U.S. Department of Health and Human Services

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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.

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. Responses to questions will be published only in statistical summaries so that individual treatment facilities cannot be identified.

PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE

Would you prefer to complete this questionnaire online?

See the neon green flyer enclosed in your questionnaire packet for the Internet address and your unique user ID and password. As with the N-SSATS survey, you can log on and off the website as often as needed to complete the questionnaire. When you log on again, the program will take you to the next unanswered question. If you need more information, call the OTP Survey helpline at 1-xxx-xxx-xxxx.

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-xxx-xxx-xxxx.
- 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/otp**.
- If you have any questions please contact:

MATHEMATICA POLICY RESEARCH
1-xxx-xxx-xxxx

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.*

DAYS OF WEEK	Column A Total Number of Scheduled Hours for Dispensing Medication	Column B 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.

HEALTH CONDITION	COLUMN A ROUTINELY SCREEN		COLUMN B 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.

PSYCHIATRIC CONDITION	COLUMN A ROUTINELY SCREENS		COLUMN B TREATMENT INVOLVING MEDICATION		COLUMN C 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 <u>total number</u> employed at this OTP.

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

CLINICAL STAFF	COLUMN A TOTAL NUMBER EMPLOYED AT THIS OTP (IF NONE, ENTER "0")	COLUMN B 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 <u>routinely</u> use computer or electronic resources, paper only, or a combination of both to accomplish their work…

WORK ACTIVITY	MARK ONE METHOD FOR EACH 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 <u>primarily</u> 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, <u>each way</u>, 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. <u>During the 2010 calendar year</u>, 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 <u>in treatment</u> 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 EACH CATEGORY (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, Non-Hispanic	☐
Black, Non-Hispanic	☐
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 <u>continuously</u> 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 <u>methadone</u>?

☐ ← 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 <u>maintenance</u> 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 <u>for 2 years or more</u>?

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 <u>take-home doses</u> 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 <u>buprenorphine (Subutex® or generic) or buprenorphine/ naloxone (Suboxone®)</u>?

☐ ← 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 <u>maintenance</u> patients in B6a were receiving buprenorphine doses of…

DOSAGE	ENTER THE NUMBER OF PATIENTS (IF NONE, ENTER "0")	
	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

MPR DOCUMENTATION:

N:\Shared-NJ1\Secretaries\Questionnaires (for Survey)\OTP\OTP Supplement Survey (12-10-10 lmb)-12.docx (12-10-10) 12/10/2010 2:58 PM

Lynne revised for Matthew Anderson

Shading is Custom 198, 217, 241

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