MI-PHL (SBIRT) Project Negative Screen Intake GPRA Survey

SECTION: Record Management

Clinic Information

The following items are intended to be completed administratively by clinic staff and should not be asked of the patient.

1. Select the SBIRT-funded clinic site for which you are reporting:

    a. Cassopolis Niles Community Health Center
    b. Taylor Teen Health Center
    c. Saginaw Valley State University Campus Mental Health & Wellness Center
    d. Standish-Sterling School Based Health Center
    e. Whittemore-Prescott SBHC
    f. Catherine's Health Center Dental
    g. Catherine's Health Center Townline
    h. Catherine's Health Center Creston
    i. Catherine's Health Center Wyoming
    j. Catherine's Health Center Streams
    k. Cassopolis Family Clinic
    l. Alpena Services
    m. Lincoln Clinic
    n. Oscoda Clinic
    o. Petoskey Child Health Associates

Patient Information

Note: For patients previously receiving SBIRT service via the MI-PHL project, an additional GPRA survey is only required if the patient is **assigned a new SBIRT intervention level than previously provided.**

Clinics will assign each patient a *unique Patient ID* that is 12-characters long and numeric only. Note: If the patients ID number is not 12 characters long input 0 (as many as necessary) before entering the patient ID number to ensure 12 characters are provided. To link a patient's GPRA records, the same Patient ID must be used for all encounters across the MI-PHL project.

Enter the patient's unique ID number.

1. Patient ID: _____

    Enter the date the GPRA Survey was completed.

2. GPRA survey date (MM/DD/YYYY): _____

SECTION H

SBIRT Program Specific Questions

The following items are intended to be completed administratively by clinic staff and should not be asked of the patient.

1. Please indicate which type of funding was/will be used to pay for the SBIRT services provided to this patient. *Select all that apply.*

- ○ Current SAMHSA grant funding
- ○ Other federal grant funding
- ○ State funding
- ○ Patient's private insurance
- ○ Medicaid/Medicare
- ○ TRICARE
- ○ Other (SPECIFY): _____

2. When the SBIRT was administered, how did the patient screen? *Indicate the highest level of screening or assessment completed.*

   - ○ Negative (negative screen OR negative brief assessment)
   - ○ Positive

3. What was the patient's screening and/or assessment score? Provide details for screening/assessment results **ONLY** for screening/assessment tools utilized with the patient. Do **NOT** complete sections for screening/assessment tools not utilized

   - ○ NIAAA-Single Alcohol Score: _____
   - ○ NIDA-Single Drug (+Marijuana) Score: _____
   - ○ CRAFFT Part A Score: _____
   - ○ RAAPS Score: _____
   - ○ Alcohol Use Disorders Identification Test (AUDIT) Score: _____
   - ○ Drug Abuse Screening Test (DAST) Score: _____
   - ○ CRAFFT Part B Score: _____

SECTION A: Demographics (INTAKE)

This section collects demographic information on the patient. While some of the information may seem apparent, ask all questions for clarification. Do not complete a response based on the client's appearance. Ask the question and make the response given by the client.

1. What is the patient's birth **month** and **year**?
   a. Date of birth (MM/YYYY): _____
   b. REFUSED

2. What do you consider yourself to be?
   a. Male
   b. Female
   c. Transgender (Male to Female)
   d. Transgender (Female to Male)

e. Gender non-conforming
f. Other (SPECIFY):

_____

g. REFUSED

3. Are you Hispanic, Latino/a, or of Spanish origin?
    a. Yes **(go to Q4)**
    b. No **(skip to Q5)**
    c. REFUSED **(skip to Q5)**

4. ***If Yes to Q3:*** What ethnic group do you consider yourself?
    a. Central American
    b. Cuban
    c. Dominican
    d. Puerto Rican
    e. South American
    f. Mexican
    g. Other (SPECIFY):

    _____

    h. REFUSED

5. What is your race?
    a. Black or African American
    b. White
    c. American Indian
    d. Alaska Native
    e. Asian Indian
    f. Chinese
    g. Filipino
    h. Japanese
    i. Korean
    j. Vietnamese
    k. Other Asian
    l. Native Hawaiian
    m. Guamanian or Chamorro
    n. Samoan
    o. Other Pacific Islander
    p. Other (SPECIFY):

    _____

    q. REFUSED

6. The assessment was conducted in:
    a. English
    b. Spanish

7. Do you speak a language other than English at home?
    a. Yes **(go to Q8)**
    b. No **(skip to Q9)**
    c. REFUSED **(skip to Q9)**

