HD-410: Hansen's Disease Clinic Quality Assurance Reporting Form

Directions: *Complete this form monthly and submit to HDPCR@dshs.texas.gov no later than the* ***first Monday of each month****.*

Clinic Name: _____ Date Submitted: _____

A. Key Personnel		
Title	**Name**	**Email Address**
Nurse		
Physician		
Program Manager		
Additional Clinic Staff		
Title	**Name**	**Email Address**

1. Were there any changes to key personnel (physician, nurse, program manager) during this period?

☐ Yes ☐ No

If yes*, please complete the HD-407 NOTICE OF CHANGE FOR HANSEN'S DISEASE PROGRAM (HD) PERSONNEL and submit it to HDPCR@dshs.texas.gov.*

2. Please select the key personnel that have changed this period.

☐ Physician ☐ Nurse ☐ Program Manager ☐ N/A

B. Patient Travel and Medical Co-Pay Expenses	
1. Indicate the number of patients that required travel and lodging assistance for a clinic visit this period.	
2. Indicate the number of patients that required medical co-payment reimbursement for all provider-approved HD-related care this period.	

C. Overview of Hansen's Disease Clinic Activity	
1. Indicate the total number of patients seen this period for ongoing treatment. **Please indicate patients that are in Active, Inactive, and Complication statuses that have visited this clinic for services, and/or were seen in-house or at an offsite facility for consultation/referral type services such as OT, PT, Ophthalmology, etc.*	
2. Of the total number of patients seen this period, indicate the number of <u>new patients</u> that have been seen in the clinic for HD screening/assessment this period.	
3. Of the number of new patients seen this period, how many are HD contact cases?	
4. Indicate the number of <u>newly diagnosed HD cases</u> this period. **Please ensure that a C-12 (Hansen's Disease Surveillance Form) has been submitted for each newly confirmed case.*	
5. Indicate the number of Hand Screens performed this period.	
6. Indicate the number of Foot Screens performed this period.	
7. Indicate the number of Eye Screens performed this period.	
8. Indicate the number of new patients started on a Hansen's disease medication regimen/protocol this period.	
Please provide any additional comments for work performed or patient interactions that is not captured above (e.g., hospitalizations, care provided to observation patients, etc.):	

D. Education, Training, and Outreach
Targeted Patient Education
Schedule will be provided by DSHS. Please report targeted patient education with the deadlines provided by DSHS. *Note: Targeted patient education is going above and beyond standard patient education and provides additional opportunities for HD patients and their families to learn more about Hansen's disease.*
1. Was targeted patient education performed this period? ☐ Yes ☐ No

Report targeted patient education activities performed with the following information:	
Date of Event:	

Activity Type:

- ☐ Group class
- ☐ Distribution of brochures/printed materials
- ☐ Educational poster/chart displays
- ☐ Patient family member HD education.
- ☐ Other: _____

Activity Description:
Please describe here the targeted event. For example, if family member education describe why it was started and went beyond expected routine education.

ADD

Medical Professional Education and Training Activities	
Quarterly: Must be reported monthly, but is required every three months	

Was medical professional education/training performed this period?

- ☐ Yes
- ☐ No

Report any medical professional education and training performed with the following information:	
Date of Event:	
Duration of training:	
Number of persons trained:	
Trainee type (e.g., student, provider, nurse, therapist, behaviorist, etc.):	
Mode of training (e.g., instructor-led, webinar, seminar, in-person, on-demand e-learning, etc.):	
Who conducted the training (e.g., clinic staff, contractor, etc.):	

Activity description:

- ☐ Diagnosis and treatment
- ☐ Comprehensive management
- ☐ Wound care
- ☐ Other: _____

ADD

Community Outreach and Education

Semi-Annually: Must be reported monthly, but is required twice annually

Was community outreach/education performed this period?

- ☐ Yes
- ☐ No

Report any community outreach and education activities performed with the following information:

Date of Event:	

Activity Type:

- ☐ Health fair presentation
- ☐ Distribution of flyers
- ☐ Social media post
- ☐ Education to the general public
- ☐ Other: _____

Activity Description: Please detail what was provided. Include audience and content. For example, if a flyer, what type of flyer, what is the content, etc.?

ADD

Additional Comments:

If you have any additional comments about the activities performed and information provided this period, please enter your comments below (e.g., Hansen's Disease related trainings attended).

SUBMIT