



Developing and Implementing HIV Policies and Procedures in Primary Care Settings **TOOLKIT**

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INTRODUCTION

Policies and procedures (P&P) provide a strong foundation for the successful delivery of HIV care and prevention services along the HIV care continuum. Simply put, P&P define how care teams do things in their practice setting. Policies explain the why and procedures spell out the who, what, how, when, and where that ensure the delivery of high-quality, patient-centered services.

Fulfilling important purposes in the everyday provision of high-quality HIV prevention and care services, HIV P&Ps:

- Facilitate adherence with recognized professional practices and standards of care.
- Promote compliance with regulations, statutes, and accreditation and funding requirements. Examples include requirements of the Health Insurance Portability and Accountability Act (HIPAA), Americans with Disabilities Act (ADA), Health Resources and Services Administration Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP), and those of other funders.
- Standardize practices across multiple departments and agency locations within a single health system. For example, HIV testing may be offered in a health system's sexually transmitted infection (STI) clinic, primary health care clinic, and mobile van that visits targeted neighborhoods. Standardizing practices across locations, departments, and staff persons who will be doing the testing is critical to maintaining consistency and quality of patient care.
- Clarify how services are to be provided by capturing, retaining, and updating important information. This not only saves time and effort, but it also assists with decision-making and helps to avoid conflict and the potential for misunderstanding.
- Promote safety and reduce risk for errors or oversights by not having staff rely on memory.
- Serve as a resource for staff, particularly as a training tool for existing and new personnel.
- Ensure accountability to the health care system, colleagues, and patients.
- Create a culture of continuous process and system improvement.
- Provide an efficient way to review existing services to ensure staff and patient needs are being met.
- Improve staff and patient experience with continuity and consistency of care.

The Midwest AIDS Training and Education Center (MATEC) Toolkit for Developing and Implementing HIV Policies and Procedures in Primary Care Settings was primarily created to assist clinical sites participating in MATEC's [HIV Practice Transformation \(PT\) project](#) with their efforts to develop, implement, and update HIV P&P in alignment with the [National HIV/AIDS Strategy](#) and the [HIV care continuum](#). Clinical sites participating in the PT project included RWHAP-funded Part A and/or Part B subrecipients and health center programs that are not funded by the RWHAP as a recipient or subrecipient. Organizations providing HIV care and prevention services outside of MATEC's PT project, including Ending the HIV Epidemic in the U.S. (EHE) jurisdictions, will also find this toolkit helpful in their work.

The toolkit highlights experiences and guidance from MATEC PT coaches, PT clinic champions, and other experts for developing effective and appropriate P&P that meet the needs of the staff providing HIV care and prevention services and the patients receiving them.

Recognizing that many clinicians are stretched thin and do not have sufficient time to focus on P&P, the toolkit was developed to serve as a practical guide to reduce the time and resource burdens associated with developing P&P. It provides checklists, templates, and resources, as well as sample HIV P&P. Throughout the toolkit, the experience and thoughts of clinicians and other experts are also included with quotes and reflections.

Informed by successful approaches to developing P&P, and lessons learned from those who contributed to the content, the toolkit:

- Discusses key terms and definitions related to P&P.
- Shares an easy-to-use assessment to determine readiness for developing, implementing, and updating P&P.
- Outlines processes for developing, implementing, and updating P&P.
- Presents special considerations that can impact delivery of HIV services.
- Explores considerations specifically for RWHAP-funded clinics and FQHCs.
- Contains appendices of sample policies and procedures, templates, acronyms/definitions, and resource links.
- Encourages users to provide feedback on the toolkit's usefulness, share experiences with developing and implementing HIV policies and procedures, and identify additional resources.



Step 1: ORGANIZING HIV POLICY & PROCEDURE

Organizing HIV P&P include the following steps outlined within this section:

1. Formatting P&P

2. Writing P&P effectively

3. Cataloging P&P

The words we use when talking about developing HIV policies and procedures (P&P) are important. Terms are often used interchangeably (particularly the terms “protocols” and “procedures”), which can cause confusion and miscommunication. Standard definitions for the terms and concepts commonly used in the development of P&P are listed in Table 1. Key questions listed next to the definitions

assist in determining which item would best serve the organization’s needs. Note that health care systems, clinics, and other organizations might use slightly different definitions. Because of this, it is important for HIV service providers to understand how these terms are defined in their organization and communicate clearly to staff which terms are being used in the development, implementation, and updating of P&P.

Table 1: Terms and key questions.

Term	Definition	Key Questions
Primary Terms in this Document		
Policies (sample policy)	A written operational statement of intent that explains the organization’s stance on a subject. A statement that provides a guide to decision-making regarding processes or activities that take place on a regular basis. Outlines the goal or purpose of a specific process or activity. Describes why the process or activity has been issued and explains the context for it. Contains guiding principles that are designed to reach certain objectives by which the service is provided.	Why do we need to do this?
Procedures (sample procedure)	Written instructions on how to implement the policy. Steps to be followed for the accomplishment of a given task and/or the accomplishment of certain objectives in a defined circumstance. Indicate what will be done, when, and by whom (by role), and what records are to be kept. May require adaptation due to unique patient characteristics.	Who is responsible for each step? What do we do to complete each step? How do we actually do this? When and where are each step completed?
Protocols (sample protocol)	A set of decision-making rules and instructions based on guidelines. A written plan that specifies procedures to be followed.	How do we make decisions and what do we base them on?

Term	Definition	Key Questions
Other Terms Related to P&P		
Decision Trees	A graphical representation of solutions that help to decide quickly and with accuracy. Asks questions, and depending on the answer, guides the user to specific actions to take.	What do we do to address specific patient needs?
Guidelines	Statements that guide best practice in specific circumstances. Supported by evidence from literature, not an opinion or value alone.	What else do we need to know?
Standards	Mandatory controls that help enforce and support a policy.	What are the quantifiable requirements for implementing the policy?
Workflow Process Mapping (sample workflow)	A written and/or visual representation of the actions, decisions, or tasks performed to achieve a certain result. Aims to improve and streamline the functionality of a provider's system to offer patients the best experience possible. Minimizes the occurrence of mistakes and complications. Helps identify potential breakdowns and bottlenecks in a process.	How do we document protocols and procedures?

The following are three types of P&P that are generally created for providing HIV prevention and care services.

Administrative Policies and Procedures

state how all non-clinical functions are managed within an organization. These functions include staff recruitment and hiring, licensing and credentials, human resources (HR), HIPAA, finance, quality control, and staff development/training. HIV-specific administrative policies and procedures include data sharing with state/local health department; HIV testing and diagnosis; linkage to care; engagement and retention in care; HIV prevention; referrals for social services; case management/care coordination; team-based care with (medical) case management; and quality assurance/continuous quality improvement (CQI).

Clinical Policies and Procedures

specify how clinical functions are managed within an organization. They provide health care practitioners with parameters in which to operate and include diagnosis, treatment, and management of specific medical conditions. Clinical protocols may be individualized to the patient while adhering to established standards of care. HIV-specific clinical policies and procedures include HIV testing and diagnosis; HIV clinical care, antiretroviral therapy; medication management; viral suppression; pre-exposure prophylaxis (PrEP); referrals for specialty medical care and memoranda of understanding (MOUs) with those agencies; and HIV medical care plans.

Financial Policies and Procedures

help organizations manage money and risk to achieve their financial goals. They include copays and deductibles; insurance billing; referrals and pre-authorizations; self-pay patients (patients without insurance); fee scales; and payment plans. They also impact an organization's processes for decision-making, resource allocation, budgeting, and cash flow management. Federal, state, and private funders may also require specific policies and procedures, such as 340B and ADAP, to be in place to receive support.

The focus of this toolkit is on **administrative** and **clinical** policies and procedures. While financial policies and procedures may be required depending on the funding source of each organization, they are not in the scope of this toolkit as they do not directly impact the HIV care continuum.

Step 1.1 FORMATTING POLICIES & PROCEDURES

There are many ways to format P&P, and some organizations will already have standardized formats that all P&P should follow. Before drafting P&P, check to see if the organization it is being developed for has a preferred P&P template. If it does not, this section offers example formats (see Figures 1 and 2). The appendices also include sample P&P and templates for the user to copy or modify.

Figure 1: Sample format for policies with annotations.

Sample Format for Procedures	
Title:	
Number:	
Organization Name:	
Site/Department:	
Effective (Original) Date:	
Review Date for Original:	
Original Approved By Signature:	
Definitions:	
Resources:	
Policy the Procedure Supports:	
Procedure:	



Native American Community Clinic, Minneapolis, MN (NACC) utilizes a generalized team approach in the development of clinical procedures with board approval prior to implementation. HIV protocol development is more informal with protocols written primarily by nurse management with review and approval by the medical director. Whereas policies are comprehensive and cover a lot of information, protocols are more fluid, less standardized, and are often living documents.

Note that numbering P&P helps to reduce confusion.

Including an effective date and review date is key, so one can track when reviews should be conducted, and updates made as needed.

Including definitions is also useful because not all staff may have them or have a different understanding of what they mean. Definitions are especially helpful when onboarding new staff.

It is important to connect a policy with its respective procedure, and it can be helpful for staff to keep the policy and procedure together. Doing so gives staff a better understanding of why the procedure was developed and how it supports the policy.

Figure 2: Sample format for procedures, no annotations.

Sample Format for Procedures
Title:
Number:
Organization Name:
Site/Department:
Effective (Original) Date:
Review Date for Original:
Original Approved By Signature:
Definitions:
Resources:
Policy the Procedure Supports:
Procedure:
Procedure Checklist:
Related Procedures:
Revision History, Review Dates, Approved By, and Signatures:
Attachments:

Step 1.2 WRITING EFFECTIVE POLICIES & PROCEDURES

As discussed earlier in this section, policies and procedures are related, but they are certainly not identical. To write effective P&P, it is important to understand the differences and similarities between the information each one offers. Table 2 highlights the differences and similarities in writing and structuring P&P:

Table 2: Comparing policies and procedures.

Similarities in Structuring Policies and Procedures

Both Policies and Procedures:

Use a standard format with a simple and recognizable name for the title. Consider documenting the creation date and each edit date.

Use clear, concise, and plain language. Avoid acronyms and abbreviations and jargon. Define terms that require explanation.

It is also helpful to use gender-neutral language (e.g., they instead of she/he).

Contain sufficient and appropriate content and level of detail.

Include any references (e.g., journal articles, published guidelines, standards of care, best practices). Avoid using information that is quickly outdated because it will require frequent updating. For example, if referencing HIV guidelines, hyperlink the URL to ensure the most current guidelines are being followed.

Provide links to relevant P&P stored on the organization's intranet or other server.

Differences in Structuring Policies and Procedures

Policies

Identify what the issue is and why it needs to be addressed.

Be consistent with organization's mission, culture, strategy, and vision.

Are capable of being implemented and do not contradict other policies.

Create a standard format for service delivery.

Adhere to and cite any legal or statutory requirements.

Procedures

Spell out how exactly to carry out a policy. Use the active voice.

Develop with the user in mind. Procedures should be well thought out and benefit the user in providing a specific service.

Are understandable. Procedures need to be written so that what needs to be done can be followed easily by all users.

When appropriate, offer the user options. Procedures that are unnecessarily restrictive may limit their usefulness.

Adhere to standards of care and practice guidelines.



Native American Community Clinic (NACC), Minneapolis, MN, frequently networks with best practice organizations across the nation and in collaborative conversation with local partners and experts providing HIV services to inform their practice transformation actions and goal accomplishments. Through this resource mapping technique, the practice transformation team has been able to access policy and procedure examples from other organizations to provide ideas for developing and documenting their own processes for HIV service delivery. The clinic has stepped up as a dedicated partner to address community need by evolving very quickly in all areas of the HIV care continuum. Jace Gilbertson, former nurse manager and soon to be care provider at NACC, described their policy and procedure process as “building the plane as it is taking off.”

TIP

When writing P&P always spell out acronyms upon first use, avoid use of abbreviations, include visuals when appropriate, use plain language and no jargon, and always aim for concise and unambiguous language.

When writing a policy, important areas to specify include:

- The issue that the policy seeks to address and the policy's purpose or goal.
- How the issue was identified.
- Benefits to patients, staff, and the organization.
- Organization values and/or commitment.
- What needs to happen to realize the policy.
- How the policy will be sustained and by whom/which position.
- Measurable outcome(s).
- Any exemptions to the policy.
- Name of the person(s) approving the policy.
- Signature of person(s) responsible for approving the policy.
- Date of approval and subsequent revision dates.

When writing procedures, recommendations for items to include are listed as follows.

- Use headings to organize the steps. This helps staff find information quickly and understand the flow of the procedure.
- Be careful not to under-specify — include all essential elements of the procedure.
- Outline and provide an explanation for each step required to carry out the procedure and comply with the policy.
- Include a checklist for users to verify that everything listed in the procedure has been done.
- List the role that has responsibility for each step. It is better to use positions versus names of actual staff. If using actual names, you will need to update the procedure when a staff person leaves.
- Some individuals process visual information better than written information. Insert a graphic illustration of the procedure at the start of the document that summarizes in visual form the steps that need to be taken to carry out the procedure. Follow this with written steps. The following section of the toolkit describes two excellent visual representations of procedure: workflow maps and decision trees.



Corktown Health Center, Detroit, MI, provides extensive and comprehensive support services as a RWHAP-funded clinic and has administrative, clinical, and universal procedures in place to align the practice with standards of care. References are often made to clinical practice guidelines through direct links versus incorporating specific information directly into written procedures given their frequency of change.

Step 1.2.1 WORKFLOW MAPPING AND DECISION TREES

Offering visual representations of procedure can support some readers' comprehension. Moreover, the process of creating those representations offers numerous benefits to the team. Teams can use these tools to capture existing processes and identify areas that are strong and others that may need improvement. The tools can also support the development of new processes. This portion of the toolkit explores two types of visual representation related to P&P in greater detail: **workflow mapping and decision trees**.

