Recovery Services GPRA Form

VERMONT DEPARTMENT OF HEALTH

Vermont Department of Health
Division of Alcohol & Drug Abuse Program

Participant ID: _____

Click_____ to save form **Click _____ to reset form (this will erase all unsaved information)**

RCED Section (A)

1.**Name of Recovery Coach filling out this form:** _____

2.**Hospital:** ☐BMH ☐CVMC ☐MAH ☐NVRH ☐PMC ☐RRMC ☐SMCS ☐Copley ☐SVMC ☐UVMMC ☐NCH ☐Gifford ☐Other

3.**If other, please specify:** _____

4.**Date and Time Recovery Coach was called:** _____

5.**Referring Physician:** _____

6.**Date & Time of ED Visit** *Start Date and Time:* _____*End Date & Time*:

All other Recovery Services Section (B)

7.**Name of Recovery Coach filling out this form:** _____

8.**Which Recovery Center are you reporting on** ☐TPCR ☐JRCC ☐KRC ☐NCVRC ☐SWF ☐TPCA ☐TPCB ☐TPCCV ☐TPCCC ☐TPFC ☐TPCS ☐TPCW

Administrative Section (C)

*9.**Which GPRA Interview are you performing:**

◯Intake/Baseline ◯6-month follow up ◯Discharge

***10.Informed consent given for GPRA collection?** ◯ Yes ◯No ***If no, submit only the Administrative Section**

*11.**Date of Interview:** _____

*12.**Participant Date of Birth (mm/dd/yyyy)**
(DOB only required with "Intake" and Informed Consent)

Participant Report Section (D)

13.**How many times in the last 12 months have you visited the ER for Substance Use related causes?**_____

Reason for ED Visit (check all that apply)

☐Alcohol
☐Amphetamines
☐Barbiturates
☐Benzodiazepines
☐Buprenorphine
☐Cocaine
☐Hallucinogens
☐Inhalants
☐Marijuana/Cannabis
☐Methamphetamines
☐Methadone
☐Opiates
☐Other, specify here: _____

14.**Participant Name:** 14.1First Name: _____ 14.2Last Name: _____

15.**Participant Address:**

15.1.Address 1: _____ 15.2Address 2: _____

15.3.City: _____ 15.4.State: _____ 15.5Zip Code: _____

16.**Participant Contact Info:**

16.1Cell Phone: _____ 16.2Home Phone: _____ 16.3Other: _____

16.4Email address: _____

*17.**What is your gender?**

◯Male
◯Female
◯Transgender
◯Other, specify here:_____
◯Refused
◯Unknown

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*****18.**Are you Hispanic or Latino?**

○Yes ○No ○Refused ○Unknown

18.1 ***If "Yes," specify below by checking all that apply.***

☐Central American ☐Mexican ☐Other:_____
☐Cuban ☐Puerto Rican ☐Unknown
☐Dominican ☐South American ☐Refused

*****19.**What is your race (you may select more than one)?**

☐Black or African American ☐White ☐Native Hawaiian or Other Pacific Islander
☐Asian ☐American Indian
☐Alaska Native ☐Refused ☐Unknown

*****20.**Preferred Language:**

○English ○Spanish ○Other:_____

*****21.**Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?**

○No ○Yes, in the Reserves ○Refused
○Yes, in the Armed Forces ○Yes, in the National Guard ○Unknown

*****21.1**If yes to the above, are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard?**

○ No, separated or retired ○Yes, Reserves ○Refused
○Yes, in the Armed Forces ○Yes, National Guard ○Unknown

*****22.**Are you receiving any of the following Substance Use Disorder/Mental Health treatment(s) (check all that apply)?**

☐Detox ☐Primary care
☐Intensive Outpatient Program (IOP) ☐Outpatient services
☐Medication Assisted Treatment (MAT) ☐Telephone Recovery Support
☐Psychiatric care ☐Other:_____
☐Counseling ☐None/not applicable

