Form Approved

OMB No. 0920-New

Expiration Date: XX/XX/XXXX

Cooperative Re-Engagement Controlled Trial (CoRECT)

Attachment #8

Massachusetts Standard of Care Survey

Public reporting burden of this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

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:____
   ____
   ____