

**Characteristics of Screening, Evaluation, and Treatment of
HIV/AIDS, Hepatitis C Viral Infection, and Sexually Transmitted
Infections in Substance Abuse Treatment Programs
("Infections and Substance Abuse")**

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TABLE OF CONTENTS

LIST OF ABBREVIATIONS.....	4
DEFINITIONS	5
SYNOPSIS.....	7
1.0 INTRODUCTION	9
2.0 STUDY RATIONALE	11
3.0 OBJECTIVES	11
4.0 STUDY DESIGN.....	12
5.0 STUDY POPULATION	13
5.1 Number of Sites and Subjects	13
5.2 Duration of Study and Visit Schedule	13
5.3 Inclusion Criteria	13
5.4 Exclusion Criteria	13
6.0 STUDY ASSESSMENTS AND PROCEDURES.....	14
6.1 Study Surveys.....	14
6.2 Selection of Node Protocol Manager	15
6.3 Information Sheet in Lieu of Informed Consent.....	15
6.4 Administration of Study Surveys	16
7.0 FIELD TEST	16
8.0 ASSESSMENT AND REPORTING OF ADVERSE EVENTS.....	17
9.0 STATISTICAL CONSIDERATIONS.....	17
9.1 Sampling and Random Selection.....	17
9.2 Sample Size and Precision	18
9.3 Types of Analyses	19
9.3.1 Selected Service Areas.....	19
9.3.2 Preliminary Checks	19
9.3.3 Survey Response Rates	19
9.3.4 State Administrator Survey	20
9.3.5 Treatment Program Administrator Survey.....	21
9.3.6 Treatment Program Clinician Survey	23

9.3.7 Association Between Availability of Services and Other Variables	24
9.3.8 Correlation Between Treatment Program Administrator and Treatment Program Clinician Surveys.....	26
10.0 STUDY TIMETABLE	27
11.0 DISCONTINUATION OF STUDY	27
12.0 DISCLOSURE OF DATA.....	28
13.0 ADHERENCE TO ETHICAL, REGULATORY AND ADMINISTRATIVE CONSIDERATIONS	28
14.0 DATA ACQUISITION AND MANAGEMENT OVERVIEW	29
15.0 REFERENCES.....	33
16.0 PROTOCOL SIGNATURE PAGE.....	36
17.0 AMENDMENTS.....	37
APPENDICES	38
Appendix A. Introduction Letters and Information Sheets	38
Appendix B. Training Plan.....	52
Appendix C. Preliminary Quality Assurance (QA) Monitoring Guidelines and Checklist	54
Appendix D. Node Protocol Manager Job Description.....	56
Appendix E. Treatment Program Administrator Survey.....	57
Appendix F. Treatment Program Clinician Survey	58
Appendix G. State Administrator Survey	59

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
CC	Coordinating Center
CFR	Code of Federal Regulations
CTN	Clinical Trials Network
CTP	Community Treatment Program
DHHS	Department of Health and Human Services
DMAS	Data Management and Analysis Subcommittee
DMC	Data Management Center
DSMB	Data and Safety Monitoring Board
FDA	Food and Drug Administration
HCV	Hepatitis C virus
HIV	Human Immunodeficiency virus
IDU	injection drug user
IRB	Institutional (Human Subjects) Review Board
LI	Lead Investigator
NASDAD	National Association of State Drug and Alcohol Directors
NIDA	National Institute on Drug Abuse
NKI	Nathan Kline Institute
PI	Principle Investigator
QA	Quality Assurance
RTTC	Regional Research and Training Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Statistical Analysis System®
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection

DEFINITIONS

Treatment Program: A group of substance abuse-specific services associated with a particular modality (drug-free, agonist therapy, and/or detoxification) of substance abuse care in a particular setting (inpatient, outpatient, residential, etc.). A Treatment Program may have specially trained staff and specific funding that distinguishes it from other programs or components of an agency (or a Community Treatment Program [CTP] of the Clinical Trials Network). If the same type of Treatment Program is available at more than one geographical site, it is counted separately (for example, a CTP that has residential substance abuse services at three different locations will be counted as three different Treatment Programs. Based upon this, CTPs within the Clinical Trials Network (CTN) may have one or more different Treatment Programs.

Provider Education: The training of providers in the screening, counseling, referral, treatment and partner notification of patients who may have, or are at risk for acquiring Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Hepatitis-C Virus (HCV) or sexually transmitted infections (STIs).

Patient Education: The provision of specific information to patients about behaviors or activities that may have caused, or put them at risk for acquiring HIV/AIDS, HCV or STIs, along with information about screening, counseling, referral, treatment and partner notification.

Patient Risk Assessment: Techniques or instruments for evaluating patients that provide reliable information about behaviors or activities that may have caused, or put them at risk of acquiring HIV/AIDS, HCV or STIs.

Medical History and Physical Examination: Obtaining self-reported information from the patient or significant others about the existence currently, or in the past, of clinical symptoms, disorders or diseases suggestive of infection with HIV/AIDS, HCV or STIs. The performance of assessments through observation, palpation or other physical techniques to determine the existence of physical signs consistent with current or past infection with HIV/AIDS, HCV or STIs.

Biological Testing: The use of laboratory tests that can specifically identify past or present infection with HIV/AIDS, HCV or STIs, assess the effectiveness of treatment, or detect progression of these infections.

Patient Counseling: Counseling that specifically focuses on modifying behaviors so as to reduce risk of acquiring HIV/AIDS, HCV or STIs, along with breaking down barriers in seeking diagnosis, referral, treatment and partner notification.

Patient Treatment: The provision of on-site or via linkages of pharmacological or other interventions that target infection by HIV/AIDS, HCV or STIs, or the consequences of these infections.

Patient Monitoring: The use of any or all of the above modalities to detect: (1) acquisition of new infections or progression of current infections due to HIV/AIDS, HCV or STIs; (2) resumption of behaviors or activities that increase the risk of acquiring these infections; or (3) clinical outcomes or side effects due to pharmacologic or other interventions provided to infected persons.

Patient Reporting: Any requirement by a state or local regulatory agency that newly diagnosed patients with HIV/AIDS, HCV or STI are reported to that agency by the diagnosing entity.

Medical Staff: This includes, but is not limited to, full time and part time Treatment Program physicians, physician assistants, nurse practitioners, registered and licensed practical nurses, and medical assistants.

Non-Medical Clinical Staff: This includes, but is not limited to, full time and part time Treatment Program counselors, social workers, case managers, case workers, psychologists and peer counselors/educators.

Expert Clinician (medical and non-medical): Treatment Program clinicians knowledgeable or experienced in the education, counseling, evaluation and/or management of substance abusers who have, or are at risk for acquiring, HIV/AIDS, HCV or STIs, including clinicians having expertise in only one of these infections. This can include the Treatment Program administrator, if appropriate.

SYNOPSIS

There are a number of infections known to be associated with intravenous drug addiction. Many of these infections can be effectively prevented or treated. However, we believe that there are a number of hurdles that prevent effective education/counseling, screening, testing, treatment, and monitoring of these infections. If these hurdles can be identified, interventions can be devised allowing for more effective treatment. We believe that the hurdles can be demonstrated in a variety of spectra, including knowledge, opinion, policy, and funding. Interventions can be developed once the hurdles are identified more specifically. This study looks to identify those hurdles, and develop a database for future study and intervention.

This study is a cross-sectional, exploratory survey of attributes of Treatment Programs and their related state policies, examining the spectrum of delivered care in substance abuse treatment agencies with respect to Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS), Hepatitis C Virus (HCV), and sexually transmitted infections (STIs). Three respondent groups providing measures include the administrators of Treatment Programs within participating CTN CTPs, the direct care staff of the Treatment Programs, and the administrators of state substance abuse and health agencies with regulatory authority for the CTPs.

The component targeting Treatment Program administrators assesses administrator opinions, policies, procedures, patient characteristics, staffing, and funding at the individual clinic level (e.g., outpatient drug-free, outpatient methadone, women's clinic, etc.). The survey of direct care providers assesses knowledge, opinions, and practices. The existence and content of policies relating to clinical guidelines and reimbursement of care will be measured by the survey of administrators of state substance abuse and health departments.

This study utilizes the convenience sample of CTPs funded by the NIDA CTN. Since the concordance of these CTN CTPs to CTPs not in the CTN cannot be estimated within the scope of this study, this is an exploratory study to provide estimations of associations worthy of further examination in a future statistically sampled study. Because of known differences in agency size and staffing profiles, statistical sampling and response weighting estimation methods will be used to analyze measures contributed by direct care staff of Treatment Programs within the various CTPs.

This study focuses on the range of available services associated with the targeted infections in substance abuse treatment settings. This focus is purposeful and rational for the following reasons: There has not been a systematic investigation of these services in the substance abuse treatment health care delivery system on a scale envisioned by this study. Second, health services research of the substance abuse treatment delivery system is important, in that the current system is recognized as being less than optimal. Before one can assess the efficiency of the available services, a systematic inventory of these services is necessary. Third, this inventory is also a pre-requisite for health outcome studies.

In summary, a systematic cataloging of the available services is a necessary condition to health services research or health outcome investigations. Therefore, the findings of this study have the potential to fuel hypotheses for health services research, health outcome studies, or other scientific endeavors.

1.0 INTRODUCTION

Substance abuse is associated with a wide spectrum of medical disorders, including infectious diseases, resulting in excess morbidity and mortality in the United States. Infections due to the human immunodeficiency virus and the hepatitis C virus as well as sexually transmitted infections are the most prominent. Among substance abusers, the rates for these infections are especially significant; published studies exist demonstrating that 30-40% of injecting drug users are HIV infected, 70-90% have HCV infection, and 90% of some substance abusers have had at least one type of STI (1, 4, 21, 33)

In the general population, gonorrhea is the most commonly reported sexually transmitted infection (STI). Experts think that chlamydia, herpes simplex virus, and human papilloma virus (genital warts) are more common (29), with syphilis being less common than gonorrhea. Substance use disorders are often listed as a risk factor, as well as multiple sex partners and nonuse of condoms (11, 25). Infection with multiple STIs also occurs in these high-risk populations (2, 11, 25).

New technologies are being developed with amplified deoxyribonucleic acid (DNA) methods (polymerase chain reaction and ligase chain reaction) to detect these STIs in a simpler fashion, removing the step of culturing the pathogen (30, 32, 34). Enzyme immunoassay and nucleic acid hybridization are two other new technologies (8). Regular screening, combined with safer sex practices, partner treatment, and use of microbicides by women are all methods of reducing the incidence of STIs and their complications (18).

Since the substance dependent population is known to practice risky sexual behaviors and to trade sex for drugs (either directly or indirectly for money), clinics which treat substance dependent individuals should be alert to the new findings and should integrate these proven preventative interventions.

Injection drug users (IDUs) are the second largest group of reported AIDS cases in Europe and the United States. Injection drug users constitute the leading source for heterosexual transmission of HIV to non-injection drug users in the United States (4). Crack cocaine use has also been identified with increased incidence of HIV infection (7). IDUs and their risk behaviors have been the focus of many risk reduction interventions such as education, street outreach, needle/syringe exchange, and drug abuse treatment (23). Numerous studies have shown that drug abuse treatment is associated with risk reduction and protection from HIV infection (15, 22, 24, 27). Despite drug abuse treatment's noted protection against HIV infection, little is known about the active ingredients contributing to treatment's effectiveness at HIV prevention. In addition, little is known about the range of HIV related services provided by treatment programs.

