

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.

SAMPLE

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 1-888-324-8337.

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 or
NSSATWeb@mathematica-mpr.com

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 facility currently a SAMHSA-certified Opioid Treatment Program (OTP)?

- 1 Yes
 2 No, but was on March 31, 2011 → **SKIP TO B1 (PAGE 4)**
 3 No, but was prior to March 31, 2011 → **SKIP TO B7 (PAGE 6)**
 4 Never a SAMHSA-certified OTP

A1a. 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 (TOP OF NEXT COLUMN)**

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 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Another OTP | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. A pharmacy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Other (<i>Specify below:</i> | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. A hospital | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. A medical clinic | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Other (<i>Specify below:</i> | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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 Total Number of Scheduled Hours for Dispensing Medication	Column B Total Number of Scheduled Hours for Counseling
DAYS OF WEEK		
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 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Influenza | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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

Column A – For which of these conditions does this OTP regularly 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	<u>COLUMN A</u>		<u>COLUMN B</u>	
	ROUTINELY SCREEN		PERFORM DIAGNOSTIC TESTS	
	Yes	No	Yes	No
1. Diabetes	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
2. Hepatitis C	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
3. HIV/AIDS	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
4. Hypertension (high blood pressure)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
5. Pregnancy	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
6. Heartbeat abnormalities	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
7. Sexually transmitted infections (STIs, including gonorrhea, syphilis)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
8. Sleep apnea	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
9. Alcohol use	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
10. Tobacco use	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

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

MARK "YES" OR "NO" FOR EACH

- | | <u>YES</u> | <u>NO</u> |
|--|----------------------------|----------------------------|
| 1. Marijuana | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Cocaine | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Benzodiazepines | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Heroin | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Prescription opioids | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 6. Methamphetamines | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 7. Other stimulants (<i>Please specify:</i>) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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

Column A – Regularly screens for the condition.

Column B – Provides treatment involving medication.

Column C – Provides treatment involving counseling therapy.

PSYCHIATRIC CONDITION	<u>COLUMN A</u>		<u>COLUMN B</u>		<u>COLUMN C</u>	
	ROUTINELY SCREENS		TREATMENT INVOLVING MEDICATION		TREATMENT INVOLVING COUNSELING	
	Yes	No	Yes	No	Yes	No
1. Anxiety/Panic disorder	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
2. Bipolar disorder	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
3. Depression	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
4. Post traumatic stress disorder	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
5. Schizophrenia	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>
6. Other (<i>Specify below:</i>)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

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 of people employed at this OTP.

Column B – Please record total hours worked for this category in a typical week. For example, if this OTP has 2 physicians who each average about 15 hours per week, you should report 30 hours in Column B.

	COLUMN A	COLUMN B
	TOTAL NUMBER EMPLOYED AT THIS OTP (IF NONE, ENTER "0")	TOTAL STAFF HOURS IN A TYPICAL WEEK
CLINICAL STAFF		
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...

WORK ACTIVITY	MARK ONE METHOD FOR EACH ACTIVITY		
	COMPUTER/ELECTRONIC ONLY	PAPER ONLY	BOTH ELECTRONIC AND PAPER
1. Intake	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Assessment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Treatment plan	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Discharge	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Referrals	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Issue/Receive lab results	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Billing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Outcomes management	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Medication dispensing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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"
AND SKIP TO B7)

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

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)	<input type="text"/>

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

← DO NOT DISPENSE METHADONE AT THIS OTP, SKIP TO B6

ENTER A NUMBER
(IF NONE, ENTER "0"
AND SKIP TO B6)

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)	<input type="text"/>

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 = the number of maintenance patients in B5a)	<input type="text"/>

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

ENTER A NUMBER
(IF NONE, ENTER "0"
AND SKIP TO B6)

NUMBER RECEIVING
METHADONE FOR
2 YEARS OR MORE

B5d. Of the patients in B5c, how many receive 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)	<input type="text"/>

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

← DO NOT PRESCRIBE OR DISPENSE BUPRENORPHINE AT THIS OTP, SKIP TO B7

ENTER A NUMBER
(IF NONE, ENTER "0"
AND SKIP TO B7)

NUMBER RECEIVED
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)	<input type="text"/>

B6b. How many buprenorphine maintenance 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 <i>(Together should = B6a1)</i>		

B7. Who was primarily responsible for completing this form?

Name: _____

Title: _____

Phone Number: (____) - ____ - _____

Fax Number: (____) - ____ - _____

Email Address: _____

B8. PLEASE INDICATE ANY COMMENTS

SAMPLE

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 0930-0319.