Workflow Mapping

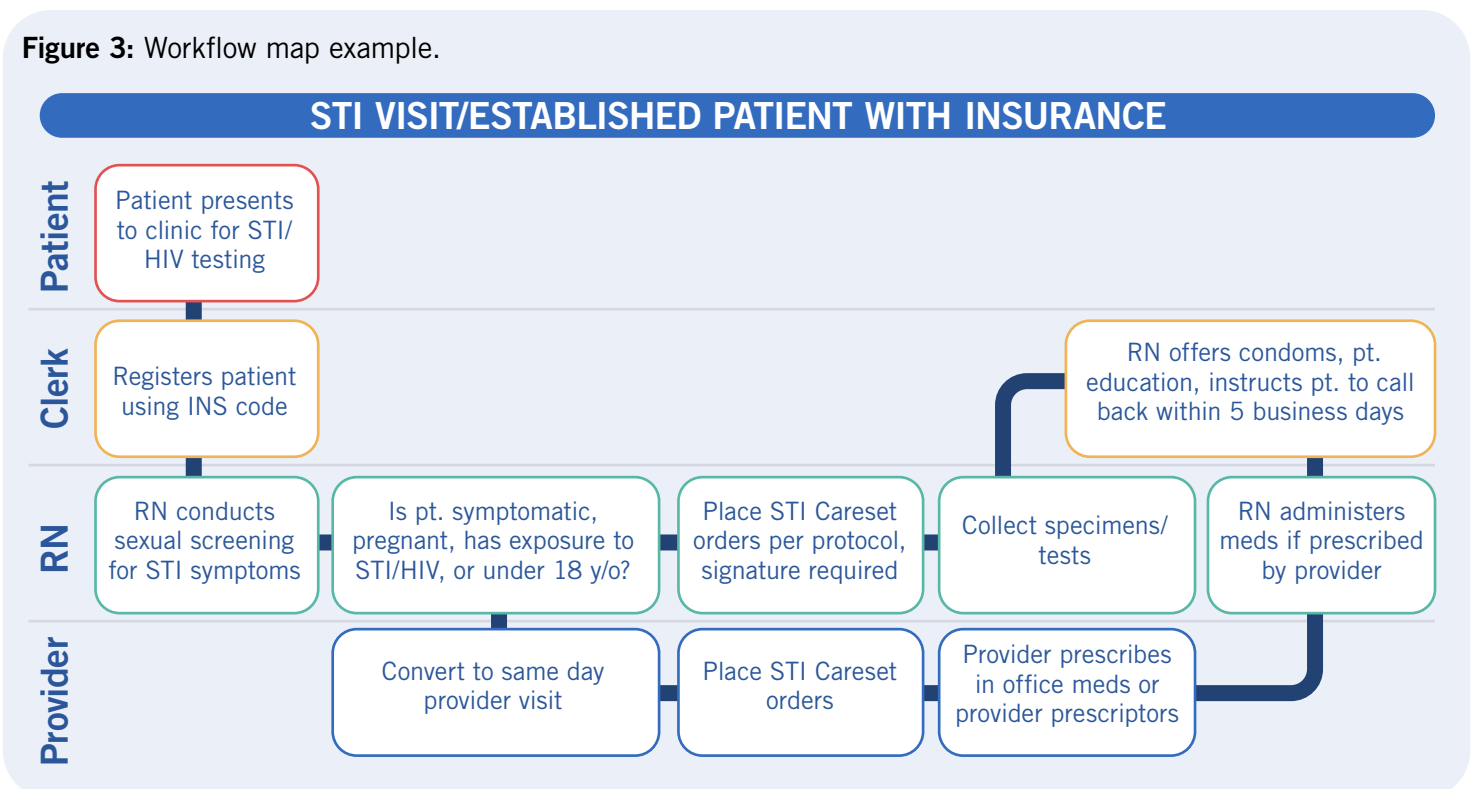
Workflow maps are a visual representation of the actions, steps, or tasks performed to achieve a certain result. Registering patients for appointments, rooming patients, refilling medications, and answering telephones are all processes that happen in a practice daily, and the required steps can be mapped to create a standard workflow or to find and remove wasted effort. Workflow maps give practices an easy and quick way to visualize the entire process from beginning to end, with all the steps that occur in between. They let you graphically see how work is currently done in your organization.

Workflow maps also show who performs each part of the process. This is very important because this allows everyone to understand what other people are doing and how each person coordinates with one another. Often people are not aware of what their colleagues in the practice actually do.

Since some processes involve several people from multiple disciplines to complete the activity, an interdisciplinary team is needed to discuss the workflow map to ensure that the details of the process are accurately captured. The [10 Building Blocks of Primary Care, Overview of Workflow Mapping](#) provides additional examples of a workflow and symbols used in them.

When writing a procedure, it is helpful to first map patient flow to determine the what, where, when, who, and how for providing said service. The workflow map or flowchart can be inserted into the written procedure at the beginning of the document or included as an attachment. One can also consider laminating the workflow map for staff to keep in office space and treatment rooms. This provides a handy reference for making sure all steps of the procedure are completed. See Figure 3 for a HIV testing workflow map example.

Figure 3: Workflow map example.



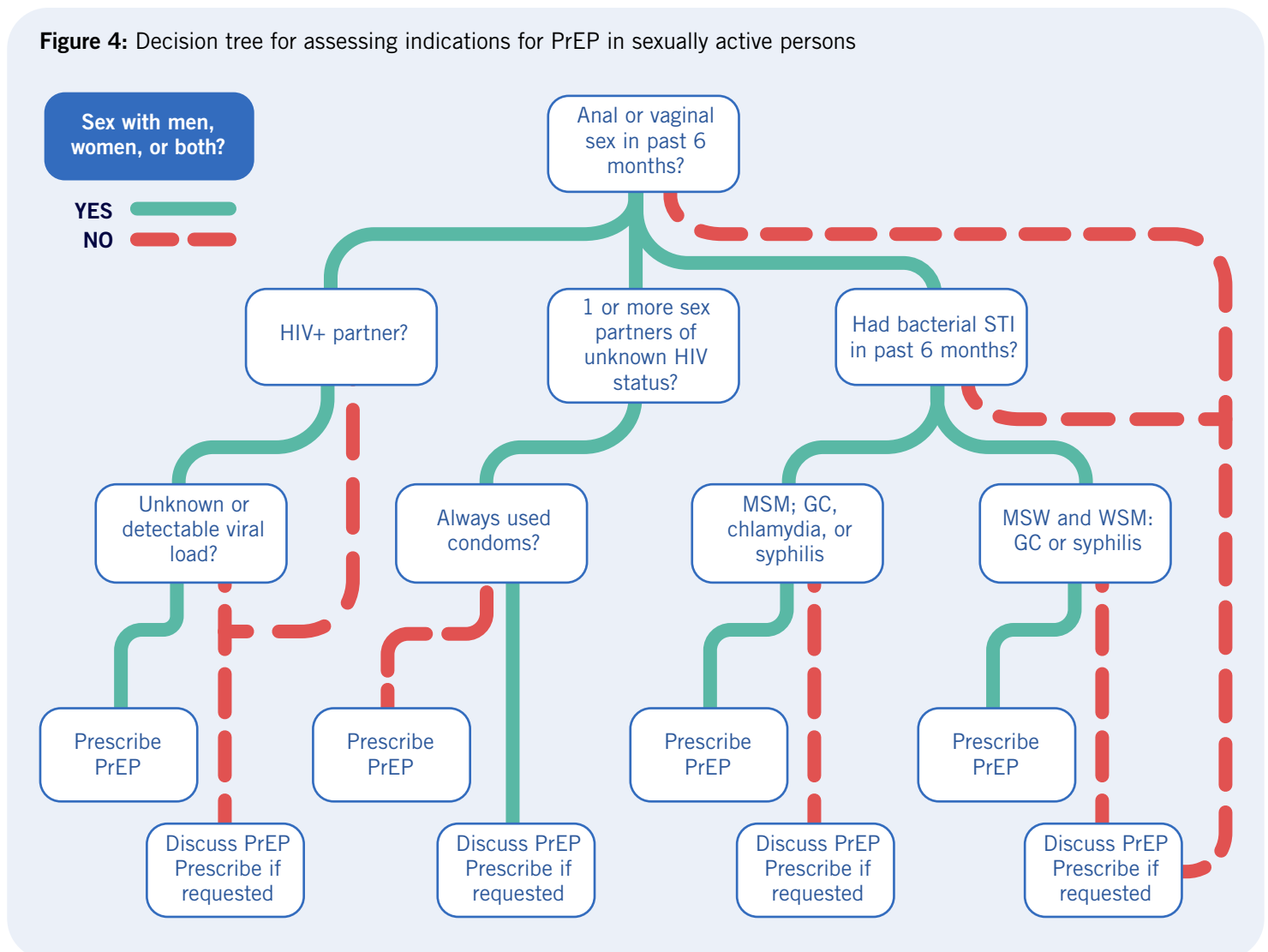
Decision Trees

Decision trees are often used in different areas of clinical decision-making. They represent gathered, evidence-based knowledge about an aspect of service provision and give the user a reliable and effective “roadmap” for how to proceed with a patient’s diagnosis and/or care. Outcomes for possible choices or courses of action to take are listed, which can help clinicians and staff make decisions faster and more effectively. Decision trees can also be used for things other than diagnosis and treatment. For example, they can assist staff in determining how to proceed in providing referrals and conducting follow-up for a patient or deciding when/how to notify a patient of their HIV infection status.

Decision trees have three main parts: 1) root node, 2) leaf nodes, and 3) branches. The root node is the starting point of the tree, and both root and leaf nodes contain questions or criteria to be answered. Branches are arrows that connect the nodes and show the flow from question to answer. Each node has two or more nodes extending from it. For example, if the question requires a “yes” or “no” answer, there will be one leaf for a “yes” response and another leaf for a “no.” Leaf nodes and branches are added until every question or criterion has been resolved and an outcome has been achieved.

While workflow maps convey straightforward procedures, decision trees are a great visual addition to procedures that involve different sequences of steps depending on various factors. See Figure 4 for an example.

Figure 4: Decision tree for assessing indications for PrEP in sexually active persons



Step 1.3 CATALOGING HIV POLICIES & PROCEDURES

Once the HIV P&P are finalized and approved, it is important to determine how they will be cataloged, shared, and stored.

Cataloging Options

The organization most likely has cataloging systems in place for HRSA site visits and patient-centered medical home accreditation, and any HIV P&P may fit best as part of a subset to what the organization already has. Remember, always check to see what system the organization already has before developing a new one.

- P&P can be cataloged in a variety of ways. To support your understanding of existing systems or your development of new ones, here are some suggestions for organizing and cataloging HIV P&P.
- Whether the organization uses numbers or letters, it's important to be consistent in the use of the cataloging system.
- Develop a system to number the P&P. For example, one may want to have different numbering systems for the different types of P&P described earlier in this toolkit —administrative, clinical, and financial. Note that some health care providers opt to only number procedures and identify policies alphabetically or with abbreviations.
- When the organization has more than one procedure for a policy, group the procedures together and indicate on each procedure what the policy number is. For example, if there is one policy for ensuring the provision of accessible HIV testing and several related procedures such as testing in the clinic and mobile testing in the community, one can number the policy HIV Testing 1 and number its related procedures for in-clinic testing as HIV Testing 1.1 and mobile testing as HIV Testing 1.2. This type of numbering allows the organization to keep a policy and its related procedures together, which will be helpful when procedures need to be revised or new ones added for a policy. One can also opt to use letters— A for the policy and A.1, A.2, A.3, etc. for the related procedures.
- When all the HIV P&P have been cataloged, it can be helpful to have a simple chart that lists everything (see Table 3). This will make it easier for staff to locate items they need. It will also help prepare for site visits from funders or accreditation organizations. Here's an example of a chart that can be developed. Note it is not inclusive of all the types of HIV P&P an organization can have.

Figure 5: Sample policy labeling

POLICY AND PROCEDURE MANUAL

SECTION: Ethics, Rights and Responsibilities

TITLE: Advance Directives

POLICY# RI.3.4

EFFECTIVE DATE: 1994

REVISION DATE: 3/2005, 5/2007, 5/2010, 8/2011, 7/2016, 9/2019

Table 3: Example of simple chart listing P&P.

HIV Policies and Procedures	
Policy	Procedures
HIV Testing	1—10
PrEP	11—15
Outreach	16—18
Referrals	19—25
Staff Training	25—27

A simple way to manage and track HIV P&P without purchasing additional software or subscription services is to have the person(s) responsible for this task develop a Microsoft Excel spreadsheet that lists the following information for each policy and procedure. Using Excel allows one to search and sort information quickly, which can be useful when the organization is undergoing site reviews from your funders.

- Name
- Date of initiation
- Due dates for reviews (quarterly, annually, or other)
- Date each review was conducted and signed off on
- Date every new or revised policy or procedure was distributed to staff and posted online
- Date staff participated in training (online or in person) for implementation of new or revised policy or procedure (if applicable)
- Person responsible for sign off on a new or revised policy or procedure

Sharing and Archiving Options

Although paper policy and procedure manuals for sharing and archiving HIV P&P can be used, we recommend making this information available on the organization's server or cloud-based storage system (e.g., SharePoint). The organization will need to determine who will be responsible for maintaining and managing the online system. The organization will also need to identify who will be allowed access to the HIV P&P and whether to password protect the site.

It is also important to develop an archive system for outdated and retired P&P. The organization will always want to make the most recent versions of the HIV P&P available, and place outdated and retired P&P in the archives. One way to do this is to have a "current" HIV P&P folder and an "archive" folder that contains older versions of current P&P, as well as retired P&P.



The Eskenazi Health System,

Indianapolis, IN, uses "PolicyStat," a document management software system, for cataloging their policies. They are searchable by title, policy series, owner, and references. The naming is based on the following:

1. Policy series (e.g., 600 Nursing; 700 Imaging Services, etc.)
2. Policy # sequence (1, 2, 3....)
3. Title

A sample Imaging Services policy might be: 700-13 Procedures Performed On-Call. Eskenazi Infectious Disease Clinic plans to house their HIV policies and procedures in the system and is considering categorizing by the HRSA site monitoring visit categories of administrative, clinical, and fiscal.

Primary Health Care, Des Moines, IA

utilizes a clinic-wide numbering system to organize policies and procedures that includes category initials, a number that corresponds to the category, and the order in which the policies in the category are sorted or created. An example is LD.1.10, indicating the 10th policy in the leadership category. The HIV team, as they develop a comprehensive Part C P&P manual, is organizing HIV P&P by topic within a folder that hyperlinks to an overarching Part B manual. All policies, procedures, workflows, and supporting documents required for Part C and falling under the administrative and clinical P&P are included in the manual. New policies developed by the HIV team are called protocols until they have gone through the clinic's full approval process and assigned a number within the clinic P&P numbering structure. Procedures and workflows are referenced by titles versus numbers.