Like HIV, viral hepatitis is a major global public health problem. The discovery of the HCV in 1989 ended a period of intensive international research efforts aimed at the elusive "non-A, non-B" virus, which was well known as a cause of post-transfusion hepatitis. An estimate of 80-85% of affected people can become chronically infected and risk serious long-term

clinical sequelae including cirrhosis and hepatocellular carcinoma. However, questions remain within the scientific community regarding the natural course, pathobiological implications, socioeconomic burden and management of acute and chronic forms of HCV.

Nearly 4 million Americans have been infected with the HCV. HCV is responsible for a third of all cases of chronic liver disease leading to cirrhosis and liver cancer, half of liver transplants, and 8,000-10,000 deaths in this country annually.

Transmission through transfusion with unscreened blood, through the use of inadequately or unsterilized equipment, or through needle sharing among drug-users, is well documented (5, 6, 13). Sexual and perinatal transmission may also occur, although less frequently; and other factors such as those linked to social, cultural, behavioral practices using percutaneous procedures (e.g., ear and body piercing, circumcision, tattooing) may be important.

Because injection drug use is the single most important factor associated with HCV infection today, public agencies and professional groups have universally recommended screening all persons with a history of injection drug use (14, 19, 20). Additionally, the HCV viral load level, the genotype of the virus, and degree of liver damage are important factors that determine response to treatment in persons who come to medical attention subsequent to HCV screening and clinical evaluation. Despite this knowledge, many persons at risk for HCV are not screened and among those who are screened, subsequent clinical evaluation often does not occur.

This is especially important in patients with concurrent HIV infection. HCV/HIV co-infection occurs in 60% to 95% of individuals due to common shared routes of transmission (35). Co-morbid HCV and HIV infection has been associated with faster progression to hepatocellular carcinoma than if infected solely with HCV (11). Persons with HCV/HIV co-infections have a 50% greater risk of dying (28) than those not dually infected, and those patients with severe immunosuppression have a reduced projected period of survival (3).

In substance abuse treatment settings, previous Substance Abuse and Mental Health Services Administration (SAMHSA)-sponsored assessments have demonstrated that there is a significant difference in desires and receipt of medical services by persons enrolled in different treatment modalities. However, there has been no systematic evaluation of the practices of healthcare providers to reduce the transmission of these infections in varied treatment modalities or of the challenges to more effective screening, evaluation, and (where applicable) treatment in substance abuse treatment programs.

It is important that these questions are answered, because substance abusers play a pivotal role in the transmission of these infections in society. Information from this study has the potential to help shape future programs and policies to further reduce the transmission of these infections among substance abusers, their families, their communities, and the American public.

2.0 STUDY RATIONALE

Epidemiological evidence demonstrates that substance abuse contributes significantly to the prevalence of HIV/AIDS, HCV, and STIs in the United States. These infections are associated with considerable morbidity and mortality. It is clear that substance abuse treatment programs provide care to persons who are at risk for these infections. It is also known that some substance abuse treatment programs have well integrated infectious disease screening, treatment and monitoring activities, while others have little in place. Substance abuse treatment programs differ in their profile of regional bureaucratic mandates, agency policies and resources, and professional staff knowledge, attitude and practice. Substance abuse treatment programs also differ in their practices with respect to screening, evaluation/diagnosis, and treatment of persons with these infections. What are the relevant aspects of agency profiles that differentiate agencies with respect to the continuum of practices for HIV/AIDS, HCV and STIs? This study will obtain data profiling state agencies, substance abuse treatment programs, and their professional staff to explore and identify the factors that distinguish programs across the spectrum of infectious disease-related clinical care.

3.0 OBJECTIVES

The overall objective of this study is to describe the availability of services for HIV/AIDS, HCV, and STIs among Treatment Programs within CTN CTPs. The portfolio of health services to be examined is: provider education, disease awareness, patient risk reduction, patient education, active disease screening (biological testing and medical examinations), counseling, treatment or referral, and treatment monitoring. In addition, Treatment Program administrators and clinicians will be asked to report on barriers to the availability of these services that they perceive to exist in their respective settings.

Since variations in the portfolio of health services between Treatment Programs may be the result of a wide range of factors, information will also be gathered from state divisions of substance abuse and state health departments. Administrators of state divisions of substance abuse and departments of health will be asked to report on statewide policies and practice guidelines as well as service funding. Administrators of Treatment Programs will be asked to report on agency incorporation, funding sources, staffing, program policies, resources, participant characteristics and local infectious disease prevalence. Individual Treatment Program clinicians will be asked about their medical knowledge, training, opinions, and practices.

The information obtained from this protocol will create an empirical database from which future studies, aimed at improving the infectious disease health of persons in drug treatment, can be designed.

Objectives

- *Service Availability* - To describe the availability of selected health care services (see Section 9.3.1) for HIV/AIDS, HCV, and STIs provided by Treatment Programs within CTN CTPs, in order to understand the breadth of infectious disease health care services in these service settings.
- *CTP Characteristics* - To describe the context in which each CTN CTP Treatment Program operates with respect to agency incorporation, local infectious disease prevalence, participant characteristics, staff characteristics, funding, disease knowledge, service practices, program guidelines, and opinions in order to understand the systemic factors that may contribute to the breadth of infectious disease health care services provided, and the perceived barriers.
- *Clinician Characteristics* - To describe the context in which each Treatment Program clinician operates with respect to clinician disease knowledge, training, service practices, clarity of guidelines, and opinions, in order to understand the clinical provider's preparation, capacity, and experience with infectious disease service delivery in CTN CTP drug treatment settings.
- *Opinions* – To describe the agency administrator and clinical staff opinions regarding the provision of infectious disease health services, in order to understand the perspective of administrators and clinicians in the CTN CTP drug treatment settings.
- *Perceived Service Barriers* -To describe the agency administrator and clinical staff perceived barriers to providing health care services for HIV/AIDS, HCV, and STIs in CTN CTP drug treatment settings, in order to understand the possible factors limiting the availability of infectious disease health care services in these settings.
- *Regulatory Guidelines* - To describe the policy and practice guidelines for the health care services for HIV/AIDS, HCV, and STIs from the state-level regulatory agencies with jurisdiction over CTN CTPs, in order to understand the range and level of mandate for infectious disease health care services in these drug treatment settings.
- *Variable Associations* - To describe the associations between the availability of selected services (see Section 9.3.1) and other factors such as, perceived barriers, regulatory guidelines, Treatment Program characteristics, and opinions, in order to generate hypotheses for future investigations.

4.0 STUDY DESIGN

This is a cross-sectional, descriptive and exploratory study of the range of available services associated with targeted infections in substance abuse treatment settings within the NIDA CTN. The study will utilize three different standardized questionnaires for three different participant populations (administrators of CTN CTP Treatment Programs, clinicians in CTN CTP Treatment Programs, and administrators of state substance abuse and health departments). All three components will be designed to uncover factors that describe CTP Treatment Programs with respect to practices associated with HIV/AIDS, HCV, and STIs.

The findings of this study have the potential to fuel hypotheses for health services research, health outcome studies, or other scientific endeavors.

5.0 STUDY POPULATION

5.1 Number of Sites and Subjects

All of the more than 300 Treatment Programs that are part of the over 100 CTPs in the National Institute on Drug Abuse Clinical Trials Network are invited to participate in the protocol. Every effort will be made to encourage complete participation of all Treatment Programs within the CTN.

A program director or manager (aka Treatment Program administrator) at each Treatment Program will be asked to complete a program survey to report site-specific information.

Up to a maximum of 10 randomly selected clinicians, along with designated clinical experts at each Treatment Program, will be asked to complete a survey to assess their knowledge, opinions and behaviors related to HIV/AIDS, HCV and STI screening, testing/diagnosis, treatment and monitoring.

The administrators of state substance abuse and health departments will be surveyed about policies, mandates and funding within their jurisdiction for HIV/AIDS, HCV and STI screening, testing/diagnosis, treatment and monitoring.

In summary, we anticipate the participation of more than 300 Treatment Program administrators, more than 3,000 Treatment Program clinicians, and 100 administrators of state health or substance abuse agencies.

5.2 Duration of Study and Visit Schedule

The duration of this study will be contingent upon the length of time necessary to train Node Protocol Managers, to obtain local IRB approval or waiver, to inform participants about the objectives of the survey, and a one-time administration of the survey to the study population. Therefore, there is one visit with the study population. Based upon this, we anticipate the duration of the study to be a year or less.

5.3 Inclusion Criteria

Entry to this study is open to both men and women, and to all racial and ethnic subgroups. Eligibility is not limited to persons with any specific health risk or disease. This protocol will collect data from drug abuse treatment program administrators and the clinicians in the programs.

Inclusion criteria are:

1. Administrators of Treatment Programs within CTPs of the NIDA CTN, or,
2. Clinicians (medical and non-medical direct care providers) of Treatment Programs within CTPs of the NIDA CTN, or
3. Administrators of single state substance abuse and health departments.

5.4 Exclusion Criteria

The exclusion criteria are: persons who are unwilling to participate in the study.

6.0 STUDY ASSESSMENTS AND PROCEDURES**6.1 Study Surveys**

The assessments being used in the study are three surveys—one for Treatment Program administrators, one for Treatment Program clinical staff and one for state administrators. A diagram of the three surveys is given in the table below and the specific questions on each survey are given in Appendices E, F and G. The Treatment Program Administrator survey has sections entitled Structure and Service Setting, Patient Characteristics, Staffing, Reimbursement, Practice, Program Guidelines, Barriers, and Opinions. The Treatment Program Clinician survey has sections on Knowledge, Behavior, Program Guidelines, Barriers, and Opinions. The State Administrator survey has sections on Policies/Regulations and Reimbursement.

Questions and Variables	SURVEY A: Treatment Program Administrators	SURVEY B: Treatment Program Clinicians	SURVEY C: State Administrators
REIMBURSEMENT			
A. By Type of Source	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. By Type of Service	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
STAFFING	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PATIENT CHARACTERISTICS			
A. Percent with HIV or Risk Factors for HIV	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Percent with HCV or Risk Factors for HCV	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Percent with STIs or Risk Factors for STIs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KNOWLEDGE			
A. Risk Behaviors	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
B. Screening Methods	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
C. Diagnostic Methods	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
D. Treatments/Monitoring	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
OPINIONS			
A. Regarding HIV/AIDS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
B. Regarding HCV	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
C. Regarding STIs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Questions and Variables	SURVEY A: Treatment Program Administrators	SURVEY B: Treatment Program Clinicians	SURVEY C: State Administrators
PRACTICES/POLICIES			
A. Educational Programs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. Counseling	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. Risk Assessments	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Screening/Diagnostic Tests	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. Medical Hx/Physical Exam	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. Treatments/Monitoring	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Abbreviations and definitions used in these surveys and the protocol are found on pages 4, 5 and 6 of this protocol. This study will not involve any biomedical or behavioral intervention. However, the results of this study have the potential to suggest interventions that may be useful to overcome any detected challenges and obstacles.

6.2 Selection of Node Protocol Manager

Each node will be asked to identify a Node Protocol Manager for this protocol. This person will be the node liaison and the individual who coordinates study implementation with the New York Node. Node Protocol Managers will be trained and will help in the recruitment and enrollment of the CTPs, and will assist and encourage the completion of study surveys. The Lead Node in collaboration with other nodes will recruit the state agencies through professional organizations [i.e., National Association of State Drug and Alcohol Directors (NASDAD)] and public agencies.

The Node Protocol Manager will identify the individual Treatment Programs within their node that are willing to participate. For the purposes of this protocol, an individual Treatment Program is equivalent to a sub-site of a CTP (e.g., if CTP A has a methadone clinic, a drug-free clinic and a women's clinic, then CTP A has 3 individual Treatment Programs).