23.**[RCED ONLY] Did the patient agree to a referral?** ☐Yes ☐No
☐If yes, to whom/where:
24.**[RCED ONLY] Family referral(s) requested?** Yes ☐No

25.**[RCED ONLY] Emergency**
25.1**Contact:**Name
25.2**Phone Number**
25.3Relationship to patient (check one):

☐Spouse ☐Sibling ☐Colleague
☐Significant Other ☐Friend ☐Other, specify:_____
☐Partner ☐Neighbor

26.***In the past 30 days, were you diagnosed with either of the following (choose all that apply but choose at least one):**

☐Opiate Use Disorder (OUD) ☐Neither ☐Unknown
☐Alcohol Use Disorder (AUD) ☐Refused

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***27.If you answered AUD or OUD in the above question, what medication, if any, was given for treatment:**

☐Methadone (if yes, **how many days**: _____)
☐Buprenorphine (if yes, **how many days**: _____.)
☐Naltrexone (if yes, **how many days**: _____.)
☐Extended-release Naltrexone (if yes, **how many days**: _____)
☐Disulfiram (if yes, **how many days**: _____.)
☐Acamprosate (if yes, **how many days**: _____.)

☐Diagnosed but DID NOT receive medication
☐NOT diagnosed AND did not receive medication
☐Unknown
☐Refused

***28.In the past 30 days, where have you been living most of the time (check one)?**

◯Shelter
◯Housed (specify below)
◯Street/Outdoors
◯Institution
◯Refused
◯Unknown

*28.1**If housed is chosen, you must choose one**
◯Own/Rent
◯Someone else's apt/home/room
◯Dorm
◯Halfway House
◯Residential Treatment
◯Other
◯Refused
◯Unknown

*28.2**How satisfied are you with your living situation (check one)?**

◯Very Satisfied
◯Satisfied
◯Neither Satisfied nor Dissatisfied
◯Dissatisfied
◯Very Dissatisfied
◯Refused
◯Unknown

***29.Are you pregnant (check one)?** ◯Yes ◯No ◯Refused ◯Unknown

***30.Do you have children (check one)?** ◯Yes ◯No ◯Refused ◯Unknown

If yes:

- 31.1**How many children do you have?** _____ ☐Refused ☐Unknown
- 31.2**Are any of your children living with someone else due to a child protection court order?** ◯Yes ◯No ◯Refused ◯Unknown
- 31.3**How many of your children live with others due to a child protection order (if zero, enter 0)?**
- 31.4**For how many of your children have you lost parental rights (if zero, enter 0)?** _____

***32.Are you enrolled in school (check one)?**

◯Not enrolled
◯Enrolled, full time
◯Enrolled, part time
◯Other, specify:_____
◯Refused
◯Unknown

***33.Are you currently employed (check one)?**

◯Employed, full time (35+ hours)
◯Employed, part time
◯Unemployed, looking for work
◯Unemployed, disabled
◯Unemployed, volunteer work
◯Unemployed, retired
◯Unemployed, not looking for work
◯Other, specify:_____
◯Refused
◯Unknown

34.**[RCED ONLY] What type of insurance do you have?**

☐Medicaid ☐Medicare ☐Private:_____

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35.**[RCED ONLY] Do you have a Primary Care Provider?** ☐Yes ☐No
If yes, who: _____

36.**[RCED ONLY] Was Narcan administered to the patient?** ☐Yes ☐No
36.2**If yes, where was it administered?** _____
36.3**Was Narcan training provided to the patient?** ☐Yes ☐No ☐Refused ☐Unknown

***37.In the past 30 days:**
37.1**How many times have you been arrested (if zero, enter 0)?** ☐Refused ☐Unknown ☐N/A
37.2**How many times have you been arrested for a drug related offense (if zero, enter 0)?** Refused Unknown
37.3**When was your last release date?** ☐Refused ☐Unknown ☐N/A