Step 2: ASSESSING ORGANIZATIONAL READINESS

Once you understand the terms and structures involved in creating P&P, you are prepared to take two important steps before developing the content:

1. Building an interdisciplinary team

2. Assessing organizational readiness for the P&P

Step 2.1 BUILD A TEAM

Building an engaged interdisciplinary team is key to assessing organizational readiness for the P&P. When you have a team assembled, each member will offer their unique perspective regarding the organization's readiness, which will help ensure a thorough evaluation. In addition to including a wide range of disciplines, consider inviting staff with diverse attitudes, such as those who play by the rules, those who challenge status quo, and those who are resistant to change. This brings a variety of perspectives to the table, which supports staff buy-in, mitigates barriers earlier in the process, and achieves positive outcomes.

Assembling an interdisciplinary team early on will give the organization more flexibility to respond quickly to organizational, funder, and patient needs, ensure inclusion of necessary disciplines, and result in more comprehensive and responsive P&P. Disciplines to consider having on the team include the following:

- **Clinicians**
- **Nurses**
- **Social workers/case managers**
- **Pharmacists**
- **Administrative staff**
- **Quality improvement/data management staff**
- **Legal representatives**
- **Finance representatives**

Including four to six people on the team is ideal. When inviting staff to join the team, acknowledge the individual's role and how the P&P may affect it, what value their experience brings, and how these strengths can be leveraged to support developing/updating the P&P. Clearly describe the time commitment and how administrative time will be factored into the staff's current schedule.

This team, in addition to any other organizational champions or representatives from leadership, should be able to provide input throughout the stages of the process, from the next step in this section (organizational readiness) all the way through the last portion (special considerations) of this toolkit.

TIP

Be sure to include staff who will be responsible for implementing the P&P.



Vibrant Health, Kansas City, KS, strongly believes in drawing on the strengths of the team when developing P&P. The process may start with a small group to develop an initial skeleton framework. Multiple voices are then brought in to add additional perspectives and to validate how realistic the defined processes are.

Step 2.2 ASSESS ORGANIZATIONAL READINESS

A readiness assessment identifies the potential challenges that might arise when implementing new or updating existing processes and structures within an organization. It involves a systematic analysis of an organization's ability to undertake a new process or change. Importantly, the assessment:

- Identifies existing gaps and needs that an organization can work on either before or during the implementation plan
- Helps team members to bond and work together as they:
 - Gain a shared understanding of the barriers that can potentially affect developing, implementing, and updating HIV P&Ps
 - Define what needs to be done to overcome such barriers

Certain readiness characteristics are associated with successful implementation of new processes or systems into an organization's current infrastructure. When present, these characteristics increase an organization's ability to achieve its desired goals and avoid the obstacles common to transformation efforts. An absence of any of these key characteristics indicates areas in which the organization is not ready to proceed with the implementation of a project. Identified gaps should be addressed with specific strategies as part of an overall implementation plan.

The readiness checklist provided in Table 4 serves as a guide for determining readiness characteristics for the successful development, implementation, and updates of HIV P&P. It looks at an organization's capacity, available resources and staff, and implementation considerations. As previously noted, it will also help identify gaps and needs to be addressed to improve success.

The checklist contains key questions to answer and provides space to list any comments and/or concerns pertinent to the organization. It can be modified to capture characteristics unique to the service delivery setting.

To help determine readiness, a scoring key is provided after the checklist. Keep in mind there are no right or wrong answers, and the total score might not fully reflect readiness. This tool is meant to give a realistic snapshot of readiness and any gaps or needs that need to be addressed; it is not an evaluation or critique of past or current efforts.

TIP

The readiness checklist can be completed as a group, or individual staff can fill it out independently and then meet as a group to discuss the results.

Table 4: Readiness checklist - an [excel version](#) is available to be downloaded

Readiness Checklist for Developing, Implementing, and Updating HIV Policies and Procedures		
Key Areas and Questions	Yes or No	Comments/Concerns
Organizational Capacity		
1) Is there executive leadership commitment and support for developing and updating P&P for HIV prevention and care?		
2) Does leadership have an understanding and appreciation of the time commitment that HIV P&P development and updating requires?		
3) Do staff involved in the delivery of HIV prevention and care services understand the importance of having P&P?		
4) Is the relationship between the staff delivering HIV services and the organization's administration open and collaborative?		
5) Does a process exist for developing HIV P&P?		
6) Is there a regular schedule for reviewing and updating existing HIV policies and procedures?		
7) Is there an established committee, group, or board that reviews and approves P&P?		
Available Resources and Staff		
8) Are there staff who can assume a leadership role in developing and updating HIV policies and procedures? Are the staff qualified? Is there a person who's a champion willing to commit to the work?		
9) Are there any existing departments or groups (e.g., HR, quality assurance, finance) within the organization available to assist with the development of P&P?		
10) Are there existing P&P for other services provided that can be adapted for HIV P&P?		
11) Are there existing guidelines and standards of care that can be used to develop and update HIV policies and procedures?		
12) Are there qualified staff available to write and update HIV policies and procedures?		
13) Is support available from any funders that require specific HIV P&P?		
Implementation Considerations		
14) Is there a process for rolling out and implementing HIV P&P?		
15) Is in-person training provided on new or updated P&P?		
16) Is there a process in place to orient new personnel to HIV P&P?		
17) Does a feedback system exist to identify concerns, problems, or emerging issues that are affecting implementation of HIV P&P?		
18) Are regular meetings held where there is the opportunity to discuss feedback received on HIV P&P?		
19) Is the quality department included in the development and review of P&P?		
20) Is there a central storage place for P&P that is accessible and convenient to all staff that need to use them?		

Organizational Readiness Score

A. If the number of Yes responses selected is: 16–20 out of 20

Indicates readiness to move forward with developing and implementing HIV P&P.

Next Steps for A: Your organization is ready to move onto the remaining steps outlined in this toolkit! If there were any items to which you or the respondents answered “no,” keep an eye on them during development and implementation in case they need to be mitigated. To support your success after receiving an A score, consider:

- Designating a project champion to communicate with executive leadership.
- Involving leadership in key meetings and communications about changes or updates to HIV prevention and care.
- Asking leadership to help launch new policies and procedures and acknowledge key accomplishments.

B. If the number of Yes responses selected is: 10–11 out of 20

Indicates the organization has gaps and issues to resolve before implementing a process for developing and updating HIV P&P.

Next Steps for B: Your organization may not be ready to immediately move on to P&P development and implementation. Based on the questions that resulted in “no” responses, take some time to determine what may need to happen in order to improve your organization’s readiness. Addressing these gaps or issues before beginning P&P development and implementation may be crucial to your team’s success. You might consider taking the readiness assessment again once some of these items have been addressed before proceeding. To support your next steps after receiving an B score, consider:

- Gathering leadership support and buy-in for developing and updating HIV P&P.
- Recruiting key influencers to help raise understanding and appreciation for HIV P&P.
 - Who do team staff members in your organization look to for answers or clarification when deciding if something is useful or a waste of time? Involve these individuals as much as possible in efforts to establish a process for developing and updating HIV policies and procedures.
- Identifying current safety and quality initiatives in the organization and explore how these can help with HIV policies and procedures.

C. If the number of Yes responses selected is: 1–5 out of 20

Indicates the organization needs to do significant work to raise its readiness for developing and implementing HIV P&P.

Next Steps for C: Moving forward without a higher level of readiness will most likely result in frustration and an incomplete effort. Addressing these gaps or issues before beginning the next steps in this toolkit is necessary to the successful development and implementation of HIV P&P. This may take some time. Once the team is confident that many of the “no” responses can be changed to sincere “yes” responses, retake the readiness assessment. To support your next steps after receiving an C score, consider:

- Seeking assistance as needed from other organizations, funders, and professional associations and organizations. See Appendix D of this toolkit for helpful links.
- Emphasizing the need for shared learning, continuous process improvement, and consistency in the delivery of high-quality HIV services. This includes team meetings, debriefings, trainings, and individual coaching on the use of policies and procedures. The key is open and transparent communication.



Step 3: DEVELOPING AND UPDATING HIV POLICIES & PROCEDURES

Once you know your team and organization are ready to dive into the process of developing or updating HIV policies and procedures, you can follow the steps outlined in this section:

1. Identify and understand existing system for managing, updating, and approving P&P
2. If needed, set up a system for managing and approving P&P
3. Identify what P&P need to be updated/developed
4. Build the case
5. Assign team responsibilities
6. Review special considerations

Step 3.1: IDENTIFY AND UNDERSTAND EXISTING SYSTEM FOR MANAGING, UPDATING, AND APPROVING P&P

As noted throughout the toolkit, the organization may already have a process in place for developing and updating P&P that can be used or adapted for the provision of HIV prevention and care services. The first step is to seek understanding on how P&Ps are developed and approved within the organization. Depending on what the organization already has prepared, you may need to modify the steps below to meet the remaining or additional needs.

Step 3.2: IF NEEDED, SET UP A SYSTEM FOR MANAGING AND APPROVING P&P

If the system does not already exist, a new one may need to be set up. The following are key steps to take and considerations to keep in mind when creating a system for P&P.

- Appoint a team lead(s) to oversee the management of both new and updated P&P. Use the scope of the P&P to consider which roles or departments would be most appropriate for identifying team leads.
- Discuss with management and/or team the involvement of executive leadership—Chief Operating Executive (CEO), Chief Operating Officer (COO), Board of Directors, Quality Director, Compliance Officer, legal counsel.
- Determine who will be the signatory(s) on P&P. This is often the Board President and/or Medical Director.
- Talk about varying levels of approval with the team. For example, if a clinic is housed within a health care system, P&P may need to be approved by both the clinic and the larger health care system.
- Create a process for rolling out new and updated P&P that includes staff training. Training can be implemented in several ways, such as formal trainings, discussion at regularly scheduled staff meetings, instruction using online modules, and building it into the onboarding process for new staff.
- Work with the quality specialist or department to ensure patient feedback mechanisms are in place (e.g., suggestion box, forms, surveys). Review this feedback at least quarterly to evaluate patient experience with how services are delivered.

TIP

Use caution when approving a policy on a specific topic or practice that simply states that staff shall adhere to the practices outlined in specific clinical guidelines and does not outline the organization's own steps.

Step 3.3: IDENTIFY WHAT P&P NEED TO BE DEVELOPED OR UPDATED

When identifying the P&P that need to be developed or updated, keep in mind that best practice is to start small in order to pilot the changes rather than to launch an organization-wide effort. Select a nurse-physician dyad, unit, or department to begin developing policies and procedures for specific HIV services. Piloting the new or updated P&P will allow the team to experience the changes on a smaller scale and make adjustments as needed prior to affecting a larger portion of the organization.

Identifying which policy and/or procedures to begin with requires the consideration of multiple factors, which may result in prioritizing P&P to meet external needs (e.g., RWHAP Part B site visit finding that needs to be responded to) or existing priorities over the items that leadership and staff feel most interested in. These considerations include:

- Meeting funder requirements
- Evaluating existing HIV care and prevention areas of priority
- Reviewing or soliciting client feedback and surveys to assess patient needs
- Recognizing gaps in HIV P&P by inventorying staff knowledge and expertise

If there are not urgent external needs or existing priorities that must be addressed, identifying an HIV service delivery opportunity or challenge that leadership and staff want to prioritize can be an effective strategy. Focusing on a service of high interest and urgency can assist with obtaining support and buy-in for additional P&P development. Figure 6 depicts HIV service delivery components and areas to consider for P&P development.



Primary Health Care, Des Moines, IA, is in the process of doing a comprehensive review of all their HIV administrative, clinical, and fiscal policies and procedures as a Ryan White Part C recipient. They have consolidated all requirements, existing HIV P&P, and hyperlinks into a full manual stored on a cloud-based storage system as the team works through the review and updating of all sections. They have established clinical and administrative teams that meet regularly to systematically review and update as necessary every policy and procedure. Missing P&P are also being identified as part of this process to ensure that there are no gaps in documentation. The process for updating P&P is as follows:

- The clinical services manager writes the initial draft.
- Draft is reviewed and edited by the clinical services manager.
- Draft is reviewed and edited by the HIV practice transformation coach.
- If clinical, two nurses who will use the P&P review and edit. The nursing team works well together, and the review nurses are selected based on expertise of the process the P&P is addressing.
- If the P&P impacts Ryan White Part B services, the social services manager will review and edit.
- The Clinical Director reviews and approves procedures.
- Executive leadership and Board of Directors approve policy.

Figure 6: HIV service delivery components and areas for P&P development. Adapted from HRSA presentation for the P4C project of the Bureau of Primary Health Care.

Enabling Services	Quality Improvement	Patient	Service Delivery & Coordination	HIV Care Team
<ul style="list-style-type: none"> • Case Management • Eligibility • Housing • Nutrition Counseling • Transportation • Translation 	<ul style="list-style-type: none"> • Performance Measures • Practice Guidelines • Policies & Procedures 	<ul style="list-style-type: none"> • Self-Care Plan • Treatment Adherence • Suppressed Viral Load • Risk/Harm Reduction • Improved Quality of Life 	<ul style="list-style-type: none"> • Testing & Linkage to Care • Basic HIV Care • Medication Management & Adherence Support • Specialty Care Referrals • Screening for STIs, Hepatitis, & TB • Prevention (PrEP & PEP) • Mental Health & Substance Use 	<ul style="list-style-type: none"> • HIV/Primary Care Provider • HIV Expert • Specialty Medical Care • Nursing • Care Coordination • Clinical Pharmacist • Oral Health • HIV Program Lead • Clinical Support Staff • Allied Health Professionals

Step 3.4: BUILD THE CASE

Once you have identified the P&P development or update that should be prioritized, prepare a strong case explaining why it matters. This will be essential when engaging and getting buy-in from individuals across the organization, from clinical staff and administration to the project team and champions themselves. Answering the following questions is an effective method to begin building your case.

1. What happens if this P&P isn't in place?
2. How does its absence affect the staff and patient experience?
3. What data is available to show the need for P&P?
4. What standards, regulations or requirements are not being met?

Step 3.5: DETERMINE WHO WILL DO THE WRITING AND REVIEWING

In most organizations, direct staff seldom write or inform the P&P. Instead, writing the P&P is often the responsibility of management-level staff or program directors. This is a missed opportunity, since direct service staff are the ones who will have to carry out the P&P. Best practice encourages deference to the expertise of the “doers” by including them in the creation process.

Of course, flexibility and context matter: different staff may be called upon to write P&P depending on their expertise and experience. Regardless of who writes the documents, it is best practice to invite and assign this responsibility to only one or two members of the team.