8. ***If Yes, to Q7:*** What is this language? (If other, please specify.)
    a. Spanish
    b. Other (SPECIFY): _____
    c. REFUSED

9. Do you think of yourself as… *Select all that apply.*
    a. Straight or Heterosexual
    b. Bisexual
    c. Asexual
    d. Homosexual (Gay or Lesbian)
    e. Queer, Pansexual, and/or Questioning
    f. Other (SPECIFY): _____
    g. REFUSED

10. **If patient NOT from Taylor Teen Health Center. Skip if patient is from Taylor Teen Health Center:** What is your relationship status?
    a. Married
    b. Single
    c. Divorced
    d. Separated
    e. Widowed
    f. In a relationship
    g. In multiple relationships
    h. REFUSED

11. **(If MALE was not selected)** Are you currently pregnant?
    a. Yes
    b. No
    c. Do not know
    d. REFUSED

12. Do you have children? *Refers to children both living and/or who may have died.*
    a. Yes **(continue to Q13)**
    b. No **(skip to Q18)**
    c. REFUSED **(skip to Q18)**

13. How many children under the age of 18 do you have?
    a. Number: _____ **(if 0, skip to Q18)**
    b. REFUSED **(skip to Q18)**

14. Are any of your children, who are under the age of 18, living with someone else due to a court's intervention?

a. Yes **(continue to Q15)**
b. No **(skip to Q18)**
c. REFUSED **(skip to Q18)**

15. How many of your children, who are under the age of 18, are living with someone else due to a court's intervention?
    a. Number: _____
    b. REFUSED

16. Have you been reunited with any of your children, under the age of 18, who have previously been removed from your care?
    a. Yes **(continue to Q17)**
    b. No **(skip to Q18)**
    c. REFUSED **(skip to Q18)**

17. How many children, under the age of 18, have you been reunited with who were previously removed from your care?
    a. Number: _____
    b. REFUSED

18. **If patient NOT from Taylor Teen Health Center. Skip if patient is from Taylor Teen Health Center:** Have you ever served in the Armed Forces, in the Reserves, in the National Guard, or in other Uniformed Services? *If served,* What area, the Armed Forces, Reserves, National Guard, or other did you serve?
    a. No
    b. Yes, in the Armed Forces
    c. Yes, in the Reserves
    d. Yes, in the National Guard
    e. Yes, Other Uniformed Service (includes NOAA, USPHS)
    f. REFUSED

19. How long does it take you, on average, to travel to the location where you receive services provided by this grant?
    a. Half an hour or less
    b. Between half an hour and one hour (30 minutes - 1 hour)
    c. Between one hour and one and a half hours (1 hour - 1.5 hours)
    d. Between one and a half hours and two hours (1.5 hours - 2 hours)
    e. Two hours or more

f. REFUSED

SECTION B: Substance Use (INTAKE)

This section contains items to measure alcohol and other substance use in the past 30 days; substance use and mental health diagnoses; receipt of FDA-approved medications to treat alcohol, opioid, tobacco, and stimulant disorders; overdose and treatment history.

B1. During the **past 30 days**, have you used any of the following substances? **Select all that apply.**

	Yes	No
Alcohol		
Opioids		
Cannabis (Marijuana)		
Sedatives, Hypnotics, or Anxiolytics		
Cocaine		
Other Stimulants (Methamphetamine)		
Hallucinogens & Other Psychedelics		
Inhalants		
Other Psychoactive Substances (Ketamine/ Bath Salts)		
Tobacco & Nicotine		

During the **past 30 days**, how many days have you used any substance, and how do you take the substance?

A. The number of days, in the past 30 days, that the client reports using a substance (DO NOT READ TO PATIENT)
The client should be encouraged to list the substances on their own. If they are unsure, the list from the table below can be read to the client. Please note that not all substance use is considered harmful or illicit - it may be that a substance is prescribed by a licensed provider, or that the client uses the substance in accordance with official, national safety guidelines. In such instances, clarification from the client should be sought, but if the substance is only taken as prescribed or used on each occasion in accordance with official, national safety guidelines, then it is not considered misuse.

B. The route by which the substance is used. (DO NOT READ TO PATIENT)
Mark one route only for each substance used. But, if the client identifies more than one route, chose the corresponding routs with the highest associated number value: (1) Oral, (2) Nasal, (3) Smoking, (4) Non-IV Injection, and (5) Intravenous (IV) Injection.

