MI-PHL (SBIRT) Project Referral to Treatment 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: _____

4. ***If screening was positive.*** Was the patient willing to continue their participation in SBIRT services? (Select **NO** if the patient refused to complete the SBIRT intervention assigned)

   - ○ Yes
   - ○ No

5. ***If screening was positive.*** If the patient screened positive for substance misuse or a substance use disorder, which of the following SBIRT services was the patient **assigned** to?

   - ○ Brief Intervention
   - ○ Brief Treatment
   - ○ Referral to Treatment

6. ***If screening was positive.*** Which of the following SBIRT services did the patient **receive**?

   ○ Brief Intervention **(skip to 8)**

   ○ Brief Treatment **(continue to 7)**

   ○ Referral to Treatment

7. Patients receiving **Brief Treatment** must complete a DISCHARGE GPRA survey at the completion of service. Indicate if the GPRA survey to be entered is a Brief Treatment Intake OR Discharge.

   ○ Intake

   ○ Discharge

8. Patients receiving **Brief Intervention** must complete a DISCHARGE GPRA survey at the completion of SBIRT service. Indicate if the GPRA survey to be entered is a Brief Intervention Intake and/or Discharge**. For patients receiving 1 session of Brief Intervention**, a GPRA intake survey and discharge can be completed in one sitting.

   ○ Intake

   ○ Discharge

   ○ Intake AND Discharge (1 session of BI provided)

Contact Information ROI

GPRA Follow-Up Surveying:

Wayne State University has partnered with the Michigan Department of Health and Human Services (MDHHS) to manage Government Performance Report Act (GPRA) data collection to fulfil reporting requirements outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Michigan-Promoting Healthy Lifestyles Grant was awarded to MDHHS to fund SUD Screening, Brief Intervention, and Referral to Treatment (SBIRT) services.

As a recipient of SBIRT services, you are eligible to participate in 6-month GPRA follow-up surveying conducted by WSU. You will receive a $30 gift card at the end of the 6-month follow-up survey in appreciation for your time.

An SBIRT Release of Information (ROI) document MUST be completed by the patient before proceeding. **Has an ROI been secured?**

If the patient does not consent to a release of information, select refused below and the patient will NOT participate in GPRA follow up surveying.

○ ROI Completed and Signed

○ Patient refused to complete ROI

○ Unable to complete ROI. If so, explain: _____

To monitor the SBIRT program, follow-up GPRA surveys are completed with patients 6 months after Intake. The survey is completed by Wayne State University and is anonymous. To get in touch with you, we are going to ask for information that may help us locate you. Personal information provided is NOT part of the GPRA survey and will not be used for any purpose other than to reach you to complete the follow up GPRA survey.

Providing us with this information is voluntary, if the patient refuses to provide contact information write REFUSED next to each that is refused.

Patient Name: _____

Phone Number: _____

Permanent Address: _____

Email: _____

Social Media or Other Contact Information: _____

Collateral Contacts

In the event you cannot be contacted for 6-Month GPRA follow-up surveying, provide 2 additional contacts (can include emergency contacts) that may be able to locate you. Providing additional contact information for up to two friends or family members will increase the likelihood that you can be reached for surveying.

Personal information, including treatment details, will not be shared with any additional contacts provided.

Contact #1 First Name: _____

Contact #1 Relationship to Patient: _____

Contact #1 Phone Number: _____

Contact #2 First Name: _____

Contact #2 Relationship to Patient: _____

Contact #2 Phone Number: _____

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 – <u>PAST 30 DAYS</u> (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 – PAST 30 DAYS (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 – PAST 30 DAYS (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 – PAST 30 DAYS (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 – PAST 30 DAYS (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 – PAST 30 DAYS (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 – PAST 30 DAYS (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 – PAST 30 DAYS (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 **alcohol use disorder**, 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 **past 30 days? 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): _____

SECTION C: LIVING CONDITIONS (ALL)

This section pertains to the client's living situation during the past 30 days.

1. **In the past 30 days, where have you been living most of the time?**

- Shelter (Safe Havens, Transitional Living Center, Low-Demand Facilities, Reception Centers, Other temporary day or evening facility)
- Street/Outdoors (Sidewalk, Doorway, Park, Public or Abandoned Building)
- Institution (Hospital, Nursing Home, Jail/prison)

- Housed: Own/Rental Apartment, Room, Trailer, or House
- Housed: Someone else's Apartment, Room, Trailer, or House (including couch surfing)
- Housed: Dormitory/College Residence
- Housed: Halfway House or Transitional Housing
- Housed: Residential Treatment
- Housed: Recovery Residence/Sober Living
- Housed: Other (please specify): _____
- REFUSED

2. Do you currently live with any person who, over the past 30 days, regularly used alcohol or other substances?

- Yes
- No
- No, lives alone
- REFUSED

SECTION D: EMPLOYMENT, EDUCATION, AND INCOME (ALL)

This section collects information about the patient's educational and financial resources.

