Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

FACILITY ID ___ ___ ___ ___ ___ ___ ___ ___

GUIDANCE FOR COMPLETING THE FACILITY ATTRIBUTES WORKSHEET

WHO SHOULD FILL OUT THE WORKSHEET:

- The worksheet can be filled out by facility staff or by MMP staff based on responses obtained from the facility and other sources.
  - Other source of information may include:
    - Facility website
    - Resource inventories (published listings of available health resources and services)
    - Health Department staff with recent experience working with the facility
  - If information is obtained from non-facility sources, facility staff should review the information to ensure accuracy, and this should be documented in the "Sources of information used to complete this form" section.

- MMP staff should ensure that the most appropriate facility staff are providing and/or verifying facility information. These are most often:
  - Clinic manager/administrator/director
  - Office/practice manager
  - Chief Operating Officer
  - Medical director
  - Nurse manager

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."
  - 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.
  - For more information refer to the MMP protocol.

- Verification that each clinic/provider practice that comprises this facility delivers HIV care.
  - "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*.

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? (Please see definition above and in the MMP protocol)

- 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.

CONTINUE

Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

FACILITY ID ___ ___ ___ ___ ___ ___ ___ ___

ONLY ONE "FACILITY ATTRIBUTES INFORMATION" WORKSHEET IS TO BE COMPLETED FOR A GIVEN MMP FACILITY (REGARDLESS OF WHETHER THAT FACILITY HAS MULTIPLE CLINIC/PROVIDER PRACTICE LOCATIONS).

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

****THE DATE OF FACILITY VERIFICATION OF INFORMATION SHOULD BE NOTED IF ANY INFORMATION WAS OBTAINED FROM NON-FACILITY SOURCES****	
Source(s) of information used to complete this form:	Date information was obtained from each source:

CONTINUE

Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

FACILITY ID ___ ___ ___ ___ ___ ___ ___ ___

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……	❑a
b.	Staff model……	❑b
c.	Network model……	❑c
d.	Individual Practice Association……	❑d
e.	Other HMO model……	❑e
	(Please specify) _____	
f.	None of the above……	❑f
	Not sure/unknown (to all above choices)……	❑Unk
	Refuse to answer……	❑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……	❑Yes
No……	❑No
Not sure/unknown……	❑Unk
Refuse to answer……	❑Ref

→ ***SKIP TO QUESTION 3***

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

Yes……	❑Yes
No……	❑No
Not sure/unknown……	❑Unk
Refuse to answer……	❑Ref

CONTINUE

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

a. Private Practice (solo or group practice)…..... ❑a
b. Hospital-affiliated …….....……..... ❑b
c. Clinical Research …….....…….....… ❑c
d. Community Health Center.....…….…..... ❑d
e. Other Community-Based Service Organization.....…….. ❑e
f. State or Local Health Department…….....……..❑f
g. Another type of facility.....….....…….....… ❑g
(Please specify) _____

Not sure/unknown (to all above choices)…… ❑Unk
Refuse to answer…… ❑Ref

4. Who owns this facility? Please **select <u>ONE</u> only**.

a. Federal government……..…… ❑a
b. State or local government……..❑b
c. A nonprofit, faith-based organization…….…….. ❑c
d. A nonprofit organization, not faith-based……..... ❑d
e. An individual, partnership, or corporation (privately owned)……..... ❑e
f. Other…….....… ❑f
(Please specify) _____

Not sure/unknown……❑Unk
Refuse to answer……..……❑Ref

Medical Monitoring Project (MMP)
2011 Facility 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)?..... ❑a
b. Private grants or donations (from individuals, corporations, or foundations)?.... ❑b
c. Medicare/Medicaid?..... ❑c
d. Private insurance or out-of-pocket payments by patients?..... ❑d
e. Another public (government) source?..... ❑e
(Please specify) _____
f. Another private source?..... ❑f
(Please specify) _____

Not sure/unknown…… ❑Unk
Refuse to answer…… ❑Ref

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

a. Outpatient care only..... ❑a
b. Both inpatient and outpatient care..... ❑b

Not sure/unknown…… ❑Unk
Refuse to answer…… ❑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..... ❑a
b. Multi-specialty care practice..... ❑b → ***SKIP TO QUESTION 9***
c. Primary care practice, including internal medicine, family practice, obstetrics/gynecology, or pediatrics……. ❑c → ***SKIP TO QUESTION 10***

Not sure/unknown…… ❑Unk
Refuse to answer…… ❑Ref
→ ***SKIP TO QUESTION 12***

CONTINUE

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……..... ❑a
b. HIV/AIDS…….……..... ❑b
c. Tuberculosis (as in a TB specialty clinic)…… ❑c
d. Sexually transmitted disease (as in an STD clinic)……...…… ❑d
e. Dermatology……..…… ❑e
f. Ophthalmology……..... ❑f
g. Pulmonology……..... ❑g
h. Allergy/Immunology……..… ❑h
i. Hematology/Oncology……..... ❑i
j. Hepatology……..... ❑j
k. Gastroenterology……. ❑k
l. Another type of single-specialty practice..... ❑l