Substance	Number of days used:	Route of administration
Alcohol		

OPIOIDS – PAST 30 DAYS (continue if OPIOIDS was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
Heroin		
Morphine		
Fentanyl (Prescription diversion or illicit source)		
Dilaudid		
Demerol		
Percocet		
Codeine		

Tylenol 2, 3, 4		
Oxycontin/Oxycodone		
Non-prescription methadone		
Non-prescription buprenorphine		
Other (specify):		

CANNABIS – <u>PAST 30 DAYS</u> (continue if CANNABIS was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
Cannabis (Marijuana)		
Synthetic Cannabinoids		
Other (specify):		

SEDATIVES, HYPNOTICS, OR ANXIOLYTICS – (continue if SEDATIVES, HYPNOTICS, OR ANXIOLYTICS was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
Sedatives		
Hypnotics		
Barbituates		
Anxiolytics/Benzodiazephines		
Other (specify):		

COCAINE – <u>PAST 30 DAYS</u> (continue if COCAINE was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
Cocaine		
Crack		
Other (specify):		

OTHER STIMULANTS – <u>PAST 30 DAYS</u> (continue if OTHER STIMULANTS was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
Methamphetamine		
Stimulant Medications		
Other (specify):		

HALLUCINOGENS & OTHER PSYCHEDELICS – <u>PAST 30 DAYS</u> (continue if HALLUCINOGENICS & OTHER PSYCHEDELICS was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
PCP		
MDMA		
LSD		
Mushrooms		
Mescaline		
Salvia		

DMT		
Other (specify):		

INHALANTS – <u>PAST 30 DAYS</u> (continue if INHALANTS was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
Inhalants		
Other (specify):		

OTHER PSYCHOACTIVE SUBSTANCES – <u>PAST 30 DAYS</u> (continue if OTHER PSYCHOACTIVE SUBSTANCES was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
Non-prescription GHB		
Ketamine		
MDPV/Bath salts		
Kratom		
Khat		
Other Tranquilizers		
Other Downers		
Other Sedatives		
Other Hypnotics		
Other (specify):		

TOBACCO & NICOTINE – <u>PAST 30 DAYS</u> (continue if TOBACCO & NICOTINE was selected in B1. Skip if NOT SELECTED)

Substance	Number of days used:	Route of administration
Tobacco		
Nicotine (Including vape products)		
Other (specify):		

B2. Have you been diagnosed with an **<u>alcohol use disorder</u>**, if so which U.S. Food and Drug Administration (FDA)-approved medication did you receive for the treatment for this alcohol use disorder in the **<u>past 30 days?</u> Select all that apply.**

- ○ Naltrexone - if received, specify how many days received _____
- ○ Extended-release naltrexone – if received, specify how many days _____
- ○ Disulfiram – if received, specify how many days _____
- ○ Acamprosate– if received, specify how many days _____
- ○ PATIENT DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED ALCOHOL USE DISORDER

- ○ PATIENT DOES NOT REPORT SUCH A DIAGNOSIS

B3. Have you been diagnosed with an **opioid use disorder**, if so which U.S. Food and Drug Administration (FDA)-approved medication did you receive for the treatment for this opioid use disorder in the **past 30 days? Select all that apply.**

- ○ Methadone – if received, specify how many days _____
- ○ Buprenorphine – if received, specify how many days _____
- ○ Naltrexone – if received, specify how many days _____
- ○ Extended-release naltrexone – if received, specify how many days _____
- ○ PATIENT DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED OPIOD USE DISORDER
- ○ PATIENT DOES NOT REPORT SUCH A DIAGNOSIS

B4. Have you been diagnosed with a **stimulant disorder**, if so which U.S. Food and Drug Administration (FDA)-approved medication did you receive for the treatment for this stimulant disorder in the **past 30 days? Select all that apply.**

- ○ Contingency Management – if received, specify how many days _____
- ○ Community Reinforcement – if received, specify how many days _____
- ○ Cognitive Behavioral Therapy – if received, specify how many days _____
- ○ Other evidence-based intervention – if received, specify how many days _____
- ○ PATIENT DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED STIMULANT DISORDER
- ○ PATIENT DOES NOT REPORT SUCH A DIAGNOSIS

B5. Have you been diagnosed with a **tobacco use disorder**, if so which U.S. Food and Drug Administration (FDA)-approved medication did you receive for the treatment for this tobacco use disorder in the **past 30 days? Select all that apply.**

- ○ Nicotine Replacement – if received, specify how many days _____
- ○ Bupropion – if received, specify how many days _____
- ○ Varenicline – if received, specify how many days _____
- ○ PATIENT DID NOT RECEIVE AN FDA-APPROVED MEDICATION FOR A DIAGNOSED TOBACCO USE DISORDER
- ○ PATIENT DOES NOT REPORT SUCH A DIAGNOSIS