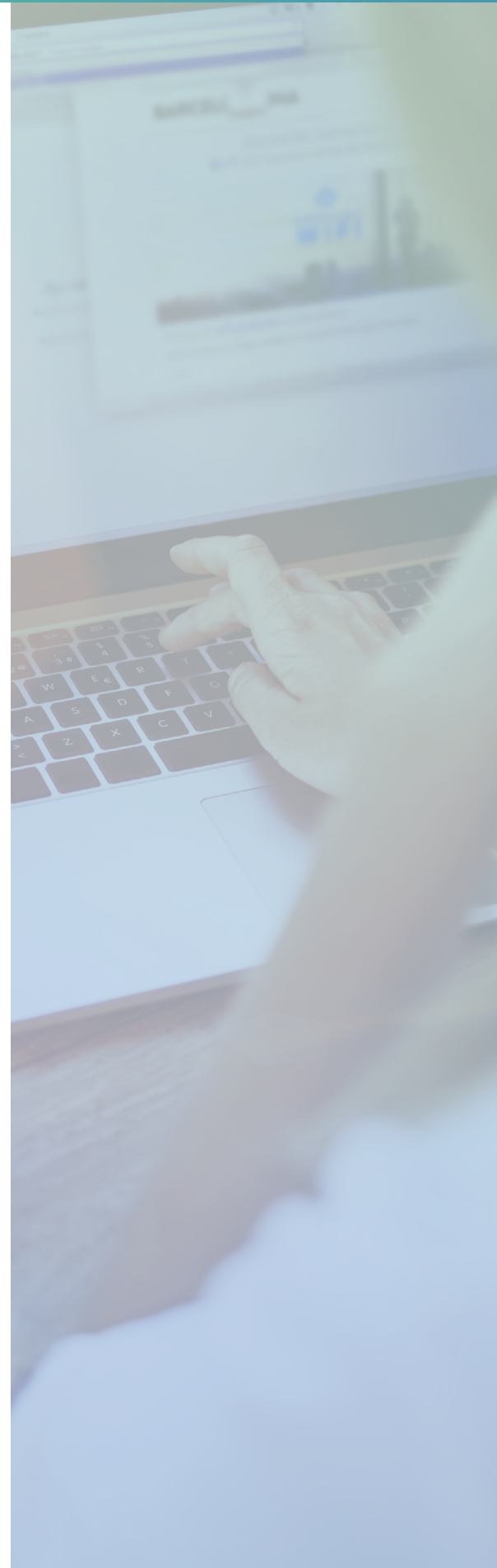
Similarly, the composition of reviewers might change depending on the content of the policy or procedure. Ensure that the reviewer understands their responsibilities and consider giving a separate team member the responsibility of tracking and initiating the P&P review process.

TIP

If your organization does not have existing standards for P&P and your writers need to start from scratch, consider researching best practice P&P to use as a starting point.

Step 3.6: SPECIAL CONSIDERATIONS

To create the most effective P&P possible, teams should aim to be aware of and actively incorporate health equity considerations into their content. Section 6 of this toolkit offers explanations of central health equity considerations as well as how they may be relevant to developing P&P. Section 7 of the toolkit explores specific organizational health considerations, including those for federally qualified health centers (FQHCs) and organizations supported by the RWHAP. Teams are encouraged to become familiar with this guidance before or during the process of drafting their new or updated P&P.





Step 4: IMPLEMENTING HIV POLICIES & PROCEDURES

Once you have created your P&P, now you can implement them using the steps within this section:

1. **Piloting P&P**
2. **Implementing and monitoring P&P**
3. **Ensure accountability through QI**

Step 4.1 PILOTING POLICIES & PROCEDURES

As described in the section on identifying P&P, piloting P&P is critical to the success of implementation, sustainability and spread to other departments/locations. It should be sound within one area before being spread to others. Piloting P&P can be done with one provider, one department, or one clinic before expanding. Discuss the new P&P with key staff to determine:

- Which provider/staff should pilot it
- How long the pilot should last (three months is common for piloting)
- How success will be tracked

Upon completion of the pilot, review the data, interview the pilot staff, and make any changes needed for a successful rollout.

Step 4.2 IMPLEMENTING & MONITORING POLICIES & PROCEDURES

P&P are essentially useless if the organization does not follow them. Having a plan in place to implement and monitor P&P will help to ensure routine usage. Key components of a successful implementation and monitoring plan include mechanisms for accessibility; staff training; and monitoring and feedback.

It is also important to note that there can be challenges to implementation, particularly if the organization has multi-site locations or departments where the same HIV service is being delivered. Staff may have different preferences and experiences in multiple locations, especially when different populations are being served. Including staff from each location or department in the development process can help address this. It can also be helpful to assess location or departmental characteristics and needs to identify potential barriers to implementation.

4.2.1 Accessibility of Information.

This is key to facilitating routine and correct usage of HIV P&P. As discussed in the Sharing and Archiving Options portion of Section 1.4 of this toolkit, staff will most likely have different preferences for accessing information. Some individuals prefer paper copies, while others want electronic access only. P&P can be housed on the organization's intranet or server, where they can be viewed on a cell phone, tablet, laptop, or computer. For those who prefer paper copies, one can format the document so it can be downloaded, printed out on three-hole punch paper and inserted into a ring binder.

TIPS

- **Be sure to grant access on the organization's intranet or server to all who need to use these documents.**
- **When organizing HIV P&P, it is helpful to group together the policy with its respective procedure(s). This gives staff the context for the procedure, which can enhance understanding and usage. A numbering system for grouping P&P accordingly is described in Section 1.4 of the toolkit.**
- **Individual procedures for HIV services that are provided frequently can be printed out and laminated for ease of use. Use caution when utilizing hard copies of P&P to ensure updated versions are being used and available in real time. Ensure staff have access to the current electronic copies as well.**



Protocols are available on a shared drive for staff availability at **Eskenazi Infectious Diseases Clinic**, Indianapolis, IN. The Quality Management (QM) Committee oversees the clinic's HIV protocols. QM meeting agendas and minutes are shared with all staff, making the P&P development and review process fully transparent. The QM Committee also provides an update as part of all staff meetings. Beyond these mechanisms, specific protocol work groups provide an additional forum for discussion and education. Protocols are beneficial to the onboarding of new staff and provide expectations for consistency of process across all staff

4.2.2 Staff Training.

When rolling out both new and updated P&P, it is essential to have a process in place to deliver the information to staff. Depending on the nature of the policy or procedure, organizations can conduct staff training in a variety of ways.

- **In-person training.** Provides the opportunity for questions and discussion, which can help ensure a more thorough understanding of what needs to be done.
- **Training at regularly scheduled staff meetings.** A way to introduce new P&P or review updated ones that do not require another meeting. Also offers the opportunity to discuss staff concerns or problems with the implementation of current P&P. Organizations can also hold lunch and learns and offer continuing education units (CEUs) as incentives for participation.
- **Online learning modules.** Offers a way for staff to learn about new and updated P&P in a time that is convenient for them. Also provides a handy reference for refresher training.
- **Onboarding new staff.** Training can be provided in-person and through online learning modules, or a combination of both. The onboarding process can give new staff an introduction into how HIV services are delivered in your organization.

4.2.3 Monitoring and Feedback.

Once P&P are rolled out or updated, it is important to provide a mechanism for ongoing monitoring and soliciting feedback from both staff and patients. This can be done through:

- **Discussion at regular staff meetings or periodic scheduled review meetings.** For new P&P or significant changes to existing ones, it can be especially helpful to set up a schedule to review and discuss them. This gives management the opportunity to hear how implementation is going, address staff concerns and questions, address staff resistance to change, and learn about how patients are experiencing any changes in service delivery.
- **Designating a lead staff person for each HIV service area.** This allows staff to ask questions and express concerns for themselves and their patients. The lead individual can be an opinion leader or champion for the service being provided.
- **Informal observations of staff and patient interactions.** Information can be gathered by a lead staff person (discussed in the previous bullet), supervisors, quality control, and other staff. This information needs to be noted and shared with staff as appropriate (e.g., during one-on-ones, staff meetings, quality review meetings, etc.).
- **A system or log for urgent concerns.** A mechanism can be established to identify, record, and track urgent staff and patient concerns that need to be addressed immediately. Organizations can set up an alert system using email, a priority incident log, or other means to share information quickly.
- **Audits.** Findings of relevant audit results from federal, state, and private funders with staff, particularly findings that highlight areas for change, can be shared with staff and used to modify P&P or create new ones.
- **Other options for staff feedback** are important for those not comfortable providing thoughts and feedback openly. Options could include one-on-one supervisor meetings or an anonymous suggestion box.
- **Health care secret/mystery shopper** could be a creative way to receive feedback from your patient population.



Corktown Health Center, Detroit, MI, disseminates new and updated P&P based on the depth and breadth of each one. Some are shared via email with resource links provided. If more impactful for a specific team or the organization, overview training may be provided in a staff meeting.



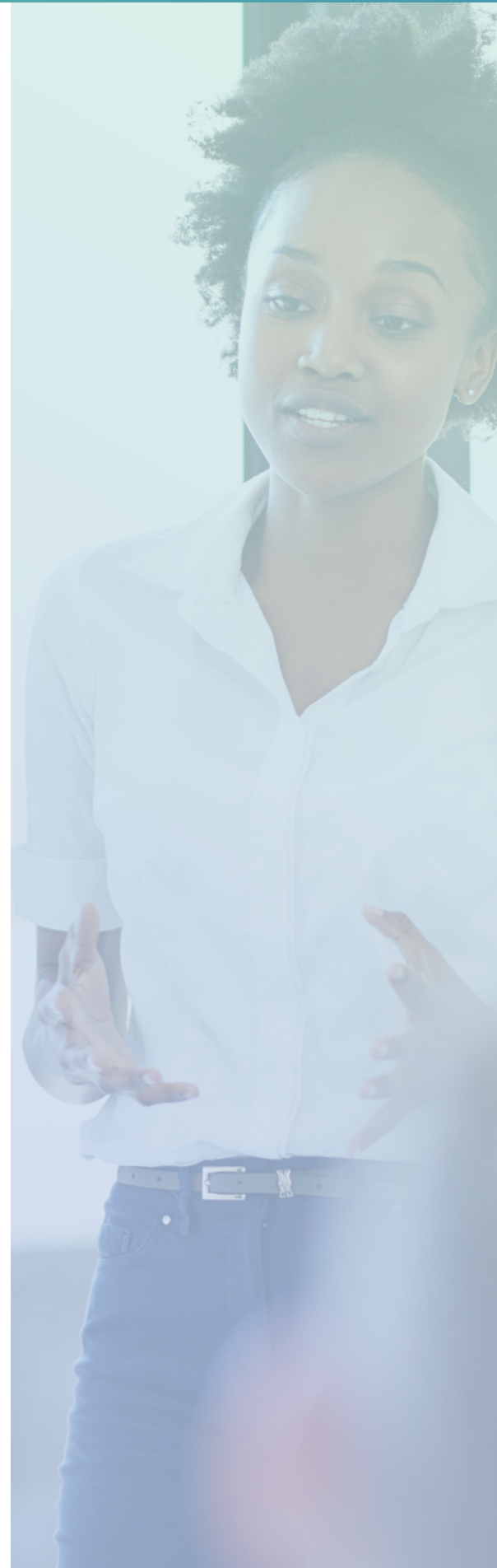
Morning meetings serve as a good access point to train providers and nursing staff on new HIV policies and protocols at **Native American Community Clinic, Minneapolis, MN (NACC)**. New employees are oriented to policies and procedures during the onboarding process.

Step 4.3 ENSURING ACCOUNTABILITY - BUILDING A SYSTEM OF CONTINUOUS QUALITY IMPROVEMENT

Continuous quality improvement (CQI) is a process that improves quality and performance in a health care setting. Improvements can help clinic staff with reliable, responsive, and sustainable processes, enabling them to better meet patient needs and enhance patient outcomes. In HIV service delivery, the goal is to ensure accountability to the organization and its patients by building a culture of CQI for consistent and high-quality care. Most organizations work with a quality control team or staff person on CQI. Depending on the types of HIV services being delivered, ways to ensure accountability and compliance with P&P can include:

- Regular (e.g., monthly, quarterly) quality meetings to discuss service delivery, service gaps, and staffing and procedural issues
- Case conferencing to discuss patients' progress and unmet needs
- Monitoring of external referrals for patient progress reports
- Review of patient feedback forms or any special patient surveys
- Staff feedback on what is working, what is not working or could be improved, and noncompliance.
- Review of data along the HIV care continuum

Some organizations also have Compliance Officers who monitor and assess service delivery and P&P to ensure compliance with federal and state statutes and requirements of different funding sources.





Step 5: REVIEWING HIV POLICIES & PROCEDURES

Reviewing HIV P&P is an important step, as outlined below:

1. Re-engaging staff with existing P&P

TIP

Include annual P&P review in job duties for the role assigned. Identify what role oversees this being sustained (e.g., P&P to be reviewed annually by medical director; program director takes on role of project manager) to make sure it is done annually.

Establish a time frame and a process for reviewing new and updated P&P. Because of the changing nature of HIV prevention and care, it is helpful to conduct reviews of clinical P&P at least annually, or upon the release of new HIV guidelines.

TIP

As referenced earlier, the P&P should not only reference the clinical guidelines, but expand upon how those are to be utilized within your setting. When writing clinical P&P, generally referencing and/or hyperlinking to “the most current HIV guidelines” can help reduce the need for frequent updates as guidelines change.

The toolkit briefly discussed assigning both writing and reviewing duties to the team. This section provides additional detail regarding what is involved in a P&P review.

HIV P&P need to be reviewed and updated on a regularly scheduled basis. The organization will need to determine how often P&P need to be reviewed (e.g., annually, quarterly, every two to three years). Review times are often based on the type of policy/procedure, funder and accreditation requirements, and updated HIV guidelines. Although organizations typically utilize the quality control staff to manage this process, it is important to designate staff or a department to oversee the reviews and updates. Note that procedures are the most likely candidates for updating. Policies usually need to be approved by an organization’s Board of Directors and do not change that often.



The Quality Management (QM) Committee at Eskenazi Infectious Diseases Clinic, Indianapolis, IN, is tasked with the review of HIV protocols. If an update is identified or required, a work group is established to discuss requested changes to the protocol. Work groups consist of staff members whose roles may intersect with the protocol, though any staff member is invited to participate if they have interest. If the protocol is clinical, providers will be included in development. The clinic director, often with the assistance of PT coaches, drafts new and updated protocols based on suggestions of the work group. The work group will review changes prior to the protocol going to the QM Committee for approval. The clinic develops HIV protocols versus policies or procedures that are required to go through a hospital committee for approval. Protocols may provide an overview and link to clinical guidelines, or they may be more workflow oriented. The primary reason for protocol updates is to reflect ongoing transitions of clinic teams rather than missing or incomplete information.

When conducting reviews and making updates, keep in mind the following points.