***38.In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization (check one)?** ◯Yes ◯No ◯Refused ◯ Unknown

***39.In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery (check one)?** ◯Yes ◯No ◯Refused ◯Unknown

***40.How satisfied are you with your personal relationships (check one)?**
◯Very Satisfied ◯Neither Satisfied nor Dissatisfied ◯Dissatisfied ◯Refused
◯Satisfied ◯Very Dissatisfied ◯Unknown

***41.To whom do you turn when you are having trouble (check one)?**
◯No one ◯Friends ◯Refused
◯Clergy member ◯Other, specify:_____ ◯Unknown
◯Family member

42.**[RCED ONLY] Would you like to receive 10 day follow up calls?** ☐Yes ☐No

43.**Would you like to be referred to a Recovery Coach at our center?** ☐Yes ☐No

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6-MONTH FOLLOW UP Section (E)

This section is to be completed within the window of one month prior and two months after the 6-month 'anniversary' of the intake interview, in addition to the sections above.

***44.What is the follow-up status of the participant?**

- ◯ Deceased at time of due date
- ◯ Completed interview within specified window
- ◯ Completed interview outside specified window
- ◯ Located, but refused, unspecified
- ◯ Located, but unable to gain institutional access
- ◯ Located, but otherwise unable to gain access
- ◯ Located, but withdrawn from project
- ◯ Unable to locate, moved
- ◯ Unable to locate, other: _____

***45.Is the participant still receiving services from your program?** ☐Yes ☐No

DISCHARGE Section (F)

This section is to be completed on the day of discharge if the participant completes the program, or within 14 days of the day the client is terminated from the program, in addition to the sections above (except the 6-month follow

***46.On what date was the participant discharged?** _____

***46.1What is the participant's discharge status?** ☐Completed ☐Terminated

***47.If the participant was terminated, what was the reason for termination (select one)?**

- ◯ 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:_____

***48.Identify the number of days each of these services was provided to the participant:**

Peer coaching or mentoring: _____
Housing support: _____
Sober social activities: _____
Information & referral: _____

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SIGNATURES

Person completing this form:

First name: _____ **Last name:** _____

Signature: _____

Person entering data into RDP:

First name: _____ **Last name:** _____

Signature: _____

Once this form is complete and information is entered into the Recovery Data Platform, please secure form in a locked filing cabinet.

*****GPRA Requirements***** In accordance with the draft from the Vermont Department of Health, this form must be submitted through Survey Gizmo link located at www.healthvermont.gov or faxed to (802) 652-2019 within 48 hours after intake, follow up or discharge. All questions relating to GPRA data are required, but any question can be refused by participant. Click _____ to submit form.

As a last resort, this form can be mailed to:
Vermont Department of Health Division of Alcohol and Drug Abuse Programs
Attn: GPRA Coordinator
108 Cherry St, Suite 207
Burlington, VT 05401

GPRA Participant ID Key		
Program Name	Center Name	Center Abbreviation
MOMS, RCED or COVID	Turning Point Center of Rutland	TPCR
MOMS, RCED or COVID	Journey to Recovery Community Center	JRCC
MOMS, RCED or COVID	Kingdom Recovery Center	KRC
MOMS, RCED or COVID	North Central VT Recovery Center	NCVRC
MOMS, RCED or COVID	SecondWind Foundation	SWF
MOMS, RCED or COVID	Turning Point Center of Addison	TPCA
MOMS, RCED or COVID	Turning Point Center of Bennington	TPCB
MOMS, RCED or COVID	Turning Point Center of Central VT	TPCCV
MOMS, RCED or COVID	Turning Point Center of Chittenden	TPCCC
MOMS, RCED or COVID	Turning Point of Franklin County	TPFC
MOMS, RCED or COVID	Turning Point Center of Springfield	TPCS
MOMS, RCED or COVID	Turning Point Center of Windham	TPCW
GPRA ID Example #1	MOMSTPCCC1	
GPRA ID Example #2	RCEDTPCR1	
GPRA ID Example #3	COVIDSWF1	

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Notes Section