Data to Care
Data Collection Tool

Instructions: Please fill out <u>all</u> sections of this form

<u>Pages 1 and 2: Contact Attempts</u>

- **Data to Care #*:** Fill in the DtC # that is provided for each client in the Out of Care (OOC) List Excel file. ***<u>Please make sure that this number is correct, as this is the only way to identify the client from the DtC Form. DIS must also be sure to include the DtC # on every form.</u>***
- **Facility/Agency Name Completing the Form*:** Please provide the name of the facility/agency that is completing the investigation.
  - ***<u>*Must be included on every page of the DtC Data Collection Tool.</u>***
- **Field Record #** (For DIS only): Provide the field record number for the field record that was cut for this client.
- **Start Date: Provide** the date the investigation of the client begins.
- **End Date:** Provide the date in which the investigation is completed.
- **Due Date:** Provide the date in which the investigation is due back to VDH (60 days after Start Date).
- **Attempt Date:** Provide the date of the attempt to contact the client.
- **Method:** Select the method that was used to contact the client for this attempt (visit, phone call, text message, social media, letter, medical record, or other).
- **Progress:** Describe the steps you took to contact the client using the method above and the result of that contact attempt. You may note the time of day the contact attempt was made, etc.
- **Status:** Please check all that status boxes that apply, corresponding with the result of the contact attempt.
- **General Notes:** Please provide any general notes about the contact attempt or client that is necessary or important to include.

Repeat these instructions for each contact attempt, as necessary. At minimum, three different contact attempts should be made until the client is successfully contacted; however, the investigator must exhaust all possible avenues until they either locate and speak with the client or determine the client's outcome

<u>Page 3: Final Client Outcome:</u> refers to the overall outcome of the contact attempts that were made by the investigator. It is important that the outcome that is selected corresponds with the results of the contact attempts. Please select only one outcome and completely fill out any additional information for that outcome.

- **Current Client Address*:** Please provide the current street address, city, state/country and zip code of the client's current residence (Only include country if the client's current address is in a country other than the US). ***Complete this for all clients, regardless of outcome status.***
- **Client was Located and has Been in Medical Care Within the Last 12 Months:** This outcome should only be selected if there is evidence (through client contact, medical provider contact, medical records, etc.) that the client has had an HIV-related medical visit within the last 12 months. If this outcome is selected, the date of the most recent HIV-related medical appointment is required. If you are unsure of whether the client has been in care in the past 12 months then <u>DO NOT</u> select this outcome.
  - **Name of Medical Provider**: Please provide the name of the client's physician/provider
  - **Name of Medical Facility**: Please provide the name of the facility where the client had the HIV-related medical visit
  - **Facility Address**: Please provide the address of the facility listed above.
  - **Facility Phone Number**: Please provide the phone number of the facility listed above.
  - **Last Date of Medical Visit*:** Please provide the date of the client's last HIV-related medical visit.
  - **Date of Upcoming Appointment**: if the client has an upcoming HIV-related medical appointment scheduled, please provide the date of the future appointment.
- **Client was Located and is Not in Care:** Select this outcome only if the client was contacted and has not had a HIV-related medical visit in the last 12 months. The investigator must ask the client to sign the CCSA form, explaining that if the client experiences difficulty maintaining engagement with care in the future, signing the document will ease the process of providing assistance to get back in medical care. *Clients who refuse to sign the CCSA should still be offered referrals to care.*
  - **Barriers to Care:** Please check all boxes that apply to the client's barriers from engaging in HIV care.
  - **Currently Reengaging in Care:** Only select this outcome if the client has actively reengaged themselves in care prior to the investigator contacting the client. Please provide the date of the client's upcoming appointment, if possible.
  - **Want to Reengage in Care:** Select this outcome if the client agrees to be reengaged in care after speaking with the investigator. This is where the investigator offers reengagement/ linkage services.
    - **Referred to Navigator:** Provide the name of the navigator the client was referred to, if applicable.
    - **Referred to Provider:** Provide the name of the provider the client was referred to.
    - **Date of Appointment:** Please provide the date of medical appointment for the client to be reengaged in care.
  - **Refused Care:** Select this outcome if the client refused to be reengaged in care.
- **Client Relocated Out of State:** If there is evidence that the client has relocated out of state, provide the client's new state of residence, and the month and year the client moved (if available).
- **Client is Deceased:** Select this outcome if there is evidence that the client is deceased; provide the date of death and source of information.
- **Client is Incarcerated:** If the client is currently incarcerated, please provide the name of the correctional facility where the client is located and the expected date of release. ****<u>Refer to CHARLI or Care Coordination if the client's expected date of release is within 6 months.</u>***
- **Client is Unable to be Located:** Select this outcome if the client can't be located after all contact methods/attempts are exhausted.
- **Client is Discharged:** If there is evidence the client was discharged, provide the date of discharge and which agency the client was discharged to (if available).
- **Other:** Select this outcome if none of the above outcomes are applicable to the client and provide an explanation of the outcome.

