eHIVQUAL

Manual Data Collection Form

CASE MANAGEMENT PATIENT PROFILE

All Indicators

Note: To ensure that you only need to refer to each patient's medical chart once, please make sure to answer all of the *applicable* follow-up questions on this form.

REVIEW PERIOD: ____________________________

*NB: ALL REVIEWS FOR SUBMISSION TO THE AIDS INSTITUTE RUN FROM **JANUARY 1ST** THROUGH **DECEMBER 31ST***

1. PATIENT DEMOGRAPHIC INFORMATION

LAST NAME:				
FIRST NAME:				
MIDDLE INITIAL (OPTIONAL):				
MEDICAL RECORD #				
GENDER:		FEMALE		
		MALE		
		TRANSGENDER		BIOLOGICAL CERVIX Y N
DATE OF BIRTH: / / (FOUR DIGIT YEAR)				
RACE/ETHNICITY:		WHITE, NON-HISPANIC/LATINO		
		BLACK, NON-HISPANIC/LATINO		
		HISPANIC		
		ASIAN		
		AMERICAN INDIAN/ALASKA NATIVE		
		NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER		
		MORE THAN ONE RACE OR ETHNICITY		
EXPOSURE CATEGORY		INJECTING DRUG USER (IDU)		
		HEMOPHILIA/COAGULATION DISORDER		
		PERINATAL TRANSMISSION		
		HETEROSEXUAL		
		TRANSFUSION/BLOOD COMPONENTS		
		HETEROSEXUAL & IDU		
		MEN WHO HAVE SEX WITH MEN (MSM)		
		MSM & IDU		
		OTHER		
		UNKNOWN		
PRIMARY PAYOR (REQUIRED IN NYS; OPTIONAL OUTSIDE NYS):		MEDICAID FEE-FOR-SERVICE		FAMILY HEALTH PLUS
		MEDICAID MANAGED CARE		CHILD HEALTH PLUS
		MEDICAID SPECIAL NEEDS PLAN (NYC ONLY)		PRIVATE MANAGED CARE OR COMMERCIAL COVERAGE
		MEDICARE FEE-FOR-SERVICE		WORKER'S COMP OR NO-FAULT
		MEDICARE MANAGED CARE		CORRECTIONS
		SELF-PAY		VETERAN'S ADMINISTRATION
		ADAP OR ADAP+		OTHER
		MEDICAID AND MEDICARE		UNKNOWN
PRIMARY PAYOR NUMBER (OPTIONAL):				

2. VISITS

WAS THE PATIENT SEEN IN THE CLINIC BEFORE THE BEGINNING OF THE REVIEW PERIOD?	Y	N

LIST ALL VISITS DURING THE REVIEW PERIOD WITH A PRIMARY CARE OR HIV-EXPERIENCED PROVIDER.
IF THE PATIENT SAW AN HIV-EXPERIENCED PROVIDER, MARK THE INDICATED BOX

VISIT DATE	X	VISIT DATE	X	VISIT DATE	X

3. PSYCHOSOCIAL ASSESSMENT

DURING THE FIRST SIX MONTHS OF THE REVIEW PERIOD (January 1st through June 30th), WAS A PSYCHOSOCIAL ASSESSMENT PERFORMED THAT INCLUDED THE FOLLOWING ELEMENTS?			DURING THE FINAL SIX MONTHS OF THE REVIEW PERIOD (July 1st through December 31st), WAS A PSYCHOSOCIAL ASSESSMENT PERFORMED THAT INCLUDED THE FOLLOWING ELEMENTS?		
FAMILY/DOMESTIC SITUATION	Y	N	FAMILY/DOMESTIC SITUATION	Y	N
HOUSING STATUS	Y	N	HOUSING STATUS	Y	N
DISCLOSURE	Y	N	DISCLOSURE	Y	N
SOURCE OF INCOME	Y	N	SOURCE OF INCOME	Y	N
HEALTH INSURANCE	Y	N	HEALTH INSURANCE	Y	N
CULTURAL BELIEFS & PRACTICES	Y	N	CULTURAL BELIEFS & PRACTICES	Y	N
LANGUAGE	Y	N	LANGUAGE	Y	N
HIV PRIMARY CARE PROVIDER	Y	N	HIV PRIMARY CARE PROVIDER	Y	N
MENTAL HEALTH STATUS	Y	N	MENTAL HEALTH STATUS	Y	N
SUBSTANCE USE STATUS	Y	N	SUBSTANCE USE STATUS	Y	N
DOMESTIC VIOLENCE	Y	N	DOMESTIC VIOLENCE	Y	N