6.3 Information Sheet in Lieu of Informed Consent

An information Sheet, which explains the purpose of the survey and the benefits of participation, is offered for use instead of informed consent. We believe this study meets DHHS criteria for IRB waiver of informed consent [45CFR46.116(d)]. Specifically, (1) the research involves no more than minimal risk to the subjects; (2) the waiver or alteration will not adversely affect the rights and welfare of the subjects; (3) the research could not practicably be carried out without the waiver or alteration; and (4) whenever appropriate, the subjects will be provided with additional pertinent information after participation. We encourage requesting IRBs for a waiver of informed consent based on this.

The Node Protocol Managers will assist in the distribution of survey material, including the Information Sheet, an Introduction Letter, a Definitions sheet, and the appropriate survey.

6.4 Administration of Study Surveys

Every CTP in each of the NIDA CTN nodes will be asked to participate in these surveys. As with any CTN project, participation is entirely voluntary for both nodes and individual Treatment Programs. However, 100% participation is our objective, and we will do everything possible to reduce the barriers to participation. We will compensate CTPs for their time and inconvenience to complete the survey, using the usual practice within the NIDA CTN whereby the RRTCs negotiate with CTPs within their CTN nodes to come to a mutually agreed upon rate of compensation for their Treatment Program administrators and clinicians. State officials will not be compensated.

Administrators of Treatment Programs will be asked to complete the Treatment Program Administrator survey, and list their medical and non-medical clinicians and experts. Up to 10 randomly selected members of the clinical staff at these programs will be asked to complete the Treatment Program Clinician survey, in addition to the identified experts, all of whom will also be asked to complete the Treatment Program Clinician survey. Similarly, administrators of state substance abuse and health departments will be asked to complete the State Administrator survey.

A self-addressed, stamped postcard will be included with each survey delivered to a respondent. The postcard requests the respondent to notify the Data Management Center (DMC) of the preferred method by which a representative from DMC may contact the respondent if a data related question arises. The postcard should be completed and mailed immediately upon receipt. The postcard will be used by the DMC to log the receipt of surveys and to contact respondents in the event of overdue submission of completed surveys. When a survey is not returned within 10 days of receipt, a representative from the DMC will initiate 4 attempts (by the method preferred by the respondent) to contact the tardy respondent within a two week time period. A respondent who fails to respond to these tracking attempts will be considered a 'non-responder'. If the respondent is among the randomized staff members, the next eligible respondent on the randomization list will be sent a survey. Surveys received by non-responders will be entered into the database, but flagged as having been contributed by a 'non-responder'.

7.0 FIELD TEST

The Treatment Program Administrator and the Treatment Program Clinician surveys have been subjected to extensive field tests involving Treatment Program administrators and clinicians. Participants in the field tests provided important feedback about various aspects of the surveys. More importantly, participants expressed agreement with the purpose of the study and interest about various aspects of the surveys (for example, curiosity about the

answers to the knowledge questions). These field tests resulted in further clarification of the content and wording of the surveys and in substantiation of the estimates used in this protocol of the time required for completion of the surveys. We envision further field-testing to continue to refine survey instruments.

8.0 ASSESSMENT AND REPORTING OF ADVERSE EVENTS

Since this study is limited to the completion of a questionnaire, the occurrence of adverse events is unlikely, and no standardized form will be developed for reporting adverse events. Node Protocol Managers are expected to comply with both Good Clinical Practices and their Institutional Review Board's regulatory reporting requirements.

9.0 STATISTICAL CONSIDERATIONS

9.1 Sampling and Random Selection

For each of the fifty states, administrators of state health and substance abuse departments will be asked to complete the State Administrator survey.

Each Community Treatment Program (CTP) participating in the CTN will be asked to participate in this study. The Executive Director for each CTP will be asked to identify an administrator for each Treatment Program that might participate in a CTN protocol. Note that a CTP may have one or more different Treatment Programs (see definitions for more details) that might participate. Each administrator of a Treatment Program will be asked to complete the Treatment Program Administrator survey.

For each Treatment Program, up to 10 members of the clinical staff will be asked to complete the Treatment Program Clinician survey. In cases where an individual Treatment Program has less than 10 clinical staff members, all members will be asked to participate. In cases where an individual Treatment Program has more than 10 clinical staff members, the New York Node Data Management Center will randomly select 10 members. Randomization will be performed in such a way as to ensure that the proportion of medical to non-medical staff reflects the composition of the Treatment Program as closely as possible (see below). In addition to the randomly selected clinical staff members, all experts (as designated by the Treatment Program administrator) will be asked to complete a Treatment Program Clinician survey. Any participant has the right to refuse to complete the survey. In Treatment Programs having more than 10 non-expert clinicians, those who fail to return a survey after four (4) attempts at contact within a two-week period will be replaced with another clinician of the same type: medical or non-medical. Experts cannot be replaced since all experts are being asked to complete a survey.

Selection of the clinical staff members will be based upon the following technique. The Node Protocol Manager will develop a list of all eligible medical and non-medical personnel from the Treatment Program administrator. This list will also designate

each individual as medical or non-medical; and, as an expert or non-expert. The subdivision into expert and non-expert is to ensure that programs that have only one individual who is an expert, is sampled and that any such programs are not misrepresented. Thus, each clinical staff member will fall into one of four categories: Medical expert, medical non-expert, non-medical expert or non-medical non-expert. The non-experts will be randomly ordered within their categories (medical or non-medical) using the Proc Plan procedure of the Statistical Analysis System (SAS). In order to ensure proportional representation, due to the relatively small number of individuals being sampled, the number of individuals selected from each stratum will be determined using a second implementation of SAS Proc Plan to sample medical or non-medical. To illustrate with a simple example, if a Treatment Program has 21 staff members, one of whom is designated as an expert, 5 as medical non-experts, and 15 as non-medical non-experts, then 7 non-medical and 3 medical non-experts may be chosen (to meet the proportional sampling ratio of approximately 75% non-medical). The first 7 non-medical experts and the first 3 medical non-experts from the random ordering of names created by the first SAS Proc Plan invocation will be asked to complete a survey.

9.2 Sample Size and Precision

Due to the exploratory nature of the protocol, sample size was not based on statistical test considerations. Instead, the following calculations show that the precision of the estimated mean is more than adequate when 10 clinicians per Treatment Program are randomly sampled.

Smith, et al (26) performed a survey of knowledge and opinions related to HIV. They had 1 question "My department does a good job of making AIDS education available" rated on a 5-point Likert scale (1=strongly agree to 5=strongly disagree) which was similar to questions on our survey. There were approximately 365 respondents with an overall mean of 2.62. Respondents were classified several ways: residents (n=46) versus attending physicians (n=149); physician (n=201) versus non-physicians (n=167); and, direct caregiver (n=260) versus non-direct caregivers (n=105). The mean response to the question was 2.91, 2.77, 2.80, 2.41, 2.68 and 2.47 for residents, attending physicians, physicians, non-physicians, direct caregivers and non-direct caregivers, respectively. The estimates of the standard deviation ranged from 1.135 to 1.137.

Using the information from Smith, et al, and using the assumptions on the number of Treatment Programs within the CTN (300), the following statements can be made about precision in the subgroups of clinic staff (medical or non-medical) when we select 10 per Treatment Program:

- A sample size of 500 produces a 95% confidence interval equal to the sample mean plus or minus 0.1 when the estimated standard deviation is 1.136.

- A sample size of 1500 produces a 95% confidence interval equal to the sample mean plus or minus 0.057 when the estimated standard deviation is 1.136.

The above statements were based upon determining precision for confidence intervals for one mean using PASS 2000 software (16). A value of 1500 would correspond to an equal number of medical and non-medical staff. A value of 500 would correspond to one-sixth of the estimated 3000 clinical staff surveys being for one subgroup (medical or non-medical). The same precision would be obtained if the number of experts were 500 or 1500.

9.3 Types of Analyses

The following sections will describe the analytic approach that will be used for one of the three diseases being examined in this protocol, namely Hepatitis-C. The same approach will be used for the other two diseases: HIV/AIDS and sexually transmitted infections. According to a recent article by Strauss, et al (31), there has been very little documented in the literature regarding drug Treatment Programs and their response to Hepatitis-C infection. In fact, their article is the only one that surveyed drug Treatment Programs in the United States. Unfortunately, their article was limited to drug-free Treatment Programs and was limited to a handful of questions asked over the phone with no time to prepare or provide more than a value within a category (e.g., 25-50%) in many cases.

9.3.1 Selected Service Areas

The three different surveys are intended to complement each other. Each of the surveys will ask for information about 8 selected service areas:

1. provider education,
2. patient education,
3. patient risk assessment,
4. medical history/physical examinations,
5. any type of biological testing,
6. patient counseling,
7. patient treatment, and
8. monitoring of patients.

9.3.2 Preliminary Checks

Prior to the analysis of any data we will generate the appropriate statistical and graphic presentations (frequency distributions, histograms, scatter-plots, box plots, etc.) of the distributions of values for each variable. These presentations will be used to identify potential outliers and to determine whether any questions were answered identically for all respondents.

9.3.3 Survey Response Rates

For the State Administrator survey, the response rates for the state health administrators and the substance abuse agency administrators will be determined separately and overall.

For the Treatment Program Administrator survey, the response rates for each node and overall will be reported.

For the Treatment Program Clinician survey, the response rates for each node and overall will be reported by clinician type (expert, medical non-expert and non-medical non-expert).

Frequencies and percentages will be used to achieve the above analyses. Any comparisons between nodes and or clinician strata will be descriptive in nature. No statistical tests will be used.

9.3.4 State Administrator Survey

The primary purpose of the State Administrator survey is to collect information regarding policies, regulations and funding related to the three diseases. The following are the questions we wish to answer regarding Hepatitis-C and the proposed analysis.

Do state health departments and/or substance abuse agencies provide any type of written guidelines related to Hepatitis-C? (Objective #6)

The responses from Section B (Policies/Regulations) will be summarized using frequencies and proportions by agency type and overall. Each of the eight targeted service areas will be summarized separately. For the overall summary, if either the state health department or the substance abuse agency provides any guideline then the state will be considered to provide a written guideline.

What types of funding exist in the state and what types of funding are available to substance abuse programs for Hepatitis-C (Objective #7)?

The responses from Section C (Reimbursement) will be summarized using frequencies and proportions, by agency type and overall, to determine the types of funding that exist in the state for each of the targeted service areas; and, the types of funding that exist in the state for substance abuse providers. It is possible that funding exists in the state, but not for substance abuse providers. Since Treatment Programs are substance abuse providers, this is an important distinction to make.

Do states that provide written guidelines for Hepatitis-C also provide funding for those services? (Objective #7)

The responses from Section C will also be summarized separately for those states that provide guidelines and those that do not using frequencies and proportions. A cross-tabulation will be performed to determine the frequencies and proportions. For example, among those states that provide written guidelines for patient risk assessment, the types of funding sources available in the state and the types of funding available to substance abuse providers

will be described. In addition, the proportion of states that have written guidelines but provide no funding will be determined.

What is the priority of state agencies related to Hepatitis-C services (Objective #7)?

The responses from Section D will be summarized two ways: one using frequencies and proportions and one using means and standard deviations. These summaries will be performed for the different agency types. An overall state summary will be performed by computing the average of the values for the different agencies within the state and then summarizing those values.

9.3.5 Treatment Program Administrator Survey

The primary purpose of the Treatment Program Administrator survey is to describe the Treatment Program modality, staffing, services, and clientele (Sections A, B, and C); the types of services offered (Section E) and reimbursement received (Section D) for the targeted service areas; and, the guidelines (Section F), barriers (Section G) and opinions from the administrator's perspective. The following are the questions we wish to answer regarding Hepatitis-C and the proposed analysis.

