



NATIONAL ASSESSMENT OF HEALTH CENTER HIV TESTING, PREVENTION, CARE AND TREATMENT PRACTICES

Person completing this questionnaire contact information:

Name: _____

Position: _____

Telephone Number: _____

CHC Site: _____

Thank you very much for joining the National Association of Community Health Centers and your health center colleagues for this first-ever national assessment of health center practices related to HIV testing, prevention, care and treatment.

Please take the time to answer the questions as completely and as accurately as possible. Whether your center provides a full array of HIV-related services or none at all, your collective responses are essential to defining and highlighting the role Community, Migrant, and Homeless Health Centers currently hold, and have the capacity to hold, in the HIV/AIDS arena.

We thank you for your time and consideration. Please note that the completed questionnaire is to be returned by Friday, October 29, 2004.

Please start indicating your questionnaire responses:

During the calendar year 2003 (CY 2003) did your health center provide any HIV services (including counseling and testing, prevention, and care and treatment)? *(Unless otherwise noted, by "provide" we mean services were performed at the health center or at one of its sites OR the health center paid for the service(s) to be performed elsewhere because the health center does not perform the service(s) itself.)*

Yes → If Yes, GO to **Question 1 on page 2.**

No → If No, please do the following:

- 1) Answer the question below on this page.
- 2) Answer questions 22 and 23 on page 9.
- 3) Return the entire booklet using the enclosed self-addressed envelope.

Where do patients of your health center receive HIV services (including counseling and testing, prevention, and care and treatment)? Please be as specific as possible. _____

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1) For CY 2003, estimate the total number of *unduplicated* patients for whom your health center provided* HIV services (including counseling and testing, prevention, and care and treatment):

2) For CY 2003, estimate the percentage of patients in each age range below that your health center served for all HIV services (including counseling and testing, prevention, and care and treatment):

- a) Under 18: _____%
- b) Ages 18 - 29: _____%
- c) Ages 30 - 39: _____%
- d) Ages 40 - 49: _____%
- e) Ages 50 - 59: _____%
- f) Ages 60 - 65: _____%
- g) Over 65: _____%

Total should equal 100%

3) Considering the total number of patients in CY 2003 who used your health center's HIV services (including counseling and testing, prevention, and care and treatment), approximate the percentage of patients who were:

Percentages might not total to 100%

- a) Asian/Native Hawaiian/Pacific Islander: _____%
- b) Black/African American not Hispanic: _____%
- c) American Indian/Alaska Native: _____%
- d) White/Caucasian not Hispanic: _____%
- e) Hispanic _____%
- f) Other _____%
- g) Unreported / Refused to report: _____%

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4) For the last 12-month period for which you have fiscal data, complete the table below. Estimate the total dollar amount you received from each of the funding sources. Of that funding, estimate the dollar amount spent by your health center on HIV prevention services and the dollar amount spent on HIV care and treatment services. Please write out the complete numbers; do not use abbreviations for thousands or millions. When no funds were received, please write \$0.00.

The 12-month period on which the answers to this question are based is: _____ to _____
(mm/yyyy) mm/yyyy)

HIV service Funding source:	Total funding	HIV prevention services, including counseling & testing	HIV care and treatment, including support services
a) Consolidated Health Center Funding 330 grant dollars	\$	\$	\$
b) Ryan White CARE Act Title I Indirect Funding	\$	\$	\$
c) Ryan White CARE Act Title II Indirect Funding	\$	\$	\$
d) Ryan White CARE Act Title III Funding	\$	\$	\$
e) Ryan White CARE Act Title IV Funding	\$	\$	\$
f) County or City Funding	\$	\$	\$
g) State General Funding	\$	\$	\$
h) CDC Grants/Cooperative Agreements	\$	\$	\$
i) SAMHSA Grants	\$	\$	\$
j) Private Funding/Donations	\$	\$	\$
k) Other Funding: (Please specify) _____	\$	\$	\$

5a) In CY 2003, how many *unduplicated* patients were tested for HIV? _____ patients

5b) In CY 2003, how many clients (non-health center patients) received HIV testing services in your outreach program(s)? _____ clients

6) Based on the total number of patients/clients tested in CY 2003 (5a + 5b above), indicate the total number for each of the questions below:

	Total
a) Overall, how many patients/clients were informed of their HIV test results regardless of whether they were positive or negative?	
b) How many of the patients/clients tested HIV positive?	
c) How many of the patients/clients that tested HIV positive received their HIV test results?	
d) How many of the patients/clients that tested positive were lost to care?	

