FACILITY ID	 	 	 	

GENERAL CONSIDERATIONS (FOR MMP STAFF)

BEFORE USING THIS WORKSHEET, THE FOLLOWING DETERMINATIONS SHOULD ALREADY HAVE BEEN MADE:

- The specific clinic(s)/provider practice(s) that comprise each facility according to the MMP definition of "facility."
- Verification that each clinic/provider practice that comprises this facility delivers HIV care.

WHEN USING PARTICULAR SOURCE(S) OF INFORMATION FOR FACILITY ATTRIBUTES, PLEASE CONSIDER THE FOLLOWING:

- Does/Do the current source(s) of information (that you are using to complete this worksheet) provide information for ALL affiliated clinics or practices that comprise this "facility," as defined by MMP?
- If the current source(s) of information only provide information for some (but not all) of the affiliated clinics/practices that comprise this "facility," then
 - Note that the requested information is pertinent to only those clinics/practices that are represented by the source(s) of information and <u>frame the questions in this worksheet accordingly.</u>
 - Identify and <u>seek out other sources of information</u> for the affiliated clinics/practices that are not represented here and add it to the existing form.
 - Only **one** "Facility Attributes Information" worksheet is to be completed for a given MMP facility.

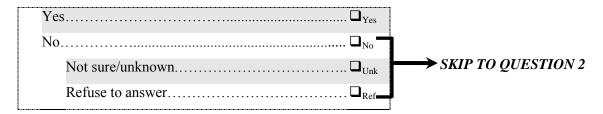
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^{*&}quot;...for MMP a facility is defined as any clinic, health care facility, group or private physician practice, or grouping of such entities that share medical records or a medical records system..." (2007 MMP protocol, pp 5-6, https://team.cdc.gov/team/cdc/dispatch.cgi/mmp Protocol)

^{** &}quot;HIV care" is defined as ordering CD4 lymphocyte count or viral load or prescribing antiretroviral (ARV) medications for the purpose of managing and treating HIV infection in the outpatient setting.

FACILITY ID

1. Is this facility an HMO / managed care organization?

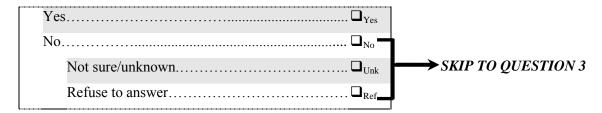


1A. What HMO model(s) is/are used by this facility? Please **select ALL that apply**.

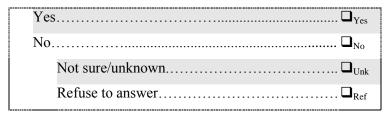
a.	Group model	$\square_{\rm a}$
b.	Staff model	\Box_{b}
c.	Network model	$\Box_{\rm c}$
d.	Individual Practice Association.	\Box_{d}
	Not sure/unknown (to all above choices)	\square_{Unk}
	Refuse to answer	\square_{Ref}

[For definitions of HMO models, please see page 10, end of this worksheet]

2. Is this facility a University-affiliated, Teaching, or Academic Facility?



2A. Is this facility also part of a tertiary care center?



FACILITY ID				

3. What other term(s) would accurately describe this facility? Please **select <u>ALL</u> that apply**.

a.	Private Practice (solo or group practice)	$\Box_{\rm a}$
b.	Hospital-affiliated	\Box_{b}
c.	Clinical Research	$\Box_{\rm c}$
d.	Community Health Center	$\square_{\rm d}$
e.	Other Community-Based Service Organization	$\Box_{\rm e}$
f.	State or Local Health Department	\square_{f}
g.	Veterans Administration (or V.A.)	\square_{g}
h.	Correctional facility	\square_{h}
i.	Another type of facility	\square_{i}
	(Please specify)	
	Not sure/unknown (to all above choices)	\square_{Unk}
	Refuse to answer.	1101

4. Who owns this facility? Please **select ONE only**.

a.	Federal government.	$\Box_{\rm a}$
b.	State or local government.	\Box_{b}
c.	Tribal government	$\Box_{\rm c}$
d.	A nonprofit, faith-based organization.	\Box_{d}
e.	A nonprofit organization, not faith-based.	\Box_{e}
f.	An individual, partnership, or corporation (privately owned)	\square_{f}
g.	Other	\square_{g}
	(Please specify)	
	Not sure/unknown.	Unk
	Refuse to answer	