VDH VIRGINIA DEPARTMENT OF HEALTH

Data to Care

Data Collection Tool

Data to Care #: _____ **Facility/Agency Name Completing the Form:** _____

Field Record #: _____ **Start Date:** _____ **End Date:** _____

☐ **1509 Client** **Due Date:** _____

1. Attempt Date: _____

Method: ☐ Visit ☐ Phone Call ☐ Text Message ☐ Social Media ☐ Letter ☐ Medical Record ☐ Other

Progress: _____

_____

_____

_____

_____

Status: ☐ Successful ☐ Unsuccessful ☐ Will Try Again ☐ Will Proceed to Next Method ☐ Final Attempt
[check all that apply]

2. Attempt Date: _____

Method: ☐ Visit ☐ Phone Call ☐ Text Message ☐ Social Media ☐ Letter ☐ Medical Record ☐ Other

Progress: _____

_____

_____

_____

_____

Status: ☐ Successful ☐ Unsuccessful ☐ Will Try Again ☐ Will Proceed to Next Method ☐ Final Attempt
[check all that apply]

3. Attempt Date: _____

Method: ☐ Visit ☐ Phone Call ☐ Text Message ☐ Social Media ☐ Letter ☐ Medical Record ☐ Other

Progress: _____

_____

_____

_____

_____

Status: ☐ Successful ☐ Unsuccessful ☐ Will Try Again ☐ Will Proceed to Next Method ☐ Final Attempt
[check all that apply]

General Notes:

VDH VIRGINIA DEPARTMENT OF HEALTH

Data to Care
Data Collection Tool

Data to Care #: _____ **Facility/Agency Name Completing the Form:** _____

4. Attempt Date: _____

Method: ☐ Visit ☐ Phone Call ☐ Text Message ☐ Social Media ☐ Letter ☐ Medical Record ☐ Other

Progress: _____

_____

_____

_____

_____

Status: ☐ Successful ☐ Unsuccessful ☐ Will Try Again ☐ Will Proceed to Next Method ☐ Final Attempt
[check all that apply]

5. Attempt Date: _____

Method: ☐ Visit ☐ Phone Call ☐ Text Message ☐ Social Media ☐ Letter ☐ Medical Record ☐ Other

Progress: _____

_____

_____

_____

_____

Status: ☐ Successful ☐ Unsuccessful ☐ Will Try Again ☐ Will Proceed to Next Method ☐ Final Attempt
[check all that apply]

6. Attempt Date: _____

Method: ☐ Visit ☐ Phone Call ☐ Text Message ☐ Social Media ☐ Letter ☐ Medical Record ☐ Other

Progress: _____

_____

_____

_____

_____

Status: ☐ Successful ☐ Unsuccessful ☐ Will Try Again ☐ Will Proceed to Next Method ☐ Final Attempt
[check all that apply]

General Notes:

VDH VIRGINIA DEPARTMENT OF HEALTH

Data to Care

Data Collection Tool

Data to Care #: _____ **Facility/Agency Name Completing the Form:** _____

Final Client Outcome

Current Client Address: _____
Address

_____ City _____ State/Country _____ Zip Code

☐ **Client was Located and in Medical Care Within the Last 12 Months**

Name of Medical Provider: _____

Name of Medical Facility: _____

Facility Address: _____

Facility Phone Number: _____

Date of Last Medical Visit: _____ Date of Upcoming Appointment: _____

☐ **Client was Located and is Not in Care**

Barriers to Care: **[check all that apply]**

☐ Lack of Transportation ☐ Lack of Knowledge (disease, treatments, services) ☐ Financial Issues
☐ Client Reports Feeling Well ☐ Discrimination/Stigma ☐ Privacy Concerns ☐ Housing Issues
☐ Dissatisfied With Medical Provider ☐ Fear of Disease ☐ Religious Reasons ☐ Lack of Insurance
☐ Other, Please Specify: _____

☐ Currently Reengaging in Care Date of Appointment: _____

☐ Want to Reengage in Care

☐ Referred to Navigator _____

☐ Referred to Provider _____

☐ Date of Appointment: _____

☐ Refused Care

☐ **Client Relocated Out of State (OOS)** State Name: _____

Month and Year of Move: _____

☐ **Client is Deceased** Date of Death: _____

Source of Death Information: _____

☐ **Client is Incarcerated** Correctional Facility Name: _____

Expected Date of Release*: _____

Refer to CHARLI or Care Coordination if expected date of release is within 6 months.

☐ **Client is Unable to be Located**

☐ **Client was Discharged** Date of Discharge: _____

Agency Discharged to: _____

☐ **Other, Specify:** _____