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7) In CY 2003, what kinds of HIV counseling and testing were made available by your health center? (Check all that apply)

If no on-site or off-site testing was available, please check here: Not-applicable and GO to Question 14.

- On-site HIV counseling and testing provided by health center staff
- On-site, provided by the health department
- On-site, provided by another organization
- Off-site referral, your health center covers the cost
- Off-site referral, your health center does **not** cover the cost

8) Use the table below to indicate which divisions of the health center provide* HIV testing. For each division, indicate whether or not the division exists at your health center, and if yes, the number of tests performed in CY 2003, and the number of unduplicated, confirmed HIV positive test results.

Divisions	Does the division exist at your health center— Yes or No?	Number of tests performed in 2003	Number of <u>unduplicated, confirmed HIV positive</u> test results
a) Family Medicine, Internal Medicine (and Pediatrics)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b) Obstetrical Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
c) Pediatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
d) Urgent Care/Walk In Clinic	<input type="checkbox"/> Yes <input type="checkbox"/> No		
e) Dental Clinic	<input type="checkbox"/> Yes <input type="checkbox"/> No		
f) HIV Clinic	<input type="checkbox"/> Yes <input type="checkbox"/> No		
g) Adolescent/Teen Clinic	<input type="checkbox"/> Yes <input type="checkbox"/> No		
h) School-based Clinic	<input type="checkbox"/> Yes <input type="checkbox"/> No		
i) Substance Abuse Program	<input type="checkbox"/> Yes <input type="checkbox"/> No		
j) Outreach/Offsite testing location	<input type="checkbox"/> Yes <input type="checkbox"/> No		
k) Mobile Unit	<input type="checkbox"/> Yes <input type="checkbox"/> No		
l) Other, specify _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

9) What kinds of HIV tests were used by your health center in CY 2003? (Check all that apply.)

- On-site conventional blood test** (blood draw, need to return on a later date for result)
- On-site conventional oral test** (OraSure – oral fluid test; need to return on a later date for result)
- On-site rapid test** (OraQuick – get result the same day)
- Off-site referral, conventional blood test** (blood draw, need to return on a later date for result)
- Off-site referral, conventional oral test** (OraSure – oral fluid test; need to return on a later date for result)
- Off-site referral, rapid test** (OraQuick – get result the same day)

10) Were patients given the choice of the collection method (blood vs. oral) for their HIV test in CY 2003?

Yes No

11) Were patients given the choice of the test type (rapid vs. conventional) for their HIV test in CY 2003?

Yes No

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12) For each collection method/assay listed below, indicate the number of tests your health center provided* in CY 2003.

- | | Number of Tests Provided* |
|--|---------------------------|
| a) Conventional blood test (blood draw, need to return on a later date for result) | _____ tests |
| b) Conventional oral test (OraSure –oral fluid test; need to return on a later date for result) | _____ tests |
| c) Rapid Test (OraQuick - get result the same day) | _____ tests |
| d) Total | _____ tests |

13) In comparison to CY 2002, in CY 2003 did the number of unduplicated patients tested for HIV increase, decrease or remain about the same?