What are the types of Treatment Programs participating in the Clinical Trials Network; and, how are they staffed? (Objective #2)

The responses from Sections A (Structure and Service Setting) and C (Staff Characteristics) will be summarized using frequencies and proportions for categorical variables, and, using means and standard errors for continuous variables.

What are the characteristics of the clientele served by Treatment Programs in the CTN? (Objective #2)

The responses from Section B (Patient Characteristics) will be summarized using frequencies and proportions for categorical variables, and, using means and standard errors for continuous variables.

How are Treatment Programs reimbursed for the Hepatitis-C services they provide? (Objective #2) And, how do the reimbursement sources relate to the funding available (for Hepatitis-C) in their state? (Objective #7)

Reimbursement sources (Section D) will be summarized using frequencies and proportions, overall. In addition, cross-tabulations by state will be generated to make comparisons between sources of funding available to substance abuse providers in the state and actual sources of reimbursement received by the Treatment Program(s). It is possible that funding is available to the Treatment Program but they are unaware of the availability. Currently, Treatment Programs do not exist in all 50 states, so only a subset of states will be represented.

What are the services related to Hepatitis-C that are provided by the programs? (Objective #1) And, how do these services relate to the existence of Hepatitis-C guidelines and/or funding at the state level? (Objective #7)

The services provided (Section E-Practice) will be summarized using frequencies and proportions, overall. There are expected to be difference between methadone Treatment Programs and drug-free programs in the services provided. In addition, there are expected to be differences between in-patient and outpatient programs. Thus, *a priori* there are three categories of programs of interest. Summary statistics will be provided for these different categories (methadone [outpatient], drug-free in-patient, and drug-free outpatient) and descriptive comparisons made between them.

Cross-tabulations by state will be generated to make comparisons between whether a written guideline exists and the provision of the service. Similar cross-tabulations will be generated for the existence of a service and the availability of funding for the service. Any comparisons will be descriptive in nature (i.e., not inference-based).

How clear are the guidelines provided to Treatment Program staff regarding Hepatitis-C services? (Objective #2)

The responses from Section F (Program Guidelines) will be summarized two ways: one using frequencies and proportions and one using means and standard deviations. The means will help describe the overall clarity of guidelines from an administrator's perspective.

What do administrators feel are the barriers to providing Hepatitis-C services to their clients? (Objective #5)

The responses from Section G (Barriers) will be summarized using frequencies and proportions. We have *a priori* identified seven potential barriers: government regulations, Treatment Program policies, staff training, funding, health insurance benefits, client acceptance, and staff acceptance that are of interest. The most significant barrier identified by the administrators will also be summarized using frequencies and proportions.

What is the range of opinions of the Treatment Program administrators? (Objective #4)

The opinions of the Treatment Program administrators will be summarized two ways: one using frequencies and proportions and one using means and standard deviations. The means will help describe the overall agreement of administrators with the given statement. In addition, the importance that the administrators place on prevention and treatment of substance abuse and communicable diseases will also be summarized using frequencies and proportions; and, means and standard deviations.

9.3.6 Treatment Program Clinician Survey

The primary purpose of the Treatment Program Clinician survey is to determine the knowledge level (Section A) and behavior (Section B) of the clinicians. Another purpose is to determine the clarity of the program's guidelines (Section C), the barriers (Section D) and the opinions (Section E) from the clinician's perspective. The following are the questions we wish to answer regarding Hepatitis-C and the proposed analysis.

For responses from the Clinician's survey, summaries will be presented for the following groups: Medical, non-medical, expert and overall. Qualitative comparisons between the three groups will be performed, but no statistical inferences will be made. There is no desire to separate out medical and non-medical experts.

What is the level of knowledge of Treatment Program staff regarding Hepatitis-C? (Objective #3)

The responses from Section A (Knowledge) related to Hepatitis-C will be summarized using means and standard deviations for experts, medical non-experts, non-medical non-experts, and overall. There is no desire to create a validated scale for Hepatitis-C knowledge, so reliability analyses will be performed.

What are the range of services and treatment practices of Treatment Program staff related to Hepatitis-C? (Objectives #1 and 3)

The responses from Section B (Behavior) will be summarized using frequencies and proportions for the categorical variables (e.g., question 3) and using means and standard deviations for continuous variables (e.g., question 16).

How clear are the guidelines provided to Treatment Program staff regarding Hepatitis-C services? (Objective #6)

The responses from Section C (Program Guidelines) will be summarized two ways: one using frequencies and proportions and one using means and standard deviations. The means will help describe the overall clarity of guidelines from a clinician's perspective.

What do clinicians feel are the barriers to providing Hepatitis-C services to their clients? (Objective #5)

The responses from Section D (Barriers) will be summarized using frequencies and proportions. We have *a priori* identified seven potential barriers: government regulations, Treatment Program policies, staff training, funding, health insurance benefits, client acceptance, and staff acceptance that are of interest. The most significant barrier identified by the clinicians will also be summarized using frequencies and proportions.

*What is the range of opinions of the Treatment Program clinicians?
(Objective #4)*

In Section E (Opinions) of the Treatment Program Clinician survey, clinicians will be summarized two ways: one using frequencies and proportions and one using means and standard deviations. The means will help describe the overall agreement of clinicians with the given statement. In addition, the importance that the clinicians place on prevention and treatment of substance abuse and communicable diseases will also be summarized using frequencies and proportions; and, means and standard deviations.

9.3.7 Association Between Availability of Services and Other Variables

In order to determine which factors help discriminate between Treatment Programs that offer a service and those that do not, Logistic or Polytomous Logistic regression techniques will be used. Two example questions are given below and the analytic technique described.

Both a forward and backward step-wise procedure will be used for selection of variables in the model. The forward procedure selects the most highly predictive variables first, while the backward procedure removes the least predictive variables first. The backward procedure permits inclusion of variables that together may be more predictive, but individually are less predictive. Ideally, the two strategies will provide the same answer; however, the results from the two will be compared for consistency and interpretability. For both stepwise procedures, the steps and recommendations given in Hosmer and Lemeshow, Section 4.3, pp. 106-118, (17) will be used.

Since this is an exploratory study with no published information on what might influence availability of a service, we will screen potential variables using a p-value of 0.15 for entry of variables and a p-value of 0.20 for removal of variables (as recommended by Hosmer and Lemeshow). Although the ability to screen a potentially large number of variables quickly is considered one of the strengths of stepwise logistic regression, such screening is also likely to result in a number of variables being selected by chance alone. We will examine, together with subject matter experts, any variables selected to ensure that inclusion of the variable(s) in a final model is meaningful.

We anticipate screening as many as 50 variables for inclusion in a model. However, the descriptive statistics for the variables may eliminate some, and the correlation between variables may eliminate others. Our goal is to obtain a parsimonious model with a few main variables (maximum of 7 variables); and then consider interaction terms.

After reduction of the possible variables using descriptive statistics and a manual examination of the correlation matrix, we will use Classification and Regression Tree (CART) procedures to further reduce the number of potential variables being considered in the stepwise logistic regression analyses.

CART procedures classify individuals into the number of groups requested by considering all possible variables at each step. The first step, selects the one variable that best classifies subjects into the requested number of groups. Then for each of those groups, the process is repeated. Using this type of procedure creates a “tree” of variables and classifications. The path leading to the group classifications will inform us of which are the potentially most useful variables to include in the stepwise logistic regression.

Example 1: Why is Hepatitis-C testing offered in some Treatment Programs and not in others? That is, what are the factors that discriminate between Treatment Programs that offer Hepatitis-C testing to new clients and those that do not? (Objective #7)

A logistic regression will be performed. The dependent variable will be the testing of new patients for hepatitis (yes/no).

The independent variables will be characteristics of the program (Sections A & C of the Treatment Program Administrator survey), characteristics of the clientele served (Section B of the Treatment Program Administrator survey), guidelines provided by the state (Section B of the State survey), and funding (Section C of the State survey and Section D of the Treatment Program Administrator survey). Of particular interest are: state reimbursement policies, staffing patterns, prevalence of injecting drug use history among patients, availability of trained counselors, and referral agreements.

A final group of independent variables will be selected and fitted into the logistic regression model. Although we will test for multi-collinearity, it is likely that such will be too large and we will be unable to draw conclusions about the relative impact of individual variables. Rather, we anticipate making statements such as “in our analysis, the following small group of factors (i.e., the variables selected by stepwise regression) together, had the greatest association with the availability of service x.

Example 2: What are the factors that discriminate between Treatment Programs that perform a behavioral risk assessment and those that do not? (Objective #7)

A polytomous logistic regression will be performed. The dependent variable will be the performance of a behavioral risk assessment (Yes, all clients; Yes, “high risk” only clients, No clients).

The independent variables will be characteristics of the program (Sections A & C of the Treatment Program Administrator survey), characteristics of the clientele served (Section B of the Treatment Program Administrator survey), guidelines provided by the state (Section B of the State survey), and funding (Section C of the State survey and Section D of the Treatment Program Administrator survey). Of particular interest are: state reimbursement policies,

staffing patterns, prevalence of injecting drug use history among patients, availability of trained counselors, and referral agreements.

9.3.8 Similarity of Treatment Program Administrator and Treatment Program Clinician Ratings

In order to determine if administrators and clinicians have similar views on the clarity of guidelines, opinions, and barriers, a comparison of the results of the two surveys will be performed.

Do administrators and clinicians rate the clarity of the guidelines similarly overall? (Objective #3)

The following mixed effects model will be used:

$$Y_{ijk} = \mu_k + a_j + b_i + \gamma_1 I_A + \gamma_2 I_E + \gamma_3 I_M + \varepsilon_{ijk}$$

where Y_{ijk} is the response by Rater i in Treatment Program j for clarity question k ; μ_k is the mean for question k , a_j is the random effect for Treatment Program j , b_i is the random effect for Rater i , γ_1 , γ_2 , and γ_3 are the fixed effects for being an Administrator (I_A), expert (I_E) or medical non-expert (I_M), respectively and ε_{ijk} is the error term. The responses for question k will be limited to the 5-point Likert scale, eliminating the choices of “Do not know” and “Have no guidelines.”

The model will be fit using mixed effects models with Treatment Program and Rater as random effects. The fixed effects will be the indicator variables for Administrator, Expert, and Medical non-expert, relative to non-medical non-expert. Since raters from the same Treatment Program are expected to have correlated responses, each Treatment Program will be a different cluster, with a compound symmetric structure.

If we find that they are not similar overall, we will examine the individual questions to determine where the dis-similarities occur. A positive value for the parameter estimate of I_A indicates that administrators rate higher than non-medical non-experts. The use of contrast statements will further examine the overall similarity between raters. In particular, $\gamma_1 - (\gamma_2 + \gamma_3)/2$ compares the response of the administrator to the average response of the clinicians. If this is not different from zero, then administrators and clinicians tend to rate the clarity of guidelines similarly.

Do administrators and clinicians have similar opinions? (Objective #3)

The same type of analysis as was performed for clarity of guidelines will be performed for opinions.

*Do administrators and clinicians select the most significant barrier similarly?
(Objective #3)*

To examine the differences between administrators and clinicians selections on the most significant barriers for each targeted service, the following model will be fit using generalized estimating equations (Diggle, Liang & Zeger [10]):

$$P(Y_{ij} = k) = \mu + a_j + b_i + \gamma_1 I_A + \gamma_2 I_E + \gamma_3 I_M + \varepsilon_{ij}$$

where $P(Y_{ij} = k)$ is the probability that rater i in Treatment Program j selected barrier k ; μ is the overall mean, a_j is the random effect for Treatment Program j , b_i is the random effect for Rater i , γ_1 , γ_2 , and γ_3 are the fixed effects for being an Administrator (I_A), expert (I_E) or medical non-expert (I_M), respectively and ε_{ij} is the error term. Generalized estimating equations are proposed so that a robust variance estimator for correlated data can be obtained.

