eHIVQUAL

Manual Data Collection Form
ALL HIV+ Patients (regardless of age)
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. *See the eHIVQUAL indicator guide for details regarding which data elements are required based on the patient's care status*.

Note for users who will be uploading patient data:
Variable names for data import are specified in red font. Allowable values, where applicable, are specified in green. *Please see data dictionary and other data import documentation for additional details*.

REVIEW PERIOD: _____

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

PRELIMINARY STEP: PATIENT IDENTIFYING INFORMATION

WAS THE PATIENT ENROLLED IN YOUR HIV PROGRAM AS OF THE END OF THE REVIEW PERIOD (12/31/16)? (PatientEnrollment)	YES (Yes)	
	NO (No)	

LAST NAME (LastName):

FIRST NAME (FirstName):

MIDDLE INITIAL (OPTIONAL) (MI):

DATE OF BIRTH (DOB): / / (FOUR DIGIT YEAR)

MEDICAL RECORD # (MRN):

GENDER (SEX):		FEMALE (Female)		TRANSGENDER: MALE TO FEMALE (TransMF)		UNKNOWN (UK) [Non-active only]
		MALE (Male)		TRANSGENDER: FEMALE TO MALE (TransFM)		

RACE/ETHNICITY (Race):		WHITE, NON-HISPANIC (1)
		BLACK, NON-HISPANIC (2)
		HISPANIC (3)
		ASIAN (4)
		AMERICAN INDIAN/ALASKA NATIVE (5)
		NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER (6)
		MORE THAN ONE RACE OR ETHNICITY (9)
		UNKNOWN (8) [Non-active only]
EXPOSURE CATEGORY (Risk)		INJECTING DRUG USER (IDU) (1)
		HEMOPHILIA/COAGULATION DISORDER (2)
		PERINATAL TRANSMISSION (3)
		HETEROSEXUAL (4)
		TRANSFUSION/BLOOD COMPONENTS (5)
		HETEROSEXUAL & IDU (6)
		MEN WHO HAVE SEX WITH MEN (MSM) (7)
		MSM & IDU (8)
		OTHER (9)
		UNKNOWN (10)

WHEN WAS THE PATIENT FIRST DIAGNOSED AS BEING HIV+ (AT YOUR CLINIC OR ELSEWHERE)? (VisitHIVDiagnosis)	PRIOR TO THE REVIEW PERIOD (BEFORE 1/1/2016) (B2016)
	DURING THE REVIEW PERIOD (1/1/2016 TO 12/31/16) (Y2016)
	UNKNOWN (UK) [Non-active only]

1. PATIENT PROFILE

Part 1

IF THE PATIENT WAS ENROLLED IN YOUR HIV PROGRAM AS OF THE END OF THE REVIEW PERIOD (SEE ABOVE), SKIP TO **Part 2**. OTHERWISE PROCEED TO THE NEXT QUESTION HERE.

DID THE PATIENT DIE DURING THE REVIEW PERIOD (1/1/16 TO 12/31/16)? (PatientLapseExp)

- YES (1) -> Go To Part 2
- NO (0) -> Proceed to Next Question

WAS THE PATIENT INCARCERATED AS OF THE END OF THE REVIEW PERIOD (12/31/16)? (PatientLapseInc)

- YES (1) -> Stop (no other data needed)
- NO (0) -> Proceed to Next Question

WAS THE PATIENT RECEIVING ONGOING HIV CARE FROM ANOTHER PROVIDER BY THE END OF THE REVIEW PERIOD (1/1/16)? (PatientLapseTransfer)

- YES, IN NYS (1)
  - ENTER THE NAME OF THE EXTERNAL FACILITY WHERE THE PATIENT IS RECEIVING CARE (PatientLapseOthSpec):
  - -> Stop (no other data needed)
- YES, OUTSIDE NYS (2)
  - ENTER THE NAME OF THE STATE OR COUNTRY WHERE THE PATIENT IS RECEIVING CARE (PatientLapseOthSpec):
  - -> Stop (no other data needed)
- NO (3)
  - WAS THE PATIENT SEEN ONLY IN YOUR EMERGENCY DEPARTMENT DURING THE REVIEW PERIOD (1/1/16 - 12/31/16) ? (PatientLapseER)
    - YES (1)
    - NO (0)
    - NOT APPLICABLE (2)
  - WAS THE PATIENT SEEN ONLY AS AN INPATIENT DURING THE REVIEW PERIOD (1/1/16 - 12/31/16)? (PatientLapseIP)
    - YES (1)
    - NO (0)
    - NOT APPLICABLE (2)
  - -> Proceed to Part 2