- Increase
 Decrease
 Remain about the same

14) Answer the following questions about availability of materials and services:

a) In CY 2003, were condoms available to patients?	<input type="checkbox"/> Yes, for all patients <input type="checkbox"/> Yes, for patients in special programs and/or special populations	<input type="checkbox"/> No
b) In CY 2003, were HIV prevention education materials (posters, flyers, pamphlets, etc.) posted in locations visible to patients?	<input type="checkbox"/> Yes, for all patients <input type="checkbox"/> Yes, for patients in special programs and/or special populations	<input type="checkbox"/> No
c) In CY 2003, did the health center use a standardized tool to ask HIV-uninfected (HIV negative) patients about sexual behaviors that increase risk of HIV infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) In CY 2003, did the health center use a standardized tool to ask HIV-infected (HIV positive) patients about sexual behaviors that increase their risk of transmitting HIV to others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) In CY 2003, did the health center routinely work with HIV-uninfected (HIV negative) patients at regular intervals to develop a personalized plan to reduce risk of infection with HIV/STDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) In CY 2003, did the health center routinely work with HIV-infected (HIV positive) patients at regular intervals to develop a personalized plan to reduce risk of transmitting HIV to others and acquiring other strains of HIV and/or STDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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15) In CY 2003, did your health center have *written procedures requiring staff to do the following?*

a) Offer HIV testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Provide HIV pre-test counseling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Provide HIV post-test counseling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Make referrals to local health department services for HIV Partner Counseling and Referral Services (PCRS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) Deliver "Prevention with Positives" counseling to HIV infected (HIV positive) patients to help reduce their risk of transmitting HIV to others	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Discuss specific sexual behaviors with patients	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) Discuss drug use with patients	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) Discuss alcohol use with patients	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i) Offer HIV testing for patients receiving STD testing or services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j) Offer STD testing for patients receiving HIV testing or services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k) Provide routine HIV risk assessments	<input type="checkbox"/> Yes	<input type="checkbox"/> No

16) In CY 2003, did your health center have *written procedures requiring staff to do the following with pregnant women?*

a) Provide HIV testing to pregnant women	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Provide HIV test counseling to pregnant women	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Obtain and document consent for HIV testing by pregnant women	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Document refusal of HIV testing by pregnant women in the medical chart	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) Test all pregnant women for HIV in their first trimester of pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Screen or re-screen all pregnant women in the third trimester	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) Ensure that documented HIV test results are available in the medical chart at labor and delivery	<input type="checkbox"/> Yes	<input type="checkbox"/> No

17) In CY 2003, what was the likelihood that a patient would receive the following services at your health center if pregnant?

If your center did not have OB (obstetrical care) services in CY 2003, please check here: Not-applicable.

"0" indicates that the item was not at all likely; a "6" indicates that the item was completely likely.

	Not at all Likely						Completely Likely
	0	1	2	3	4	5	6
a) Written consent/refusal for HIV testing placed in medical chart	0	1	2	3	4	5	6
b) HIV test counseling	0	1	2	3	4	5	6
c) HIV testing	0	1	2	3	4	5	6
d) HIV testing during the first trimester	0	1	2	3	4	5	6
e) HIV testing during the third trimester	0	1	2	3	4	5	6
f) HIV Education	0	1	2	3	4	5	6
g) HIV test result documentation in medical chart at labor and delivery	0	1	2	3	4	5	6

18) Use the table below to indicate if the following training topics were available to, or required of, staff in your health center in CY 2003:

Training Topics	Available to Staff	Required of Staff
a) How to provide HIV testing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) How to provide Rapid HIV Testing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) How to refer HIV-infected (HIV positive) patients to local health department for HIV partner notification services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) How to provide HIV testing and education to pregnant women	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) How to deliver "Prevention with Positives" counseling to help HIV-infected (HIV positive) patients reduce their transmission risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) How to provide HIV testing to patients receiving STD testing or treatment services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) How to provide STD testing to patients receiving HIV testing or care and treatment services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) How to conduct routine HIV risk assessments with patients	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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19) How likely is it that providers at your health center receive training in the areas listed below?

"0" indicates that the item is not at all likely; a "6" indicates that the item is completely likely.

	Not at all Likely						Completely Likely	
a) US Public Health Service HIV Treatment Guidelines	0	1	2	3	4	5	6	
b) CDC/HRSA Recommendations on Incorporating HIV Prevention into the Medical Care of Persons Living with HIV	0	1	2	3	4	5	6	
c) Prevention Case Management (PCM)	0	1	2	3	4	5	6	
d) HIV and STD Risk Reduction Counseling	0	1	2	3	4	5	6	
e) HIV Counseling and Testing	0	1	2	3	4	5	6	
f) Partner Counseling and Referral Services (PCRS)	0	1	2	3	4	5	6	
g) Treatment Adherence	0	1	2	3	4	5	6	
h) Mental Health/Psychosocial Issues	0	1	2	3	4	5	6	

20) Are patients required to sign written consent for HIV tests provided* by your health center?