1
4

racinty Attributes Worksheet	
	FACILITY ID

5. Which one of the following sources provides for the largest proportion of this facility	s patient care revenue/operating
expenses? Please select ONE only.	

a.	Public grants (from federal, state, or local government)?	$\Box_{\rm a}$
b.	Private grants or donations (from individuals, corporations, or foundations)?	\Box_{b}
c.	Medicare/Medicaid?	$\Box_{\rm c}$
d.	Private insurance or out-of-pocket payments by patients?	\Box_{d}
e.	Another public (government) source?	$\square_{\rm e}$
	(Please specify)	
f.	r	\square_{f}
	(Please specify)	
	Not sure/unknown	\square_{Unk}
	Refuse to answer	\square_{Ref}

6. Which one of the following is/are provided at this facility? Please **select ONE** only.

a.	Outpati	ent care only	$\square_{\rm a}$
b.	Both in	patient and outpatient care	\Box_{b}
		Not sure/unknown	□ _{Unk}
		Refuse to answer	\square_{Ref}

7. Which one of the following best describes the type of medical practice at this facility? Please **select** \underline{ONE} **only**.

a.	Single-specialty care practice. \square_a	
b.	Multi-specialty care practice	SKIP TO QUESTION 9
c.	Primary care practice, including internal medicine, family practice, obstetrics/gynecology, or pediatrics	SKIP TO QUESTION 10
	Not Sure/unknown	
	Refuse to answer. \square_{Ref}	

FACILITY ID				

8. [Verification: this question is for single-specialty care practices only]

Please indicate the specialty or sub-specialty that is practiced at this facility. Please **select ONE** only.

a.	General infectious disease	\Box_a
b.	HIV/AIDS, as a <u>designated</u> HIV/AIDS care center	\Box_{b}
c.	HIV/AIDS, but NOT as a designated HIV/AIDS care center	$\Box_{\rm c}$
d.	Tuberculosis (as in a TB specialty clinic)	\Box_{d}
e.	Sexually transmitted disease (as in an STD clinic)	$\Box_{\rm e}$
f.	Dermatology	\square_{f}
g.	Ophthalmology	\square_{g}
h.	Pulmonology	\Box_{h}
i.	Allergy/Immunology	\square_{i}
j.	Hematology/Oncology	$\square_{\rm j}$
k.	Hepatology	\square_k
1.	Gastroenterology.	
m.	Another type of single-specialty practice	\square_{m}
	(Please specify)	
	Not Sure/unknown	\square_{Unk}
	Refuse to answer	\square_{Ref}

→ AFTER QUESTION 8, PLEASE SKIP TO QUESTION 11

FACILITY ID				

9. [Verification: this question is for multi-specialty facilities only]

Please indicate whether the each of the following is practiced at this facility. Please select ALL that apply.

a.	General infectious disease.	$\square_{\rm a}$
b.	HIV/AIDS, as a <u>designated</u> HIV/AIDS care center	\Box_{b}
c.	HIV/AIDS, but <u>NOT</u> as a designated HIV/AIDS care center	$\Box_{\rm c}$
d.	Tuberculosis (as in a TB specialty clinic)	\Box_{d}
e.	Sexually transmitted disease (as in an STD clinic)	\Box_{e}
f.	Dermatology	$oldsymbol{\square}_{\mathrm{f}}$
g.	Ophthalmology	\square_{g}
h.	Pulmonology	\square_{h}
i.	Allergy/Immunology	$\square_{\rm i}$
j.	Hematology/Oncology.	$\square_{\rm j}$
k.	Hepatology	\square_k
1.	Gastroenterology	\square_1
m.	Other specialties.	\square_{m}
	(Please specify)	
	Not Sure/unknown (to all above choices)	\square_{Unk}
	Refuse to answer	

→ AFTER QUESTION 9, PLEASE SKIP TO QUESTION 11



FACILITY ID				

10. [<u>Verification</u>: This question is for <u>primary care practices</u> only]

Does this facility provide the following medical services in an <u>outpatient</u> setting? Please **select** <u>ALL</u> that apply.

