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|  | CTN-0116: Implementing a Pharmacist-Integrated Collaborative Model of Medication Treatment for Opioid Use Disorder (PharmICO) | Logo, company name  Description automatically generated |  |
| SITE SELECTION SURVEY | | | | |

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| Overall Site Information |
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In this study, a “site” is defined as both the primary care clinic and the integrated pharmacy that would participate in this study. The study team envisions that each site will have one of each; if your site is comprised of a different combination, please describe the arrangement here:

Surveys are due back to the Lead Team by **Friday, October 1, 2021**. Please email completed surveys to [Northeast.Node.CTN@Dartmouth.edu](mailto:Northeast.Node.CTN@Dartmouth.edu).

Please refer to the companion Brief Study Overview document for descriptions of study roles and site inclusionary criteria. For sections of free text indicated below, please be succinct.

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| OVERALL SITE INFORMATION | | | | | | | | | | | | | |
| **Site Name** | | **Organization name:**  **Primary care clinic name** (if different)**:**  **Pharmacy name** (if different)**:** | | | | | | | | | | | |
| **Site Location** | **Address:** | | **City:** | | | **County:** | | | **State:** | | | | **Zip Code:** |
| **Person(s) completing this form** | **Name:** | | | **Title:** | | | | **Email address:** | | | | | |
| **Proposed Site PI** | **Name:** | | | **Title:** | | | | **Email address:** | | | | | |
| **Length of time employed by the site** (approximately)**:** | | | | **Prior research experience?**  **Yes**  **No**  **Comments:** | | | | | | | **Number of years prescribing MOUD:**  **NA** | |
| **Affiliated CTN Node** | **Node:** | | | **Node PI:** | | | | | | **Node Coordinator:** | | | |
| **Not currently affiliated with a CTN node** | | | | | | | | | | | | |
| **Does the clinic associated with this proposed site provide primary care services?** | **Yes**  **No Comments:** | | | | | | | | | | | | |
| **What type of facility is your site?** Check all that apply. | **Privately owned health center** | | | | **Federally qualified health center (FQHC)** | | | | | | | **Specialty SUD provider** | |
| **Hospital/medical center primary care site** | | | | | | **Other:** | | | | | | |
| **How would you describe your site’s geographic location?** | **Urban** | | | | **Suburban** | | | | | | | **Rural** | |
| **What’s the average commute time for patients?** | | | | | | | | | |  | | |
| **How has the opioid epidemic impacted your site’s community?** How has your community responded to the opioid epidemic? What changes have you observed due to the opioid epidemic? Please describe briefly. | | | | | | |  | | | | | | |
| **Does your site offer medication treatment for OUD (MOUD)?** | | | | | | | **Yes**  **No** | | | | | | |
| **Does your site offer any form of integrated or collaborative care?** Please describe. | | | | | | |  | | | | | | |
| **What types of MOUD does your site offer?** Check all that apply. | | | | | | | **Buprenorphine** (mono product)  **Buprenorphine/naloxone**  **Extended-release buprenorphine**  **Naltrexone**  **Extended-release naltrexone**  **Other:** | | | | | | |
| **Please describe the model currently used to treat OUD at your site.** For example, do you use an office-based opioid treatment model run and managed solely by one provider, does your clinic use a patient-centered model of care that involves the full clinic to operate, or does the site use some other model? | | | | | | |  | | | | | | |
| **Please describe the psychoeducational support offered to patients receiving MOUD.** Are these supports required for patients in MOUD treatment? | | | | | | |  | | | | | | |
| **How has the COVID-19 pandemic affected the way this site provides treatment for OUD?** | | | | | | |  | | | | | | |
| **Is this site based in a state with Medicaid expansion, or where Medicaid coverage for MOUD is provided?** | | | | | | | **Yes**  **No Comments:** | | | | | | |
| **Will your organization agree to share non-identifying EHR data (clinic and pharmacy) with the study team?** This would occur only with the full execution of all legally required documents, (i.e., Data Use Agreement). | | | | | | | **Yes**  **No Comments:** | | | | | | |
| **Does your site have its own Institutional Review Board (IRB)?** An official letter stating that your local IRB would cede oversight may be requested later. | | | | | | | **Yes**  **No** | | | | | | |
| **If yes, would they cede oversight to a single IRB?**  **Yes**  **No** | | | | | | |
| **Does your IRB require extensive local review when relying on a single IRB?**  **Yes**  **No Comments:** | | | | | | |
| **What is the site’s Federal Wide Assurance (FWA) number** (if known)**:** | | | | | | |
| **Please describe the internal approval process that would need to occur at your site to participate in this study.** | | | | | | |  | | | | | | |
| **Is this site located in an area where a HEALing Communities study is being conducted?** Visit [this NIH site](https://heal.nih.gov/research/research-to-practice/healing-communities) for a list of participating communities. | | | | | | | **Yes**  **No**  **Not sure** | | | | | | |
| **Is your site participating in any other research studies focused on the treatment of OUD?** | | | | | | | **Yes**  **No  If yes:**  **Study title:**  **PI:**  **Funding source:**  **Link to study website** (if applicable)**:** | | | | | | |