- Establish a review cycle that meets the organization's needs and satisfies all funder and accreditation requirements. Develop a calendar of review dates and post this online for staff who will be involved in the process.
- Develop review guidelines and conduct all reviews in the same manner to ensure consistency for all P&P.
- Based on the review, update the policy and/or procedure. Consider highlighting the changes, so staff can more easily see what they need to do differently.
- Be sure to note the review date and all changes made for all reviews conducted.
- Secure any required approvals for the changes made.
- Replace the older version of the policy and/or procedure in the online manual, network, internal drive, intranet, cloud, etc., and archive the older version.
- Don't forget that education and training is key after a policy or procedure is updated or revised. The review team will then need to determine how to roll out the updated policy or procedure. See Section 4.2.2 for staff training options.

TIP

When determining frequency of review, look to the organizational policies first, followed by funder or accreditation requirements, clinical guideline updates, etc.

TIP

When using a cloud-based storage and file sharing system, you can update the version but maintain the same link and version history.

Step 5.1 RE-ENGAGING STAFF WITH EXISTING HIV POLICIES & PROCEDURES

It is not uncommon for an organization to experience challenges with staff who are not following existing HIV P&P. For example, an organization may have a staff person who has developed significant expertise over several years with HIV testing and does not always follow everything that is stated in the procedure. In addition, chances are the organization has busy times and higher patient loads and times when they are understaffed, both which can affect the correct implementation of procedures. Here are some ways an organization can re-engage staff with HIV P&P.

- Use all audits and site visits to reacquaint staff with existing P&P. They can discuss the audit results and how they affect the delivery of HIV prevention and care services at a special meeting or a regular staff meeting.
- Involve staff in orienting and training new staff on existing HIV P&P.
- Conduct periodic, simple assessments with staff to find out how things are going with the implementation of your HIV procedures. What are the barriers to implementation? Does staff need additional education on how to implement the procedures? They can work with the quality control person or team to conduct these assessments at least annually.
- Also conduct periodic assessments with different departments or clinic sites to identify needs and implementation barriers. Again, one can work with the quality control person or team to help with this on at least an annual basis.
- Provide a mechanism for staff to give feedback and ask for help with special situations that make implementation challenging.
- Increase communication with staff about the development and review process for P&P and the need for them.
- Regularly share journal articles, evidence-based educational materials, best practices, trends in HIV rates and populations at risk, and standards of care.



Step 6: HEALTH EQUITY CONSIDERATIONS FOR HIV POLICIES & PROCEDURES

Health equity plays a critical role in the successful delivery of HIV care and prevention services. The CDC defines health equality as “the state in which everyone has a fair and just opportunity to attain their highest level of health,” and also states, “to achieve health equity, we must change the systems and policies that have resulted in the generational injustices that give rise to racial and ethnic health disparities.” “Differences in sexual behavior account for some of these disparities, but others are associated with social and structural inequities, such as the stigma and discrimination that LGBT populations experience.” As organizations who provide HIV care and prevention services, the goal is to ensure the delivery of equitable HIV care to the diverse populations we serve, recognizing that different persons have different circumstances and may need specially tailored services, resources, and support to achieve optimal health and well-being.

Organizations providing HIV care and prevention services know well that health can be affected by discrimination, stereotyping, and prejudice. They also know discriminatory practices can be embedded in an organization’s systems and processes. The challenge for organizations is to examine their processes and practices, identify areas that prevent their service populations from achieving optimal health, and develop P&P that ensure health equity.

This section gives an overview of areas for the organization to consider to ensure health equity is integrated into HIV P&P. We highlight key topics relevant to health equity with the understanding that there may be other areas specific to the service population to consider as well. Topics include:

1. Social determinants of health
2. Racial equity
3. LGBTQ+ friendly
4. Gender neutrality
5. Unstably housed populations
6. Mental health and substance use
7. Health literacy

Step 6.1 SOCIAL DETERMINANTS OF HEALTH

Understanding social determinants of health (SDOH) and how they can impact health equity is key to developing effective HIV P&P. The U.S. Department of Health and Human Services defines SDOH as “conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” Those disproportionately at risk for poor SDOH include people from racial and ethnic minority groups (Black, Latino, Asian, Native American and Pacific Islanders), people living in a low-income household, and members of the lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ+) community. [Healthy People 2030](#) has a strong focus on SDOH grouped into five domains to eliminate health disparities (see Figure 7), as outlined in Table 5.

Figure 7: SDOH domains.

Social Determinants of Health



* Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved March 30, 2023, from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

TIP

Adapt no-show/cancellation P&P to accommodate patients with HIV who were unable to take time off work at the risk of losing their employment, housing, etc.



Vibrant Health, Kansas City, KS describes their P&P development and implementation process as dynamic and ongoing, identifying their procedures as living documents. As the team providing HIV preventive and testing services has expanded, there has been greater awareness as to the understanding and educational needs of the staff. Standard processes are documented but may be expanded to include special “what-ifs” and nuances for various patient populations. The Federally Qualified Health Center (FQHC) serves a significant pediatric population and has recognized that conversations and processes may require adaptation to accommodate the unique needs of younger patients and their families

Table 5: CDC Framework for SDOH

CDC Framework for SDOH*	
Key Area	Description
Health care access and quality	The connection between people’s access to and understanding of health services and their own health. This includes key issues such as access to health care, access to primary care, health insurance coverage, and health literacy.
Education access and quality	The connection of education to health and well-being. This includes key issues such as graduating from high school, enrollment in higher education, educational attainment in general, language and literacy, and early childhood education and development.
Social and community context	The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, and incarceration.
Economic stability	The connection between the financial resources people have—income, cost of living, socioeconomic status—and their health. This includes key issues such as poverty, employment, food security, and housing stability.
Neighborhood and built environment	The connection between where a person lives—housing, neighborhood, and environment—and their health and well-being. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and neighborhood crime and violence.

* Social Determinants of Health, Centers for Disease Control and Prevention. Retrieved March 30, 2023 from <https://www.cdc.gov/socialdeterminants/about.html>

Differences in health can be striking in communities with poor SDOH. Use Table 5 to help assess the needs and information and resource gaps of service populations and determine what can realistically be done to advance or improve health equity. Providing webinars or talks to other organizations and community groups the organization works with to educate other service providers on the needs of the specific populations served.

- Offering mobile health screenings to populations who do not have access to or cannot afford transportation.
- Having evening and/or weekend appointments for people who work longer and/or different hours than a standard 9 to 5, Monday through Friday.
- Enhancing education, testing, and treatment access for HIV services.
- Providing low-cost, sliding scale, or no-cost services to persons with low or no income.
- Assisting people with no insurance in obtaining insurance or public support.

Considerations When Developing HIV P&P

Utilizing the social determinants of health framework when creating P&P is an important consideration for people with HIV (PWH) your organization serves. Sample P&P considerations include:

- Adapting “no-show” and cancellation policies to accommodate SDOH
- Integrating HIV prevention and care services into primary care settings to reduce stigma
- Providing field-based telehealth services to unstably housed patients
- Integrating opt-out HIV testing into primary care services to reduce stigma
- Using peer navigators to link and re-engage patients in HIV prevention and care
- Incorporating regular stigma and bias training for all staff; motivational interviewing for clinicians and case managers
- Developing integrated supportive housing services into care to improve viral load suppression
- Using prescription refill information to decrease the length of time between refills and reduce antiretroviral therapy (ART) interruption
- Leveraging community advisory boards to inform the development and implementation of HIV P&P

Step 6.2 RACIAL EQUITY

Health equity includes ensuring HIV care and prevention services are delivered with an anti-racist lens. The [National Association of Counties](#) has an excellent definition of diversity, equity, and inclusion, and a list of terms that are used in the advancement of equity in communities and organizations.

- **Diversity** is the presence of different and multiple characteristics that make up individual and collective identities, including race, gender, age, religion, sexual orientation, ethnicity, national origin, socioeconomic status, language, and physical ability.
- **Equity** is the process of identifying and removing the barriers that create disparities in the access to resources and means, and the achievement of fair treatment and equal opportunities to thrive.
- **Inclusion** is creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to participate fully.

Considerations When Developing HIV P&P

P&P need to address racial equity. One way to do so is to include a statement on the organization's position on diversity, equity, and inclusion.

Things to consider when developing HIV P&P for your organization include the following.

- State the goal—say that the organization cares about and is committed to serving and advocating for diverse patients—all racial, ethnic, gender, sexual, age, and different dispositions (e.g., people with mental/physical challenges, people from historically and intentionally excluded/disinvested communities and resource poor).
- Include the patients' voices and learn from their input to better meet their needs and deliver high-quality, culturally appropriate services.
- Ensure leadership and staff are representative of the communities the organization serves.
- Commit to modeling anti-racism principles to ensure patients are treated with respect and sensitivity, and without stigma.

TIP

A great resource on diversity, equity, and inclusion is the American Academy of HIV Medicine (AAHIVM). The [AAHIVM Public Policy Platform](#) provides guidance on policy statements to support diversity, equity, and inclusion in HIV service delivery and access to affordable and high-quality HIV care and prevention for communities disproportionately affected by HIV.

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

– Rev. Dr. Martin Luther King, Jr.

Step 6.3 LGBTQ+ FRIENDLY

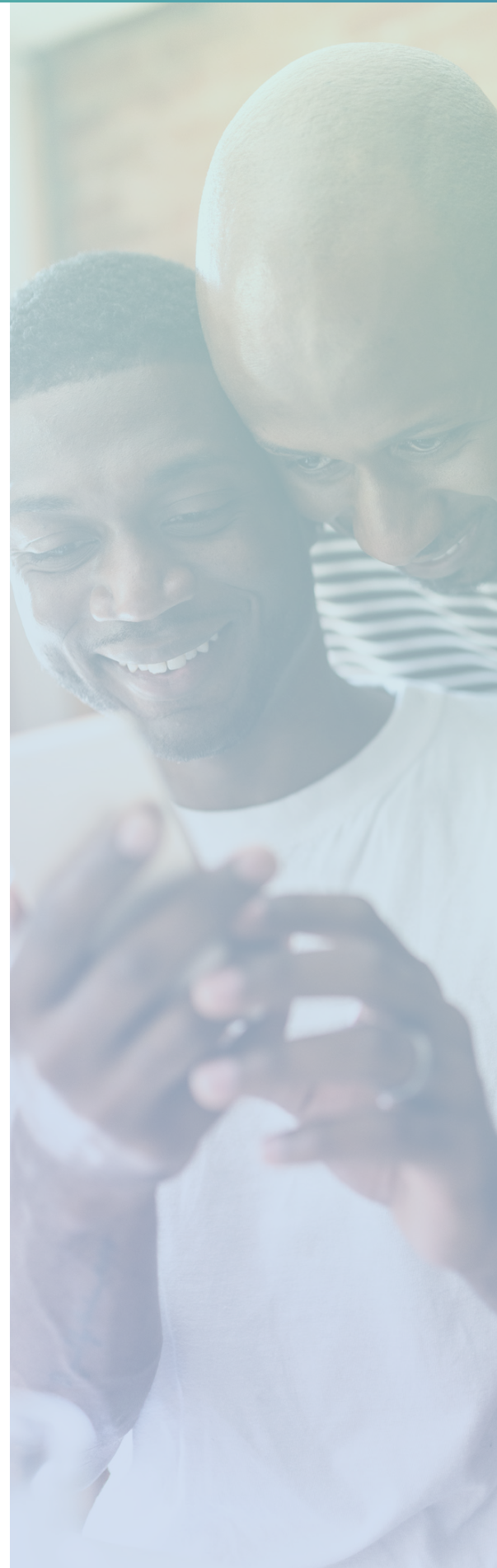
It is well documented that the LGBTQ+ community members who use language to describe their identity, LGBTQ+, are disproportionately affected by HIV. Discrimination against the LGBTQ+ community has had a direct impact on access to HIV care and prevention services. In addition, stigma is still high against this [community](#). Dealing with the potential consequences of bias and discrimination (e.g., job loss, homelessness, lack of health insurance) can result in engaging in behaviors that result in the spread of HIV. For example, an individual might begin performing sex work to meet basic needs due to employment discrimination or becoming homeless because of revealing identity. Health inequities also exist in HIV diagnosis, treatment, and prevention for racial and ethnic groups. Negative attitudes and beliefs about PWH also impact the LGBTQ+ community, which can decrease the likelihood that individuals will get tested, use prevention interventions like PrEP, engage in care, and be virally suppressed.

To reduce health inequities in this population, [CDC](#) suggests using innovative and culturally responsive strategies that keep individuals from knowing their HIV status and receiving HIV care and prevention services. Organizations can consider:

- Providing programs to give HIV self-testing kits to those who may not have access to in-person testing services or do not feel comfortable accessing in-person services.
- Adapting appropriate RWHAP service models that include enhanced collaboration with local partners, increased community engagement, and training.
- Increasing the availability of PrEP using distribution methods acceptable to all populations.
- Developing a status-neutral approach to engage people in HIV care and prevention.

Considerations When Developing HIV P&P

When developing HIV P&P, it is important to include LGBTQ+ services and considerations in mind. Ensuring the LGBTQ+ audience is included within P&P and that services are available and accessible, is important for a strong HIV program.



Step 6.4 GENDER NEUTRALITY

Gender is traditionally defined as social, cultural, or community designations of masculinity and femininity, using the standard pronouns she/her/hers and he/him/his. Gender neutrality, however, promotes using language that does not distinguish a person's role according to sex or gender, using the gender-neutral pronouns they/them/theirs. Non-binary is a term for gender identities that are neither male nor female. Transgender people do not identify as the gender they were assigned at birth.