a.	Dental care	$\Box_{\rm a}$
b.	Mental health counseling by psychiatrists, psychologists, or others who are	_
	licensed to conduct mental health counseling.	\Box_{b}
c.	Substance abuse treatment.	
С.	Substance douse dedinient	— c
d.	Prenatal care, general care for pregnancies not considered at high-risk for	
	complications	\Box_{d}
		_
e.	Prenatal care, specialized care for high-risk pregnancies	□ _e
f.	Other	\square_{f}
	(Please specify)	
	Not Sure/unknown (to all above choices)	\square_{Unk}
	Refuse to answer.	\square_{Ref}
	AFTER QUESTION 10. PLEASE SKIP TO QUESTION 12	

11. [Verification: This question is for single- or multi-specialty care practices]

Does this facility provide the following medical services in an outpatient setting? Please select ALL that apply.

a. General ambulatory medical care	$\Box_{\rm a}$
b. Dental care	\Box_{b}
c. Mental health counseling by psychiatrists, psychologists, or others who are licensed to conduct mental health counseling	\Box_{c}
d. Substance abuse treatment.	\Box_{d}
e. Prenatal care, general care for pregnancies not considered at high-risk for complications.	\Box_{e}
f. Prenatal care, specialized care for high-risk pregnancies	\square_{f}
g. Other(Please specify)	□g
Not Sure/unknown (to all above choices)	\square_{Unk}
Refuse to answer.	\square_{Ref}

FACILITY ID				

12. What other <u>outpatient</u> resources / services are provided by this facility? Please **select** <u>ALL</u> that apply.

a.	An on-site pharmacy	$\Box_{\rm a}$
b.	Consultations or programs specifically designed to support or improve patient adherence to HIV treatment	$\Box_{\rm b}$
C.	HIV risk reduction counseling sessions by a counselor trained specifically to conduct this type of counseling	. □ _c
d.	Nutrition consultation with a dietician or nutritionist	. _ d
e.	HIV/AIDS Case-management services	\Box_{e}
f.	Social services	\square_{f}
g.	Language translation services.	
h.	On-site childcare services.	\square_{h}
i.	Transportation services or financial assistance with transportation	$\square_{\rm i}$
j.	Alternative therapies (like homeopathy, acupuncture, herbs, massage therapy) by licensed providers	$\Box_{\rm j}$
k.	Other	\square_k
	(Please specify)	
	Not Sure/unknown (to all above choices).	\square_{Unk}
	Refuse to answer	\square_{Ref}

13 How many	v clinicians em	inloved at thi	s facility nr	rovide care to 1	patients with H	IV infection
13. 110 w man	y Cillincians Cill	ipioyed at un	s racinty pr	ovide care to p	panents with H	I V IIIICCIIOII



- "Clinicians" include doctors, nurse practitioners, or physician's assistants.
- Please <u>do not</u> include in this count the number of students, residents, or other trainees or the number of nurses who are not nurse practitioners.

FACILITY ID				

14. Did this facility receive any Ryan White CARE Act (RWCA) funding during the 2006 calendar year?

Ye	S	. \square_{Yes}
No		$\square_{ m No}$
	Not sure/unknown	\square_{Unk}
	Refuse to answer	\square_{Ref}

14A. If yes, which types of RWCA funding did this facility receive in 2006? Please select ALL that apply.

a.	Title I	\square_a	
b.	Title II	\Box_{b}	
c.	Title III	\Box_{c}	
d.	Title IV	$\Box_{ m d}$	
e.	Special Projects of National Significance (SPNS)	□ e −	1
f.	AIDS Education and Training Centers (AETC)	$oldsymbol{\square}_{\mathrm{f}}$	Title VI
g.	Dental reimbursements	\square_{g}	
h.	Minority AIDS Initiative (MAI)	□ _h _	J
i.	None	\Box_{i}	
	Not sure/Unknown (to all above choices)	$oldsymbol{\square}_{\mathrm{Unk}}$	
	Refuse to answer	\square_{Ref}	

FACILITY ID				

Types of HMO Models (Reference for Question 1A):

The definitions on this page can be found at http://www.cdc.gov/nchs/datawh/nchsdefs/hmo.htm

Group Model HMO

An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated per capita rate, which the group distributes among its physicians, usually on a salaried basis.

Staff Model HMO

A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The providers see members in the HMO's own facilities.

Network Model HMO

An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multi-specialty groups.

Individual Practice Association (IPA)

A type of healthcare provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs, PPOs (preferred provider organizations), and insurance companies. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

Mixed An HMO that combines features of more than one HMO model.

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