- Yes
 - No
 - Not applicable (no testing provided by this health center)
- If your health center does NOT provide* HIV testing, please GO to Question 22.**

21) Do any of the following policies apply to obtaining written consent to test for HIV in your health center? (Check all that apply.)

- Health center procedure
- State law
- Federal requirement
- At provider discretion

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22) Please indicate to what extent the following barriers to *providing HIV testing* existed at your health center in CY 2003.

“0” indicates that the item was not a barrier at all; a “6” indicates that the item was a major barrier.

	No barrier							Major barrier
a) Funding	0	1	2	3	4	5	6	
b) HIV was not a problem in our community	0	1	2	3	4	5	6	
c) Time	0	1	2	3	4	5	6	
d) Staff knowledge/skill	0	1	2	3	4	5	6	
e) Staff experience	0	1	2	3	4	5	6	
f) Facilities/space	0	1	2	3	4	5	6	
g) Laboratory	0	1	2	3	4	5	6	
h) Staff size	0	1	2	3	4	5	6	
i) Health center did not want to be known as an HIV provider	0	1	2	3	4	5	6	
j) Staff resistance	0	1	2	3	4	5	6	
k) Board resistance								
l) Informed consent	0	1	2	3	4	5	6	
m) Requirement to provide counseling along with HIV testing	0	1	2	3	4	5	6	
n) No place to refer patients who were identified as HIV infected (positive)	0	1	2	3	4	5	6	
o) Other, please specify _____	0	1	2	3	4	5	6	

23) Please indicate to what extent the following barriers to *providing HIV care and treatment* existed at your health center in CY 2003.

“0” indicates that the item was not a barrier at all; a “6” indicates that the item was a major barrier.

	No barrier							Major barrier
a) Funding	0	1	2	3	4	5	6	
b) HIV was not a problem in our community	0	1	2	3	4	5	6	
c) Staff knowledge/skill	0	1	2	3	4	5	6	
d) Staff experience	0	1	2	3	4	5	6	
e) Facilities/space	0	1	2	3	4	5	6	
f) Cost/reimbursement	0	1	2	3	4	5	6	
g) Health center did not want to be known as an HIV provider	0	1	2	3	4	5	6	
h) Laboratory	0	1	2	3	4	5	6	
i) Staff resistance	0	1	2	3	4	5	6	
j) Board resistance	0	1	2	3	4	5	6	
k) Other, please specify: _____	0	1	2	3	4	5	6	

24) Please indicate to what extent the following barriers to accurate *medical record documentation* of HIV risk factors for each patient existed at your health center in CY 2003.

“0” indicates that the item was not a barrier at all; a “6” indicates that the item was a major barrier.

	No barrier						Major barrier
a) Time constraints	0	1	2	3	4	5	6
b) Lack of trained staff	0	1	2	3	4	5	6
c) No established procedure to document HIV risk factors	0	1	2	3	4	5	6
d) Obstacles the patient presented	0	1	2	3	4	5	6
e) Subjects providers found personally uncomfortable	0	1	2	3	4	5	6
f) Cost/reimbursement	0	1	2	3	4	5	6
g) Provider’s desire to protect patient’s insurability	0	1	2	3	4	5	6
h) Patient refusal	0	1	2	3	4	5	6
i) HIV risk factors did not relate to patient care	0	1	2	3	4	5	6
j) Other, please specify: _____	0	1	2	3	4	5	6

25a) For CY 2003, provide the *total number* of unduplicated HIV-infected (HIV positive) patients your health center served.

_____ patients
If zero patients were served, please GO to Question 26a.

25b) Of these, how many were new patients in CY 2003?

_____ patients

26) When a patient/client tests positive for HIV (new positive) and demonstrates a need for a given service, what is the likelihood that he/she will receive the following?

