Form Approved

OMB No. 0920-New

Expiration Date: XX/XX/XXXX

Cooperative Re-Engagement Controlled Trial (CoRECT)

Attachment #8

Massachusetts Standard of Care Survey

Massachusetts Standards of Care Survey

Clinic: _____ Date Completed: _____/_____/_____

Name of Person Completing Survey: _____

Contact Information: _____

Telephone Email

1. Do you currently have a formal, written protocol in your clinic to contact patients who have missed appointments? 1☐ Yes 0☐ No

    a. If Yes, has this protocol been updated since [INSERT DATE OF LAST SURVEY] mm/yy?

2. Do you collection information regarding patient preferences for contact? 1☐ Yes 0☐ No
    2a.If Yes, where is this information kept
    1☐ Electronic health record
    2☐ Case management record
    3☐ Other: _____

3. If you have a protocol please indicate how patients are contacted, when outreach is initiated, how many attempts are made and over what time period patient contacts are attempted. If you do not conduct a specific type of outreach, write "N/A[9]"

Modality	3i. Initiation of Outreach (e.g. after every missed appointment, if no appointment in 6 months)	3ii. Frequency and Time Period (e.g. three attempts)	3iii. Time Period (ex. over 30 days)
3a.Telephone calls	1☐ Yes 0☐ No	_____(# of times)	_____ (days)
3b.Letters mailed to patient	1☐ Yes 0☐ No	_____(# of times)	_____ (days)
3c.Emails sent to patient	1☐ Yes 0☐ No	_____(# of times)	_____ (days)

3d.Text message sent to patient	1☐Yes 0☐No	_____(# of times)	_____ (days)
3e.Notification through electronic patient portal	1☐Yes 0☐No	_____(# of times)	_____ (days) _____ (days)
3f.Referral to case manager	1☐Yes 0☐No	_____(# of times)	_____ (days)
3g.Other	1☐Yes 0☐No	_____(# of times)	_____ (days)

4. Who has primary responsibility for contacting patients who have missed appointments?

1☐ Receptionist
2☐ Medical assistant
3☐ Nurse
4☐ Mid-level practitioners (APRN or PA)
5☐ Nurse case manager
6☐ Practice manager
7☐ Medical director
8☐ other case manager
9☐ Peer
10☐ Other: _____

5. Since [INSERT DATE OF LAST SURVEY mm/yy] have any of the following changes occurred to medical, social or support services provided by your clinic onsite or through referral?

5a.☐ Change in the health plans accepted by the clinic (e.g. one or more health plans has been added or dropped by the clinic) 1☐Yes 0☐No

5b.☐ Change in network by one or more health plans (i.e. the clinic is no longer "in network" for one or more health plans) accepted by the clinic 1☐Yes 0☐No

5c.☐ Changes to clinic operations (e.g. change in hours, location) 1☐Yes 0☐No

5d.☐ Changes to clinic capacity (e.g. increase or decrease in number of clinicians; increase or decrease in number of patients) 1☐Yes 0☐No

5e.☐ Change in care coordination or support services provided by the clinic (e.g. the number of medical case managers has increased or decreased) 1☐Yes 0☐No

5f.☐ Change in care coordination or support services provided through referral (e.g. eligibility for services has changed) 1☐Yes 0☐No

5g.☐ Other: _____ 1☐Yes 0☐No

6. Please describe the changes to the medical, social, or support services provided by your clinic on-site or through referral:_____
_____
_____