3. Are you currently enrolled in school or a job training program? If enrolled, Is it full time or part time? If the patient is incarcerated, select not enrolled.

- Not Enrolled (select if incarcerated)
- Enrolled, Full Time
- Enrolled, Part Time
- REFUSED

4. What is the highest level of education you have finished, whether or not you received a degree?

- Less than 12th Grade
- 12th Grade/High School Diploma/Equivalent
- Vocational/Technical Diploma
- Some College or University
- Bachelor's Degree (For example: BA, BS)
- Graduate Work/Graduate Degree
- Other (please specify): _____
- REFUSED

5. Are you currently employed? (Focus on the previous week). If the patient is incarcerated and has no work outside of jail, indicate not employed, not looking for work.

- Employed, Full Time (35+ hours per week, or would be, if not for leave or an excused absence)
- Employed, Part Time

- Unemployed--But Looking for Work
- Not Employed, NOT Looking for Work (Student)
- Not working due to a disability
- Retired, not working
- Other (please specify):_____
- REFUSED

6. Do you, individually, have enough money to pay for the following living expenses? Select all that apply.

- Food
- Clothing
- Transportation
- Rent/Housing
- Utilities (Gas/Water/Electric)
- Telephone Connection (Cell or Landline)
- Childcare
- Health Insurance
- None. The patient does not have enough money to pay for any of the expenses. (0)
- REFUSED

7. What is your personal annual income, meaning the total pre-tax income from all sources, earned in the past year?

- $0 - $9,999
- $10,000 - $14,999
- $15,000 - $19,999
- $20,000 - $34,999
- $35,000 - $49,999
- $50,000 - $74,999
- $75,000 - $99,999
- $100,000 - $199,999
- $200,000 or more
- REFUSED

MI-PHL (SBIRT) Project Referral to Treatment Discharge GPRA Survey

SECTION J & K : Discharge status & Services received (DISCHARGE ONLY)

The following section is intended to be completed administratively by staff and should not be asked of the patient.

1. On what date was the patient discharged?

   - ○ Month: _____
   - ○ Day: _____
   - ○ Year: _____

2. What is the patient's discharge status?

   - ○ Completion/Graduate **(skip to 4)**
   - ○ Termination **(continue to 3)**

3. **If the patient was terminated,** what was the reason for termination?

   - ○ Left on own against staff advice with satisfactory progress
   - ○ Left on own against staff advice without satisfactory progress
   - ○ Involuntarily discharged due to nonparticipation
   - ○ Involuntarily discharged due to violation of rules
   - ○ Referred to another program or other services with satisfactory progress
   - ○ Referred to another program or other services with unsatisfactory progress
   - ○ Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
   - ○ Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
   - ○ Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
   - ○ Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
   - ○ Transferred to another facility for health reasons
   - ○ Death
   - ○ Other (please specify) _____

4. Did the program order an HIV test for this patient?

- ○ Yes
- ○ No

5. Did the program refer this patient for HIV testing with another provider?

- ○ Yes
- ○ No

6. Did the program provide Naloxone and/or Fentanyl Test Strips to this patient at any time during their involvement in grant funded services?

- ○ Naloxone
- ○ Fentanyl Test Strips
- ○ Both Naloxone and Fentanyl Test Strips
- ○ Neither

7. Is the patient fully vaccinated against the virus that causes COVID-19?

- ○ Yes
- ○ No, partially vaccinated with plans to receive the subsequent vaccination on time
- ○ No, partially vaccinated with no plan to receive the subsequent vaccination
- ○ No, patient refused vaccination
- ○ REFUSED to answer

8. Which of the following **service categories** did the patient **receive** services from? Service type will be provided in the next section

- ○ Service Modalities (Inpatient/Outpatient Treatment) **(continue to 9 if selected)**
- ○ Case Management Services
- ○ Medical Services
- ○ After Care Services
- ○ Education Services
- ○ Recovery Support Services

9. Identify the number of **Days** of service provided to the patient during the patient's course of treatment/recovery.

Service	**Number of Days**
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: free standing residential	
Withdrawal management: ambulatory detoxification	
After care	
Recovery support	
Other (specify):	

TREATMENT SERVICES

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery. SBIRT interventions must be provided accordingly.

