Attachment # 7

Form Approved

OMB No. 0920-1359

Expiration Date: 12/31/2024

National Syringe Services Program Evaluation

Survey Year 1

Privacy Act Statement:

This information is collected under the authority of the Public Health Service Act, Section 301, "Research and Investigation," (42 U.S.C. 241); and Sections 304, 306 and 308(d) which discuss authority to maintain data and provide assurances of confidentiality for health research and related activities (42 U.S.C. 242 b, k, and m(d)). This information is also being collected in conjunction with the provisions of the Government Paperwork Elimination Act and the Paperwork Reduction Act (PRA). This information will be used by the Centers for Disease Control and Prevention (CDC) with the support of the University of Washington, the North American Syringe Exchange Network, and New York University in order to help build a stable foundation for SSP monitoring and establish a system for program improvement, and ensure quality service delivery at SSPs nationwide.

DAVE PURCHASE MEMORIAL SURVEY
QUESTIONNAIRE SECTIONS

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OVERVIEW

Abbreviations

R	Respondent
DK	Don't know
REF	Refused to answer
NA	Not applicable (question asked of R but this is a codable response option)
EQ	Equal to
GT	Greater than
GE	Greater than or equal to
LE	Less than or equal to
LT	Less than
NE	Not equal to

Key Terms

Term	Prefix / format	Definition
Calculated variable	CALC_	Item identifier (not prefix for variable name) for variables calculated by the CAPI program that appear in the CRQ.
Message	**INTERVIEWER**:	Message displayed to the interviewer that is not to be read to R. May be triggered by an edit check. Distinct from Interviewer Instruction. 'FIELD NOTE' indicates instructions that will be added as a field note rather than directly included in the question.
Filter question		A question that determines whether the respondent should receive subsequent question or set of questions, typically on a related topic.
Logic Check	Check_	Logic that must be checked (by the CAPI program) in order to determine proper routing to the next item in the CAPI programmed questionnaire.
Interviewer instruction		Instruction to interviewer regarding survey administration. Standard instructions are 'Give Respondent Flashcard {letter}', 'READ choices', 'DO NOT READ choices', & 'CHECK ALL that apply'.
Introductory statement	INTRO_	Transitional statement read to R at the beginning of a new topic (e.g., Section, set of questions, etc.). Prefix is followed by section abbreviation, series, or first item in set to which it applies.
Range		Range of valid response values for items collecting or computing numeric data. E.g., the valid range of responses to number of sex partners in past 12 months is 0 to 7000.
Section		Section of the Questionnaire. Each section has a unique two letter abbreviation.
Soft Edit Check	SoftEdit_	A check to determine whether the response entered is implausible. If yes, CAPI program displays message to interviewer; program may advance after closing the error message dialog box.

DAVE PURCHASE MEMORIAL SURVEY
PRELIMINARY INFORMATION

INTRO_OMB.	Public reporting burden of this collection of information is estimated to average 35 minutes per survey, including the time for reviewing instructions, administering questions and entering responses. 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, US8-4, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-1359); Expiration: 12/31/2024

CALC_YR	**Hidden variable: Year of recall period. This is the period that the participant will be asked to recall throughout the survey. This needs to be updated manually by survey staff each time the survey is administered.** *Field note: Must be 4 digits.*
YEAR	Recall year _ _ _ _

PI1.	**Are you completing this survey by yourself or by speaking with an interviewer?**
ADMIN	Mode of administration Completing survey in REDCap..... 0 Completing survey with interviewer..... 1

Check_INTRO.	If R self-administering survey (PI1 [ADMIN] EQ 0), go to INTRO_SA. Else, go to INTRO_IA.

INTRO_SA.	Thank you for taking the time to complete this program survey. When answering questions, please refer to the period from January 1, [YEAR], to December 31, [YEAR] unless otherwise stated. If program data are not available, please use your best estimate to complete the questions below. If your program only operated during some of the specified time period, please provide information reflective of the time period(s) during which your program did operate. If you need any clarifications about any of the questions in this survey or how this information will be used, please contact [project coordinator name, phone, email]. If you need to step away, **PLEASE REMEMBER TO SAVE YOUR SURVEY,** as not saving it will result in losing your responses. To save, first click on the save button at the bottom of the screen. You will then be prompted to enter an email address and a link will be sent to you to continue the survey later.

INTRO_IA.	Thank you for taking the time to complete this program survey. When answering questions, please refer to the period from January 1, [YEAR], to December 31, [YEAR] unless otherwise stated. If program data are not available, please use your best estimate to complete the questions below. If your program only operated during some of the specified time period, please provide information reflective of the time period(s) during which your program did operate. If you need any clarifications about any of the questions in this survey or how this information will be used, please

let me know.

During the survey, you may need to refer to your records to answer some questions. If you are unable to answer a question today, but later find the answer in your records, you can reach us later to provide this additional information by contacting [project coordinator name, phone, email].

CALC_SDATE

Automatic, hidden variable: Survey date (today)

Automatic start date

_ _ / _ _ / _ _ _ _

CALC_START

Automatic, hidden variable: Start time of survey

Preliminary information: Start time

__ : __

What is the name of your program?

PI2. *[FIELD NOTE: IF REFUSED, LEAVE BLANK]*

PROGNAM Name of program

__ __ __ __ __ __ __ __ __ __ ____ __ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

What month and year did the program start? Start by selecting the month. If you do not remember the exact month, please provide your best estimate.

PI3a.

SDATE_M SDATE month

January	1
February	2
March	3
April	4
May	5
June	6
July	7
August	8
September	9
October	10
November	11
December	12
Don't Know	99
Refuse to Answer	77

PI3b. **Enter the year. If you do not remember the exact year, please provide your best estimate.**
Please enter four digits.

[FIELD NOTE: IF REFUSED OR DON'T KNOW, LEAVE BLANK]

SDATE_Y SDATE year

---- ---- ---- -----

Range.....1950-[YEAR]....

SoftEdit_SDATE_Y	If [SDATE_Y] > [YEAR], then display error message: "The year the SSP started is later than [YEAR]. Please confirm that this year is accurate."

