**SECTION A: ORGANIZATION DATA**

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| **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_  **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Hours of Operation: Day:** \_\_\_\_\_\_\_\_\_ **Evening:**  \_\_\_\_\_\_\_\_\_ **Weekend**: \_\_\_\_\_\_\_\_\_  **How long has the organization been established?** [ ] <2 years [ ] < 5 years [ ] 5 years or more |
| ***Note:*** *Please note estimates with an asterisk (\*).*  **Provider Type** (Check all that apply):  **[ ]** PHC – Public Health/STD Clinic **[ ]** PP – Private Provider Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **[ ]** ACO – Accountable Care Org **[ ]** HMO – Health Maintenance Org  **[ ]** CBO – Community Based Org **[ ]** CHC – Community Health Clinic  **[ ]** HCP – HIV Clinic **[ ]** IDC - Infectious Disease Clinic    **Patient/client capacity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** patients seen per week   * Specialize in adolescent/youth populations? No [ ] Yes [ ] * Specialize in MSM or LGBT populations? No [ ] Yes [ ] * Specialize in Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No [ ] Yes [ ]   **STD/HIV morbidity** (past 3 months):   * GC \_\_\_\_\_\_\_ cases Syphilis \_\_\_\_\_\_\_\_ cases HIV \_\_\_\_\_\_\_\_ cases (new) * CT \_\_\_\_\_\_\_ cases HIV \_\_\_\_\_\_\_\_ cases (in tx)   **Records Management approach** (If Yes, please indicate Vendor):   * Electronic Medical Records (EMR) No [ ] Yes [ ] Vendor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Electronic Health Records (EHR) No [ ] Yes [ ]   Vendor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Insurance/payments management capacity** (Check all that apply):  **[ ]** Private **[ ]** Medicaid **[ ]** Medicare **[ ]** Patients charged directly  **[ ]** We do not bill for services  **What type of resources do you receive from the Health Department** (check all that apply)?  **[ ]** Funding **[ ]** Bicillin **[ ]** Condoms **[ ]** Informational brochures or pamphlets  **[ ]** Training/CEUs **[ ]** Staff **[ ]** Screening support  **[ ]** Assistance with partner services **[ ]** Other (please specify below) |

**SECTION B SERVICES CHECKLIST**

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| --- | --- | --- | --- | --- | --- |
|  | **These services are offered for:** | | | **Comments** | |
| **Screening or testing:**  **Sample collected onsite** | **MSM** | **Adolescents** | **General** |  | |
| **If NO screening or testing skip to Other Services** | | | | | |
| HIV/Rapid |  |  |  |  | |
| HIV/Mouth Swab |  |  |  |  | |
| HIV/Blood |  |  |  |  | |
| **IF HIV Testing Site Only** Skip to **Outreach Screening/Testing** | | | | | |
| Chlamydial infection |  |  |  |  | |
| Gonorrhea |  |  |  |  | |
| Extra-genital testing (Throat/anal) for chlamydia or gonorrhea |  |  |  |  | |
| Syphilis (Blood draw) |  |  |  |  | |
| Syphilis (finger stick rapid test) |  |  |  |  | |
| Herpes simplex virus, type 1 or 2 |  |  |  |  | |
| Human papillomavirus |  |  |  |  | |
| Bacterial Vaginosis |  |  |  |  | |
| Trichomoniasis |  |  |  |  | |
| Hepatitis A |  |  |  |  | |
| Hepatitis B |  |  |  |  | |
| Hepatitis C |  |  |  |  | |
| Other (Please specify) |  |  |  |  | |
| **History and Physical Exam** | **MSM** | **Adolescents** | **General** |  | |
| Sexual History & Risk Assessment |  |  |  |  | |
| Physical Examination |  |  |  |  | |
| **Onsite treatment** | **MSM** | **Adolescents** | **General** | **Onsite Pharmacy/Medications** | **Prescription Given** |
| Chlamydial infection |  |  |  |  |  |
| Gonorrhea |  |  |  |  |  |
| Syphilis |  |  |  |  |  |
| Herpes, type 1 or 2 |  |  |  |  |  |
| HPV (genital warts) |  |  |  |  |  |
| Bacterial vaginosis |  |  |  |  |  |
| Trichomoniasis |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |
| Hepatitis C |  |  |  |  |  |
| **Outreach Screening/testing** | **MSM** | **Adolescents** | **General** |  | |
| Jails |  |  |  |  | |
| Screening on College/high school Campuses |  |  |  |  | |
| Bars/ Night Clubs/Bathhouses |  |  |  |  | |
| Other community venues |  |  |  |  | |
| Use of a mobile testing unit |  |  |  |  | |
| Other community outreach to promote STD services |  |  |  | Check if outreach includes using social media  [ ] |  |
|  |  |  |  |  | |
| **Onsite Vaccination** | **MSM** | **Adolescents** | **General** |  | |
| Human papillomavirus |  |  |  |  | |
| Hepatitis A |  |  |  |  | |
| Hepatitis B |  |  |  |  | |
| **Onsite Reproductive Health Services** | **MSM** | **Adolescents** | **General** |  | |
| Long-acting reversible contraception (LARC) or Birth Control Pills |  |  |  |  | |
| Emergency Contraceptive  Provision |  |  |  |  | |
| Family planning counseling |  |  |  |  | |
| STD testing for pregnant women |  |  |  |  | |