Treatment Program and Rater will be random effects in the model. The fixed effects will be the indicator variables for Administrator, Expert, and Medical non-expert relative to non-medical non-expert. Since raters from the same Treatment Program are expected to have correlated responses, Treatment Program will be the cluster; and we will use a compound symmetric structure.

10.0 STUDY TIMETABLE

Estimated study start date	March, 2003
Estimated date when 50% of subjects will be completed	August, 2003
Estimated study end date	December, 2003

11.0 DISCONTINUATION OF STUDY

The study may be discontinued or terminated at any time if, in the opinion of the investigator, the IRB, the CTN Steering Committee, the DSMB or NIDA, 1) continuation of the study would present a serious risk to the participants or 2) for other administrative reasons.

12.0 DISCLOSURE OF DATA

It is understood by the investigator that the information and data included in this protocol may be disclosed to and used by the investigator's staff and associates as may be necessary to conduct this study.

The NIDA CTN Data and Safety Monitoring Board, NIDA CTN contracted Clinical Monitors, representatives from the Lead Investigator's Node, and Quality Assurance representatives from the participating node, will be given access to facilities and records to review and verify data pertinent to the study.

All investigators will allow representatives of the sponsor to periodically audit, at mutually convenient times during and after the study, all regulatory documents. These monitoring visits provide the sponsor with the opportunity to evaluate the progress of the study and to inform the sponsor of potential problems at the study sites. The monitors will assure that all essential documentation required by good clinical practices guidelines are appropriately filed.

13.0 ADHERENCE TO ETHICAL, REGULATORY AND ADMINISTRATIVE CONSIDERATIONS

FDA Form 1572

This study does not involve the use of investigational drugs, so this form is not applicable. The ethical and regulatory requirements must be observed to comply with Principles of Good Clinical Practice for the conduct and monitoring of clinical investigations. By signing this protocol, the investigator agrees to adhere to these requirements.

IRB Approval

We encourage expedited review by the Institutional Review Boards (IRB) for each participating study site (Community Treatment Program) of this protocol and waiving of informed consent. A copy of the IRB approval letter(s) must be sent to the NY Lead Node regulatory office, along with a copy of the site's current IRB membership list and assurance number, prior to study initiation. The IRB approval letter should include the version dates of the protocol. A copy of the annual IRB approval is also required for the Lead Node.

Certificate of Confidentiality

Because the study participants do not represent a vulnerable population, this section is not applicable.

Investigator Qualifications

Curriculum vitae or other statement of qualifications and applicable licenses for study personnel should be kept in the regulatory binder for each participating site.

Training

In addition to study-specific training, all study personnel having direct contact with research participants are required to complete Good Research Practice training, as well as a training course for the responsible conduct of research involving human participants.

14.0 DATA ACQUISITION AND MANAGEMENT OVERVIEW

The New York Node will coordinate data acquisition and management activities and provide ongoing consultation and assistance to participating nodes throughout the study. Because the Infections and Substance Abuse protocol is a survey-based study, the data acquisition and management approach will be different from most CTN studies.

The New York Node will have responsibility for the distribution and performance of all required data acquisition and management activities for the State Administrator surveys. The New York Node will provide a web-based data acquisition and management system that can be used to process information from the Treatment Program Administrator and Treatment Program Clinician surveys for all participating nodes and Community Treatment Programs (CTPs). In accordance with the CTN informatics model, participating nodes may develop their own data acquisition and management system. If nodes choose to develop their own system, the node Data Management Center will be responsible for the necessary procedures for collecting data, ensuring data timeliness and accuracy, error checking and data quality assurance. Node system development and data management operations must be conducted in accordance with the policies and standard operating procedures published by the NIDA CTN Data Management and Analysis Subcommittee (DMAS). The New York Node Data Management Center will provide all specifications required for nodes to develop their own automated data acquisition and management system.

The New York Node will provide both traditional paper-based surveys and the capability to directly enter (paperless) surveys into a centralized web-based data acquisition and management system for the Infections and Substance Abuse protocol. Using the web-based system will allow other CTN nodes to participate in this protocol with minimal technical development and minimal costs if their CTPs have access to the Internet. In addition to these cost savings, the time from collection to the storage of final, "clean" data in the study database will be minimized and data quality should be enhanced. Additionally, it is anticipated that some CTP staff will perceive the web-based system as preferable to the paper-based method due to perceptions of enhanced confidentiality. If CTPs do not have Internet access or choose not to use Internet access, the paper surveys will be sent to the New York Node Data Management Center for processing. Processing survey data via the New York Node web-base data acquisition and management system relieves participating nodes and CTPs of the data processing and data quality assurance burden.

Confidentiality

Maintaining data confidentiality and privacy will be a primary and essential goal of the protocol data management process. No identifying data from either the survey respondents or from the CTP Treatment Programs will be recorded on the surveys or stored in the study

database. Each CTP Treatment Program and survey respondent will be assigned a unique indecipherable code. The New York Node will use the identical coding structure used by the Oregon Node for the Baseline protocol to code CTP Treatment Programs. The use of the same coding structure will provide the capability for data from the Baseline study to be used for data analytic purposes. Of course, appropriate Institutional Review Board approval will be required for the use of combined Baseline and Infections and Substance Abuse protocol data. Codes used cannot be duplicated within or across nodes. To protect the confidentiality of survey respondents, only New York Data Management Center personnel will know the identity of all CTPs, Treatment Programs, and survey respondents. New York Data Management Center personnel will need to know the identity of all CTPs, Treatment Programs, and survey respondents in order to rectify missing and problematic data, and to link data from the three different survey types for data analytic purposes. To assist and encourage the completion of surveys by Treatment Program administrators and clinicians, the Node Protocol Managers will know the identity of the CTPs, Treatment Programs, and survey respondents within their node, but will not have access to any survey data.

Data Collection

Each node will be asked to identify a Node Protocol Manager. The Node Protocol Manager will be the node liaison and the individual with whom the New York Node will coordinate study implementation. Node Protocol Managers will be responsible for facilitating data collection and communication with node CTPs and their Treatment Programs.

Node Protocol Managers will be responsible for obtaining the names of CTPs and Treatment Programs within the CTPs that will be participating in the study. The Node Protocol Manager will also be responsible for obtaining the contact information for the administrators of each Treatment Program and providing this information to the New York Node Data Management Center. The New York Node Data Management Center will be responsible for distributing packets containing instructions, clinician information requests, and surveys. The Treatment Program administrators will send clinician information and their completed surveys directly to the New York Node Data Management Center.

Clinicians will be randomly selected to participate in the clinician survey by the New York Node Data Management Center. The New York Node Data Management Center will prepare individual packets addressed to each clinician selected to participate. The New York Node Data Management Center will send the clinician survey packets to the address provided. The Node Protocol Manager will be responsible for clinician survey completion. Because different methods may work better at participating nodes, the methods used to complete the clinician surveys will be at the discretion of the Node Protocol Manager in consultation with the New York Node Data Management Center. All completed surveys will be returned to the New York Node Data Management Center.

The New York Node Data Management Center in conjunction with Node Protocol Managers will track the survey return rates and inform the Node Protocol Manager of outstanding surveys. The Node Protocol Manager will be responsible for contacting and following up each participant who has not submitted their survey.

Upon receipt of the completed surveys, both paper and web-based, the New York Node Data Management Center personnel will review each survey for data completeness. New York Data Management Center personnel will contact survey respondents to resolve any general data issues. After all general data issues have been resolved, New York Node Data Entry Specialists will enter the survey data into the web-based automated data acquisition and management system. Completed surveys will be processed in accordance with Data Timeliness and Completeness Standard Operating Procedure (SOP) published by the CTN Data Management and Analysis Subcommittee.

The New York Data Management Center will implement comprehensive error checking/tracking, data quality assurance and management procedures. Comprehensive automated error checking/tracking and data quality assurance programs will be run each day to attempt to resolve any data issues as close to the completion of each survey as possible. Error check/tracking will be conducted in accordance with the Error Checking and Tracking Standard Operating Procedure published by the CTN Data Management and Analysis Subcommittee. Data quality assurance procedures will be implemented as specified in the Data Accuracy and Auditing Standard Operating Procedure (SOP) published CTN Data Management and Analysis Subcommittee.

Automated Data Acquisition and Management System

The New York Node uses the Nathan Kline Institute web-based Clinical Trial System (CTS 2). CTS 2 is based upon a secure Internet client/server technical architecture. All communication or data transmissions between the node and the NKI network will be encrypted using 128-bit Secure Socket Layer (SSL) encryption to insure the security of data.

Online edits are immediately performed when data is entered. Checks for illogical, out of range, and inconsistent values for each data element are performed as well as within survey logic checks. Where possible, warning messages or error messages are displayed on the screen at the time of data entry. This allows the person entering data to immediately correct the error or enter the missing data, thus saving the more time consuming task of rectifying data issues at a later time. In addition to the online edits discussed above, data error checking across the entire database is performed each night. Error reports are available online to the New York Data Management Center personnel each morning to resolve missing and problematic data. In addition, reports indicating what surveys have not been entered and specific surveys with problematic data are available as well as numerous other data management reports.

Security Measures

The New York Node Data Management Center uses several layers of security measures to insure that only authorized users can access databases and programs. Initial access from the "outside world" (e.g., over the Internet) is controlled by a Raptor Eagle firewall. This blocks unauthorized access to the NKI Local Area Network (LAN) and its servers by any unauthorized user originating from the Internet by using a sophisticated combination of secure application proxies and packet filtering. Once access to the NKI network has been obtained, users must go through the process of authentication by providing a valid user identification code (ID) and password to access any resources on the network. User IDs and

passwords are assigned and controlled by the New York Node Data Management Center. User IDs and passwords provide access to specific databases and programs. Other than individual survey respondents having access to their own survey data, only New York Node Data Management Center personnel will have access to the study databases to protect the confidentiality of Treatment Programs and survey respondents. In addition, each user is assigned authorization to perform specific functions within a database, which may include enter, modify, delete and/or view data. For example some personnel will only be authorized to read data. Other personnel may be permitted to enter, delete, modify and read data. An electronic audit trail maintains a permanent database record of which personnel entered each data element as well as which personnel changed or deleted the data. In addition, the audit record documents the field(s) changed and the value of the field(s) prior to the change. No data is permanently deleted from the system.

The building at NKI is a locked facility and has twenty-four (24) hour security to insure physical security at all times. The NKI hardware, software, master libraries, tapes, etc. are located in a locked room with access by authorized personnel only. Only employees with computerized access cards can enter the computing facilities and authorized access is strictly enforced. An Uninterrupted Power Supply (UPS) protects all computing equipment. Smoke and fire detectors, as well as fire suppression equipment are maintained within the locked computing facilities. Daily, weekly, monthly, quarterly and yearly database back-ups are maintained that permits recovery of all study data to within a period of twenty-four hours of a disaster. Off site storage of weekly, monthly, quarterly and yearly database back-ups is maintained.

Central Data Repository

Data will be transmitted by any node data management center that is operating a data acquisition system for the Infections and Substance Abuse protocol to the NIDA central data repository on the first day of every month. The New York Data Management Center will receive data from the NIDA central data repository on a monthly basis for data completeness, timeliness and accuracy quality assurance review. At the completion of the study, all data will be transmitted from the NIDA central data repository to the New York Node Data Management Center for data analysis and the development of the final study report. The New York Data Management Center will send the final analysis dataset to NIDA for storage and archive.

