Cooperative Re-Engagement Controlled Trial (CoRECT)

Attachment #10

Philadelphia Standard of Care Survey

Form Approved
OMB No. 0920-1133
Expiration Date: 08/31/2019

Facility and Patient Services

* 1. What date are you completing this survey?

Date MM / DD / YYYY

2. What is the name of your facility?

* 3. Please indicate how many staff provide medical care to HIV patients at your facility. Please do not include interns, fellows, and residents in your tally.

	Number of staff	Total amount of FTE for the staff (round to the nearest tenth)
MD/DO		

4. Please indicate how many staff at your facility provide mental health and supportive services on site to patients who are HIV positive. Please do not include interns, fellows, and/ or residents in your tally.

	Number of staff	Total amount of FTE for the staff (round to the nearest tenth)
Psychiatrist		
Psychologist		
Behavioral Health Consultant		
Social Worker		
Medical Case Manager		
General Case Manager		
Linkage Coordinator		
Nutritionist		

Please indicate below if you do not have any of these support services staff at your facility.

5. Please indicate how many administrative support staff you have at your facility.

	Number of staff	Total amount of FTE to the nearest tenth
Office Manager		
Medical Billing Staff		
Scheduling Staff		

Please indicate below if you do not have any of these support services staff at your facility.

6. If any new positions have been added to your practice please indicate them below. If there have been no new positions added please enter "no changes" in the box below.

7. If any positions have been eliminated from your practice please indicate them below. If there have been no positions eliminated please enter "no changes" in the box below.

8. What clinical services are available for patients with HIV on site at your facility?

- [ ] Phlebotomy (*Please answer questions 9 and 10 if you check this option*)
- [ ] Pharmacy
- [ ] Radiology
- [ ] Substance Abuse Treatment
- [ ] Mental Health Treatment

Please indicate any other services you offer below. ---OR--- If you do not offer any additional clinical services please indicate that in the space below.

9. (Skip to question 11 if you do not draw blood on site at your facility)
Please indicate where you draw blood at your facility for patients who are HIV positive. (Please check all that apply)

- [ ] In the same office where patients have their clinical appointments.
- [ ] In a separate building associated with the facility (ie. main hospital, lab across the street from the building, etc.)
- [ ] In the same building on a separate floor from where patients have their clinical appointments.
- [ ] Please indicate here any other location at your facility where you draw blood.

10. Please list circumstances when you may not be able to draw blood on-site.

11. What ancillary/ support services are available for patients with HIV at your facility? (Please check all that apply.)

- [ ] Support Groups
- [ ] Health Education
- [ ] Adherence Counseling
- [ ] Food Banks
- [ ] Congregate Meals
- [ ] Transportation
- [ ] We do not offer any ancillary/support services to patients at our facility.

If you offer other services not listed above please list them here.

12. Please indicate what changes have occurred at your practice since the last time you took this survey.

	Nothing has changed	Nothing has changed yet but we expect some change within the next six months	There has been a change
The address or location of the practice.	○	○	○
Insurance providers accepted by the facility.	○	○	○
Facility billing procedures.	○	○	○
Patient hours.	○	○	○

If there has been OR will be a change please describe it here.

Addition or loss of affiliated practices.	◯	◯	◯

If there has been OR will be a change please describe it here.

Providers practicing HIV care at the facility.	◯	◯	◯

If there has been OR will be a change please describe it here.

Re-linkage Practices and Protocol

13. In the last six months, what methods has your practice has used to re-link HIV patients back to care? (Please check all that apply.)

- ☐ Called the patient after a missed medical office visit
- ☐ Made a field visit to the patient after a missed medical office visit
- ☐ Sent letters to the patient after a missed medical visit
- ☐ Sent the patient a text message
- ☐ Sent the patient a message via your health system's secure patient portal

Other (please specify)

* 14. Does your facility have a protocol for re-linking HIV patients back to care?

- ◯ yes we have a written protocol
- ◯ yes but it is not a written protocol
- ◯ no

15. (Skip to question 18 if you answered NO to question 14.)
Briefly describe your facility's protocol for re-linking HIV patients to care. If it is too long to describe below, please send it separately to Crystal.Lucas@phila.gov.
If nothing has changed since your last survey please indicate no change in the box below.

16. Are there segments of your HIV patient population that are prioritized differently for re-linkage to care (i.e. pregnant women, patients with high viral loads etc.)?

- ◯ yes (please indicate below how and why patients are prioritized differently)
- ◯ no

Please indicate below how and why patients are prioritized differently for re-engagement.

17. How often is your facility's protocol for re-linkage to care reviewed?

- ◯ twice a year
- ◯ once a year
- ◯ every 1-2 years

Data Collection and Management

18. Are any of your computer or data systems scheduled to undergo replacement, upgrades or development?

Please indicate below WHICH systems are scheduled to undergo change and WHEN the change is expected to occur.

19. Are any of your computer or data systems currently undergoing replacement, upgrades or development?

Please indicate WHICH systems are undergoing change below.

Provider Concerns

20. If your facility has incurred any new costs as a result of participating in the CoRECT project please describe them below.

◯ never

Other (please specify)

describe them below.

21. Do you have any concerns about participating in CoRECT that you'd like to share with us?