

**Medical Monitoring Project (MMP)
2008 Facility Attributes Worksheet**

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 frame the questions in this worksheet accordingly.
 - Identify and seek out other sources of information 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.

- If there are discrepancies between different sources of information, these discrepancies should be resolved before documenting the information.

* “...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...” (2008 MMP protocol, pp 6, https://team.cdc.gov/team/cdc/dispatch.cgi/mmp_Protocol)

** “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.*

**ONLY ONE WORKSHEET IS TO BE COMPLETED FOR EACH MMP FACILITY
(REGARDLESS OF WHETHER THAT FACILITY HAS MULTIPLE CLINIC/PROVIDER PRACTICE LOCATIONS)**

Source(s) of information used to complete this form:	Date information was obtained from each source:

CONTINUE



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1A. What HMO model(s) is/are used by this facility?

Please select **all HMO models that apply** **OR** select “None of the above,”
“Not sure/unknown (to all above choices),” or “Refuse to answer.”

a. Group model.....	<input type="checkbox"/>	a
b. Staff model.....	<input type="checkbox"/>	b
c. Network model.....	<input type="checkbox"/>	c
d. Individual Practice Association.....	<input type="checkbox"/>	d
e. Other HMO model.....	<input type="checkbox"/>	e
(Please specify)_____		
f. None of the above.....	<input type="checkbox"/>	f
Not sure/unknown (to all above choices).....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	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?

Yes.....	<input type="checkbox"/>	Yes
No.....	<input type="checkbox"/>	No
Not sure/unknown.....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

→ SKIP TO QUESTION 3

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

Yes.....	<input type="checkbox"/>	Yes
No.....	<input type="checkbox"/>	No
Not sure/unknown.....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

CONTINUE



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

a. Private Practice (solo or group practice).....	<input type="checkbox"/>	a
b. Hospital-affiliated	<input type="checkbox"/>	b
c. Clinical Research	<input type="checkbox"/>	c
d. Community Health Center.....	<input type="checkbox"/>	d
e. Other Community-Based Service Organization.....	<input type="checkbox"/>	e
f. State or Local Health Department.....	<input type="checkbox"/>	f
g. Veterans Administration (or V.A.)	<input type="checkbox"/>	g
h. Correctional facility.....	<input type="checkbox"/>	h
i. Another type of facility.....	<input type="checkbox"/>	i
(Please specify) _____		
Not sure/unknown (to all above choices).....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

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

a. Federal government.....	<input type="checkbox"/>	a
b. State or local government.....	<input type="checkbox"/>	b
c. Tribal government.....	<input type="checkbox"/>	c
d. A nonprofit, faith-based organization.....	<input type="checkbox"/>	d
e. A nonprofit organization, not faith-based.....	<input type="checkbox"/>	e
f. An individual, partnership, or corporation (privately owned).....	<input type="checkbox"/>	f
g. Other.....	<input type="checkbox"/>	g
(Please specify) _____		
Not sure/unknown.....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

CONTINUE



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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)?.....	<input type="checkbox"/>	a
b. Private grants or donations (from individuals, corporations, or foundations)?.....	<input type="checkbox"/>	b
c. Medicare/Medicaid?.....	<input type="checkbox"/>	c
d. Private insurance or out-of-pocket payments by patients?.....	<input type="checkbox"/>	d
e. Another public (government) source?..... (Please specify) _____	<input type="checkbox"/>	e
f. Another private source?..... (Please specify) _____	<input type="checkbox"/>	f
Not sure/unknown.....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

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

a. Outpatient care only.....	<input type="checkbox"/>	a
b. Both inpatient and outpatient care.....	<input type="checkbox"/>	b
Not sure/unknown.....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

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

a. Single-specialty care practice.....	<input type="checkbox"/>	a	
b. Multi-specialty care practice.....	<input type="checkbox"/>	b	→ SKIP TO QUESTION 9
c. Primary care practice, including internal medicine, family practice, obstetrics/gynecology, or pediatrics.....	<input type="checkbox"/>	c	→ SKIP TO QUESTION 10
Not Sure/unknown.....	<input type="checkbox"/>	Unk	} → SKIP TO QUESTION 12
Refuse to answer.....	<input type="checkbox"/>	Ref	