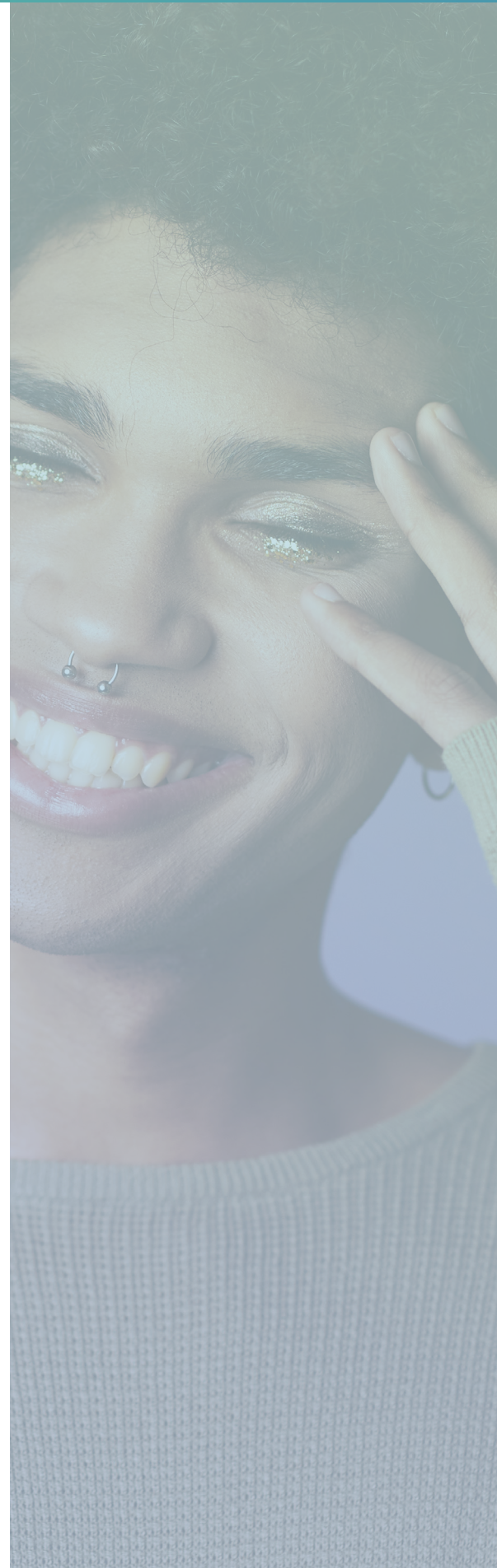
Considerations When Developing HIV P&P

When developing HIV P&P, keep gender neutrality front and center. Using the pronouns they/them/theirs is inclusive and does not disrespect, invalidate, or alienate a person for how they choose to define their individual identities. Make sure to include the following in P&P: For patients not using sex assigned at birth, request the name patient would like to be called and gender identity.

Traditional gender norms, roles, and relations can affect the HIV risk-related behaviors of the LGBTQ+ community due to stigma and discrimination. Understanding the impact of gender terms on the organization's service populations is needed to develop gender-neutral, culturally competent services and HIV P&P.

TIP

For insurance purposes, the sex assigned at birth and name on birth certificate needs to match, but there can be sexual orientation, gender identity, and expression (SOGIE) fields that are the primary source of reference for the front desk and clinical care team.



Step 6.5 UNSTABLY HOUSED POPULATIONS

[Data from HRSA](#) show that stable housing is closely linked to successful HIV outcomes. Stable housing is strongly associated with access to medical care and supportive services, prevention services, engagement and retention in HIV care, and regular visits to a health care provider. In other words, the more stable a person's living situation is, the better they do in HIV care and prevention. Individuals who are unstably housed (at risk of losing housing) or are homeless are more likely to delay HIV testing and treatment and, once in treatment, are more prone to skip medical visits, not stick to treatment regimens, and not use prevention such as PrEP and condoms. In addition, throughout many communities, PWH risk losing their housing due to factors such as stigma and discrimination, increased medical costs, and limited incomes or reduced ability to work due to HIV-related illnesses.

HRSA RWHAP works in tandem with the Department of Housing and Urban Development (HUD) Housing Opportunities for People with AIDS (HOPWA) program. This program provides technical assistance to organizations serving unstably housed and homeless populations.

Special Considerations When Developing HIV P&P

When developing HIV P&P, incorporate the HOPWA resource into your processes for working with unstably housed and homeless patients. Establishing connections with other community agencies that address housing is also helpful, particularly for emergency housing needs. It is also important to educate staff on available resources and factors that contribute to unstable housing and homelessness.

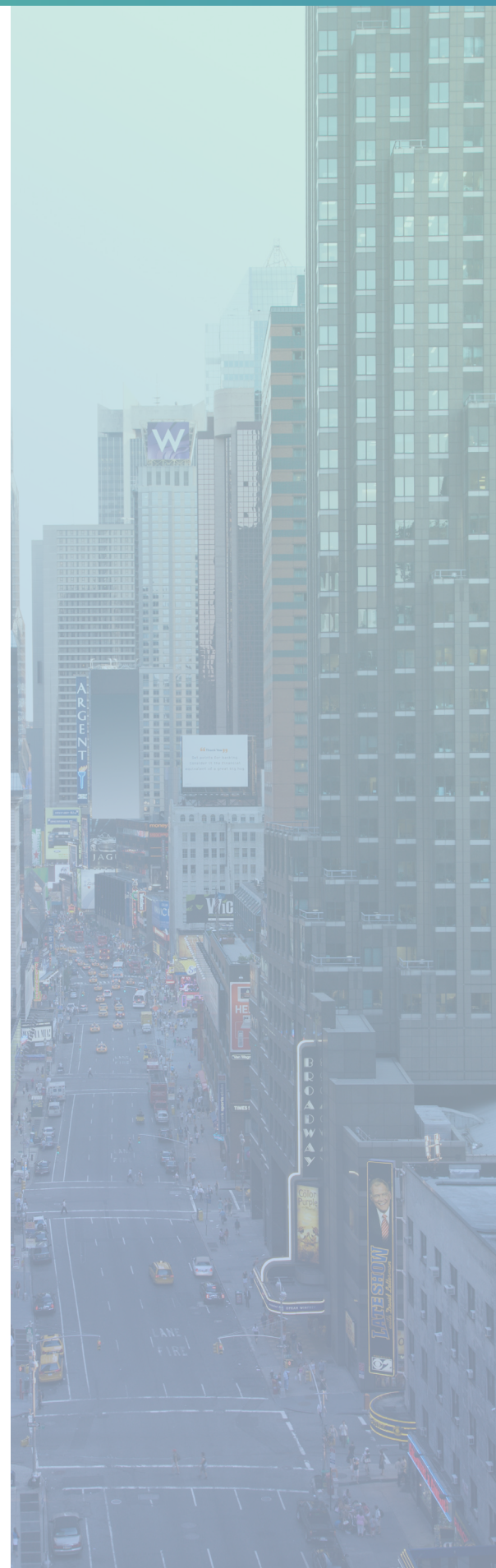
Step 6.6 MENTAL HEALTH AND SUBSTANCE USE

Almost everyone faces mental health challenges at some point in life. Major stressors that can have a big impact on mental health include death of a loved one, divorce, loss of a job, or moving. One of the most common mental health conditions PWH have is depression. Both HIV-related medical conditions and certain HIV medications can contribute to depression. When a PWH or at risk for HIV has mental health issues and is a substance user, positive overall health and mental health can become even harder to achieve and maintain.

Special Considerations When Developing HIV P&P

When developing HIV P&P, it is critical for organizations to understand the needs of their populations who have co-occurring mental illness and substance use disorders. The Substance Abuse and Mental Health Services Administration (SAMHSA) has excellent resources to help with developing P&P for providing HIV care and prevention services to this population, including persons who use or inject drugs and alcohol. It will also help the organization develop P&P for linking this population to mental health and substance abuse services. [Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Health Disorders](#) is an excellent resource to explore care of this population.

Additional resources for developing P&P for providing HIV services to this population are included in the Appendix D: Resource Links and References.



Step 6.7 HEALTH LITERACY AND NO ENGLISH OR ENGLISH AS A SECOND LANGUAGE

Providing successful HIV care and prevention services includes developing P&Ps that consider effective communication. This includes recognizing and addressing the unique culture, language, and health literacy of the diverse patient populations served by the organization. Building cultural competence within the organization enables staff to work more effectively in cross-cultural situations and facilitates greater understanding and communication between staff and patients. This will lead to more effective treatment, adherence to treatment regimens, and retention in care.

Cultural competence and health literacy are areas the organization will want to consider when developing HIV P&P. This includes patients that do not speak English as their primary language and have limited ability to read, speak, write, or understand information. Also keep in mind that different cultures use different figures of speech that can affect communication and understanding of health information. Health literacy addresses the degree to which a person can process and understand basic health information and services necessary to make appropriate and informed health decisions.

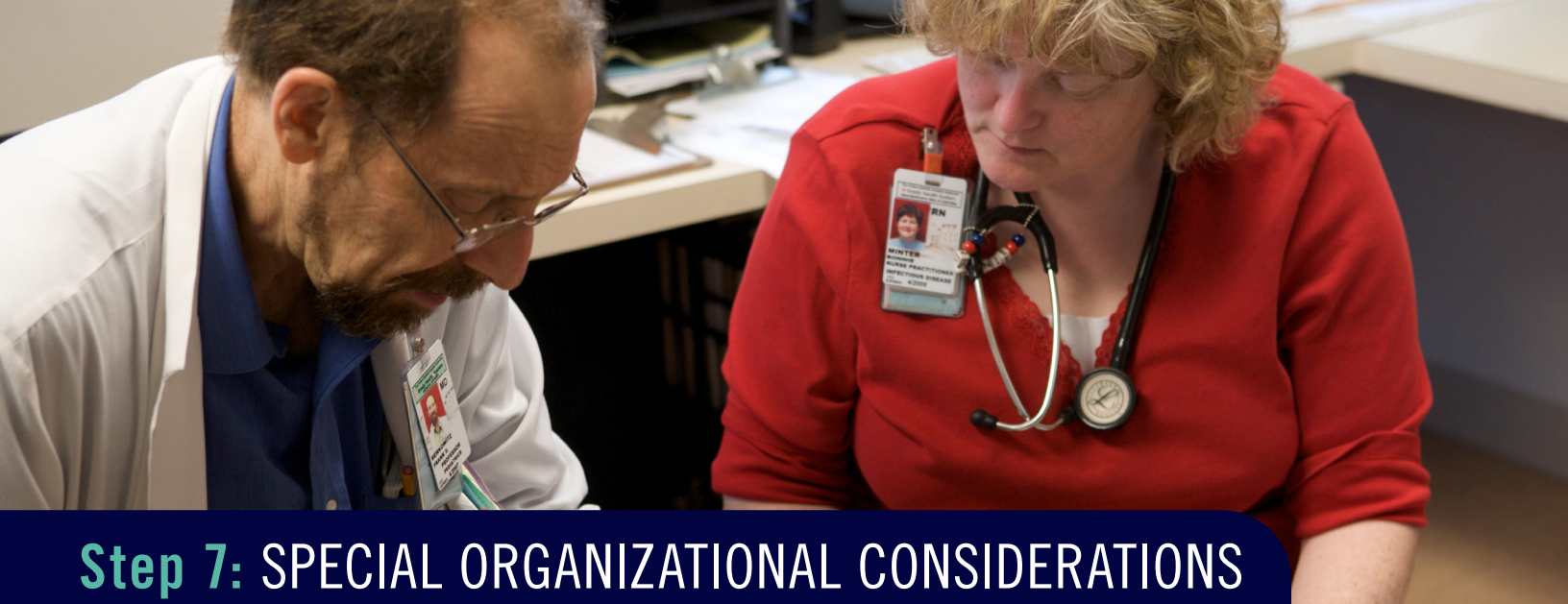
Special Considerations When Developing HIV P&P

To increase health literacy, we recommend writing all HIV P&Ps in “plain language,” which is writing that is clear, concise, to the point, and does not use jargon or acronyms. This type of writing helps to improve the communication of information to patients and takes patients less time to read and understand. All of what we’ve discussed can also apply to staff who do not have English as their first language.

Helpful resources for developing P&P around culture, language, and health literacy include:

- [The National Center for Cultural Competence](#) The Center’s mission is to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity. Another helpful resource of the Center is its [Cultural and Linguistic Competence Policy Assessment](#) developed at HRSA’s request. It assists organizations with advancing and sustaining cultural and linguistic competence.
- [The Office of Disease Prevention and Health Promotion’s Health Literacy Online: A Guide for Simplifying the User Experience](#) This research-based guide will help you develop intuitive health websites and digital tools that can be easily accessed and understood by all users—including the millions of Americans who struggle to find, process, and use online health information.





Step 7: SPECIAL ORGANIZATIONAL CONSIDERATIONS FOR HIV POLICIES & PROCEDURES

This section includes special considerations such as:

1. Federally Qualified Health Center

Step 7.1 FEDERALLY QUALIFIED HEALTH CENTER

Sections 3 and 4 of this toolkit provide the organization with a general process for developing and implementing HIV policies and procedures. If the organization is a FQHC, however, there are special factors to take into consideration regarding HIV P&P. In the following text, we define what an FQHC is and the special role FQHCs play in the delivery of quality health care, and outline considerations for developing HIV policies and procedures within the FQHC structure.

What is an FQHC?

FQHCs are community-based, primary health care providers who receive funds from the HRSA Bureau of Primary Health Care (BPHC) to provide primary care services in medically underserved areas. To become an FQHC, a provider needs to meet HRSA's requirements, including providing care on a sliding scale based on ability to pay and operating under a governing board that includes patients. FQHCs deliver comprehensive, culturally competent health care services to vulnerable populations, which can include or facilitate access to pharmacy, mental health, substance use, and oral health services. They serve diverse populations, including individuals and families living at less than 200 percent of the Federal Poverty Level, people experiencing homelessness, migrant and seasonal agricultural workers, undocumented individuals, residents of public housing, and veterans. FQHCs also provide supportive services such as health education, translation, and transportation that promote access to care.

2. Ryan White HIV/AIDS Program

Considerations for FQHCs When Developing HIV P&P

Keep in mind when reviewing the list of considerations below that not all may apply to the organization and will depend on the type of HIV services offered. Review funding applications and accreditation organizations' requirements to help determine the areas that need P&P, including administrative, clinical, and financial.

- FQHCs with accreditation through The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA) are all required to maintain P&P for providing HIV care.
- Because FQHCs serve diverse populations, the organization will need to develop HIV P&P that address cultural competency, staff training, and the needs of any unique populations served (e.g., individuals transitioning from incarceration).
- If the HIV program has RWHAP grant funding, a policy should exist on patient eligibility to receive services provided by that grant.
- If the FQHC is using specific types of personnel to work with PWH, include a policy that says all personnel necessary to fulfill regulatory and specific HIV services and programs will be hired. In the procedure, the responsibilities of each position can then be clarified and spelled out.

- FQHCs typically have a high patient visit no-show rate, due to social determinants of health (SDOH) obstacles. The organization should have a policy regarding HIV treatment and the number of no-shows a patient is allowed to stay in the program.
- The organization will also need P&P around the sharing of their electronic health records with other health care providers or social services organizations involved in providing care and services to PWH.
- If the organization has an AIDS Drug Assistance Program (ADAP) funded by RWHAP Part B, it will need to establish a policy on its use and any related procedures for implementing the program.
- Any time a new grant is received, there are typically billing codes that need to be added or changed. The organization will need a policy for this, as well as a procedure for how the codes will be added or changed. It will also need to state whether the operations budget is linked to any revenue generated from the HIV program, such as a 340B pharmacy.
- There are many regulatory bodies overseeing and shaping the work done by FQHCs. The [HRSA Compliance Manual](#) informs FQHCs what P&P are required by this agency. There are several HIV-related HRSA policies that an FQHC must have in place.
- Common to all FQHCs, and a HRSA requirement, is that the Board of Directors must approve all policies. In some organizations, the Board of Directors is also responsible for approving procedures.
- FQHCs can also receive RWHAP funding and must follow the guidelines for P&P for the type of grant you have. See the next section for information on special considerations in developing HIV P&P for RWHAP recipients.