15.0 REFERENCES

1. Battjes RJ, Pickens RW, Brown LS. HIV infection and AIDS risk behaviors among injecting drug users entering methadone treatment: an update. *J Acquir Immune Defic Syndr Hum Retrovirology* 1995; 10:90-6
2. Belongia EA, Danilia RN, Angamuthu V, et al. A population-based study of sexually transmitted disease incidence and risk factors in human immunodeficiency virus-infected people. *Sex Transm Dis* 1997; 24:251-6
3. Benhamou Y, Bochet M, Di Martino V et. al. Liver fibrosis progression in human immunodeficiency virus and hepatitis C virus coinfecting patients. The Multivirc Group. *Hepatology* 1999 Oct 30(4):1054-8.
4. Booth RE, Watters JK, & Chitwood DD. HIV risk-related sex behaviors among Injection drug users, crack smokers, and injection drug users who smoke crack. *American Journal of Public Health* 1993; 83(8):1144-1147.
5. Broers B, Junet C, Bourquin M, Deglon JJ, Perrin L, Hirschel B. Prevalence and incidence rate of HIV, hepatitis B and C among drug users on methadone maintenance treatment in Geneva between 1988 and 1995. *AIDS* 1998; 12: 2059-66
6. Brunton C, Kemp R, Raynel P, Harte D, Baker M. Cumulative incidence of hepatitis C seroconversion in a cohort of seronegative injecting drug users. *New Zealand Medical Journal* 2000; 113:98-101
7. Chiasson MA, Stoneburner RL, Hilderbrandt DS, Ewing WE, Telzak EE, & Jafee HA. Heterosexual transmission of HIV-1 associated with the use of smokeable freebase cocaine (crack). *AIDS* 1991 ; 5:1121-1126.
8. Chomvarin C, Chantarsuk Y, Thongkrajai P, et al. An assessment and evaluation of methods for diagnosis of chlamydial and gonococcal infections. *Southeast Asian J Trop Med Public Health* 1997; 28:791-800.
9. Crofts N, Nigro L, Oman K, Stevenson E, Sherman J. Methadone maintenance and hepatitis C virus infection among injecting drug users. *Addiction* 1997; 92:999-1005.
10. Diggle PJ, Liang KY, and Zeger SL. *Analysis of Longitudinal Data*. Oxford University Press, Inc., 1994.
11. Fortenberry JD, Brizendine EJ, Katz BP, et al. Subsequent sexually transmitted infections among adolescent women with genital infection due to *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, or *Trichomonas vaginalis*. *Sex Transm Dis* 1999; 26:26-32.

12. Garcia-Samaniego J., Rodriguez M., Berengeruer J, Rodriguez-Rosado R, Carbo J, Asensi V & Soriano V. Hepatocellular carcinoma in HIV infected patients with chronic hepatitis C. *Am J Gastroenterol* 2001; 96:179-183.
13. Garfein RS, Doherty MC, Monterroso ER, Thomas DL, Nelson KE, Vlahov D. Prevalence and incidence of hepatitis C virus infection among young adult injection drug users. *JAIDS* 1998; 18 SUPPL 1:s11-9.
14. Gordon FD. Cost effectiveness of screening patients for hepatitis C. *American Journal of Medicine* 1999; 107:36S-40S.
15. Hartel, et. al. Methadone treatment protects against HIV infection : Two decades of experience in the Bronx, NYC. *Pub Health Report* 1998 ; 113(S1) : 107-15.
16. Hintze, J (2001). NCSS and PASS. Number Cruncher Statistical Systems, Kaysville, Utah.
17. Hosmer, DW and Lemeshow, S. Applied Logistic Regression. John Wiley & Sons, Inc., 1989.
18. Kissinger P, Clark R, Dumestre J, et al. Incidence of three sexually transmitted diseases during a safer sex promotion program for HIV-infected women. *J Gen Intern Med* 1996; 11:750-2.
19. Lapane KL, Jakiche AF, Sugano D, Weng CS, Carey WD. Hepatitis C infection risk analysis: who should be screened? Comparison of multiple screening strategies based on the national Hepatitis Surveillance Program. *American Journal of Gastroenterology* 1998; 93: 591-6.
20. Latt NC, Spencer JD, Beeby PJ, McCaughan GW, Saunders JB, Collins E, Cossart YE. Hepatitis C in injecting drug-using women during and after pregnancy. *Journal of Gastroenterology & Hepatology* 2000; 15:175-82.
21. Lorvich, et. al. Prevalence and duration of Hepatitis C among injection drug users in San Francisco, Ca. *Am J Pub Health* 2001; 91: 46-7.
22. Metzger DS, Navaline H & Woody GE. Drug abuse treatment as AIDS prevention. *Pub Health Report* 1998; 113(S1):97-106.
23. Needle RH, Coyle SL, Normand J, Lambert E & Casari H. HIV prevention with drug abusing populations - current status and future prospects: An introduction and overview. *Pub Health Report* 1998; 113(S1): 4-18.
24. NIH Consensus Statement: Effective Medical Treatment of Opiate Addiction. Vol 15 #6; Nov 17-19, 1997.

25. Poulin C, Alary M, Bernier F, et al. Prevalence of Chlamydia trachomatis, Neisseria gonorrhoeae, and HIV infection among drug users attending an STD/HIV prevention and needle-exchange program in Quebec City, Canada. *Sex Transm Dis*, 1999, 26:410-20.
26. Smith MU, Goudeau RE, Katner HP, and Farmer JT. Human immunodeficiency virus infection: Knowledge of the disease and opinions toward related issues and policies among health care workers in a low-incidence non urban hospital. *Southern Medical Journal* 1993, May 86(5):537-44.
27. Sorenson J, Copeland A. Drug abuse treatment as an HIV prevention strategy: A review. *Drug and Alcohol Dependence* 2000; 59: 17-31.
28. Soriano V, Kirk O, Antunes F, et al. The influence of hepatitis C virus (HCV) on the prognosis of HIV-infected persons: The EuroSIDA study. The 13th International AIDS Conference, Durbin, South Africa 2000.
29. Sparling PF. Introduction to sexually transmitted diseases and common syndromes. In Goldman L and Bennett JC editors. *Cecil Textbook of Medicine, 21st edition, v. 2*, 2000, 1738-1742.
30. Stary A. Correct samples for diagnostic tests in sexually transmitted diseases: which sample for which test? *FEMS Immunol Med Microbiol* 1999; 24:455-9.
31. Strauss, M, et al. A nationwide survey of hepatitis C services provided by drug treatment programs. *JSAT* 2002; 22: 55-62.
32. Tabrizi SN, Paterson BA, Fairley CK, et al. Comparison of tampon and urine as self-administered methods of specimen collection in the detection of Chlamydia trachomatis, Neisseria gonorrhoeae and Trichomonas vaginalis in women. *Int J STD AIDS* 1998, 9:347-9.
33. Thomas, Vlahov. Correlates of Hepatitis C virus infection among injection drug users. *Medicine* 1995; 74: 212-20.
34. Xu K, Glanton V, Johnson SR, et al. Detection of Neisseria gonorrhoeae infection by ligase chain reaction testing of urine among adolescent women with and without Chlamydia trachomatis infection. *Sex Transm Dis* 1998, 25:533-8
35. Zylberberg H and Pol S., Reciprocal interactions between human immunodeficiency virus and hepatitis C virus infections. *Clin Infect Dis* 1996, Nov 23(5):1117-25. Review.

16.0 PROTOCOL SIGNATURE PAGE**SPONSORS REPRESENTATIVE**

Typed Name	Signature	Date
_____	_____	_____

INVESTIGATOR (S)

I agree to conduct this clinical study in accordance with the design and specific provisions of this protocol and will only make changes in the protocol after notifying the sponsor.

I agree to personally conduct or supervise this investigation and to ensure that all associates, colleagues, and employees assisting in the conduct of this study are informed about their obligations in meeting these commitments.

I will ensure that the requirements relating to obtaining institutional review board (IRB) review and approval in 45 CFR 46 are met.

I agree to maintain adequate and accurate records and to make those records available for inspection in accordance with 45 CFR 46.

I will ensure that an IRB that complies with the requirements of 45 CFR 46 will be responsible for the initial and continuing review and approval of the clinical investigation. I also agree to promptly report to the IRB all changes in the research activity and all unanticipated problems involving risks to human subjects or others. Additionally, I will not make any changes in the research without IRB approval, except where necessary to eliminate apparent immediate hazards to human subjects.

Typed Name	Signature	Date
_____ Principal Investigator	_____	_____
_____ Sub-Investigator	_____	_____
_____ Sub-Investigator	_____	_____

17.0 AMENDMENTS

This amendment, 12.15.03: To facilitate distribution of clinician surveys, the protocol was revised on page 30 to read: “The New York Node Data Management Center will send the clinician survey packets to the address provided.” “Address provided” replaces “Node Protocol Manager.”

APPENDICES

Appendix A. Introduction Letters and Information Sheets

Community Treatment Program Director Introduction Letter- 0012

Dear Executive Director:

The National Institute on Drug Abuse Clinical Trials Network (NIDA CTN) has approved the collection of three levels of data from agencies in the CTN, and from substance abuse and health departments in your state. Your organization has been identified as a participant in the CTN. The purpose of this data collection is to facilitate a better understanding of the agencies that are involved in the CTN with regard to drug abusing patients with HIV/AIDS, hepatitis C and/or sexually transmitted infections. We realize that programs vary in size, complexity, philosophies, funding streams and regulatory mandates, and these attributes are likely to influence the adoption of treatment approaches. In order to collect this information about CTN members and their governing state agencies, and explore program influences, the following three surveys have been developed:

- Treatment Program Administrator Survey – administrators describe their organization and give details about patient characteristics and services provided.
- Treatment Program Clinician Survey – medical and non-medical clinicians having patient contact, whether “expert” or not, provide details on their characteristics, knowledge and beliefs related to the treatment of patients with these infections.
- State Administrator Survey - administrators of state substance abuse and health departments describe policies/ regulations, funding, and priorities.

You will be contacted by a Node Protocol Manager, and asked to provide the name of the Administrator of each Treatment Program within your organization. We will then contact them and provide survey materials, and get information about clinical staff so that we can survey them, as well. Your cooperation with the Node Protocol Manager, and encouragement of your staffs’ participation are critical to the success of this project.

Between state administrators, program administrators, and up to 10 or more clinicians from each Treatment Program, we will attempt to survey over three thousand persons.

Thank you in advance for your time.

Sincerely,

Lawrence S. Brown, Jr., MD, MPH
Lead Investigator,
Infections and Substance Abuse Study

Treatment Program Administrator Introduction Letter- 0012**Note: Read this document first**

There are a number of infections known to be associated with intravenous drug addiction. Many of these infections can be effectively prevented or treated. However, we believe that there are a number of hurdles that prevent effective education/counseling, screening, testing, treatment, and monitoring of these infections. If these hurdles can be identified, interventions can be devised allowing for more effective treatment. We believe that the hurdles can be demonstrated in a variety of spectra, including knowledge, opinion, policy, and funding. Interventions can be developed once the hurdles are identified more specifically. This study looks to identify those hurdles, and develop a database for future study and intervention.

Substance abuse is associated with a wide spectrum of medical disorders, including infectious diseases, resulting in excess morbidity and mortality in the United States. Epidemiological evidence demonstrates that substance abuse contributes significantly to the prevalence of the human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted infections (STIs). Among substance abusers, the rates for these infections are especially high; published studies exist demonstrating that 30-40% of injecting drug users are HIV infected, 70-90% have HCV infection, and 90% of some substance abusers have had at least one type of STI.