4. PATIENT HIV KNOWLEDGE

DURING THE FIRST SIX MONTHS OF THE REVIEW PERIOD (January 1st through June 30th), WAS AN ASSESSMENT OF THE PATIENT'S HIV KNOWLEDGE PERFORMED?			DURING THE FINAL SIX MONTHS OF THE REVIEW PERIOD (July 1st through December 31st), WAS AN ASSESSMENT OF THE PATIENT'S HIV KNOWLEDGE PERFORMED?		
IMPORTANCE OF CD4/VL MONITORING	Y	N	IMPORTANCE OF CD4/VL MONITORING	Y	N
TRANSMISSION RISKS/FACTORS	Y	N	TRANSMISSION RISKS/FACTORS	Y	N
IMPORTANCE OF REGULAR MEDICAL CARE	Y	N	IMPORTANCE OF REGULAR MEDICAL CARE	Y	N
ASSESSMENT OF PATIENT UNDERSTANDING OF HIV INFORMATION	Y	N	ASSESSMENT OF PATIENT UNDERSTANDING OF HIV INFORMATION	Y	N

5. ADHERENCE TO ARV MEDICATION

DURING THE FIRST FOUR MONTHS OF THE REVIEW PERIOD (January 1st through April 30th):				DURING THE FINAL FOUR MONTHS OF THE REVIEW PERIOD (September 1st through December 31st):			
WAS THE PATIENT ON ARV MEDICATION?		Y	N	WAS THE PATIENT ON ARV MEDICATION?		Y	N
IF YES	WAS ARV MEDICATION ADHERENCE ADDRESSED?	Y	N	IF YES	WAS ARV MEDICATION ADHERENCE ADDRESSED?	Y	N
	WAS A QUALITATIVE ASSESSMENT OF BARRIERS TO ADHERENCE PERFORMED THIS TRIMESTER?	Y	N		WAS A QUALITATIVE ASSESSMENT OF BARRIERS TO ADHERENCE PERFORMED THIS TRIMESTER?	Y	N
	WERE BARRIERS TO MEDICATION ADHERENCE IDENTIFIED?	Y	N		WERE BARRIERS TO MEDICATION ADHERENCE IDENTIFIED?	Y	N
	IF YES, WERE ACTIONS TAKEN TO ADDRESS THE BARRIERS?	Y	N		IF YES, WERE ACTIONS TAKEN TO ADDRESS THE BARRIERS?	Y	N