CONTINUE



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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.....	<input type="checkbox"/>	a
b. HIV/AIDS.....	<input type="checkbox"/>	b
c. Tuberculosis (as in a TB specialty clinic).....	<input type="checkbox"/>	c
d. Sexually transmitted disease (as in an STD clinic).....	<input type="checkbox"/>	d
e. Dermatology.....	<input type="checkbox"/>	e
f. Ophthalmology.....	<input type="checkbox"/>	f
g. Pulmonology.....	<input type="checkbox"/>	g
h. Allergy/Immunology.....	<input type="checkbox"/>	h
i. Hematology/Oncology.....	<input type="checkbox"/>	i
j. Hepatology.....	<input type="checkbox"/>	j
k. Gastroenterology.....	<input type="checkbox"/>	k
l. Another type of single-specialty practice.....	<input type="checkbox"/>	l
(Please specify) _____		
Not Sure/unknown.....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

→ AFTER QUESTION 8, PLEASE SKIP TO QUESTION 11

CONTINUE



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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.....	<input type="checkbox"/>	a
b. HIV/AIDS.....	<input type="checkbox"/>	b
c. Tuberculosis (as in a TB specialty clinic).....	<input type="checkbox"/>	c
d. Sexually transmitted disease (as in an STD clinic).....	<input type="checkbox"/>	d
e. Dermatology.....	<input type="checkbox"/>	e
f. Ophthalmology.....	<input type="checkbox"/>	f
g. Pulmonology.....	<input type="checkbox"/>	g
h. Allergy/Immunology.....	<input type="checkbox"/>	h
i. Hematology/Oncology.....	<input type="checkbox"/>	i
j. Hepatology.....	<input type="checkbox"/>	j
k. Gastroenterology.....	<input type="checkbox"/>	k
l. Another type of multi-specialty practice.....	<input type="checkbox"/>	l
(Please specify) _____		
Not Sure/unknown.....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

→ AFTER QUESTION 9, PLEASE SKIP TO QUESTION 11

CONTINUE



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10. [Verification: This question is for primary care practices only]

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

a. Dental care.....	<input type="checkbox"/>	a
b. Mental health counseling by psychiatrists, psychologists, or others who are licensed to conduct mental health counseling.....	<input type="checkbox"/>	b
c. Substance abuse treatment.....	<input type="checkbox"/>	c
d. Prenatal care, general care for pregnancies not considered at high-risk for complications.....	<input type="checkbox"/>	d
e. Prenatal care, specialized care for high-risk pregnancies.....	<input type="checkbox"/>	e
f. Other.....	<input type="checkbox"/>	f
(Please specify)_____		
Not Sure/unknown (to all above choices).....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	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.....	<input type="checkbox"/>	a
b. Dental care.....	<input type="checkbox"/>	b
c. Mental health counseling by psychiatrists, psychologists, or others who are licensed to conduct mental health counseling.....	<input type="checkbox"/>	c
d. Substance abuse treatment.....	<input type="checkbox"/>	d
e. Prenatal care, general care for pregnancies not considered at high-risk for complications.....	<input type="checkbox"/>	e
f. Prenatal care, specialized care for high-risk pregnancies.....	<input type="checkbox"/>	f
g. Other.....	<input type="checkbox"/>	g
(Please specify)_____		
Not Sure/unknown (to all above choices).....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

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

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

13. How many individual clinicians (full-time, part-time, or volunteer) provide care to patients with HIV infection at this facility?

- “Clinicians” include doctors, nurse practitioners, or physician’s assistants.
- Please **do not** include in this count the number of students, residents, or other trainees or the number of nurses who are not nurse practitioners.

13A. What is the number of full-time equivalents, in terms of HIV care providers (whether volunteer or paid), at this facility?

13B. How many of the full-time equivalents reported in 13A are represented by volunteer providers?

CONTINUE



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14. Did this facility receive any Ryan White CARE Act (RWCA) funding during the 2007 calendar year?

Yes.....	<input type="checkbox"/>	Yes
No.....	<input type="checkbox"/>	No
Not sure/unknown.....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

14A. If yes, which types of RWCA funding did this facility receive in 2007? Please **select ALL that apply.**

a. Part A (Title I).....	<input type="checkbox"/>	a
b. Part B (Title II).....	<input type="checkbox"/>	b
c. Part C (Title III).....	<input type="checkbox"/>	c
d. Part D (Title IV).....	<input type="checkbox"/>	d
e. Special Projects of National Significance (SPNS)....	<input type="checkbox"/>	e
f. AIDS Education and Training Centers (AETC).....	<input type="checkbox"/>	f
g. Dental reimbursements.....	<input type="checkbox"/>	g
h. Minority AIDS Initiative (MAI).....	<input type="checkbox"/>	h
i. None.....	<input type="checkbox"/>	i
Not sure/Unknown (to all above choices).....	<input type="checkbox"/>	Unk
Refuse to answer.....	<input type="checkbox"/>	Ref

Part F (Title VI)

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Types of HMO Models (Reference for Question 1):

The definitions on this page can be found at <http://www.cdc.gov/nchs/dataawh/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.