A group of treatment providers and researchers in the Clinical Trials Network (CTN) developed the surveys that can be found at https://www.rfmh.org/cts/ctn0012_survey/login/login.cfm web site. The purpose is to gain a better understanding of the scope of, and the challenges to identifying, diagnosing and evaluating persons in substance abuse treatment. The information gathered will be the basis for improving patient care.

Three different standardized surveys were developed for three different participant populations: 1) administrators of Treatment Programs within CTPs in the CTN, 2) clinicians of Treatment Programs within CTPs in the CTN, and 3) administrators of state substance abuse and health departments. These surveys have been developed to assess knowledge, opinions, practices, guidelines and policies for care and reimbursement for the treatment of HIV/AIDS, HCV, and STIs.

Your name was given to us by your CTP Director to receive a Treatment Program Administrator survey. In addition, we will attempt to get clinician surveys from up to ten medical and non-medical clinicians from your program, along with clinicians that you designate as experts. See the Definitions sheet at the web site to determine who constitutes your medical and non-medical clinicians, and to determine who qualifies as an expert.

Please provide a list of your entire clinician staff, including job position. This should be done prior to completion of the Treatment Program Administrator survey via web or paper form. Please also designate which clinicians on your list are your program's experts

Treatment Program Administrator Introduction Letter- 0012

or specialists in treating substance abusers who have, or are at risk for acquiring, HIV/AIDS, HCV and/or STIs. If you yourself qualify as an expert, please list yourself, and you will be sent a Clinician survey. If your program has ten or less total clinicians, we will try to survey all of them. As part of the study, we will attempt to survey all those clinicians that you indicate have the most expertise. If your program has more than ten non-expert clinicians, we will attempt to survey ten of them, randomly selected, in a proportion of medical to non-medical clinicians, which reflects the make-up of your program staff.

We are seeking to determine whether or not there is an association between Treatment Program factors (staffing, treatment modality, reimbursement, knowledge, and opinions) and Treatment Program practices. Also we would like to know the extent to which there is an association between state reimbursement policies, and other relevant regulations relating to these infections, and Treatment Program practices. As such, there are no “desirable” responses to survey questions, and any enhancements will not be of any benefit to you or your program.

The confidentiality and privacy of respondents will be maintained. No identifying data for either the survey respondents or the Treatment Programs will be stored in the study database and there will be no methodology to identify survey respondents or Treatment Programs from the database. Therefore, personnel at the New York Node of the Clinical Trials Network will be blind to the identity of the Treatment Programs and the survey respondents from all nodes. However, the protocol does require the linkage of clinician and administrator data from the same Treatment Program, and there must be a capability to rectify missing or problematic data. There must also be linkage of data between Treatment Programs from a given state, and the regulations and funding policies of the substance abuse and health departments of that state.

Please take time to respond at https://www.rfmh.org/cts/ctn0012_survey/login/login.cfm or you may complete a paper survey. You are encouraged to consult other staff members to ensure accurate data collection. The survey should take approximately 60 to 90 minutes to fill out.

Thank you in advance for your time.

Sincerely,

Lawrence S. Brown, Jr., MD, MPH
Lead Investigator,
Infections and Substance Abuse Study

IRB APPROVAL STAMP (if applicable)

TREATMENT PROGRAM ADMINISTRATOR SURVEY INFORMATION SHEET

TITLE: Infections and Substance Abuse, NIDA-CTN-0012

NODE PRINCIPAL INVESTIGATOR:

Name, affiliation, address, phone number

NODE PROTOCOL MANAGER/STUDY INVESTIGATORS:

Names w/affiliation, address, phone number

SPONSOR:

National Institute on Drug Abuse

LEAD INVESTIGATIVE SITE/LEAD INVESTIGATOR:

Addiction Research and Treatment Corporation (ARTC)

22 Chapel Street, Brooklyn, New York 11202

Lawrence S. Brown, Jr., MD, MPH, Lead Principal Investigator (718) 260-2915

PURPOSE:

The overall objective of this study is to describe the availability of services for human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hepatitis-C virus (HCV), and sexually transmitted infections (STIs) among Treatment Programs within Clinical Trials Network (CTN) Community Treatment Programs (CTPs). The portfolio of health services to be examined includes: provider education, disease awareness, patient risk reduction, patient education, active disease screening (biological testing and medical examinations), counseling, treatment or referral, and treatment monitoring. In addition, Treatment Program administrators and clinicians will be asked to report on barriers to the availability of these services that they perceive to exist in their respective settings.

PROCEDURES:

You have received a sealed envelope that contains an Introduction Letter (which should be read first), barcode, URL for the website, a Definitions sheet, this Information Sheet, a postcard requesting contact information, and a return envelope. Respondents are encouraged to complete the survey and provide clinician information using the Internet; directions to the web site are included. Completed paper surveys and/or clinician information should be sealed in the return envelope. Use the US mail to return the sealed envelope to the pre-printed addressee. The survey and clinician staff information can be completed in approximately 90 minutes.

RISKS AND DISCOMFORTS:

Risks associated with participation in the survey are minimal. The code numbers and sealed envelopes are designed to prevent potential disclosure to your employer. You may refuse to answer any questions that you do not wish to answer.

BENEFITS:

You may or may not personally benefit from participating in this study. However, by completing the survey, you may contribute new information that may help to improve services at substance abuse treatment programs.

ALTERNATIVES:

You may choose not to participate in this study. If you prefer not to participate, place the survey in the return envelope, seal, and return.

CONFIDENTIALITY:

Neither your name nor your identity will be used for publication or publicity purposes. A code number is the only mechanism used to identify respondents. Your name will never be attached to the responses. Unique identifiers are being used so that individual data can be linked for quality assurance purposes (missing data or incomplete forms). The list of identifiers is kept secure on a separate computer and controlled by individuals not associated with your Clinical Trials Network node. Data will be transmitted to the study sponsor, but names will not be released. Representatives of the study sponsor, the lead study site (ARTC), and personnel from the IRBs overseeing the research at the sites listed on page one may review research records, but names will not be attached to the records.

COSTS:

There are no costs associated with study participation other than the time required to complete the instrument.

LIABILITY:

It is not anticipated that there will be any injuries or adverse reactions from your participation in this study.

PARTICIPATION:

The Principal Investigator, Node Protocol Manager, and the investigators listed on page 1 will answer any questions you may have about this study.

Treatment Program Clinician Introduction Letter- 0012

Note: Read this document first

There are a number of infections known to be associated with intravenous drug addiction. Many of these infections can be effectively prevented or treated. However, we believe that there are a number of hurdles that prevent effective education/counseling, screening, testing, treatment, and monitoring of these infections. If these hurdles can be identified, interventions can be devised allowing for more effective treatment. We believe that the hurdles can be demonstrated in a variety of spectra, including knowledge, opinion, policy, and funding. Interventions can be developed once the hurdles are identified more specifically. This study looks to identify those hurdles, and develop a database for future study and intervention.

Substance abuse is associated with a wide spectrum of medical disorders, including infectious diseases, resulting in excess morbidity and mortality in the United States. Epidemiological evidence demonstrates that substance abuse contributes significantly to the prevalence of the human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted infections (STIs). Among substance abusers, the rates for these infections are especially high; published studies exist demonstrating that 30-40% of injecting drug users are HIV infected, 70-90% have HCV infection, and 90% of some substance abusers have had at least one type of STI.

A group of treatment providers and researchers in the Clinical Trials Network (CTN) developed the surveys that can be found at https://www.rfmh.org/cts/ctn0012_survey/login/login.cfm web site, and in your packet. The purpose is to gain a better understanding of the scope of, and the challenges to identifying, diagnosing and evaluating persons in substance abuse treatment. The information gathered will be the basis for improving patient care.

Three different standardized surveys were developed for three different participant populations: 1) administrators of Treatment Programs within CTPs in the CTN, 2) clinicians of Treatment Programs within CTPs in the CTN, and 3) administrators of state substance abuse and health departments. These surveys have been developed to assess knowledge, opinions, practices, guidelines and policies for care and reimbursement for the treatment of HIV/AIDS, HCV, and STIs.

Your name was given to us by your Treatment Program administrator to receive a Treatment Program Clinician survey. We will attempt to get clinician surveys from up to ten medical and non-medical clinicians from your program, along with clinicians designated as experts. See the Definitions sheet in your packet to determine who constitutes medical and non-medical clinicians, and to determine who qualifies as an expert.

We are seeking to determine whether or not there is an association between Treatment Program factors (staffing, treatment modality, reimbursement, knowledge, and opinions) and Treatment Program practices. Also we would like to know the extent to which there is an association between state reimbursement policies, and other relevant regulations relating to these infections, and Treatment Program practices. As such, there are no “desirable” responses to survey

Treatment Program Clinician Introduction Letter- 0012

questions, and any enhancements will not be of any benefit to you or your program.

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Please take time to respond at https://www.rfmh.org/cts/ctn0012_survey/login/login.cfm or you may complete a paper survey. The survey should take approximately 30 to 60 minutes to fill out.

Thank you in advance for your time.

Sincerely,

Lawrence S. Brown, Jr., MD, MPH
Lead Investigator,
Infections and Substance Abuse Study

IRB APPROVAL STAMP (if applicable)

TREATMENT PROGRAM CLINICIAN SURVEY INFORMATION SHEET

TITLE: Infections and Substance Abuse, NIDA-CTN-0012

NODE PRINCIPAL INVESTIGATOR:

Name, affiliation, address, phone number

NODE PROTOCOL MANAGER/STUDY INVESTIGATORS:

Names w/affiliation, address, phone number

SPONSOR:

National Institute on Drug Abuse

LEAD INVESTIGATIVE SITE/LEAD INVESTIGATOR:

Addiction Research and Treatment Corporation (ARTC)

22 Chapel Street, Brooklyn, New York 11202

Lawrence S. Brown, Jr., MD, MPH, Lead Investigator (718) 260-2915

PURPOSE:

The overall objective of this study is to describe the availability of services for human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hepatitis-C virus (HCV), and sexually transmitted infections (STIs) among Treatment Programs within Clinical Trials Network (CTN) Community Treatment Programs (CTPs). The portfolio of health services to be examined includes: provider education, disease awareness, patient risk reduction, patient education, active disease screening (biological testing and medical examinations), counseling, treatment or referral, and treatment monitoring. In addition, Treatment Program administrators and clinicians will be asked to report on barriers to the availability of these services that they perceive to exist in their respective settings.

PROCEDURES:

You have received a sealed envelope that contains an Introduction Letter (which should be read first), a copy of the survey, a Definitions sheet, this Information Sheet, barcode, URL for the website, a postcard requesting contact information, and a return envelope.

Respondents may complete the survey using the Internet; directions to the web site are included. Completed paper surveys should be sealed in the return envelope. Use the US mail to return the sealed envelope to the pre-printed addressee. The survey can be completed in approximately 30 to 60 minutes.

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ALTERNATIVES:

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CONFIDENTIALITY:

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COSTS:

There are no costs associated with study participation other than the time required to complete the instrument.

LIABILITY: It is not anticipated that there will be any injuries or adverse reactions from your participation in this study.

PARTICIPATION:

The Principal Investigator, Node Protocol Manager, and the investigators listed on page 1 will answer any questions you may have about this study.

State Administrator Introduction Letter- 0012

Note: Read this document first

There are a number of infections known to be associated with intravenous drug addiction. Many of these infections can be effectively prevented or treated. However, we believe that there are a number of hurdles that prevent effective education/counseling, screening, testing, treatment, and monitoring of these infections. If these hurdles can be identified, interventions can be devised allowing for more effective treatment. We believe that the hurdles can be demonstrated in a variety of spectra, including knowledge, opinion, policy, and funding. Interventions can be developed once the hurdles are identified more specifically. This study looks to identify those hurdles, and develop a database for future study and intervention.