Part 2

WAS THE PATIENT ON ARV MEDICATION AT ANY TIME DURING THE REVIEW PERIOD? (ARVTx)		YES (Yes)		
		NO (No)		
		UNKNOWN (UK)		
PRIMARY INSURANCE AT LAST STATUS CHECK DURING THE REVIEW PERIOD (Payor):		ADAP Plus (Primary Care) (22)		
		PRIVATE MANAGED CARE OR COMMERCIAL COVERAGE (2)		
		MEDICAID (11)		MEDICARE (8)
		MEDICAID AND MEDICARE (17)		
		OTHER OR UNKOWN (23)		
WHAT WAS THE PATIENT'S HOUSING SITUATION DURING THE LAST THREE MONTHS OF THE REVIEW PERIOD? (PatientHouse)		STABLE HOUSING (Stable)		
		UNSTABLE HOUSING OR LITERALLY HOMELESS (Unstable)		
		UNKNOWN (UK)		

2. HIV MONITORING

WHAT WAS THE DATE OF THE LAST VIRAL LOAD (VL) OBTAINED DURING THE REVIEW PERIOD? (LastVLDate)		NO TEST PERFORMED DURING REVIEW PERIOD (No)	
		UNKNOWN IF A TEST WAS PERFORMED DURING REVIEW PERIOD (UK)	
		DATE ENTERED (MM/DD/YY):	
IF DATE ENTERED:	WHAT WAS THE RESULT OF THIS TEST? (LastVLResult)		FEWER THAN 200 COPIES PER mL (DETECTABLE BUT < 200 OR BELOW QUANTITATIVE LEVEL OF DETECTABILITY) (Less200)
			DETECTABLE VIRAL LOAD OF 200 OR MORE COPIES PER mL (Over200)

3. STI TESTING (Only Required for Active Patients at Least 13 Years Old)

WAS PRIMARY SYPHILIS DIAGNOSED DURING THE REVIEW PERIOD? (STDMngTx)						☐	YES (Yes)
						☐	NO (No)
	IF YES, WAS THE INFECTION TREATED DURING THE REVIEW PERIOD (STDRxTx)					☐	YES (Yes)
						☐	NO (No)
	IF YES, ENTER THE FOLLOWING:	MEDICATION NAME (Medication) [Cat = Syphilis]	☐	BENZATHINE PENICILLIN G (305)			
			☐	PENICILLIN G (310)			
			☐	AQUEOUS PENICILLIN G (315)			
			☐	PROCAINE PENICILLIN G (320)			
			☐	PENICILLIN V (325)			
			☐	OTHER (320)			
			☐ ☐	IF OTHER, PLEASE SPECIFY (MedSpec):			
		ROUTE (MedRoute)	ORAL (PO)		DOSE (mg) (MedDose):		
					FREQUENCY (times per day) (MedFreq):		
					DURATION (days) (MedDuration):		
			INTRAMUSCULAR INJECTION (IM)		DOSE (millions of units) (MedDose):		
WAS A GENITAL (URINE, URETHRAL (M) OR CERVICAL (F), OR VAGINAL) GONORRHEA TEST PERFORMED DURING THE REVIEW PERIOD? (GonPerfTx)						☐	YES (Yes)
						☐	NO (No)
	IF YES, WAS THE RESULT POSITIVE? (GonPosTx)				☐ YES (Yes)	☐	NO (No)
		IF YES, WAS THE INFECTION TREATED? (GonRxTx)			☐ YES (Yes)	☐	NO (No)

IF TREATED, ENTER THE FOLLOWING (UP TO FOUR MEDICATIONS) [Cat = GonorrheaGenital]

MEDICATION (See List) (Medication); IF OTHER, PLEASE SPECIFY (MedSpec)	ROUTE (MedRoute): ORAL (PO) OR IM (IM)	DOSE (mg) (MedDose)	IF ORAL ADMINISTRATION	
			FREQUENCY (Times per day) (MedFreq)	DURATION (Days) (MedDuration)