INTRO_PI.	First, we would like to ask a series of questions about your program and the services your program provided between January 1, [YEAR], and December 31, [YEAR]. Following these questions, we will then ask a few of the same questions about 2020. The COVID-19 pandemic likely impacted program operations and services provided by programs nationwide during 2020, so this information will be extremely important to help understand these impacts and the continuing challenges to programs moving forward.

PI4. **Did your program provide any services at <u>any time</u> between January 1, [YEAR], and December 31, [YEAR]?**

OPRCL Operated during recall period

No..... 0

Yes..... 1

Check_PI4.	If R did not operate at any time during the recall period (PI4 [OPRCL] EQ 0), go to INTRO_MD1. Else, go to INTRO_PC.

PROGRAM CHARACTERISTICS

INTRO_PC.	The next set of questions is about your program background and overall set-up. All information is important, and we appreciate your time and effort in completing this survey. However, we understand if you cannot answer some of these questions; in these situations, you have an option to select "don't know" or "refuse to answer" responses, whichever best applies.

S_TIME1	**Automatic hidden variable: Respondent start time** Respondent start time __ : __

Was your program operated by a...

PC1. **Select all that apply.**

OPBY Program operator

Community-based organization without 501(c)(3) status .....

Community-based organization with our own 501(c)(3) status

Community-based organization with a sponsor's 501(c)(3) status

City health department.....

County health department.....
State health department.....
Academic health care organization
Non-academic health care organization

Volunteers only.....
Other (please specify).....
Refuse to Answer..... 7

Check_PC1spec.	If R selected 'Other (please specify)' (PC1(7) [OPBY(7)] EQ 1), go to PC1spec [OPBY_S]. Else, go to PC2 [SFUND].

PC1spec. **Specify other program operator.**
OPBY_S Specify other program operator

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

What were your program's sources of funding?
PC2. **Select all that apply.**
SFUND Sources of funding
City government.....
County government.....
State government.....
Federal government.....
Non-profit foundation/organization.....
Individual donations.....
Personal funds from program managers or staff.....
Corporate donation.....
Other (please specify).....
Don't Know.....99
Refuse to Answer.....77

Check_PC2spec.	If R selected 'Other (please specify)' (PC2(9) [SFUND(9)] EQ 1), go to PC2spec [SFUND_S]. Else, go to PC3 [BUDGET].

PC2spec. **Specify other source of funding.**
SFUND_S Specify other funding source

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

What was your total program budget? If your program is part of a larger, multi-service organization, please only
PC3. **provide the budget for your part of the program. Please provide the best estimate to your knowledge.**
BUDGET Total program budget
Less than $25,000..... 1
$25,000–$99,999..... 2
$100,000–$249,999..... 3

$250,000–$499,999..... 4
$500,000–$999,999..... 5
Between $1 million and $2 million..... 6
$2 million or more..... 7
Don't Know.....99
Refuse to Answer.....77

PC4. **Did your program employ any full-time paid staff-?**
FTSTAF Full-time paid staff
No..... 0
Yes..... 1
Refuse to Answer..... 7

PC5. **Did your program have any <u>paid employees</u> who formerly or currently inject drugs? Include paid outreach workers and those paid with stipends or salaries.**
PWIDST Current or former PWID staff
No..... 0
Yes..... 1
Don't Know..... 9
Refuse to Answer..... 7

PC6. **Did your program have any <u>volunteers</u> who formerly or currently inject drugs? Include outreach volunteers.**
PWIDVL Current or former PWID volunteers
No..... 0
Yes..... 1
Don't Know..... 9
Refuse to Answer..... 7

PC7. **What were your program's total hours of operation in a typical week? If your program had more than one location (including mobile locations), consider the hours of operation for the overall program. For example, if your program had 3 locations, and each was open from 1-5pm for 5 days per week, that would be 20 hours, <u>not</u> 60 hours, of overall coverage for that week. If you do not know or prefer not to answer, you may leave the response blank.**
NUMHRS Number of hours per week

— — —
Range.....0-168

INTRO_GEO. To help us understand geographic coverage of syringe services programs, please enter the state and county(ies) where your program operates. If your program has multiple locations, please list counties for all locations. Please also consider mobile units in your responses.

PC8a. **Please specify the state(s) or territory(ies) where your program is located: Select all that apply.**
SSPSTAT State(s) or territory(ies)
Alabama.....01.....
Alaska.....02.....
Arizona.....04.....

Arkansas	05
California	06
Colorado	08
Connecticut	09
Delaware	10
District of Columbia	11
Florida	12
Georgia	13
Hawaii	15
Idaho	16
Illinois	17
Indiana	18
Iowa	19
Kansas	20
Kentucky	21
Louisiana	22
Maine	23
Maryland	24
Massachusetts	25
Michigan	26
Minnesota	27
Mississippi	28
Missouri	29
Montana	30
Nebraska	31
Nevada	32
New Hampshire	33
New Jersey	34
New Mexico	35
New York	36
North Carolina	37
North Dakota	38
Ohio	39
Oklahoma	40
Oregon	41
Pennsylvania	42
Puerto Rico	72
Rhode Island	44
South Carolina	45
South Dakota	46
Tennessee	47
Texas	48
US Virgin Islands	78
Utah	49
Vermont	50
Virginia	51
Washington	53
West Virginia	54
Wisconsin	55
Wyoming	56
Refuse to Answer	77

PC8b. **In which counties does your program provide services? Please include brick and mortar locations, mobile services, deliveries, and other ways you provide services. If you do not know or prefer not to answer, you may leave the response blank.**

SSPCNTY County(ies)

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 255}

PC9. **Did your program serve communities that you would consider urban, suburban, or rural? Please consider all the locations in which your program operates and select all that apply.**

SRVAREA Service area type

Urban.....

Suburban.....

Rural.....

Refuse to Answer..... 7

PC10. **How did your program deliver services? If your program had more than one location or service delivery type, select all that apply.**

SDELIV Service delivery type

Brick and mortar building/storefront.....