B6. In the **past 30 days**, did you experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?

a. Yes **(continue to B7)**
b. No **(skip to B8)**
c. REFUSED **(skip to B8)**

B7. In the **past 30 days**, after taking too much of a substance or overdosing, what intervention did you receive? **Select all that apply.**

a. Naloxone (Narcan)
b. Care in an Emergency Department
c. Care from a Primary Care Provider
d. Admission to a hospital
e. Supervision by someone else
f. Other (please specify): _____
g. REFUSED

B8. Not including this current episode, how many times in your life have you been treated at an inpatient or outpatient facility for a substance use disorder?

a. One time **(continue to B9)**
b. Two times **(continue to B9)**
c. Three times **(continue to B9)**
d. Four times **(continue to B9)**
e. Five times **(continue to B9)**
f. Six or more times **(continue to B9)**
g. Never **(skip to B10)**
h. REFUSED **(skip to B10)**

B9. Approximately when was the last time you received inpatient or outpatient treatment for a substance use disorder?

a. Less than 6 months ago
b. Between 6 months and one year ago
c. One to two years ago
d. Two to three years ago
e. Three to four years ago
f. Five or more years ago
g. REFUSED

B10. Have you ever been diagnosed with a **mental health illness** by a health care professional?

a. Yes – please indicate the diagnosis below **(continue)**
b. No **(skip to B11)**
c. REFUSED **(skip to B11)**

Have you ever been diagnosed with **schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders**? **Select all that apply.**

- ○ Brief psychotic disorder
- ○ Delusional disorder
- ○ Schizoaffective disorders
- ○ Schizophrenia
- ○ Schizotypal disorder
- ○ Shared psychotic disorder
- ○ Unspecified psychosis

Have you ever been diagnosed with **mood affective disorders**? **Select all that apply.**

- ○ Bipolar disorder
- ○ Major depressive disorder, recurrent
- ○ Major depressive disorder, single episode
- ○ Manic episode
- ○ Persistent mood (affective) disorders
- ○ Unspecified mood (affective) disorder
- ○ Unspecified psychosis

Have you ever been diagnosed with **phobic anxiety or other anxiety disorders**? **Select all that apply.**

- ○ Agoraphobia without panic disorder
- ○ Agoraphobia with panic disorder
- ○ Agoraphobia, unspecified
- ○ Generalized anxiety disorder
- ○ Panic disorder
- ○ Phobic anxiety disorders
- ○ Social phobias (social anxiety disorder)
- ○ Specific (isolated) phobias

Have you ever been diagnosed with **obsessive compulsive disorders**? **Select all that apply.**

- ○ Excoriation (skin-picking) disorder
- ○ Hoarding disorder
- ○ Obsessive-compulsive disorder
- ○ Obsessive-compulsive disorder with mixed obsessional thoughts and acts

Have you ever been diagnosed with **a reaction to severe stress or adjustment disorders**? **Select all that apply.**

- ○ Acute stress disorder; reaction to severe stress, and adjustment disorders
- ○ Body dysmorphic disorder
- ○ Dissociative identity disorder
- ○ Somatoform disorders
- ○ Adjustment disorders
- ○ Dissociative and conversion disorders
- ○ Post traumatic stress disorder

Have you ever been diagnosed with **behavioral syndromes associated with physiological disturbances and physical factors**? **Select all that apply.**

- ○ Eating disorders
- ○ Sleep disorders not due to a substance or known physiological condition

Have you ever been diagnosed with **disorders of adult personality and behavior**? **Select all that apply.**

- ○ Antisocial personality disorder
- ○ Avoidant personality disorder
- ○ Borderline personality disorder
- ○ Dependent personality disorder
- ○ Histrionic personality disorder
- ○ Intellectual disabilities
- ○ Obsessive-compulsive personality disorder
- ○ Other specific personality disorder
- ○ Paranoid personality disorder
- ○ Personality disorder, unspecified
- ○ Pervasive and specific developmental disorders
- ○ Schizoid personality disorder

B11. Was the patient screened by **your program**, using an evidence-based tool, or set of questions, for co-occurring mental health and/or substance use disorders?

a. Yes
b. No

[IF YES] Did the patient screen positive for co-occurring mental health and substance use disorders?

a. Yes
b. No

[IF YES] Was the patient referred for further assessment for a co-occurring mental health and substance use disorder?

a. Yes
b. No

SECTION B: Planned Services (INTERVENTION ONLY)

The following section is meant to identify grant funded services the patient is planned to receive under the MI-PHL project. **Check all that apply in the section.** These items are intended to be completed administratively by staff and should not be asked of the patient.