Step 7.2 RYAN WHITE HIV/AIDS PROGRAM (RWHAP)

Ryan White CARE Act

Ryan White was 13 years old when he was diagnosed with AIDS in 1984. He was the first child, and one of the first hemophiliacs, to contract AIDS from a blood transfusion. When he tried to return to school in his Indiana community, he experienced AIDS-related discrimination. Through his mother's efforts for his right to attend school, Ryan gained national attention and became the face of public education about AIDS. Ryan died in 1990, one month before his high school graduation. That same year, Congress passed the [Ryan White Comprehensive AIDS Resources Emergency \(CARE\) act](#).

What is the Ryan White HIV/AIDS Program?

With Congressional funding, HRSA developed the national Ryan White HIV/AIDS Program (RWHAP) in 1990 to provide support to ambulatory-based clinics for primary and specialty care for low-income, underinsured, and uninsured people with HIV and AIDS. The RWHAP has five parts that award grants to clinics and organizations.

Part A grants are targeted to eligible metropolitan areas and transitional grant areas to provide medical and support services to cities and counties most severely affected by HIV.

Part B grants are for all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, and six U.S. territories. These grants improve the quality of and access to HIV health care and support and provide medications to low-income PWH through the AIDS Drug Assistance Program (ADAP).

Part C grants are for local community-based groups and provide outpatient ambulatory health services and support. They also help community-based groups to strengthen their capacity to deliver high-quality HIV care.

Part D grants are for local community-based organizations to provide medical care for low-income women, infants, children, and youth with HIV. Part D recipients also provide support services for PWH and their family members.

Part F grants support the work of HRSA AIDS Education and Training Centers (AETC) and help develop innovative models of HIV care and treatment through the Special Projects of National Significance (SPNS) program. Part F also supports dental programs for PWH and education about HIV for dental care providers, and the Minority AIDS Initiative to improve access to HIV care and health outcomes for minority populations.

Considerations for RWHAP-Funded Clinics When Developing HIV P&P

Keep in mind when reviewing the following list of considerations that not all may apply to every organization and will depend on the type of RWHAP grant(s) the organization has. Be sure to review the grant application carefully to help identify areas that will need P&P for administrative, clinical, and fiscal functions.

RWHAP grants require specific HIV P&P. Like FQHCs, the response, work plan, collaboration, and evaluation sections of the grants will provide a strong outline of what P&P are expected to meet the funding requirement. For greater detail for Part A, B and C grants, refer to the links below.



[Part A Manual](#)



[Part B Manual](#)



[Part C Grant Funding](#)

P&P that will be needed for RWHAP funding are listed as follows. Always check with the assigned HRSA Project Officer when there are questions about requirements and expectations.

- Eligibility policy, RWHAP funding is always considered to be the “funding of last resort.” The organization will also need a procedure to outline how eligibility will be determined for each patient.
- Policy on new patient intakes and a sliding fee discount schedule that is tied to procedures for conducting patient intakes and determining patient fees.
- An overview policy that outlines the 13 core medical services specified in the legislation and appropriate support services that assist persons with HIV/AIDS. This policy needs to be consistent with [DHHS Treatment Guidelines](#).
- Linkage-to-care P&P that identify appropriate memoranda of understanding (MOUs) with other health care providers, specialty services, and supportive social services.
- Clinical P&P can include screening and testing, counseling, continuity of care, care plan, patient education, the use of antiviral therapy, STI testing on PWH, quality control and measures collected through the clinical quality program (line items in RWHAP grants), and the use of laboratory services in testing, diagnosis, and treatment.
- Administrative P&P can include outreach, staff training, sharing of electronic health records (HER) with other health care providers and other organizations, and services for special populations (for example if funding is going to be used for transitional social support and primary care services for incarcerated persons, behavioral health, and substance use disorder services).
- The organization should have a policy on the forbidden uses of RWHAP funds.
- If some patients are eligible for insurance, there should be a policy establishing what can still be provided under RWHAP funding.
- If the organization has a [340B Program](#), HRSA encourages tracking of income/revenue specific to 340B and the RWHAP. A procedure can be developed for how this tracking will take place.

APPENDICES



- A. Sample HIV Policies and Procedures
- B. Acronyms and Definitions
- C. Midwest AID Training + Education Center (MATEC)
- D. Resource Links and References

Appendix A: Sample HIV Policies & Procedures

Sample documents may include policies, procedures, protocols, workflows, and supporting documentation. As additional samples are gathered, new links will be added. If you have a P&P that you would like to share, please reach out to MATEC.

A huge thank you to the following clinics, within the MATEC region, for sharing their P&P documents for the purpose of educating other clinics on HIV best practices.

- Cook County Health, Chicago, Illinois
- Equitas Health, Chicago, Illinois
- Eskenazi Health, Indianapolis, Indiana
- KC Care Health Center, Kansas City, Missouri
- Primary Health Care, Des Moines, Iowa

HIV Care Continuum Step 1: Diagnosed with HIV

1. HIV TESTING
 - Procedure - [HIV Screening Procedures](#)
 - Workflow – [Routine HIV Testing Workflow](#)
2. HIV OPT-OUT TESTING/UNIVERSAL TESTING
 - Policy – [Routine Opt-Out HIV and Hepatitis C Screening Policy](#)
 - Procedure – [HIV and Hepatitis C Opt-Out Screening Procedure](#)
 - Refusal Form – [HIV Test Refusal Form](#)
3. AT-HOME TESTING/TELE-TESTING
 - Policy - [Home HIV Testing Protocol](#)
 - Procedure – Included within [Home HIV Testing Protocol](#)
4. DELIVERING HIV TEST RESULTS

HIV & STI Prevention

1. PREP
 - Policy – [PrEP Protocol](#)
 - Procedure – Included within [PrEP Protocol](#)
2. WALK-IN STI TESTING
 - Policy – [Walk-In Sexually Transmitted Infections \(STI\) Screening](#)
 - Standing Orders – Included within [Walk-In Sexually Transmitted Infections \(STI\) Screening](#)
 - Procedure – Included within [Walk-In Sexually Transmitted Infections \(STI\) Screening](#)
 - Workflow – Included within [Walk-In Sexually Transmitted Infections \(STI\) Screening](#)

HIV Care Continuum Step 2: LINKAGE TO CARE

1. REFERRAL TO CARE/LINKAGE TO CARE
2. RAPID ART
 - Referral Partner Brochure - [Rapid ART Initiative: Immediate support and access to treatment for those newly diagnosed with HIV](#)

HIV Care Continuum Step 3: RECEIVED IN MEDICAL CARE

1. TREATMENT OF HIV
 - Policy – Guidelines for the Treatment of HIV/AIDS
2. ART INITIATION
3. RAPID ART
 - Procedure – [Internal Rapid Antiretroviral Therapy \(ART\) Procedure](#)
 - Referral Partner Brochure - [Rapid ART Initiative: Immediate support and access to treatment for those newly diagnosed with HIV](#)
 - Referral Form – [HIV Services Referral Form](#)
4. MEDICATION RENEWAL
 - Policy – [Medication Renewal Protocol](#)
 - Procedure – Included in [Medication Renewal Protocol](#)
5. STI TREATMENT
 - Policy – [Sexually Transmitted Infection Diagnosis, Treatment, and Referral for Patients Living with HIV Infection Protocol](#)
 - Procedure – Included in [Sexually Transmitted Infection Diagnosis, Treatment, and Referral for Patients Living with HIV Infection Protocol](#)
6. CO-INFECTION

HIV Care Continuum Step 4: RETAINED IN CARE

1. LOST TO CARE/OUT OF CARE
 - Policy – [Patients Who Experience Disruption in Outpatient Care Protocol](#)
 - Procedure – Included in [Patients Who Experience Disruption in Outpatient Care Protocol](#)
 - Procedure – [RW Engagement in Care Procedure](#)
 - Procedure and Forms – [RW Part C Diligent Search Procedure](#)
2. CASE MANAGEMENT
 - Policy – [Case Management Policies & Procedures](#)
 - Procedure – Included in [Case Management Policies & Procedures](#)
3. REFERRALS
 - Policy – [Ryan White Program Referrals Protocol](#)

HIV Care Continuum Step 5: ACHIEVED VIRAL SUPPRESSION

1. MONITORING VIRAL SUPPRESSION
2. CLINICAL TRIALS
 - a. Policy – [Referral to HIV Clinical Trials Protocol](#)
 - b. Procedure – Included in [Referral to HIV Clinical Trials Protocol](#)

Other Sample Documents

1. STAFF TRAINING/ORIENTATION/CONTINUING EDUCATION
 - Procedure – Tracking Continuing Education [Protocol](#)
 - Onboarding Checklist – [RN Training Checklist](#)

Appendix B: Acronyms and Definitions

AAAH – Accreditation Association for Ambulatory Health Care

ADA – Americans with Disabilities Act (ADA) of 1990 is a federal civil rights law that prohibits discrimination based on disability.

ADAP – AIDS Drug Assistance Program

AETC – AIDS Education and Training Center (AETC) Program supports national HIV priorities by building clinician and care team capacity and expertise along the HIV care continuum.

ART – Antiretroviral therapy (ART) for treatment of HIV.

BBPCA – Building Blocks of Primary Care Assessment (BBPCA), a 46-question tool that can be used by primary care practice to assess and reassess organizational change.

CDC – Centers for Disease Control and Prevention

CQI – Continuous Quality Improvement (CQI), a quality management process that continuously assesses how things are going and how things can be done better.

Decision Trees – A graphical representation of solutions that help to decide next steps quickly and with accuracy.

Diagnosed with HIV – Receiving a positive HIV test confirmed by a health care provider.

EHE – Ending the HIV Epidemic in the United States: A Plan for America (EHE), plan announced by the U.S. Department of Health and Human Services in 2019 that aims to end the HIV epidemic in the United States by 2030.

Engaged in HIV care – Having had at least one CD4 or viral load test run by a health care professional, within a predetermined time period as indicated by HRSA.

FQHC – Federally Qualified Health Centers (FQHC) are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas that meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.

Gender neutrality – Using language that does not distinguish a person's role according to sex or gender, using the gender-neutral pronouns they/them/theirs.

Guidelines – Statements that guide best practice in specific circumstances.

Health equity – Every person can attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances, as defined by CDC.

HIPAA – Health Insurance Portability and Accountability Act (HIPAA) of 1996. The federal act modernized the flow of health care information, stipulates how personally identifiable information maintained by the health care and health care insurance industries should be protected from fraud and theft, and addressed some limitations on health care insurance coverage.

HIV care continuum – A public health model that maps the steps that individuals should go through from HIV diagnosis to viral suppression and helps health care providers ensure that persons with HIV are getting the care they need.

HHS – U.S. Department of Health and Human Services

HRSA – Health Resources and Services Administration

IHS – Indian Health Service

Integrated team-based care – A type of care in which a group of health care professionals coordinate their work in the prevention or treatment of disease. Patients are engaged as full participants in their care, and health care professionals are encouraged to function at the top level of their education, certification, and experience.

Kotter's 8-Step Change Model – Framework outlining steps to leading successful change.

LGBTQ+ – Lesbian, gay, bisexual, transgender, queer (or sometimes questioning), and others (LGBTQ+). The acronym is used to represent a diverse range of sexualities and gender identities.

Linked to care – The time between the HIV diagnosis date and either the first clinic attendance date, first CD4+ count, viral load date, or HIV treatment start date, with prompt linkage measured within a predetermined number of days, as defined by HRSA.

MATEC – Midwest AIDS Training + Education Center (MATEC), provides local programming and technical assistance to health care professionals through our offices in Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, and Wisconsin.

MSM – Men who have sex with men

National HIV/AIDS Strategy – Developed by the White House Office of National AIDS Policy (ONAP) in collaboration with federal partners and the collective HIV community to end the HIV epidemic in the United States by 2030.

NCQA – National Committee for Quality Assurance

NIH – National Institutes of Health

Non-binary – Gender identities that are neither male nor female.

OASH – Office of the HHS Assistant Secretary for Health

Patient-centered medical home – A team-based health care delivery model to provide comprehensive and continuous medical care to patients with a goal to obtain maximal health outcomes.

PWH – People with HIV

PDSA Cycle – Plan, Do, Study, Act (PDSA) is a four-stage problem-solving model used for improving a process or carrying out change.

Policies – A statement that provides a guide to decision-making regarding processes or activities that take place on a regular basis.

Practice Transformation (PT) – Defined by the Centers for Medicare & Medicaid (CMS) as “a process that results in observable and measurable changes to practice behavior.” Such changes are intended to improve health outcomes, create closer patient-provider relationships, and help replace costly acute care episodes with preventive care management.

Practice transformation coach – A professional who assists primary care practices and clinics to improve the way they deliver care.

PrEP – Pre-exposure prophylaxis

Procedures – Steps to be followed for the accomplishment of a given task and/or the accomplishment of certain objectives in a defined circumstance. Indicate what will be done, when, and by whom and what records are to be kept.

Protocols – A set of decision-making rules and instructions based on guidelines.

Readiness Assessment – A systematic analysis of an organization’s ability to undertake a new process or **change**.

Retained in HIV care – The person enrolled in HIV care routinely attends care services and received viral load tests in accordance with their needs within a predetermined number of days, as defined by HRSA.

Ryan White Comprehensive AIDS Resources Emergency Act of 1990 – A federal act to provide grants to improve the quality and availability of care for individuals and families affected by HIV, and for other purposes.

SAMHSA - Substance Abuse and Mental Health Services Administration

SDOH – Social Determinants of Health (SDOH), conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes, as defined by CDC.

SPNS – Special Projects of National Significance (SPNS) support the development of innovative models of HIV care and treatment to quickly respond to emerging needs of organizations providing HIV care and services.

Standards – Mandatory controls that help enforce and support a policy.

STI – Sexually transmitted infection (STI), an infection transmitted through sexual contact, caused by bacteria, viruses, or parasites.

Transgender – Describes a person whose gender identity is different from the gender they were assigned at birth.