IF THE PATIENT WAS A MAN WHO HAS SEX WITH MEN OR A MALE-TO-FEMALE TRANSGENDERED PERSON, WAS A PHARYNGEAL GONORRHEA TEST PERFORMED DURING THE REVIEW PERIOD? (GonPerfPharyTx)								YES NO (No)
	IF YES	WAS THE RESULT POSITIVE? (GonPosPharyTx)			YES (Yes)			NO (No)
			IF YES, WAS THE INFECTION TREATED? (GonRxPharyTx)					YES (Yes) NO (No)

IF TREATED, ENTER THE FOLLOWING (UP TO FOUR MEDICATIONS) [Cat = GonorrheaPhary]				
MEDICATION (See List) (Medication); IF OTHER, PLEASE SPECIFY (MedSpec)	ROUTE (MedRoute): ORAL (PO) OR IM (IM)	DOSE (mg) (MedDose)	IF ORAL ADMINISTRATION	
			FREQUENCY (Times per day) (MedFreq)	DURATION (Days) (MedDuration)

IF THE PATIENT WAS A MAN WHO HAS SEX WITH MEN OR A MALE-TO-FEMALE TRANSGENDERED PERSON, WAS A RECTAL GONORRHEA TEST PERFORMED DURING THE REVIEW PERIOD? (GonPerfRectalTx)								YES NO (No)
	IF YES	WAS THE RESULT POSITIVE? (GonPosRectalTx)			YES (Yes)			NO (No)
			IF YES, WAS THE INFECTION TREATED? (GonRxRectalTx)					YES (Yes) NO (No)

IF TREATED, ENTER THE FOLLOWING (UP TO FOUR MEDICATIONS) [Cat = GonorrheaRectal]				
MEDICATION (See List) (Medication); IF OTHER, PLEASE SPECIFY (MedSpec)	ROUTE (MedRoute): ORAL (PO) OR IM (IM)	DOSE (mg) (MedDose)	IF ORAL ADMINISTRATION	
			FREQUENCY (Times per day) (MedFreq)	DURATION (Days) (MedDuration)

WAS A GENITAL (URINE, URETHRAL (M) OR CERVICAL (F), OR VAGINAL) CHLAMYDIA TEST PERFORMED DURING THE REVIEW PERIOD? (ChlmPerfTx)								YES (Yes) NO (No)
	IF YES, WAS THE RESULT POSITIVE? (ChlmPosTx)				YES (Yes)			NO (No)
		IF YES, WAS THE INFECTION TREATED? (ChlmRxTx)			YES (Yes)			NO (No)

IF TREATED, ENTER THE FOLLOWING (UP TO FOUR MEDICATIONS) [Cat = ChlamydiaGenital]				
MEDICATION (See List) (Medication); IF OTHER, PLEASE SPECIFY (MedSpec)	ROUTE (MedRoute): ORAL (PO) OR IM (IM)	DOSE (mg) (MedDose)	IF ORAL ADMINISTRATION	
			FREQUENCY (Times per day) (MedFreq)	DURATION (Days) (MedDuration)

IF THE PATIENT WAS A MAN WHO HAS SEX WITH MEN OR A MALE-TO-FEMALE TRANSGENDERED PERSON, WAS A RECTAL CHLAMYDIA TEST PERFORMED DURING THE REVIEW PERIOD? (ChlmPerfRectalTx)					YES NO (No)
	IF YES	WHAT TYPE OF TEST WAS PERFOMED?		NUCLEIC ACID TEST (Y_N)	CULTURE (Y_C)
		WAS THE RESULT POSITIVE? (ChlmPosRectalTx)		YES (Yes)	NO (No)
			IF YES, WAS THE INFECTION TREATED? (ChlmRxRectalTx)		YES (Yes) NO (No)

IF TREATED, ENTER THE FOLLOWING (UP TO FOUR MEDICATIONS) [Cat = ChlamydiaRectal]

MEDICATION (See List) (Medication); IF OTHER, PLEASE SPECIFY (MedSpec)	ROUTE (MedRoute): ORAL (PO) OR IM (IM)	DOSE (mg) (MedDose)	IF ORAL ADMINISTRATION	
			FREQUENCY (Times per day) (MedFreq)	DURATION (Days) (MedDuration)

MEDICATION LIST:

- AMOCXICILLIN (405)
- AZITRHROMYCIN (410)
- CEFIXIME (415)
- CEFTRIAXONE (420)
- DOXYCYCLINE (425)
- ERYTHROMYCIN (430)
- LEVOFLOXACIN (435)
- OFLOXACIN (440)
- OTHER (445)