Mobile unit, such as an RV, van, or car.....

Tent or outdoor area.....

Home delivery.....

“Backpack” delivery.....

Mail order.....

Vending machine.....

Other (please describe).....

Don’t Know.....99

Refuse to Answer.....77

Check_PC10spec. If R selected ‘Other (please describe)’ (PC10(8) [SDELIV(8)] EQ 1), go to PC10spec [SDELIV_S]. Else, go to PC11 [DSRPT].

PC10spec. **Specify other service delivery type.**

SDELIV_S Specify other service delivery type

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

PC11. **Did your program have to stop providing services for any period of time between January 1, [YEAR], and December 31, [YEAR] (that is, you did not provide services for at least one day or more when you had expected to be open)?**

DSRPT Stop providing services

No..... 0

Yes..... 1

Don’t Know..... 9

Refuse to Answer..... 7

Check_PC12. If R had to stop providing services (PC11 [DSRPT] EQ 1), go to PC12 [WHYDSRP]. Else, go to PC13 [INEVAL].

Please choose the reason(s) for the disruption.

PC12. **Select all that apply.**

WHYDSRP Why services disrupted

Inadequate funding for materials or supplies.....

Inadequate funding for operations.....

Lack of personnel to staff the program.....

Legal or political intervention.....

COVID-19 pandemic.....

Other (please describe).....

Don't Know..... 9

Refuse to Answer..... 7

Check_PC12spec. If R selected 'Other (please describe)' (PC12(6) [WHYDSRP(6)] EQ 1), go to PC12spec [WHYDSRP_S].
Else, go to PC13 [INEVAL].

PC12spec. **Specify other reason for disruption(s) to services.**

WHYDSRP_S Specify other disruption

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

PC13. **Did your program review your program's data for monitoring or evaluation purposes between January 1, [YEAR], and December 31, [YEAR]?**

INEVAL Did program review internal data

No..... 0

Yes..... 1

Refuse to Answer..... 7

PC14. **What computer software program did you use to manage your program's data? Select all that apply.**

SFTWR Software to manage client data

None.....

Excel.....

Google Sheets

Access.....

Neo360.....

REDCap.....

Qualtrics.....

SurveyMonkey.....

Other (please describe) .....

Refuse to Answer.....77

Check_PC14spec. If R selected 'Other (please describe)' (PC14 [SFTWR] EQ 8), go to PC14spec [SFTWR_S].
Else, go to PC15 [UNIQID].

PC14spec. **Specify other software used to manage client data.**

SFTWR_S Specify other software

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

PC15. **Did your program assign each client a unique ID?**

UNIQID Did program assign unique ID

No..... 0

Yes..... 1

Refuse to Answer..... 7

PC16. **How many unique clients did your program directly serve (not counting secondary exchange)? Please provide the best estimate to your knowledge. If you do not know or prefer not to answer, you may leave the response blank.**

NUMCLI Number of unique clients

__ __ __ __ __ __ __ __

Range.....0-99999999

PC17. **Did your program have residency restrictions on who could access services, that is, only people from certain geographic locations could receive services from your program?**

RESRSTR Residency restrictions

No..... 0

Yes..... 1

Don't Know..... 9

Refuse to Answer..... 7

PC18. **Did your program require clients to provide identifying documents (for example, a driver's license) to enroll or receive services?**

IDDOC Require identifying documents

No..... 0

Yes..... 1

Don't Know..... 9

Refuse to Answer..... 7

CLIENT CHARACTERISTICS

INTRO_CC. The next questions are about the characteristics of the clients served directly by your program (not counting secondary exchange). As a reminder, as you answer these questions, please think about your program's operations between January 1, [YEAR], and December 31, [YEAR].

CC1. **Which demographic groups did your program reach in [YEAR]? Select all that apply.**

DEMSRV Demographic groups served

Cisgender women.....

Cisgender men.....

Transgender women.....

Transgender men.....

Genderqueer/non-binary persons.....
American Indian or Alaska Native persons.....
Asian persons.....
Black or African American persons.....
Hispanic or Latinx persons.....
Native Hawaiian or Other Pacific Islander persons.....
White persons.....
Persons aged <18 years.....
Persons aged 18 to 29 years.....
Persons aged 30 to 39 years.....
Persons aged ≥40 years.....
Lesbian, gay, bisexual, or queer persons.....
Other (please describe).....
Refuse to Answer.....77

Check_CC1spec.	If R selected 'Other (please describe)' (CC1 [DEMSRV] EQ 16), go to CC1spec [DEMSRV_S]. Else, go to CC2 [DEMRCH].

CC1spec. **Specify other demographic group reached.**
DEMSRV_S Specify other group

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

CC2. **Which demographic groups in your community did your program have difficulty reaching in [YEAR]? Select all that apply.**
DEMRCH Difficulty reaching demographic groups
Cisgender women
Cisgender men.....

Transgender women
Transgender men.....

Genderqueer/non-binary persons.....
American Indian or Alaska Native persons.....
Asian persons.....
Black or African American persons.....
Hispanic or Latinx persons.....
Native Hawaiian or Other Pacific Islander persons.....
White persons.....
Persons aged <18 years.....
Persons aged 18 to 29 years.....
Persons aged 30 to 39 years.....
Persons aged ≥40 years.....
Lesbian, gay, bisexual, or queer persons.....
Other (please describe).....
Refuse to Answer.....77

Check_CC2spec.	If R selected 'Other (please describe)' (CC2 [DEMRCH] EQ 16), go to CC2spec [DEMRCH_S]. Else, go to CC3 [DEMRCH].

