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

Instructions: Complete this form every month and submit to HDPCR@dshs.texas.gov by the first Monday of each month. Each reporting period starts on the 28th of one month and concludes on the 27th of the subsequent month (for example, the February reporting period starts on January 28th and concludes on February 27th).

Clinic Name: _____ Submission Date: _____

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 new patients 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 newly diagnosed HD cases 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	
The targeted patient education reporting schedule for each clinic will be 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.*	
Was targeted patient education performed during this period? ☐ Yes ☐ No	
Date of event:	

Activity type:

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

Activity description: *Describe the targeted patient education conducted. For example, if education of family members was performed, describe why it was started and how it went beyond the 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 during this period? ☐ Yes ☐ No	
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.):	
Name(s) of instructor(s)/medical professional(s) that conducted the training:	

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 during this period? ☐ Yes ☐ No	
Date of event:	
Activity type: ☐ Health fair presentation ☐ Distribution of flyers ☐ Social media post ☐ Education to the general public ☐ Other: _____	
Activity description: *Detail the community outreach or education provided. For example, if a flyer was distributed, what type of flyer was it, and what content did it cover?*	

ADD

Medical Consultations	
Were any medical consultations performed during this period? ☐ Yes ☐ No	
Date of consultation:	
Consultee name (the requesting medical provider):	
Consultee clinic name (the full name of the clinic):	
Consultee location (city, state):	
Name of physician who provided the consultation:	

ADD

Out-of-State Patient Referrals	
Were any out-of-state patients seen in your clinic during this reporting period? ☐ Yes ☐ No	
Date of referral:	
Referral source: ☐ Private provider ☐ National Hansen's Disease Program (NHDP) ☐ Patient self-referral ☐ Other (including Ambulatory Care Clinics): _____	
Patient residence (city, state):	

ADD

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

SUBMIT