B2)* |  |

**B4. Of the patients in treatment on March 31, 2011, how many had been in treatment continuously at this OTP for…**

|  |  |  |
| --- | --- | --- |
| **ENTER THE NUMBER OF PATIENTS**  **(IF NONE, ENTER “0”)** | |  |
| 0-90 days | \_\_\_\_\_\_\_ |  |
| 91-180 days | \_\_\_\_\_\_\_ |  |
| 181-365 days | \_\_\_\_\_\_\_ |  |
| More than 1 year to less than 2 years | \_\_\_\_\_\_\_ |  |
| 2 years or longer | \_\_\_\_\_\_\_ |  |
| **TOTAL** *(Should = B2)* |  |  |
|  |  |  |

**B5. How many of the patients in treatment on March 31, 2011 were dispensed methadone?**

🞎 NONE, DO NOT DISPENSE METHADONE

SKIP TO B6

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ENTER A NUMBER**  **(IF NONE, ENTER “0”)** | | |
| **NUMBER DISPENSED METHADONE** |  |  |  |

**B5a. Of these patients, how many were receiving methadone for…**

|  |  |  |
| --- | --- | --- |
| **ENTER THE NUMBER OF PATIENTS**  **(IF NONE, ENTER “0”)** | |  |
| Maintenance | \_\_\_\_\_\_\_ |  |
| Detoxification | \_\_\_\_\_\_\_ |  |
| **Total Receiving Methadone**  *(Should = B5)* |  |  |
|  |  |  |

**B5b. How many methadone maintenance patients in B5a were receiving methadone doses of…**

|  |  |  |  |
| --- | --- | --- | --- |
| **ENTER THE NUMBER OF PATIENTS**  **(IF NONE, ENTER “0”)** | | |  |
| Less than 40 mg. | \_\_\_\_\_\_\_ | |  |
| 40 to 79 mg. | \_\_\_\_\_\_\_ | |  |
| 80 to 119 mg. | \_\_\_\_\_\_\_ | |  |
| 120 mg. or above | \_\_\_\_\_\_\_ | |  |
| **Total Receiving Methadone**  *(Should = B5)* |  | |  |
|  | |  |  |

**B5c. How many of the patients in B5 had been receiving methadone for 2 years or more?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ENTER A NUMBER**  **(IF NONE, ENTER “0”)** | | |
| **NUMBER RECEIVING METHADONE FOR 2 YEARS OR MORE** |  |  |  |

**B5d. Of the patients in B5c, how many were receiving take-home doses for the following number of days…**

|  |  |  |  |
| --- | --- | --- | --- |
| **NUMBER OF DAYS** | **ENTER THE NUMBER OF PATIENTS**  **(IF NONE, ENTER “0”)** | |  |
| 0 days (did not receive take-home doses) | | \_\_\_\_\_\_\_ |  |
| 1-7 days | | \_\_\_\_\_\_\_ |  |
| 8-14 days | | \_\_\_\_\_\_\_ |  |
| 15-30 days | | \_\_\_\_\_\_\_ |  |
| **Total Receiving Methadone for 2 years or more**  *(Should = B5c)* | |  |  |
|  | |  |  |

**B6. How many of the patients in treatment on March 31, 2011 were receiving buprenorphine (Subutex® or generic) or buprenorphine/ naloxone (Suboxone®)?**

🞎 NONE, DO NOT DISPENSE BUPRENORPHINE

SKIP TO B7

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ENTER A NUMBER**  **(IF NONE, ENTER “0”)** | | |
| **NUMBER DISPENSED BUPRENORPHINE OR BUPRENORPHINE/NALOXONE** |  |  |  |

**B6a. Of these patients, how many were receiving buprenorphine for…**

|  |  |  |
| --- | --- | --- |
| **ENTER THE NUMBER OF PATIENTS**  **(IF NONE, ENTER “0”)** | |  |
| Maintenance | \_\_\_\_\_\_\_ |  |
| Detoxification | \_\_\_\_\_\_\_ |  |
| **Total Receiving Buprenorphine**  *(Should = B6)* |  |  |
|  |  |  |

**B6b. How many buprenorphine maintenance patients in B6a were receiving buprenorphine doses of…**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **ENTER THE NUMBER OF PATIENTS**  **(IF NONE, ENTER “0”)** | | | | | |  |
| **Dosage** | **Buprenorphine (Subutex® or Generic)** | | | **Buprenorphine/Naloxone (Suboxone®)** | | |  |
| Less than 8 mg. | \_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_ | | |  |
| 8 to 16 mg. | \_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_ | | |  |
| 17 to 24 mg. | \_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_ | | |  |
| 25 to 32 mg. | \_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_ | | |  |
| More than 32 mg. | \_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_ | | |  |
| **TOTAL RECEIVING BUPRENORPHINE**  *(Should = B6)* |  |  |  |  |  |  |  |
|  |  | | |  | | |  |

**B7. Who was primarily responsible for completing this form?**

Name:

Title:

Phone Number: (\_\_\_\_\_) – \_\_\_\_\_\_ -

Fax Number: (\_\_\_\_\_) – \_\_\_\_\_\_ -

Email Address:

**B8. PLEASE INDICATE ANY COMMENTS**

**Thank you for your participation. Please return this questionnaire in the envelope provided. If you no longer have the envelope, please mail this questionnaire to:**

**MATHEMATICA POLICY RESEARCH**

ATTN: RECEIPT CONTROL - Project 06667-OTP

P.O. Box 2393

Princeton, NJ 08543-2393

Public burden for this collection of information is estimated to average 50 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer, Room 8-1099, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB number for this project is xxxx-xxxx.