

Survey ID 

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Form Approved

OMB No.: 0920-New

Expiration date: XX/XX/XXXX

## Medical Monitoring Project Short Facility Survey

Attachment 6

MMP Short Facility Survey

Public reporting burden of this collection of information is estimated to average 5 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)

**General instructions**

1. Your health care facility was selected to receive the Centers for Disease Control and Prevention (CDC) Medical Monitoring Project (MMP) HIV facility survey because 1 or more patients with HIV have received care at your facility.
2. **Who should complete the survey?** The survey should be completed by a senior facility administrator, nurse manager, and/or clinical director. If preferred, that person may call [insert name of CDC contractor] to provide their responses over the phone (xxx-xxx-xxxx).
3. Survey questions refer to characteristics of the facility providing HIV care at the location named in the survey invitation.
  - a. Survey questions refer to characteristics of the facility **during the past 12 months**, unless otherwise specified.
  - b. The term *provider* refers to a health care professional with prescribing privileges authorized by the state.
4. **Do not include information that would identify the facility, e.g. name of facility, your name, or names of anyone who works at the facility.** Survey data will only be associated with a facility ID number.

**I. GENERAL CHARACTERISTICS**

Facility ID code:

11-digit FIPS code:

Which terms describe the facility (Choose all that apply.)

- 1 Federally qualified Health Center (FQHC): [Search](#)
- 2 FQHC look-alike: [Definition](#)
- 3 Hospital-based (infectious disease clinic)
- 4 Hospital-based (primary care clinic)
- 5 Private practice
- 6 State or local health department
- 7 Veterans Administration
- 8 STD clinic
- 9 Research
- 10 Other community-based organization
- 11 Correctional facility
- 12 Indian Health Service, Tribal Health, or Urban Indian Health Center
- 13 Other, specify: \_\_\_\_\_

Which types of health coverage does the facility accept? (choose all that apply)

- 1 Medicaid, including Medicaid managed care
- 2 Medicare, including Medicare Advantage
- 
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- <sub>3</sub> Private insurance
- <sub>4</sub> ADAP or other Ryan White coverage
- <sub>5</sub> Veterans Administration
- <sub>6</sub> Tricare
- <sub>7</sub> Other, specify: \_\_\_\_\_
- <sub>8</sub> None of the above

Does at least one infectious disease physician practice at the same geographic location as the facility (onsite)?

- <sub>1</sub> No
- <sub>2</sub> Yes

Does the facility provide medical care for people who do not have HIV?

- <sub>1</sub> No (Skip next 2 questions)
- <sub>2</sub> Yes

Does the facility provide HIV pre-exposure prophylaxis (PrEP)?

- <sub>1</sub> No
- <sub>2</sub> Yes

Does the facility provide HIV post-exposure prophylaxis (PEP)?

- <sub>1</sub> No
- <sub>2</sub> Yes

**II. CLINICAL AND SUPPORTIVE SERVICES**

Which of these clinical and supportive services are currently available at the same geographic location (onsite) or through established outside referral relationships? (Choose all that apply.)

|  |  | Onsite                     | Established outside referral relationship |
|--|--|----------------------------|---|
|  |  | <input type="checkbox"/>   | <input type="checkbox"/>                  |
|  | Clinical case management provided by a nurse | 1 <input type="checkbox"/> | 2 <input type="checkbox"/>                |
|  | Other case management                        | 1 <input type="checkbox"/> | 2 <input type="checkbox"/>                |
|  | Patient navigation                           | 1 <input type="checkbox"/> | 2 <input type="checkbox"/>                |

|  |  | Onsite                     | Established outside referral relationship |
|--|--|----------------------------|---|
|  | Access to tools that support ART adherence, such as pill trays or dose reminder apps | 1 <input type="checkbox"/> | 2 <input type="checkbox"/>                |
|  | Mental health services   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/>                |
|  | Substance use disorders treatment  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/>                |

**III. ENROLLMENT AND INITIATION OF ANTIRETROVIRAL THERAPY**

Within how many business days of an initial request are HIV patients who are new to the facility routinely offered an appointment with an HIV care provider?

**IV. HIV TELEHEALTH/TELEMEDICINE**

Have any providers provided HIV clinical care for patients via remote conferencing?

1 No  
 2 Yes

**V. SUPPORTING RETENTION IN CARE**

Does the facility use data to systematically monitor retention in care of all HIV patients?

1 No  
 2 Yes

Does the facility collaborate with the state or local health department to identify or contact patients who are out of care, e.g., by providing clinic data or contact information to the health department?

1 No  
 2 Yes