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| **Onsite STD/HIV Patient Management and other Services** | **MSM** | **Adolescents** | **General** |  | | |
| Website with STD information |  |  |  |  | | |
| STD prevention written guidance |  |  |  |  | | |
| Sex Education |  |  |  |  | | |
| Contact infected patient’s sex partners to notify of exposure & suggest care. |  |  |  | Check if ever done through email, text, or social media [ ] | Check if done through collaboration with HD  [ ] | |
| Interview patients for partners and inform health department |  |  |  |  | | |
| Patients receive notification letter(s) to give to their partner(s) |  |  |  |  | | |
| Brief interactive counseling to encourage infected patients to notify partners of exposure |  |  |  |  | | |
| Patients can get meds or prescriptions to give to partners |  |  |  | Please name infections for which this is done here, if applicable (e.g., gonorrhea, chlamydia). | | |
| Brief STI/HIV behavioral counseling intervention sessions (up to 30 minutes) |  |  |  |  | | |
| STI/HIV behavioral counseling intervention sessions (more than 30 minutes) |  |  |  |  | | |
| PrEP counseling |  |  |  |  | | |
| PrEP medication |  |  |  |  | | |
| PEP counseling |  |  |  |  | | |
| PEP medication |  |  |  |  | | |
| HIV Case Management (including re-linkage to care) |  |  |  |  | | |
| **Non STD Services** | **MSM** | **Adolescents** | **General** | **Onsite** | | **Referred to other provider** |
| Substance abuse treatment |  |  |  |  | |  |
| Primary Care medical services |  |  |  |  | |  |
| Health management services (e.g., chronic disease prevention) |  |  |  |  | |  |
| Mental health services |  |  |  |  | |  |
| Social service programs (e.g., job-seeking assistance, WIC, SNAP) |  |  |  |  | |  |
| Health insurance enrollment |  |  |  |  | |  |
| Community-located protective services (e.g., shelters, domestic violence) |  |  |  |  | |  |

**SECTION C PARTNERSHIP AND REFERRAL LIST**

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| --- | --- | --- | --- |
| Please list the organizations or facilities **with which you work most frequently or most closely to provide services for your patients or clientele**.  These organizations do not have to provide the same types of service as your facility.  Referral means you advise patients to seek services at a given organization (or vice versa).  Co-management of patients means an ongoing relationship that allows for sharing information or taking joint action on individual patients. | Name: | Address/contact: | \_\_ I refer patients to them.  \_\_ They refer patients to us.  \_\_ We co-manage patients. |
| Name: | Address/contact: | \_\_ I refer patients to them.  \_\_ They refer patients to us.  \_\_ We co-manage patients. |
| Name: | Address/contact: | \_\_ I refer patients to them.  \_\_ They refer patients to us.  \_\_ We co-manage patients. |
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| Name: | Address/contact: | \_\_ I refer patients to them.  \_\_ They refer patients to us.  \_\_ We co-manage patients. |
| **Notes/Additional Information**  Is there anything else that we did not ask, that you think we should consider or know?  Thank you again for participating. Please return completed checklist back to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  by \_\_\_\_\_\_\_\_\_\_\_\_. | | | |