CC2spec. **Specify other demographic group your program had difficulty reaching.**

DEMRCH_S Specify other group

— — — — — — — — — ——— — — — ——— — — — ——— — — — ——— — — — ——— — — —

{text response; max characters = 100}

CC3. **Approximately what percentage of your clients did <u>not</u> have health insurance? Please use your records if available but provide your best estimate if no records are kept or are not readily available.**

INSUR Client insurance

Less than 25%..... 1
25-50%..... 2
51-75%..... 3
More than 75%..... 4
Don't Know..... 9
Refuse to Answer..... 7

CC4. **For each of the following substances, please indicate the approximate percentage of your clients who were <u>injecting</u> each substance on a weekly or more frequent basis. Please use your records if available but provide your best estimate if no records are kept or are not readily available.**

INJDRUG Substances injected by clients

		None	Less than 25%	25-50%	51-75%	More than 75%	Don't Know	Refuse to Answer
INJDRUGA	Heroin							
INJDRUGB	Fentanyl							
INJDRUGC	Painkillers, such as Oxycontin, Dilaudid, or Percocet							
INJDRUGD	Methamphetamine also known as meth or speed							
INJDRUGE	Powder cocaine							
INJDRUGF	Crack cocaine							
INJDRUGG	Benzodiazepines or other downers, such as Valium, Xanax, or Klonopin							
INJDRUGH	Combined opioids (e.g., heroin and fentanyl together)							
INJDRUGI	Combined opioids and stimulants (e.g., heroin and cocaine together)							
INJDRUGJ	Other 1 (please describe).....							
INJDRUGK	Other 2 (please describe).....							
INJDRUGL	Other 3 (please describe).....							

Check_CC4specA. If R selected 'Other 1 (please describe)' (CC4 [INJDRUGJ]), go to CC4specA [INJDRUGJ_S].
Else, go to Check_CC4specB.

CC4specA. **From the previous question, specify 'Other 1' substance injected by clients.**

INJDRUGJ_S Specify other substance injected

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

Check_CC4specB. If R selected 'Other 2 (please describe)' (CC4 [INJDRUGK]), go to CC4specB [INJDRUGK_S].
Else, go to Check_CC4specC.

CC4specB. **From the previous question, specify 'Other 2' substance injected by clients.**

INJDRUGK_S Specify other substance injected

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

Check_CC4specC. If R selected 'Other 3 (please describe)' (CC4 [INJDRUGL]), go to CC4specC [INJDRUGL_S].
Else, go to INTRO_CR.

CC4specC. **From the previous question, specify 'Other 3' substance injected by clients.**

INJDRUGL_S Specify other substance injected

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

COMMUNITY RELATIONS AND CHALLENGES

INTRO_CR. The next questions are about your program's relationships with members of the community and any related challenges. As a reminder, as you answer these questions, please think about your program's operations between January 1, [YEAR], and December 31, [YEAR].

CR1. **Which individuals or types of organizations advocated for your program or provided any type of support? Select all that apply.**

SUPADV Sources of support or advocacy

Local health officials.....
Law enforcement.....
HIV or other medical providers.....
Religious organizations.....
Local politicians.....
Local residents.....
Drug user unions.....
Other community-based organizations.....
Other (please describe).....
No advocate support.....

Refuse to Answer.....77

Check_CR1spec.	If R selected 'Other (please describe)' (CR1(8) [SUPADV(8)] EQ 1), go to CR1spec [SUPADV_S]. Else, go to CR2 [CHLNG].

CR1spec. **Specify other source of support**
SUPADV_S Specify other source of support

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

CR2. **What types of <u>external</u> challenges did your program face, not including challenges related to funding? Select all that apply.**
ECHLNG Types of external challenges
Limited/no law enforcement support.....
Active police harassment/arrest of program clients.....
Program operations disrupted by government or law enforcement.....
Local policy/law that restricts program services.....
Lack of support from local health officials.....
Lack of community support.....
Active community harassment.....
COVID-19 pandemic.....
Other (please describe).....
Did not face external challenges.....
Refuse to Answer.....77

Check_CR2spec.	If R selected 'Other (please describe)' (CR2(9) [ECHLNG(9)] EQ 1), go to CR2spec [ECHLNG_S]. Else, go to CR3 [ICHLNG].

CR2spec. **Specify other external challenges**
ECHLNG_S Specify other external challenges

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 255}

CR3. **What types of <u>internal</u> challenges did your program face? Select all that apply.**
ICHLNG Types of internal challenges
Staff burnout.....
Staff shortage.....
Limited/no funding.....
Limited/no resources or supplies (other than funding).....
Other (please describe).....
Did not face internal challenges.....
Refuse to Answer.....77

Check_CR3spec.	If R selected 'Other (please describe)' (CR3(5) [ICHLNG(5)] EQ 1), go to CR3spec [ICHLNG_S]. Else, go to CR4 [RLHO].

CR3spec. **Specify other internal challenges**
ICHLNG_S Specify other internal challenges

— — — — — — — — — — —— — — — —— — — — —— — — — — —— — — — — —— — — — — —— — — — —

{text response; max characters = 255}

CR4. **How would you describe your program's relationship with your local health department(s)?**
RLHO Relationship with local health officials

Very good..... 1
Somewhat good..... 2
Neither good nor poor..... 3
Somewhat poor..... 4
Very poor..... 5
Nonexistent..... 6
Refuse to Answer..... 7

CR5. **How would you describe your program's relationship with law enforcement?**
RLAW Relationship with law enforcement

Very good..... 1
Somewhat good..... 2
Neither good nor poor..... 3
Somewhat poor..... 4
Very poor..... 5
Nonexistent..... 6
Refuse to Answer..... 7

SYRINGE COLLECTION, DISTRIBUTION, AND DISPOSAL

INTRO_SYR. The next set of questions pertain to syringe services provided by your program between January 1, [YEAR], and December 31, [YEAR].

SYR1. **How many total sterile syringes did your program provide to clients? Please provide your best estimate if records are not readily available. If you do not know or prefer not to answer, you may leave the response blank.**
NUMSYR Number of sterile syringes provided

— — — — — — —

Range..... 0-9999999

SYR2. **Did your program provide syringes to clients based on the clients' needs, without any restrictions?**
CLINEED Needs-based provision of syringes

No..... 0
Yes..... 1
Refuse to Answer..... 7

SYR3. **Did your program provide clients with extra syringes to distribute to other people in the community (i.e., secondary exchange or peer delivery)?**

SECXCHNG Secondary exchange

No..... 0
Yes..... 1
Refuse to Answer..... 7

Check_SYR4.	If R selected 'Yes' (SYR3 [SECXCHNG] EQ 1), go to SYR4 [SETRAIN]. Else, go to INTRO_PN.