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| PROVIDER INFORMATION | | |
| **Proposed Provider Champion** | **Name, credentials:**  **Role at the site:** | |
| **Length of time employed by the site** (approximately)**:** | |
| **Prior research experience?**  **Yes**  **No**  **Comments:** | |
| **Number of years prescribing MOUD:** | |
| **How many primary care providers (PCPs) see patients at your site?** | |  |
| **How many of those PCPs prescribe MOUD at your site?** Either DATA 2000 waivered or under the new non-waivered 30-patient limit. Medications prescribed would include all buprenorphine and/or naltrexone-based products. | |  |
| **On average, how many patients does each prescriber treat with MOUD?** | |  |
| **Please describe the diversity of your providers and staff (e.g., race, ethnicity, gender).** | |  |
| **Does your site staff’s diversity reflect the diversity of the patients and community served by the site?** | | **Yes**  **No**  **Not sure** |

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| PHARMACY INFORMATION | | |
| **Proposed Pharmacist Champion** | **Name, credentials:**  **Role at the site:** | |
| **Length of time employed by the site** (approximately)**:** | |
| **Prior research experience?**  **Yes**  **No**  **Comments:** | |
| **Does your organization have a retail pharmacy?** | **Yes**  **No** | **Is it co-located or within walking distance of the primary care clinic?**  **Yes**  **No** |
| **How many of the following staff do you have?** | **Pharmacists:** **Pharmacy Technicians:** | |
| **Describe your pharmacy staffing structure:** |  | |
| **Do your pharmacists currently have access to your primary care clinic’s EHR?** | **Yes**  **No** | **If yes, which level best describes this access?**  **View Only**  **Limited**  **Full**  **Comments:** |
| **Does your pharmacist currently work with any of your primary care providers in an integrated treatment model for OUD?** | **Yes**  **No** | **Comments (if any):** |
| **Does your organization bill for pharmacist services, within the retail pharmacy (excluding dispensing prescriptions)?** | **Yes**  **No** | **If yes, please describe:** |
| **Does your organization bill for pharmacist services within the primary care clinic setting?** | **Yes**  **No** | **If yes, please describe:** |
| **Does your organization participate as a covered entity within the 340B Program?** | **Yes**  **No** | **If yes, please describe:** |
| **Does your retail pharmacy bill Medicare Part D, Medicaid, or commercial insurance?** | **Medicare**  **Medicaid**  **Commercial** | **Comments:** |
| **Is your organization’s retail pharmacy Open-Door (open to the general public) or Closed-Door (exclusively serving patients)?** | **Open Door**  **Closed Door** | **Comments:** |

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| IT INFORMATION | | | |
| **Proposed IT Specialist** (if known) | | **Name:**  **Role:** | |
| **Length of time employed by the site** (approximately)**:** | |
| **Not yet identified** | |
| **Do you have IT staff available to help extract and share data from the clinic and pharmacy EHR?** | | | **Yes**  **No**  **Comments:** |
| **Which EHR systems do you use?** Name and version | **Clinic:** | | **Pharmacy:** |
| **Do you have the capability to send any of the following EHR file types?** Select all that apply. | | | **CSV**  **XML**  **FHIR**  **HL7**  **JSON**  **Other:** |
| **Does your pharmacy EHR collect Proportion of Days Covered (PDC) on medications?** | | | **Yes**  **No**  **Comments:** |
| **Does your IT team have experience pulling reports for research studies?** Has this included reformatting (or harmonizing) data prior to sharing it with the funder/sponsor? | | | **Yes**  **No**  **Comments:** |
| **Please provide a sample list of reports that your organization already runs.** Do not include any information that could be identifying. | | |  |

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| SITE-LEVEL EHR DATA |

To answer the questions below, you may need to be pull data from the site’s clinic and/or pharmacy EHR systems.

