




HARRISHEALTH
SYSTEM



SPNS Initiative:
Building a Medical Home for
Multiply-Diagnosed HIV Homeless
Populations

Preceptorships

5. Any other topic in clinical management: - Specify: _____

6. Please indicate your level of knowledge in the following <u>Organizational and Delivery</u> topics.	I know next to nothing <u>None/novice</u>	I know a little bit <u>Some/Basic Knowledge</u>	I have basic knowledge <u>Intermediate</u>	I am comfortable teaching patients <u>Advanced</u>	<u>Expert</u>	7. Please <u>choose</u> TOP 5 topics that you would be most interested in receiving training on. 
1. Agency Needs Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Community Linkages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Cultural Competence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Education Development/Delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Grant Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Health Literacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Healthcare Development/ Clinical Service Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Healthcare Organization and Finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. HIPAA/Confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Quality Improvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Resource Allocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Risk Assessment/Screening/ Routine HIV Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Psychosocial/Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Alcohol/Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Any other topics in organizational and delivery: Specify: _____

9. Please indicate your level of knowledge on the following <u>Target Population</u> topics	I know next to nothing <u>None/novice</u>	I know a little bit <u>Some/Basic Knowledge</u>	I have basic knowledge <u>Intermediate</u>	I am comfortable teaching patients <u>Advanced</u>	<u>Expert</u>	10. Please choose TOP 5 topics that you would be most interested in receiving training on. ↓
Adolescent (Ages 13-24)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children (Birth – 12months)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gay/Lesbian/Bisexual/Transgender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless/Unstably Housed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immigrant/Border Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incarcerated Individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV in People Over 50 Years of Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African Americans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latino Population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
American Indian/Alaska Natives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rural Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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11. Other populations – Specify: _____

12. What are your preferred ways to receive education/training? Please choose all that apply.

- Individual clinical case discussions/consultations
- Group clinical case discussions
- Clinical practicum/preceptorship (hands-on clinical training)
- Technical Assistance (Resources, Quality Management, Performance Improvement)
- Skills-building interactive workshops/sessions
- Conference Lecture/Didactic
- Internet - Live webinar format
- Internet based -Self Study
- Internet - Podcasts (audio only)
- Non-internet Self study -Training manuals/materials
- Telephone Consultations
- Preceptorship/Mini-Residency
- Other

13. Other Specify: _____

14. What are the **TOP THREE** factors that would influence your decision to attend trainings/seminars/workshops?

CHOOSE 3 FROM THE LIST BELOW:

- Speaker
- Topic
- Length of time of the training
- Workplace support
- Ability to receive time off from work
- Offered during non-work hours (lunch or dinner)
- Offered on a weekend
- Availability of Continuing Education Units
- Venue/location of training
- If a meal is provided
- If the event does not have pharmaceutical support (employer doesn't allow attendance at pharma events)
- Other:

15. Other Specify: _____

16. Estimate the **NUMBER of HIV-infected** clients/patients to whom you provide direct services on **average in a MONTH.**

- | | |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> 75-99 |
| <input type="checkbox"/> 1-9 | <input type="checkbox"/> 100-1150 |
| <input type="checkbox"/> 10-19 | <input type="checkbox"/> other |
| <input type="checkbox"/> 20-49 | |
| <input type="checkbox"/> 50-74 | |

17. Other - Specify: _____

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18. What type of services do you personally provide to your patients/clients? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Admit orders | <input type="checkbox"/> Medication education |
| <input type="checkbox"/> Case management | <input type="checkbox"/> Prescription verification |
| <input type="checkbox"/> Coordinate inpatient and outpatient care | <input type="checkbox"/> Prevention education |
| <input type="checkbox"/> Discharge planning | <input type="checkbox"/> Review/interpret HIV lab results |
| <input type="checkbox"/> Referral to medical specialist | <input type="checkbox"/> Dental care |
| <input type="checkbox"/> Follow-up with referrals/missed appointments | <input type="checkbox"/> Symptom management |
| <input type="checkbox"/> Referral to social services | <input type="checkbox"/> OBGYN services |
| <input type="checkbox"/> Mental health services | <input type="checkbox"/> Substance (drug) abuse treatment |
| <input type="checkbox"/> HIV testing | <input type="checkbox"/> Alcohol abuse treatment |
| <input type="checkbox"/> Pre/post HIV test counseling | <input type="checkbox"/> Home care/hospice |
| <input type="checkbox"/> Prescribe HIV medications | <input type="checkbox"/> Triage |
| <input type="checkbox"/> Treatment adherence support | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medication administration/management | |

19. Other: please specify: _____

20. What is your primary profession/job title? (select ONE)

- | | |
|--|--|
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Other Dental Professional | <input type="checkbox"/> Case manager |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Other Advanced Practice Nurse | <input type="checkbox"/> LVN/LPN |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Community Health Representative |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> other |
| <input type="checkbox"/> Physician | |

21. Other specify: _____

22. What is your primary specialty/area of practice? (Please select one that best describes)

- | | |
|--|---|
| <input type="checkbox"/> Addiction Medicine | <input type="checkbox"/> Oral/Dental Medicine |
| <input type="checkbox"/> Community/Public Health | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> General/Family Practice | <input type="checkbox"/> Psychiatry/Mental Health |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Other |
| <input type="checkbox"/> OB/GYN | <input type="checkbox"/> None/Does not apply |
| <input type="checkbox"/> Oncology | |

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23. Other specify: _____