SYR4. **Did your program provide training or other support for clients to distribute new, sterile syringes to others (i.e., secondary exchange) and/or facilitate syringe disposal?**

SETRAIN Secondary exchange training

No..... 0
Yes..... 1
Refuse to Answer..... 7

PROVISION OF NALOXONE AND OTHER OVERDOSE REVERSAL MEDICATIONS

INTRO_PN.	In this section, we will ask you about overdose prevention services your program may have provided, such as overdose prevention training and naloxone distribution. As a reminder, we are asking about services provided by your program between January 1, [YEAR], and December 31, [YEAR].

PN1. **What overdose prevention or treatment services did your program provide? Select all that apply.**

WHATOD What OD prevention or treatment services provided

None.....
Naloxone kits.....
Naloxone prescription.....
Fentanyl test strips.....
Overdose prevention and response training for opioids.....
Overdose prevention and response training for drugs other than opioids (e.g., cocaine, methamphetamine).....
Refuse to Answer.....77

Check_PN2.	If R provided naloxone kits (PN1 [WHATOD] EQ 1), go to PN2 [NALKIT]. Else, go to INTRO_PS1.

PN2. **How many naloxone kits were distributed by your program? Please provide the number of kits distributed regardless of how many doses were contained in each kit. If your program does not collect these data, please provide your best estimate. If you do not know or prefer not to answer, you may leave the response blank.**

NALKIT Number of naloxone kits distributed

__ __ __ __

Range.....0-9999

How many doses were distributed in each naloxone kit by your program? If you do not know or prefer not to answer, you may leave the response blank.

PN3.
NALDOS Number of doses distributed in each naloxone kit

__ __
Range.....1-99

PN4. **In what ways did your program distribute naloxone kits? Select all that apply.**
NALDIS How distributed naloxone
Direct distribution from staff to client.....
In-person delivery (kit delivered directly to client).....
Mail delivery (kit mailed to client).....
Secondary distribution (client distributed kit to peers).....
Provider referral for prescription or referral to pharmacy.....
Offered at community-based overdose education events (open to the public).....
Offered at overdose education events for staff or clients of other organizations.....
Refuse to Answer..... 7

PN5. **What barriers, if any, did your program experience in providing naloxone to your clients? Select all that apply.**
BARNAL Barriers to providing naloxone
No barriers.....
High cost of naloxone.....
Shortage of naloxone.....
Legal/political climate.....
Other (please describe)
Don't Know..... 9
Refuse to Answer..... 7

Check_PN5spec.	If R selected 'Other (please describe)' (PN5(5) [BARNAL(5)] EQ 1), go to PN5spec [BARNAL_S]. Else, go to INTRO_PS1.

PN5spec. **Specify other barrier in providing naloxone**
BARNAL_S Specify other barrier in providing naloxone

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 255}

PROVISION OF SERVICES

INTRO_PS1.	The next set of questions are about the services your program provided or needed between January 1, [YEAR], and December 31, [YEAR]. This information will help us understand the services that programs are already providing, trying to expand, or adding to meet client needs. Please indicate next to each service whether your program 1) *fully provided the service* (that is, the service was provided at a level that fully met client needs), 2) *partially provided the service* (that is, the service was provided inconsistently or at a level that did not meet client needs), 3) *did not provide the service and was not able to meet client needs*, or 4) *did not provide the service and most clients did not need the service*. If service provision varied between January 1, [YEAR], and December 31, [YEAR], choose the option

that best describes the provision of services during the majority of time during this period.

PS1. **For each of the following safer injection and drug use supplies, please indicate the extent to which the these supply was provided.**

INJSUP Safer injection and drug use supplies

		Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
INJSUPA	Syringes					
INJSUPB	Cookers					
INJSUPC	Cottons					
INJSUPD	Syringe/pill filters like Sterifilt®					
INJSUPE	Saline or sterile water					
INJSUPF	Ties/tourniquets					
INJSUPG	Alcohol pads					
INJSUPH	Wound care kits					
INJSUPI	Sharps containers for carrying used syringes					
INJSUPJ	Fentanyl test strips					
INJSUPK	Safer smoking kits					
INJSUPL	Other (please describe)					

Check_PS1spec. If R selected 'Other (please describe)' (PS1 [INJSUPL]), go to PS1spec [INJSUP_S].
Else, go to PS2 [SEXSUP].

PS1spec. **Specify other injection and drug use supplies**

INJSUP_S Specify other injection and drug use supplies

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

PS2. **For each of the following safer sex supplies, please indicate the extent to which the supply was provided.**

SEXSUP Safer sex supplies

		Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer
SEXSUPA	External condoms (male condoms)					
SEXSUPB	Internal condoms (female condoms)					
SEXSUPC	Lubricant					
SEXSUPD	Dental dams					

PS3. **For each of the following testing services, please indicate the extent to which the service was provided onsite, either by the program itself or by partners, at the location(s) where your program operated.**

ONTEST Onsite testing services

	Fully	Partially	Not	Not	Refuse to

		Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
ONTESTA	HIV rapid testing					
ONTESTB	HIV laboratory-based testing					
ONTESTC	Hepatitis C virus (HCV) rapid testing					
ONTESTD	Hepatitis C virus (HCV) laboratory-based testing					
ONTESTE	STI testing other than hepatitis or HIV					
ONTESTF	TB skin testing or laboratory-based screening for latent TB					
ONTESTG	Pregnancy testing					
ONTESTH	COVID-19 testing					
ONTESTI	Other (please describe)					

Check_PS3spec.	If R selected 'Other (please describe)' (PS3 [ONTESTI]), go to PS3spec [ONTEST_S]. Else, go to PS4 [ONVAX].