We kindly request that sites retain any such EHR report(s) that are pulled to provide the data below, as the Lead Team may request the report(s) (containing no identifiable information) be sent as a “test file” during later stages of Site Selection. This would help demonstrate the site’s ability to pull data needed for the successful conduct of this study. The Lead Team will let you know if this report will be requested after we’ve reviewed responses on this site selection survey.

If you have questions about these data points, please reach out to Project Directors Bethany McLeman and Phoebe Gauthier ([Bethany.M.McLeman@Dartmouth.edu](mailto:Bethany.M.McLeman@Dartmouth.edu); [Phoebe.R.Gauthier@Dartmouth.edu](mailto:Phoebe.R.Gauthier@Dartmouth.edu)).

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| CLINIC EHR DATA | | |
| **How many unique primary care patients has your site served in the past 12 months?** Attended any primary care-based encounter. | |  |
| **What percent of patient charts have demographic information available?** | |  |
| **Please describe the racial diversity (in percent) of all patients seen for any primary care encounter at your site in the past 12 months:** | **FEMALE PATIENTS**  **American Indian/Alaska Native:      %**  **Asian:      %**  **Native Hawaiian/Pacific Islander:      %**  **Black or African American:      %**  **White:      %**  **More than one race:      %** | **MALE PATIENTS**  **American Indian/Alaska Native:      %**  **Asian:      %**  **Native Hawaiian/Pacific Islander:      %**  **Black or African American:      %**  **White:      %**  **More than one race:      %** |
| **Please indicate the percentage of patients treated in your practice with each of the following types of insurance.** | | **Medicare      %**  **Medicaid      %**  **Private      %**  **Self-pay      %**  **Veteran Affairs      %**  **Other      %** |
| **How many unique patients seen for a primary care encounter in the past 12 months have a diagnosis of OUD (moderate/severe) listed in their chart?** Please describe how OUD diagnosis was captured (e.g., ICD-10 codes F11.20-F11.29 vs problem list). | |  |
| **In the past 12 months, how many patients have received at least one prescription order for MOUD at your site?** This can include buprenorphine, buprenorphine/naloxone, naltrexone, or other types of MOUD offered by your clinic. | |  |
| **Please describe the racial diversity (in percent) of all patients who have received a prescription for MOUD at your site in the past 12 months:** This can include buprenorphine, buprenorphine/naloxone, naltrexone, or other types of MOUD offered by your clinic. | **FEMALE PATIENTS**  **American Indian/Alaska Native:      %**  **Asian:      %**  **Native Hawaiian/Pacific Islander:      %**  **Black or African American:      %**  **White:      %**  **More than one race:      %** | **MALE PATIENTS**  **American Indian/Alaska Native:      %**  **Asian:      %**  **Native Hawaiian/Pacific Islander:      %**  **Black or African American:      %**  **White:      %**  **More than one race:      %** |
| **Please indicate the percentage of patients receiving at least one prescription for MOUD from your practice with each of the following types of insurance.** This can include buprenorphine, buprenorphine/naloxone, naltrexone, or other types of MOUD offered by your clinic. | | **Medicare:      %**  **Medicaid:      %**  **Private:      %**  **Self-pay:      %**  **Veteran Affairs:      %**  **Other:      %** |
| **How many unique patients have received a prescription order in the past 12 months for buprenorphine for the treatment of chronic pain?** | |  |

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| **PHARMACY EHR DATA** | |
| **To how many unique patients from the participating primary care clinic do you dispense medications?** All medications. |  |
| **To how many unique patients from the clinic do you dispense MOUD?** Buprenorphine, buprenorphine/naloxone, naltrexone, or other MOUD for the treatment of OUD. |  |
| **In the past 12 months, how many patients have filled at least one prescription order for MOUD at your site’s pharmacy?** This can include buprenorphine, buprenorphine/naloxone, naltrexone, or other types of MOUD offered by your clinic. |  |
| **Please indicate the percentage of patients filling at least one prescription for MOUD from your practice with each of the following types of insurance.** This can include buprenorphine, buprenorphine/naloxone, naltrexone, or other types of MOUD offered by your clinic. | **Medicare:      %**  **Medicaid:      %**  **Private:      %**  **Self-pay:      %**  **Veteran Affairs:      %**  **Other:      %** |
| **How many unique patients have filled a prescription order in the past 12 months for buprenorphine for the treatment of chronic pain?** |  |

Thank you for taking the time to complete this survey!