

Form Approved

OMB No. 0920-New

Expiration Date: XX/XX/XXXX

## **Cooperative Re-Engagement Controlled Trial (CoRECT)**

### **Attachment #9**

#### **Connecticut Standard of Care Survey**

Public reporting burden of this collection of information is estimated to average 30 minutes 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)

**CONNECTICUT STANDARD OF CARE CLINIC ASSESSMENT**

**CoRECT: Assessment of Clinic Standard of Care Practices**

Point person at your clinic for CoRECT

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**“Out of care” patients**

1. Do you currently have a protocol in your clinic to contact patients who are out of care? 1  Yes      2  No

2. If so, how do you define “out of care” in your clinic? How do you identify those that are “out of care” (e.g., electronic records, paper)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

3. Who is responsible for conducting outreach for patients that are out of care?

- |  |  |
|--|--|
| 1 <input type="checkbox"/> Receptionist                                    | 7 <input type="checkbox"/> Practice manager              |
| 2 <input type="checkbox"/> Medical assistant                               | 8 <input type="checkbox"/> Medical director              |
| 3 <input type="checkbox"/> Nurse<br>or PA)                                 | 9 <input type="checkbox"/> Mid-level practitioners (APRN |
| 4 <input type="checkbox"/> Peer  | 10 <input type="checkbox"/> Physician/ provider          |
| 5 <input type="checkbox"/> Nurse case manager                              | 11 <input type="checkbox"/> Dedicated team member other  |
| 6 <input type="checkbox"/> DIS or Linkage Coordinator<br>than case manager | 12 <input type="checkbox"/> Other                        |

\_\_\_\_\_

4. If you have a protocol, what type of outreach do you conduct for out of care patients? How often?

Process	Frequency (e.g., every missed appointment, if no appointment in six months, etc.). If you do not conduct this type of outreach, write "N/A"
4a. Telephone calls	1 <input type="checkbox"/> Yes      0 <input type="checkbox"/> No      6 <input type="checkbox"/> N/A Frequency _____
4b. Letters	1 <input type="checkbox"/> Yes      0 <input type="checkbox"/> No      6 <input type="checkbox"/> N/A Frequency _____
4c. Referral to case manager	1 <input type="checkbox"/> Yes      0 <input type="checkbox"/> No      6 <input type="checkbox"/> N/A Frequency _____
4d. Other: _____	1 <input type="checkbox"/> Yes      0 <input type="checkbox"/> No      6 <input type="checkbox"/> N/A Frequency _____
4e. Other: _____	1 <input type="checkbox"/> Yes      0 <input type="checkbox"/> No      6 <input type="checkbox"/> N/A Frequency _____

5. Has your protocol been revised or updated in the last six months? 1  Yes 0  No  
*If Yes please explain:*