6. COMPLETION OF THE CARE PLAN AND COORDINATION OF CARE

DURING THE FIRST SIX MONTHS OF THE REVIEW PERIOD (January 1st through June 30th):					DURING THE FINAL SIX MONTHS OF THE REVIEW PERIOD (July 1st through December 31st):				
WAS A SERVICE CARE PLAN COMPLETED OR UPDATED?			Y	N	WAS A SERVICE CARE PLAN COMPLETED OR UPDATED?			Y	N
IF YES	WERE GOALS ESTABLISHED?		Y	N	IF YES	WERE GOALS ESTABLISHED?		Y	N
	IF YES, IS THERE DOCUMENTATION OF PROGRESS TOWARD THESE TOWARD THESE GOALS?		Y	N		IF YES, IS THERE DOCUMENTATION OF PROGRESS TOWARD THESE TOWARD THESE GOALS?		Y	N
	WERE SERVICE NEEDS IDENTIFIED IN THE CARE PLAN?		Y	N		WERE SERVICE NEEDS IDENTIFIED IN THE CARE PLAN?		Y	N
	IF YES, WERE REFERRALS MADE FOR SERVICES?		Y	N		IF YES, WERE REFERRALS MADE FOR SERVICES?		Y	N
		IF YES, WERE SERVICES PROVIDED WITHIN FOUR MONTHS?	Y	N			IF YES, WERE SERVICES PROVIDED WITHIN FOUR MONTHS?	Y	N

7. ACCESS AND CONTINUITY OF CARE

<table>
<tr><th colspan="4">DURING THE FIRST SIX MONTHS OF THE REVIEW PERIOD (January 1st through June 30th):</th><th colspan="4">DURING THE FINAL SIX MONTHS OF THE REVIEW PERIOD (July 1st through December 31st):</th></tr>
<tr><td colspan="2">WAS AN ASSESSMENT OF ATTENDANCE AT HIV PRIMARY CARE MEDICAL VISITS PERFORMED?</td><td>Y</td><td>N</td><td colspan="2">WAS AN ASSESSMENT OF ATTENDANCE AT HIV PRIMARY CARE MEDICAL VISITS PERFORMED?</td><td>Y</td><td>N</td></tr>
<tr><td colspan="2">IF THE CLIENT WAS REFERRED FOR SPECIALTY MEDICAL CARE, WAS AN ASSESSMENT OF ATTENDANCE AT SPECIALITY MEDICAL VISITS PERFORMED?</td><td>Y</td><td>N N/A</td><td colspan="2">IF THE CLIENT WAS REFERRED FOR SPECIALTY MEDICAL CARE, WAS AN ASSESSMENT OF ATTENDANCE AT SPECIALITY MEDICAL VISITS PERFORMED?</td><td>Y</td><td>N N/A</td></tr>
<tr><td>IF YES</td><td>ENTER THE TOTAL NUMBER OF VISITS (MEDICAL PLUS SPECIALITY)</td><td colspan="2"></td><td>IF YES</td><td>ENTER THE TOTAL NUMBER OF VISITS (MEDICAL PLUS SPECIALITY)</td><td colspan="2"></td></tr>
<tr><td colspan="2">WERE BARRIERS TO ATTENDANCE AT MEDICAL/ SPECIALTIY APPOINTMENTS IDENTIFIED?</td><td>Y</td><td>N</td><td colspan="2">WERE BARRIERS TO ATTENDANCE AT MEDICAL/ SPECIALITY APPOINTMENTS IDENTIFIED?</td><td>Y</td><td>N</td></tr>
<tr><td>IF YES</td><td>WERE ACTIONS TAKEN TO REDUCE BARRIERS?</td><td>Y</td><td>N</td><td>IF YES</td><td>WERE ACTIONS TAKEN TO REDUCE BARRIERS?</td><td>Y</td><td>N</td></tr>
</table>

8. CLIENT PARTICIPATION IN THE CARE PLAN

DURING THE FIRST SIX MONTHS OF THE REVIEW PERIOD (January 1st through June 30th):			DURING THE FINAL SIX MONTHS OF THE REVIEW PERIOD (July 1st through December 31st):		
WAS THE CLIENT'S SIGNATURE IN THE CARE PLAN TO DOCUMENT THAT THE CLIENT PARTICIPATED IN DEVELOPMENT AND/OR REVISION OF THE CARE PLAN?	Y	N	WAS THE CLIENT'S SIGNATURE IN THE CARE PLAN TO DOCUMENT THAT THE CLIENT PARTICIPATED IN DEVELOPMENT AND/OR REVISION OF THE CARE PLAN?	Y	N