PS3spec. **Specify other onsite testing service**

ONTEST_S Specify other testing

__ __

{text response; max characters = 100}

PS4. **For each of the following vaccinations, please indicate the extent to which the service was provided onsite, either by the program itself or by partners, at the location(s) where your program operated.**

ONVAX Onsite vaccinations

		Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
ONVAXA	Hepatitis A vaccination					
ONVAXB	Hepatitis B vaccination					
ONVAXC	Influenza vaccination					
ONVAXD	COVID-19 vaccination					
ONVAXE	Human papillomavirus (HPV) vaccination					
ONVAXF	Other (please describe)					

Check_PS4spec.	If R selected 'Other (please describe)' (PS4 [ONVAXE]), go to PS4spec [ONVAX_S]. Else, go to PS5 [ONMED].

PS4spec. **Specify other vaccination**

ONVAX_S Specify other vaccination

__ __

{text response; max characters = 100}

PS5. **For each of the following medications, please indicate the extent to which the medication was prescribed and/or dispensed onsite, either by the program itself or by partners, at the location(s) where your program operated.**

ONMED	Onsite medications						
		Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
ONMEDA	HIV treatment					
ONMEDB	PrEP (pre-exposure prophylaxis)					
ONMEDC	PEP (post-exposure prophylaxis)					
ONMEDD	Hepatitis C treatment					
ONMEDE	STI treatment other than hepatitis or HIV					
ONMEDF	Medications for opioid use disorder (MOUD) (such as buprenorphine, naltrexone, methadone)					
ONMEDG	Medications for non-opioid substance use disorders					
ONMEDH	Other (please describe)					

Check_PS5spec.	If R selected 'Other (please describe)' (PS5 [ONMEDI]), go to PS5spec [ONMED_S]. Else, go to Check_PS6.

PS5spec. **Specify other <u>medication</u>**

ONMED_S Specify other medication

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

Check_PS6.	If R provided MOUD (PS5 [ONMEDF] EQ "Fully provided" OR "Partially provided"), go to PS6 [MOUD_S]. Else, go to PS7 [ONMSRV].

PS6. **You indicated that your program provided onsite medications for opioid use disorders (MOUD) between January 1, [YEAR], and December 31, [YEAR]. Which of the following MOUD did your program provide <u>onsite,</u> either by the program itself or by partners, at the location(s) where your program operated? Select all that apply.**

MOUD_S Which MOUD provided

Buprenorphine/naloxone (Suboxone)

Buprenorphine (Subutex)

Methadone

Naltrexone (Vivitrol)

Other (please describe)

Refuse to Answer 7

Check_PS6spec.	If R selected 'Other (please describe)' (PS6 [MOUD_S]), go to PS6spec [MOUD_SS]. Else, go to PS7 [ONMSRV].

PS6spec. **Specify other <u>MOUD</u>**

MOUD_SS Specify other MOUD

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

PS7. **For each of the following other medical services, please indicate the extent to which the service was provided onsite, either by the program itself or by partners, at the location(s) where your program operated.**

ONMSRV Other onsite medical services

		Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
ONMSRVA	Substance use disorder treatment services (excluding medications).....					
ONMSRVB	Wound care/treatment.....					
ONMSRVC	Mental health services (excluding medications) provided by a licensed physician, psychologist, nurse practitioner, or social worker.....					
ONMSRVD	Mental health services, including prescription medications					
ONMSRVE	General medical care (primary care or urgent care).....					
ONMSRVF	Reproductive cancer screening (e.g., pap smears).....					
ONMSRVG	Family planning/contraception.....					
ONMSRVH	Prenatal care and peripartum care					
ONMSRVI	Other (please describe).....					

Check_PS7spec. If R selected 'Other (please describe)' (PS7 [ONMSRVG]), go to PS7spec [ONMSRV_S].
Else, go to PS8 [CPNAV].

PS7spec. **Specify other onsite medical services**

ONMSRV_S Specify other onsite medical services

— — — — — — — — — — ——— — — — ——— — — — ——— — — — ——— — — — ——— — — — ——— — — —

{text response; max characters = 100}

PS8. **Did your program provide client navigation services/peer navigation? Client/peer navigation provides individualized support for program clients in accessing and sustaining engagement with health and other services.**

CPNAV Did program provide client/peer navigation services

No..... 0
Yes..... 1
Refuse to Answer..... 7

Check_PS9. If R provided client/peer navigation services (PS8) [CPNAV] EQ 1), go to PS9 [CPNAV_S].
Else, go to PS10 [SOCSRV].

PS9. **What services were covered by your client navigation/peer navigation program? Select all that apply.**

CPNAV_S Client/peer navigation services

HIV care.....
PrEP (pre-exposure prophylaxis for HIV prevention).....
HCV care.....
Medications for opioid use disorder (MOUD) .....
Medications for non-opioid substance use disorders.....
Legal records (e.g., birth certificate, social security card, state

ID/driver's license).....
Medicaid or other health insurance.....
Social support services (e.g., housing).....
Refuse to Answer.....77

PS10. **For each of the following social and other services, please indicate the extent to which the service was provided.**
SOCSRV Social and other services

		Fully provided	Partially provided	Not provided but needed	Not provided and not needed	Refuse to Answer/ Not Applicable
SOCSRVA	Case management.....					
SOCSRVB	Childcare.....					
SOCSRVC	Drop-in center.....					
SOCSRVD	Enrollment in Medicaid or other health insurance.....					
SOCSRVE	Family violence, domestic violence, or intimate partner violence services.....					
SOCSRVF	Food/meals, including SNAP, WIC, food pantries, or meal delivery services.....					
SOCSRVG	Housing support.....					
SOCSRVH	Hygiene-related services (e.g., laundry, showers).....					
SOCSRVI	Job-related services (e.g., placement assistance, skills training).....					
SOCSRVJ	Legal services/counseling.....					
SOCSRVK	Substance use counseling provided by certified addiction counselors or other recovery support services.....					
SOCSRVL	Other (please describe).....					

Check_PS10spec. If R selected 'Other (please describe)' (PS10) [SOCSRVL]), go to PS10spec [SOCSRV_S].
Else, go to INTRO_PS2.