(Please specify)_____

Not sure/unknown…… ❑Unk
Refuse to answer……..…… ❑Ref

→ ***AFTER QUESTION 8, PLEASE SKIP TO QUESTION 11***

Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

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……..... ❑a
b. HIV/AIDS…….……..... ❑b
c. Tuberculosis (as in a TB specialty clinic)…….. ❑c
d. Sexually transmitted disease (as in an STD clinic)……..…… ❑d
e. Dermatology……..…… ❑e
f. Ophthalmology……..... ❑f
g. Pulmonology……..... ❑g
h. Allergy/Immunology.…… ❑h
i. Hematology/Oncology……..... ❑i
j. Hepatology……..... ❑j
k. Gastroenterology…… ❑k
l. Another type of multi-specialty practice..... ❑l

(Please specify)_____

Not sure/unknown (to all above choices).…… ❑Unk
Refuse to answer…….…… ❑Ref

→ ***AFTER QUESTION 9, PLEASE SKIP TO QUESTION 11***

CONTINUE

Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

FACILITY ID ___ ___ ___ ___ ___ ___ ___ ___

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…..... ❑a
b. Mental health counseling by psychiatrists, psychologists, or others who are licensed to conduct mental health counseling……..... ❑b
c. Substance abuse treatment……..…….... ❑c
d. Prenatal care, general care for pregnancies not considered at high-risk for complications.... ❑d
e. Prenatal care, specialized care for high-risk pregnancies…….... ❑e
f. Other…….....…….... ❑f

(Please specify) _____

Not sure/unknown (to all above choices)..…… ❑Unk
Refuse to answer…….…….…….…… ❑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 care…… ❑a
b. Dental care…..... ❑b
c. Mental health counseling by psychiatrists, psychologists, or others who are licensed to conduct mental health counseling……..... ❑c
d. Substance abuse treatment……..…….... ❑d
e. Prenatal care, general care for pregnancies not considered at high-risk for complications.... ❑e
f. Prenatal care, specialized care for high-risk pregnancies…….... ❑f
g. Other…….....…….... ❑g

(Please specify) _____

Not sure/unknown (to all above choices)..…… ❑Unk
Refuse to answer…….…….…….…… ❑Ref

CONTINUE

Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

FACILITY ID ___ ___ ___ ___ ___ ___ ___ ___

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

a. An on-site pharmacy…… ❑a

b. Consultations or programs specifically designed to support or improve patient adherence to HIV treatment…….. ❑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…….. ❑e

f. Social services…… ❑f

g. Language translation services…….. ❑g

h. On-site childcare services…… ❑h

i. Transportation services or financial assistance with transportation…… ❑i

j. Alternative therapies (like homeopathy, acupuncture, herbs, massage therapy) by licensed providers…… ❑j

k. Other…… ❑k

(Please specify)_____

Not sure/unknown (to all above choices)…… ❑Unk

Refuse to answer…… ❑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

Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

FACILITY ID ___ ___ ___ ___ ___ ___ ___ ___

14. Did this facility receive any Ryan White CARE Act (RWCA) funding during the 2010 calendar year?

- Yes ❑Yes
- No ❑No
- Not sure/unknown ❑Unk
- Refuse to answer ❑Ref

14A. If yes, which types of RWCA funding did this facility receive in 2010? Please **select ALL that apply**.

- a. Part A (Title I) ❑a
- b. Part B (Title II) ❑b
- c. Part C (Title III) ❑c
- d. Part D (Title IV) ❑d
- e. Special Projects of National Significance (SPNS) ❑e
- f. AIDS Education and Training Centers (AETC) ❑f
- g. Dental reimbursements ❑g
- h. Minority AIDS Initiative (MAI) ❑h

(e–h: Part F (Title VI))

- i. None ❑i

- Not sure/Unknown (to all above choices) ❑Unk
- Refuse to answer ❑Ref

Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

FACILITY ID ___ ___ ___ ___ ___ ___ ___ ___

15. For which of the following does this facility has a computerized system?
Please select **all that apply <u>OR</u>** select "None of the above,"
"Not sure/unknown (to all above choices)," or "Refuse to answer."

a. Patient demographics…….. ❑a
b. Patient problem lists..... ❑b
c. Electronic lists of medications taken by patients…… ❑c
d. Clinical notes…..... ❑d
e. Orders for prescriptions…….. ❑e
f. Viewing laboratory results…….. ❑f
g. Viewing imaging results (e.g., x-ray, MRI)……... ❑g
h. None of the above……... ❑h

Not sure/Unknown (to all above choices)..... ❑Unk
Refuse to answer……. ❑Ref

Medical Monitoring Project (MMP)
2011 Facility Attributes Worksheet

FACILITY ID ___ ___ ___ ___ ___ ___ ___ ___

Types of HMO Models (Reference for Question 1):

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.