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A group of treatment providers and researchers in the Clinical Trials Network (CTN) developed the surveys that can be found at XXXXXX website, and in your packet to gain a better understanding of the scope of, and the challenges to identifying, diagnosing and evaluating persons in substance abuse treatment. The information gathered will be the basis for improving patient care.

Three different standardized surveys were developed for three different participant populations: 1) administrators of Treatment Programs within CTPs in the CTN, 2) clinicians of Treatment Programs within CTPs in the CTN, and 3) administrators of state substance abuse and health departments. These surveys have been developed to assess knowledge, opinions, practices, guidelines and policies for care and reimbursement for the treatment of HIV/AIDS, HCV, and STIs.

We are seeking to determine whether or not there is an association between Treatment Program factors (staffing, treatment modality, reimbursement, knowledge, and opinions) and Treatment Program practices. Also we would like to know the extent to which there is an association between state reimbursement policies, and other relevant regulations relating to these infections, and Treatment Program practices

The confidentiality and privacy of respondents will be maintained. No identifying data for either the survey respondents or the Treatment Programs will be stored in the study

State Administrator Introduction Letter- 0012

database and there will be no methodology to identify survey respondents or Treatment Programs from the database. Therefore, personnel at the New York Node of the Clinical Trials Network will be blind to the identity of the Treatment Programs and the survey respondents from all nodes. However, the protocol does require the linkage of clinician and administrator data from the same Treatment Program, and there must be a capability to rectify missing or problematic data. There must also be linkage of data between Treatment Programs from a given state, and the regulations and funding policies of the substance abuse and health departments of that state.

Please take time to answer the survey at *Web address*, or you may complete a paper survey. You may need to consult other staff members to ensure accurate data collection. The survey should take approximately 60 to 90 minutes to complete.

Thank you in advance for your time.

Sincerely,

Lawrence S. Brown, Jr., MD, MPH
Lead Investigator,
Infections and Substance Abuse Study

STATE ADMINISTRATOR SURVEY INFORMATION SHEET

TITLE: Infections and Substance Abuse, NIDA-CTN-0012

SPONSOR:

National Institute on Drug Abuse

LEAD INVESTIGATIVE SITE/LEAD INVESTIGATOR/PROJECT MANAGER:

Addiction Research and Treatment Corporation (ARTC)

22 Chapel Street, Brooklyn, New York 11202

Lawrence S. Brown, Jr., MD, MPH, Lead Investigator (718) 260-2915

Steven Kritz, MD, Project Manager (718) 260-2955

PURPOSE:

The overall objective of this study is to describe the availability of services for human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hepatitis-C virus (HCV), and sexually transmitted infections (STIs) among Treatment Programs within Clinical Trials Network (CTN) Community Treatment Programs (CTPs). The portfolio of health services to be examined includes: provider education, disease awareness, patient risk reduction, patient education, active disease screening (biological testing and medical examinations), counseling, treatment or referral, and treatment monitoring. In addition, Treatment Program administrators and clinicians will be asked to report on barriers to the availability of these services that they perceive to exist in their respective settings.

PROCEDURES:

You have received a sealed envelope that contains an Introduction Letter (which should be read first), a copy of the survey, a Definitions sheet, this Information Sheet, barcode, URL for the website, a postcard requesting contact information, and a return envelope. Respondents may complete the survey using the Internet; directions to the web site are included. Completed paper surveys should be sealed in the return envelope. Use the US mail to return the sealed envelope to the pre-printed addressee. The survey can be completed in approximately 60-90 minutes.

RISKS AND DISCOMFORTS:

Risks associated with participation in the survey are minimal. The code numbers and sealed envelopes are designed to prevent potential disclosure to your employer. You may refuse to answer any questions that you do not wish to answer.

BENEFITS:

You may or may not personally benefit from participating in this study. However, by completing the survey, you may contribute new information that may help to improve services at substance abuse treatment programs.

ALTERNATIVES:

You may choose not to participate in this study. If you prefer not to participate, place the survey in the return envelope, seal, and return.

CONFIDENTIALITY:

Neither your name nor your identity will be used for publication or publicity purposes. A code number is the only mechanism used to identify respondents. Your name will never be attached to the responses. Unique identifiers are being used so that individual data can be linked for quality assurance purposes (missing data or incomplete forms). The list of identifiers is kept secure on a separate computer and controlled by individuals not associated with your Clinical Trials Network node. Data will be transmitted to the study sponsor, but names will not be released. Representatives of the study sponsor, the lead study site (ARTC), and personnel from the IRBs overseeing the research at the sites listed on page one may review research records, but names will not be attached to the records.

COSTS:

There are no costs associated with study participation other than the time required to complete the instrument.

LIABILITY:

It is not anticipated that there will be any injuries or adverse reactions from your participation in this study.

PARTICIPATION:

The Lead Investigator and Project Manager, listed on page 1 will answer any questions you may have about this study.

Appendix B. Training Plan

This protocol gathers information about agencies and opinions that employees of those agencies have about infections and substance abuse. It does not involve any intervention with clients of those agencies. Thus, no intervention related training is required.

The protocol does require that a member of each node perform certain activities. This core person in the Infections and Substance Abuse protocol is the Node Protocol Manager. The Node Protocol Manager serves as the liaison between the Protocol Development Team, the LI, Project Manager and Treatment Program clinicians and administrators at his/her node. As such, the manager needs to be both a “marketer” of the study and a resource person for questions about the survey, its content, and the consequences of filling it out.

Core Training: The protocol assumes that the Node Protocol Manager has completed the GRP training. No other common assessment battery training is required.

Protocol Training: Even though the protocol is a survey, there is information the Node Protocol Manager needs to know, and that information will be provided in a national training session. Material covered includes to the appropriate degree, the following issues:

- Purpose of the study
- Study design and methods
- A detailed understanding of each survey question and what it means
- A marketing orientation to familiarize the Node Protocol Managers to a standardized approach for engaging Treatment Program administrators and clinicians in the study
- Training in the use of the web-based questionnaire so that troubleshooting for computer problems can be easily done
- Follow-up procedures to obtain study data from non-responders.

To help Node Protocol Managers become comfortable with their roles and interactions with CTPs and staff, role-playing practice in eliciting participation in the project and in addressing common questions and concerns will occur during the training session. Areas of emphasis will be maintaining confidentiality, eliminating retribution from administrators and funding agencies, and discouraging embellishing of survey responses.

Length of Training: This training should take around 6 - 8 hours and would be a CTN-wide session at the most convenient location. Nodes should anticipate that the Node Protocol Manager needs to spend one day, plus travel, away from their node. Continuation training required would be done via conference calls. More detailed information about the logistics of training will occur as the protocol develops and those details are finalized. The majority of costs associated with the training would be the salary for one day plus travel costs. This training may take place during the protocol kickoff meeting.

Measurement of Competency: At the end of the training, the Node Protocol Managers will take a test to show that they have successfully learned the necessary body of knowledge. The Lead Node will keep Node Protocol Managers informed of any major changes in the treatment of these diseases that might affect their interaction with the CTPs. The Lead Node will send out updated information and there will be a short quiz attached to these updates to help ensure that this new material has been learned. Further, regularly scheduled conference calls will be used to discuss training related issues and implement solutions to address the issues that arise.

Replacement Training: The Lead Node will provide training for new Node Protocol Managers if that need occurs.

Implementation conference calls with Node Protocol Managers will take place as needed after the Protocol Review Board approves the protocol. The purpose of these calls is to familiarize the Node Protocol Managers with the study procedures, discuss any issues about the study implementation, and finalize details for the study's SOPs. The Lead Investigator and Project Manager will be available to answer any questions regarding the protocol.

Appendix C. Preliminary Quality Assurance (QA) Monitoring Guidelines and Checklist

The proposed QA Monitoring guidelines are for ensuring data accuracy, compliance with protocols, and regulatory/human safety requirements. Due to the uniqueness of this protocol, many of the procedures adopted by the CTN Quality Assurance Subcommittee have been modified. This is a preliminary plan and will be finalized prior to the start of the protocol.

A Regulatory Binder will be established for each node with the following sections:

- Protocol and amendments – This section will contain the final protocol approved by the CTN, as well as, any subsequent amendments to the protocol.
- Sample Information Sheet and Introduction Letters.
- Sample Surveys – This section will contain copies of the surveys being distributed within the node.
- IRB Correspondence – This section will contain all correspondence with local IRBs, including approval letters of the protocol, as required by the local IRB.
- Site-Sponsor Correspondence – This section will contain all correspondence between the local node and the NY Node.
- Telephone Communications Log – This section will document all discussions related to the protocol occurring on the telephone.
- Monitor Visit Log – This section will document all Quality Assurance visits, by the local node QA monitor or the NIDA selected monitor. This log will capture information on the date of the visit, the name and signature of the monitor(s), and the name and signature of the site representative(s).
- Monitor Reports – This section will contain copies of all monitoring reports prepared by the monitor. This section will contain documentation related to the findings, conclusions and any actions taken to correct deficiencies noted during a visit.
- Confidential Respondent Log – This section will indicate the location of the confidential respondent log. The log will document the existence of all individuals completing the surveys. The information contained on this log must be consistent with the assigned ID.

The following is a preliminary monitoring checklist.

Preliminary Monitoring Checklist

	YES	NO	Notes
Regulatory Binder:			
Protocol and Protocol Amendments			
Sample of all Surveys used in protocol			
IRB Correspondence (all correspondence to and from IRB)			
Site-Sponsor Correspondence (all correspondence to and from sponsor)			
Telephone Communications Log			
Monitor Visit Log			
Monitor Reports (copies of site visit reports)			
Other Correspondence			

Appendix D. Node Protocol Manager Job Description

The Node Protocol Manager plays a critical role for that node in managing/overseeing the data gathering for the Infections and Substance Abuse Study. The specific activities generally will fall into three main areas: Facilitating marketing of the Infections and Substance Abuse Study within the node; serving as the liaison with the Infections and Substance Abuse Study Project Manager and LI, and; serving as the contact point for people in the node in completing the Infections and Substance Abuse Survey forms. Specific responsibilities for these activities include:

Marketing the Infections and Substance Abuse Survey activity:

To get maximum participation in the Infections and Substance Abuse Survey, each node will have their own local expert (Node Protocol Manager) who can market the Infections and Substance Abuse Study to their CTP colleagues. A part of the marketing activity could include meeting with CTPs and RRTC to discuss the purpose, the data collection process, when data collection will start and generally how to complete the survey forms. This activity is very critical in gaining node wide CTP support for actively participating in the assessment activity.

Liaison with the Lead Node:

Two main levels of specific data coordination activities occur between the Node Protocol Manager and the Lead Node. One level includes frequent communications with the Substance Abuse and Infections Study Coordinating Center (New York University VA Hospital, New York Node) for issues relating to the specifics of the data collection for the three survey forms. These activities range from serving as a liaison between the CC and node in helping the administrative staff with questions concerning the interpretation of information requested for a specific question, serving as the CC contact point for validation of information or referring the request to the appropriate node person. Another level of liaison, and one with more oversight, involves communications with the Substance Abuse and Infections Study LI and/or Project Manager in the overall management/administration of the survey in the node, including identifying issues and solutions that support meeting the CTN survey objectives.

Administering Surveys:

The Node Protocol Manager is responsible for ensuring that a valid attempt has been made to provide Treatment Program administrators and clinicians with the surveys they need to complete, and providing assistance to the people filling out the forms, whether those forms are paper or web based. This also includes providing CTP directors and Treatment Program administrators and clinicians with their personal survey identifier.

Appendix E. Treatment Program Administrator Survey

Appendix F. Treatment Program Clinician Survey

Appendix G. State Administrator Survey