PS10spec. **Specify other social service**
SOCSRV_S Specify other social service

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

INTRO_PS11. The next questions pertain to referrals provided by your program between January 1, [YEAR], and December 31, [YEAR]. By "referral," we mean directing clients to specific offsite providers where they can receive specific services.

PS11. **What types of referrals to testing services did your program provide? Select all that apply.**
REFTEST Testing referrals
No testing referrals provided.....
HIV testing.....
Hepatitis C virus (HCV) testing.....

STI testing other than hepatitis or HIV.....
TB skin testing or laboratory-based screening for latent TB.....
Pregnancy testing.....
COVID-19 testing.....
Other (please describe).....
Refuse to Answer..... 77

Check_PS11spec.	If R selected 'Other (please describe)' (PS11(8) [REFTEST(8)] EQ 1), go to PS11spec [REFTEST_S]. Else, go to PS12 [RCOVAX].

PS11spec. **Specify other <u>testing referral</u>**
REFTEST_S Specify other testing referral

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

PS12. **What types of <u>referrals for vaccinations</u> did your program provide? Select all that apply.**
REFVAX Vaccination referral
No vaccination referrals provided.....
Hepatitis A vaccination.....
Hepatitis B vaccination.....
Influenza vaccination.....
COVID-19 vaccination.....
Human papillomavirus (HPV) vaccination
Other (please describe).....
Refuse to Answer.....77

Check_PS12spec.	If R selected 'Other (please describe)' (PS12(6) [REFVAX(6)] EQ 1), go to PS12spec [REFVAX_S]. Else, go to PS13 [REFMED].

PS12spec. **Specify other <u>vaccination referral</u>**
REFVAX_S Specify other vaccination referral

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

PS13. **What types of <u>referrals to treatment</u> or medications did your program provide? Select all that apply.**
REFMED Referrals to treatment
No treatment referrals provided.....
HIV treatment.....
PrEP (pre-exposure prophylaxis).....
PEP (post-exposure prophylaxis).....
Hepatitis C treatment.....
STI treatment other than hepatitis or HIV.....
Buprenorphine alone or with naloxone (including Suboxone or Subutex).....
Methadone
Naltrexone
Naloxone.....

Medications for non-opioid substance use disorders.....

.....

Other (please describe).....

Refuse to Answer..... 77

Check_PS13spec.	If R selected 'Other (please describe)' (PS13(12) [REFMED(12)] EQ 1), go to PS13spec [REFMED_S]. Else, go to PS14 [RMSRV].

PS13spec. **Specify other <u>treatment referral</u>**

REFMED_S Specify other treatment referral

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

PS14. **What types of <u>referrals to other medical services</u> did your program provide? Select all that apply.**

RMSRV Other medical services referrals

No referrals to other medical services provided.....

Substance use disorder treatment services (excluding medications) .....

Wound care/treatment.....

Mental health services (excluding medications) provided by a licensed physician, psychologist, nurse practitioner, or social worker.....

Mental health services, including prescription medication

General medical care (primary care or urgent care).....

Reproductive cancer screening (e.g., pap smears) .....

Prenatal care and peripartum care

Other (pleasse describe).....

Refuse to Answer.....77

Check_PS14spec.	If R selected 'Other (please describe)' (PS14(8) [RMSRV(8)] EQ 1), go to PS14spec [RMSRV_S]. Else, go to INTRO_MD1.

PS14spec. **Specify <u>other medical services referrals</u>**

RMSRV_S Specify other medical services referrals

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __

{text response; max characters = 100}

2020 MODULE

INTRO_MD1.	Next, we would like to ask you a few questions about the services you provided in 2020.

MD1. **Did your program provide any services at <u>any time</u> between January 1, 2020, and December 31, 2020?**

OP20 Operated during 2020

No..... 0
Yes..... 1

Check_MD1.	If R did not operate at any time during 2020 (MD1 [OP20] EQ 0), go to INTRO_PE. Else, go to INTRO_MD2.

INTRO_MD2.	The next set of questions is about the services your program provided from January 1, 2020, to December 31, 2020. To the extent possible, please refer to your records to answer these questions. If your program only operated during some of this time period, please provide information reflective of the time period(s) during which your program did operate.

MD2. **How many unique clients did your program directly serve (not counting secondary exchange) between January 1, 2020, and December 31, 2020? Please provide the best estimate to your knowledge. If you do not know or prefer not to answer, you may leave the response blank.**

CLI20 Number of unique clients

— — — — — — — —

Range..... 0-99999999

MD3. **Between January 1, 2020, and December 31, 2020, how many total sterile syringes did your program provide to clients? Please provide your best estimate if records are not readily available. If you do not know or prefer not to answer, you may leave the response blank.**

SYR20 Number of sterile syringes provided

— — — — — — — —

Range..... 0-99999999

MD4. **Between January 1, 2020, and December 31, 2020, did your program provide syringes to clients based on the clients' needs, without any restrictions?**

NEED20 Needs-based provision of syringes

No..... 0
Yes..... 1
Don't Know..... 9
Refuse to Answer..... 7

MD5. **Did your program distribute naloxone kits between January 1, 2020, and December 31, 2020?**

ONNAL20 Onsite naloxone distribution

No..... 0
Yes..... 1
Don't Know..... 9
Refuse to Answer..... 7

MD6. **What was your total program budget between January 1, 2020, and December 31, 2020? If your program is part of a larger, multi-service organization, please only provide the budget for your part of the program. Please provide the best estimate to your knowledge.**

BUDG20 Total program budget

Less than $25,000..... 1
$25,000–$99,000..... 2

$100,000–$249,999..... 3
$250,000–$499,999..... 4
$500,000–$999,999..... 5
Between $1 million and $2 million..... 6
$2 million or more..... 7
Don't Know.....99
Refuse to Answer.....77