Indicate the types of service categories to be provided to the patient. You will then provide service type in the following section based on category responses.

- ○ Treatment modalities (Inpatient/Outpatient Treatment) **(Continue to B12a)**
- ○ Case management services **(Skip to B12b)**
- ○ Medical Services **(Skip to B12c)**
- ○ After Care Services **(Skip to B12d)**
- ○ Education Services **(Skip to B12e)**
- ○ Recovery Support Services **(Skip to B12f)**

B12a. Identify the treatment modality or modalities you plan to provide to the patient during the patient's course of treatment/recovery in your program. **Select at least ONE modality.**

- ○ Case management
- ○ Intensive outpatient treatment
- ○ Inpatient/Hospital (other than withdrawal management)
- ○ Outpatient therapy
- ○ Outreach
- ○ Medication – Methadone
- ○ Medication – Buprenorphine
- ○ Medication – Naltrexone (Short Acting)
- ○ Medication – Naltrexone (Long Acting)
- ○ Medication – Disulfiram
- ○ Medication – Acamprosate
- ○ Medication – Nicotine replacement
- ○ Medication – Bupropion
- ○ Medication – Varenicline
- ○ Residential/Rehabilitation
- ○ Withdrawal Management: **SPECIFY ONE OF THE FOLLOWING DETOX SERVICES**
  - ○ Hospital inpatient
  - ○ Free standing residential
  - ○ Ambulatory Detoxification
- ○ After care
- ○ Recovery support
- ○ Other (please specify): _____

Identify the treatment service(s) you plan to provide to the patient during the patient's course of treatment/recovery. **You must select "Yes" for at least ONE of these treatment services numbered 1-4**. For negative screens/assessments, only screening should be selected.

TREATMENT SERVICES

- ○ Assessment
- ○ Treatment Planning
- ○ Recovery Planning
- ○ Individual Counseling

- ○ Group Counseling
- ○ Contingency Management
- ○ Community Reinforcement
- ○ Cognitive Behavioral Therapy
- ○ Family/Marriage Counseling
- ○ Co-Occurring Treatment Services
- ○ Pharmacological Interventions
- ○ HIV/AIDS Counseling
- ○ Cultural Interventions/Activities
- ○ Other clinical services (please specify): _____

B12b CASE MANAGEMENT SERVICES:

- ○ Family Services (Including Marriage Education, Parenting, Child Development Services)
- ○ Childcare
- ○ Pre-Employment Services
- ○ Employment Coaching
- ○ Individual Services Coordination
- ○ Transportation
- ○ HIV/AIDS Services - If Neg, Pre-Exposure Prophylaxis
- ○ HIV/AIDS Services - If Neg, Post-Exposure Prophylaxis
- ○ HIV/AIDS Services - If Positive, HIV Treatment
- ○ Transitional Drug-Free Housing Services
- ○ Housing Support
- ○ Health Insurance Enrollment
- ○ Other Case Management Services (please specify): _____

B12c MEDICAL SERVICES:

- ○ Medical Care
- ○ Alcohol/Drug Testing
- ○ OB/GYN Services
- ○ Other STI Support & Testing
- ○ HIV/AIDS Medical Support & Testing
- ○ Dental Care
- ○ Viral Hepatitis Medical Support & Testing
- ○ Other Medical Services (please specify): _____

B12d AFTER CARE SERVICES:

- ○ Continuing Care
- ○ Relapse Prevention
- ○ Recovery Coaching)
- ○ Self-Help and Mutual Support Groups
- ○ Spiritual Support
- ○ Other After Care Services (please specify): _____

B12e EDUCATION SERVICES:

- ○ Substance Use Education
- ○ HIV/AIDS Education
- ○ Naloxone Training
- ○ Fentanyl Test Strip Training
- ○ Viral Hepatitis Education
- ○ Other STI Education Services (please specify): _____
- ○ Other Education Services (please specify): _____

B12f RECOVERY SUPPORT SERVICES:

- ○ Peer Coaching or Mentoring
- ○ Vocational Support
- ○ Recovery Housing
- ○ Recovery Planning
- ○ Case Management Services to Specifically Support Recovery
- ○ Alcohol- and Drug-Free Social Activities
- ○ Information & Referral
- ○ Other Recovery Support Services (please specify): _____
- ○ Other Peer Recovery Support Services (please specify): _____