“0” indicates that the item is not at all likely; a “6” indicates that the item is completely likely.

26a) On-Site:

	Not-applicable (service not provided on-site)	Not at all Likely	0	1	2	3	4	5	6	Completely Likely
a) Medical evaluation, same day	<input type="checkbox"/>	0	1	2	3	4	5	6		
b) Medical evaluation, appointment for later date	<input type="checkbox"/>	0	1	2	3	4	5	6		
c) Psychosocial evaluation	<input type="checkbox"/>	0	1	2	3	4	5	6		
d) Psychosocial Case Management/ Support Group	<input type="checkbox"/>	0	1	2	3	4	5	6		
e) Income Support Services (e.g., SSI, Disability)	<input type="checkbox"/>	0	1	2	3	4	5	6		
f) Medical Benefits Counseling (e.g., ADAP, Medicaid, etc.)	<input type="checkbox"/>	0	1	2	3	4	5	6		
g) Medical Case Management	<input type="checkbox"/>	0	1	2	3	4	5	6		
h) HIV/STD Risk Reduction Counseling	<input type="checkbox"/>	0	1	2	3	4	5	6		
i) Prevention Case Management (PCM)	<input type="checkbox"/>	0	1	2	3	4	5	6		
j) Partner Counseling and Referral Services (PCRS)	<input type="checkbox"/>	0	1	2	3	4	5	6		

26b) Referral Off-Site:

	Not-applicable (health center does not refer off-site for service)	Not at all Likely	0	1	2	3	4	5	6	Completely Likely
k) Medical evaluation, same day	<input type="checkbox"/>	0	1	2	3	4	5	6		
l) Medical evaluation, appointment for later date	<input type="checkbox"/>	0	1	2	3	4	5	6		
m) Psychosocial evaluation	<input type="checkbox"/>	0	1	2	3	4	5	6		
n) Psychosocial Case Management/ Support Group	<input type="checkbox"/>	0	1	2	3	4	5	6		
o) Income Support Services (e.g., SSI, Disability)	<input type="checkbox"/>	0	1	2	3	4	5	6		
p) Medical Benefits Counseling (e.g., ADAP, Medicaid, etc.)	<input type="checkbox"/>	0	1	2	3	4	5	6		
q) Medical Case Management	<input type="checkbox"/>	0	1	2	3	4	5	6		
r) HIV/STD Risk Reduction Counseling	<input type="checkbox"/>	0	1	2	3	4	5	6		
s) Prevention Case Management (PCM)	<input type="checkbox"/>	0	1	2	3	4	5	6		
t) Partner Counseling and Referral Services (PCRS)	<input type="checkbox"/>	0	1	2	3	4	5	6		

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27) Regardless of HIV diagnosis date (new and prior positives), what is the likelihood that an HIV-infected (HIV positive) patient at your health center, who demonstrates a need for any of the following services, will receive the service?

"0" indicates that the item is not at all likely; a "6" indicates that the item is completely likely.

27a) On-Site:

	Not-applicable (service not provided on-site)	Not at all Likely	1	2	3	4	5	Completely Likely	6
a) HIV related medical evaluation, care, and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6	6
b) Medical Case Management	<input type="checkbox"/>	0	1	2	3	4	5	6	6
c) Prevention Case Management (PCM)	<input type="checkbox"/>	0	1	2	3	4	5	6	6
d) Psychosocial Case Management/ Support Group	<input type="checkbox"/>	0	1	2	3	4	5	6	6
e) Assessment of their sexual behavior	<input type="checkbox"/>	0	1	2	3	4	5	6	6
f) Assessment of their drug use	<input type="checkbox"/>	0	1	2	3	4	5	6	6
g) Routine STD screening, care and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6	6
h) Partner Counseling and Referral Services (PCRS)	<input type="checkbox"/>	0	1	2	3	4	5	6	6
i) Reproductive health services	<input type="checkbox"/>	0	1	2	3	4	5	6	6
j) Drug or alcohol prevention and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6	6
k) Mental health services	<input type="checkbox"/>	0	1	2	3	4	5	6	6
l) Screening and vaccination for hepatitis B	<input type="checkbox"/>	0	1	2	3	4	5	6	6
m) Screening and treatment for hepatitis C	<input type="checkbox"/>	0	1	2	3	4	5	6	6
n) Other services, specify: _____	<input type="checkbox"/>	0	1	2	3	4	5	6	6

For the next section, we'd like to ask you about off-site referrals for **HIV-infected** (HIV positive) patients for which your health center covers the costs.