MD7. **Which of the following testing services were provided onsite, either by the program itself or by partners, at the location(s) where your program operated between January 1, 2020, and December 31, 2020? Select all that apply.**
ONTST20 Onsite testing services
No testing services were provided onsite.....
HIV rapid testing.....
HIV laboratory-based testing.....
Hepatitis C virus (HCV) rapid testing.....
Hepatitis C virus (HCV) laboratory-based testing.....
Don't Know.....99
Refuse to Answer.....77

MD8. **Which of the following medications for opioid use disorder (MOUD) were provided onsite, either by the program itself or by partners, at the location(s) where your program operated between January 1, 2020, and December 31, 2020? Select all that apply.**
ONMOUD20 Onsite MOUD
No medications were provided onsite.....
Buprenorphine/naloxone (Suboxone).....
Buprenorphine (Subutex).....
Methadone.....
Naltrexone (Vivitrol).....
Other (please describe) .....
Don't Know.....99
Refuse to Answer.....77

Check_MD8spec. If R selected 'Other (please specify)' (MD8(6) [ONMOUD20(6)] EQ 1), go to MD8spec [ONMOUD20_S].
Else, go to MD9[ONMSRV20].

MD8spec. **Specify other MOUD provided onsite.**
ONMOUD20_S Specify other MOUD
__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

MD9. **Which of the following other medical services were provided onsite, either by the program itself or by partners, at the location(s) where your program operated between January 1, 2020, and December 31, 2020? Select all that apply.**
ONMSRV20 Onsite other medical services
No other medical services were provided onsite.....
Substance use disorder treatment services (excluding medications).....
Wound care/treatment.....

Mental health services (excluding medications) provided by a licensed physician, psychologist, nurse practitioner, or social worker.....
Mental health services (including prescription medications)
General medical care (primary care or urgent care)
Reproductive cancer screening (e.g., pap smears).....

Family planning/contraception
Prenatal and peripartum care
Don't Know.....99
Refuse to Answer.....77

MD10. **Did your program provide referrals for buprenorphine (including Suboxone or Subutex) between January 1, 2020, and December 31, 2020?**
RFBUP20 Referrals to buprenorphine
No..... 0
Yes..... 1
Don't Know..... 9
Refuse to Answer..... 7

MD11. **Between January 1, 2020, and December 31, 2020, what types of <u>referrals to other medical services</u> did your program provide? Select all that apply.**
RMSRV20 Other medical services referrals
No referrals to other medical services provided.....
Substance use disorder treatment services (excluding medications).....
Wound care/treatment.....
Mental health services (excluding medications) provided by a licensed physician, psychologist, nurse practitioner, or social worker.....
Mental health services (including prescription medications)
General medical care (primary care or urgent care).....
Reproductive cancer screening (e.g., pap smears).....

Family planning/contraception.....
Prenatal and peripartum care
Don't Know.....99
Refuse to Answer.....77

MD12. **How was your program impacted by the COVID-19 pandemic in 2020? Select all that apply.**
COV20 COVID-19 impacts
Reduced hours or days of operation.....
Reduced funding.....
Site closure(s).....
Staff shortage or loss.....
Change to a MORE restrictive syringe distribution model (e.g., from needs-based to 1-for-1).....
Change to a LESS restrictive syringe distribution model (e.g., from 1-for-1 to needs-based) .....
Changes in physical space (e.g., moved services outdoors,

markers for social distancing, plexiglass).....
Disruptions in supply of syringes.....
Disruptions in other supplies.....
Disruptions in HIV, HCV, or other bloodborne pathogens testing.....
Disruptions in substance use disorder treatment onsite or linkage (e.g., stopped services, new regulatory practices).....
Disruptions in mental health services offered onsite or linkage
Changes in other direct client services, such as food distribution, showers, housing assistance.....
New/increased access to telehealth for clients.....
Lack of personal protective equipment (PPE).....
Other (please specify).....
Program was not impacted by COVID-19 in 2020.....
Don't Know.....99
Refuse to Answer.....77

Check_MD12spec.	If R selected 'Other (please specify)' (MD12(15) [COV20(15)] EQ 1), go to MD12spec [COV20_S]. Else, go to INTRO_PE.

MD12spec. **Specify other ways your program was impacted by COVID-19.**
COV20_S Specify other program operator

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

PROCESS EVALUATION

INTRO_PE.	We value your input and would like to ask you a few questions about your experience taking this survey so that we can improve it and ensure that the information you provide is useful.

PE1. **The length of the survey was...**
SLNGTH Survey length
Too short..... 1
Just right..... 2
Too long..... 3
Refuse to Answer..... 7

PE2. **If you were taking the survey again, what format would you prefer? Select only one.**
PREFMT Preferred survey format
Self-administered online 1
Self-administered via an electronic document (Word or PDF) that can be completed and returned by email..... 2
Interviewer-administered to me over the phone or videoconference..... 3
Interviewer-administered to me in person..... 4

Refuse to Answer..... 7

PE3. **What topic(s) were missing from this survey and need to be added in the future?**
MISTOP Missing topics

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 255}

PE4. **How would you like to see this information used? Select all that apply.**
HOWUSE How this information used
Increase awareness.....
Increase community support.....
Increase funding.....
Inform policy/law.....
Other (please describe).....
Refuse to Answer..... 7

Check_PE4spec.	If R selected 'Other (please describe)' (PE4(5) [HOWUSE(5)] EQ 1), go to PE4spec [HOWUSE_S]. Else, go to PE5 [OTHSUG].

PE4spec. **Specify other use for this information**
HOWUSE_S Specify other use for this information

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 100}

PE5. **Please use the space below for any other suggestions or comments for improving this survey to make it useful to programs.**
OTHSUG Other suggestions or comments

__ __ __ __ __ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __ __ ____ __ __ __ ____ __ __ __ ____ __ __ __
{text response; max characters = 255}

DATA_PE.	You have now completed the survey. Thank you so much for your participation. Once you submit your survey, you will not be able to go back to previous questions or change any of your answers, so please make sure you are ready before proceeding.

CALC_EDATE	
	Automatic, hidden variable: Interview end date (today)
EDATE	**End date**

__/__/____

CALC_END

End time of interview

END End time

__:__