Service	**Number of Sessions**
Screening	
Brief Intervention	
Brief Treatment	
Referral to Treatment	
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 (specify):	

CASE MANAGEMENT SERVICES (only complete if CASE MANAGEMENT SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

Service	**Number of Sessions**
Family services (e.g., marriage education, parenting, child development services)	
Child care	
Employment service: Pre-employment	
Employment service: Employment coaching	
Individual services coordination	
Transportation	
HIV/AIDS Services and counseling	
Transitional drug-free housing services	
Housing support	
Health insurance enrollment	
Other case management services (specify):	

MEDICAL SERVICES (only complete if MEDICAL SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

Service	**Number of Sessions**
Medical care	
Alcohol/drug testing	
OB/GYN services	
HIV/AIDS medical support and testing	
Hepatitis medical support and testing	
Other STI support and testing	
Dental care	
Other medical services (specify):	

AFTERCARE SERVICES (only complete if AFTERCARE SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

Service	**Number of Sessions**
Continuing care	
Relapse prevention	
Recovery coaching	
Self-help & mutual support groups	
Spiritual support	
Other after-care services (specify):	

EDUCATION SERVICES (only complete if EDUCATION SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

Service	**Number of Sessions**
Substance misuse education	
HIV/AIDS education	
Hepatitis education	
Other STI education services	
Naloxone training	
Fentanyl test strip training	
Other education service (specify):	

RECOVERY SUPPORT SERVICES (only complete if RECOVERY SERVICES was SELECTED in question 8)

Identify the number of **SESSIONS** provided to the patient during the patient's course of treatment/recovery.

Service	**Number of Sessions**
Peer coaching or mentoring	
Vocational support	
Recovery housing	
Recovery planning	
Case management services to specifically support recovery	
Alcohol- & Drug-Free Social Activities	
Information and referral	
Other recovery support services (specify):	
Other peer-to-peer recovery support services (specify):	

10. **For the clinic site completing the GPRA survey**: Has the patient attended 60% or more of their planned services?

    ○ Yes

    ○ No

11. Did the patient receive any services via telehealth or a virtual platform?

    ○ Yes

    ○ No

SERVICES RECEIVED – OPIOID USE DISORDER

12. Has this patient previously been diagnosed with an opioid use disorder?

    ○ Yes **(continue to 13)**

    ○ No **(skip to 15)**

13. In the **past 30 days**, which FDA-approved medication did the patient receive for the treatment of this opioid use disorder? ***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 OPIOID USE DISORDER **(skip to 15)**

14. Has this patient taken the medication as prescribed?

    ○ Yes

    ○ No

SERVICES RECEIVED – ALCOHOL USE DISORDER

15. Has this patient previously been diagnosed with an alcohol use disorder?

    ○ Yes **(continue to 16)**

    ○ No **(skip to 18)**

16. In the **past 30 days**, which FDA-approved medication did the patient receive for the treatment of this alcohol use disorder? ***Select all that apply***.

    ○ Naltrexone (if received, specify how many days): _____

    ○ 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 **(skip to 18)**

17. Has this patient taken the medication as prescribed?

    ○ Yes

    ○ No

SERVICES RECEIVED – STIMULANT USE DISORDER

18. Has this patient previously been diagnosed with a stimulant use disorder?

    ○ Yes **(continue to 19)**

    ○ No **(skip to 21)**

19. In the **past 30 days**, which FDA-approved medication did the patient receive for the treatment of this stimulant use disorder? ***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 treatment approach (if received, specify how many days): _____

    ○ PATIENT DID NOT RECEIVE AN FDA APPROVED MEDICATION FOR A DIAGNOSED STIMULANT USE DISORDER **(skip to 21)**

20. Has this patient taken the medication as prescribed?

    ○ Yes

    ○ No

SERVICES RECEIVED – TOBACCO USE DISORDER

21. Has this patient previously been diagnosed with a tobacco use disorder?

    ○ Yes **(continue to 22)**

    ○ No **(skip to END)**

22. In the **past 30 days**, which FDA-approved medication did the patient receive for the treatment of this tobacco use disorder? ***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 **(skip to END)**

23. Has this patient taken the medication as prescribed?

- ○ Yes
- ○ No

END OF SURVEY