27b) Referral Off-Site, costs COVERED by your health center:

	Not-applicable (health center does not refer off-site for service)	Not at all Likely						Completely Likely
a) HIV related medical evaluation, care, and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6
b) Medical Case Management	<input type="checkbox"/>	0	1	2	3	4	5	6
c) Prevention Case Management (PCM)	<input type="checkbox"/>	0	1	2	3	4	5	6
d) Psychosocial Case Management/ Support Group	<input type="checkbox"/>	0	1	2	3	4	5	6
e) Assessment of their sexual behavior	<input type="checkbox"/>	0	1	2	3	4	5	6
f) Assessment of their drug use	<input type="checkbox"/>	0	1	2	3	4	5	6
g) Routine STD screening, care and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6
h) Partner Counseling and Referral Services (PCRS)	<input type="checkbox"/>	0	1	2	3	4	5	6
i) Reproductive health services	<input type="checkbox"/>	0	1	2	3	4	5	6
j) Drug or alcohol prevention and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6
k) Mental health services	<input type="checkbox"/>	0	1	2	3	4	5	6
l) Screening and vaccination for hepatitis B	<input type="checkbox"/>	0	1	2	3	4	5	6
m) Screening and treatment for hepatitis C	<input type="checkbox"/>	0	1	2	3	4	5	6
n) Other services, specify: _____	<input type="checkbox"/>	0	1	2	3	4	5	6

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For the next section, we'd like to ask you about off-site referrals for **HIV-infected** (HIV positive) patients for which your health center does NOT cover the costs.

27c) Referral Off Site, cost NOT COVERED by your health center:

	Not-applicable (health center does not refer off-site for service)	Not at all Likely						Completely Likely
a) HIV related medical evaluation, care, and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6
b) Medical Case Management	<input type="checkbox"/>	0	1	2	3	4	5	6
c) Prevention Case Management (PCM)	<input type="checkbox"/>	0	1	2	3	4	5	6
d) Psychosocial Case Management/ Support Group	<input type="checkbox"/>	0	1	2	3	4	5	6
e) Assessment of their sexual behavior	<input type="checkbox"/>	0	1	2	3	4	5	6
f) Assessment of their drug use	<input type="checkbox"/>	0	1	2	3	4	5	6
g) Routine STD screening, care and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6
h) Partner Counseling and Referral Services (PCRS)	<input type="checkbox"/>	0	1	2	3	4	5	6
i) Reproductive health services	<input type="checkbox"/>	0	1	2	3	4	5	6
j) Drug or alcohol prevention and treatment	<input type="checkbox"/>	0	1	2	3	4	5	6
k) Mental health services	<input type="checkbox"/>	0	1	2	3	4	5	6
l) Screening and vaccination for hepatitis B	<input type="checkbox"/>	0	1	2	3	4	5	6
m) Screening and treatment for hepatitis C	<input type="checkbox"/>	0	1	2	3	4	5	6
n) Other services, specify: _____	<input type="checkbox"/>	0	1	2	3	4	5	6

Submit by October 29, 2004

28) What data sources were used to complete this questionnaire? (Check all that apply.)

- Staff estimate
- Appointment records
- Electronic medical records
- UDS data
- Billing records
- CADR (CARE Act Data Report)
- HIV Qual
- Patient surveys
- HIV/AIDS Reporting System (HARS)
- Conversations with providers/administrators
- Other (please specify)_____
- Other (please specify)_____
- Other (please specify)_____

End. Thank You!

Submit by October 29, 2004



**National Association of
Community Health Centers, Inc.®**

7200 Wisconsin Avenue, Suite 210

Bethesda, MD 20814

301/347-0400

www.nachc.com