Transtheoretical Model Stages of Change – A model that assesses an individual’s readiness to act on a new, healthier behavior, and provides strategies, or processes of change to guide the individual.

Viral suppression – Having a viral load test result of less than 200 copies/mL at the most recent test.

Workflow Process Mapping – A written and/or visual representation of the actions, decisions, or tasks performed to achieve a certain result.

10 Building Blocks of High Performing Primary Care – A model for improvement developed by the Center for Excellence in Primary Care at University of California San Francisco that outlines practices exemplified by high performing primary care organizations.

Appendix C: Midwest AIDS Training + Education Center (MATEC)

[MATEC](#) is a publicly funded training center, providing clinical training and support to health care professionals. With over 32 years of experience and expertise, MATEC offers HIV/AIDS training as well as distribution and support for integration of the National HIV Curricula e-learning platform for health professional schools. In addition, MATEC trains community-based practicing primary care physician champions to lead health care transformation and enhance teaching in community-based settings throughout the Midwest. MATEC is supported in its work through multiple public grants and contracts. These include the [AIDS Education and Training Center \(AETC\) grant](#), MATEC's oldest and largest funded work, the [Midwest Integration of the National HIV Curriculum \(MINHC\)](#), and the [Midwest Fellowship for Primary Care Champions \(MFPC\)](#). MATEC is based at the University of Illinois College of Medicine at Chicago, Department of Family Medicine.

Our Vision

Health equity and maximum health for all.

Our Mission

To develop and transform the health care system and its workforce to advance equitable and patient-centered care.

Our Values

Patient Impact: We are driven to have a positive impact in patient health outcomes.

Quality Training: We are committed to deliver evidence-based, unbiased, and innovative learning opportunities.

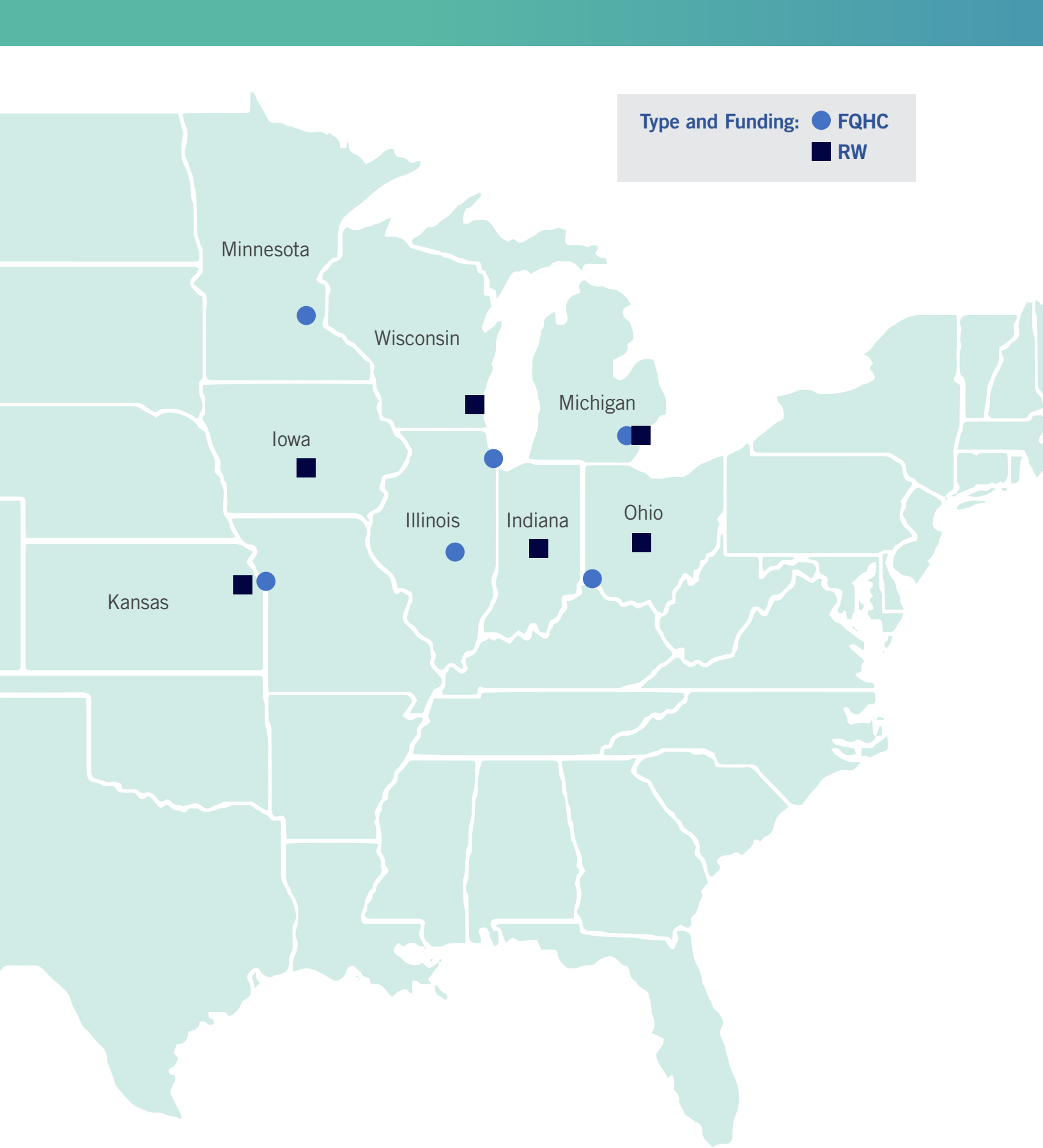
Accountability: We consistently deliver what we agreed to deliver.

Collaboration: We strive to collaborate to maximize resources and increase effectiveness.

HIV Practice Transformation Project

In 2018, MATEC partnered with 12 clinics across the region through the HIV Practice Transformation Project to expand, improve, and increase the efficiency, comprehensiveness and quality of HIV care to improve patient outcomes along the HIV care continuum by integrating principles of the patient-centered medical home model and integrated HIV care and behavioral health services. MATEC's approach to practice transformation (PT) is concerned with fundamental systems change for clinics and agencies, understanding that the highest quality and most effective care for people living with HIV involves all parts of their care setting.

MATEC coaches work with clinics that have not yet integrated HIV care into their services as well as clinics that are providing HIV care but have not yet fully integrated it into their broader services or are seeking to provide all of their services in a more patient-centered way. Practice transformation project teams identify goals as they align with the HIV National Strategic Plan and the HIV care continuum to encourage partner clinics to identify milestones for expanding care within the areas of prevention, diagnosis of HIV, linkage to care, engagement and retention in care, antiretroviral therapy care management, and viral suppression.



Appendix D: Resource Links and References

Ending the HIV Epidemic in the US Initiatives

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- US Department of Health and Human Services. (2021). [HIV National Strategic Plan: A roadmap to end the epidemic for the United States, 2021-2025](#). Accessed July 31, 2021.

The HIV Care Continuum

- Centers for Disease Control and Prevention (2019). [Understanding the HIV care continuum](#).
- Cheever, L. W. (2007). [Engaging HIV-infected patients in care: their lives depend on it](#). *Clinical Infectious Diseases*, 44(11), 1500-1502.
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- U.S. Department of Health & Human Services (2021). [HIV Care Continuum](#).

Model for Change

- Agency for Healthcare Research and Quality. [Plan-Do-Study-Act \(PDSA\) Directions and Examples](#). Health Literacy Precautions Toolkit, 2nd Edition. Accessed July 20, 2022.
- American Medical Association. [Plan-Do-Study-Act \(PDSA\): Accelerate Quality Improvement in Your Practice](#). AMA Steps Forward. Accessed July 20, 2022.
- American Society for Quality. [What is the Plan-Do-Check-Act \(PDCA\) Cycle?](#) Quality Tools. Accessed July 20, 2022.
- British Medical Journal. [The PDSA Cycle 101](#). Accessed July 20, 2022.
- Kotter. [The 8 Step Process for Leading Change](#). Accessed July 20, 2022.
- Mind Tools. [Kotter's 8-Step Change Model: Implementing Change Powerfully and Successfully](#). Accessed July 20, 2022.

Practice Transformation

- Agency for Healthcare Research and Quality. [AHRQ Practice Facilitation Training Modules](#) (2021).
- Midwest AIDS Training and Education Center. [HIV Practice Transformation Project](#). Accessed June 21, 2022.
- University of California, San Francisco, Department of Family & Community Medicine, Center for Excellence in Primary Care, [Tools for Transformation](#). Accessed July 21, 2022.
- University of California, San Francisco, Department of Family & Community Medicine, Center for Excellence in Primary Care, The 10 Building Blocks of Primary Care, [Building Blocks of Primary Care Assessment](#) (BBPCA) (2014).

Intersection with Integrated Team-Based Care

- Agency for Healthcare Research and Quality. [Creating Patient-Centered Team-Based Primary Care White Paper](#) (2016).
- Agency for Healthcare Research and Quality. [TeamSTEPPS 2.0 Curriculum](#). Accessed July 21, 2022.
- Bodenheimer, T., Ghorob, A., Willard-Grace, R., & Grumbach, K. (2014). [The 10 building blocks of high-performing primary care](#). *The Annals of Family Medicine*, 12(2), 166-171.
- Center for Innovation and Engagement. [Bilingual/Bicultural Care Team Implementation Manual](#) (2021).
- Centers for Disease Control and Prevention. [STEPS to Care Toolkit](#). Accessed July 21, 2022.
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- Saag, M. S. (2009). [Ryan White: an unintentional home builder](#). *The AIDS Reader*, 19(5), 166-168.
- University of California, San Francisco, Department of Family & Community Medicine, Center for Excellence in Primary Care, [Standing Orders](#). Accessed July 21, 2022.
- University of California, San Francisco, Department of Family & Community Medicine, Center for Excellence in Primary Care, [Teamlets](#). Accessed July 21, 2022.
- UCSF, Department of Family & Community Medicine, Center for Excellence in Primary Care, The 10 Building Blocks of Primary Care, [Building Blocks of Primary Care Assessment](#) (BBPCA) (2014).
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. [Integrating HIV Care, Treatment & Prevention Services into Primary Care – A Toolkit for Health Centers](#). Rockville, Maryland: U.S. Department of Health and Human Services, 2017.

Developing Policies and Procedures

- Centers for Disease Control and Prevention. [STEPS to Care: Establishing Policies and Protocols](#).
- Iaith. [Developing Policies, Protocols and Procedures](#).

State Specific

- State Health Departments for HIV statistics, reports, and policies and procedures (some states have already developed P&P manuals for HIV services).
- State HIV Care and Prevention Planning Groups for needs assessment reports and community resources.

Federal Government

- [HRSA Bureau of Primary Care](#) for information on Health Center Program Opportunities, Requirements, Quality Improvement, and Current News and Announcements.
- HRSA Target Center Webinars on a wide range of topics; [Webinars](#).
- Centers for Disease Control & Prevention [Division of HIV/AIDS Prevention](#) for statistical and programmatic information.
- Centers for Disease Control & Prevention [HIV Testing](#) for testing site locations throughout the United States and testing information.
- Centers for Disease Control & Prevention [Effective Interventions](#) for CDC effective interventions.
- HRSA [AIDS Education & Training Centers](#) for information on regional AETCs and the technical assistance and resources they provide—click on the Resource Library tab for Clinical Reference Tools, Guidelines, Trainings, and Web links; the Resource Library tab has a Topic Index as well.

Associations and Nonprofits

- [National Association of State and Territorial AIDS Directors](#) for the latest materials and white papers on HIV/AIDS, conference information and more—the home page scroll has a new HIV Testing Toolkit.

HIV Clinical Care Guidelines

- HRSA [Guide for HIV/AIDS Clinical Care](#).
- AIDS Info [Clinical Guidelines Portal](#).

Ryan White HIV/AIDS Program

- HRSA [Ryan White HIV/AIDS Program](#).
- HRSA [AIDS Programs](#) for information about the RWHAP, Guidelines/Protocols for Care Delivery, Performance Measures, and Funding Opportunities.
- HRSA [Target Center](#) for online resources to help deliver RWHAP HIV/AIDS care.

Patient-Centered Care

- STI and HIV [Education Through a Sex Positivity Approach](#). Mariah Wilberg. (2021)
- Institute for Health Care Improvement, Set and Document Self-Management Goals Collaboratively with HIV/AIDS Patients.

Health Equity

- Health Resources & Services Administration. [Health Equity for Diverse Populations](#).
- U.S. Department of Health and Human Services Office of Minority Health. [Minority Population Profiles](#).
- U.S. Department of Health and Human Services. [Million Hearts](#).
- Agency for Healthcare Research and Quality. Chartbook on Health Care for Blacks. [Outcomes of Diabetes Care for Blacks](#).

Social Determinants of Health

- Centers for Disease Control and Prevention. [Social Determinants of Health at CDC](#).

Diversity, Equity, and Inclusion and Racial Equity

- National Association of Counties. Diversity, Equity and Inclusion: [Key Terms and Definitions](#).
- American Academy of HIV medicine. [Diversity, Equity and Inclusion Position Statement](#).
- The Body Pro. [Five Ways to Improve Diversity and Inclusion in Your HIV Service Organization](#).

LGBTQ+ Care

- [The Catalysts for Change in Transgender Health care](#). TED Talk. Joe Codde. TEDxMSU.
- Surviving Voices. [National AIDS Memorial](#). Videos focusing on a variety of special populations impacted by HIV.
- UCSF Gender Affirming Health Program, Department of Family and Community Medicine, University of California San Francisco. [Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People](#); 2nd edition. Deutsch MB, ed. June 2016. Available at
- Human Rights Campaign Foundation. (2016) [Creating Equal Access to Quality Health Care for Transgender Patients: Transgender Affirming Hospital Policies](#).
- NYC Health + Hospitals. (2020) [Creating an LGBTQ Affirming Clinic: A Guide for Practice Managers and Providers](#).
- Patient-centered care for transgender people: [recommended practices for health care settings](#).
- ICYMI: [HRSA Promotes Access to Gender Affirming Care and Treatment in the RWHAP](#).
- Human Rights Campaign. [How HIV Impacts LGBTQ People](#).
- Centers for Disease Control and Prevention. [HIV and Gay and Bisexual Men](#).
- Lambda Legal. [Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies](#).

- Target HIV. [Transgender HIV Health Services Best Practices Guidelines](#).
- Special Projects of National Significance (SPNS) Program, [Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color](#)
- LGBT Training [Curricula for Behavioral Health and Primary Care Practitioners](#)
- Cultural Competency Curriculum: [Nurses' Health Education about LGBT Elders](#)

Gender Neutrality

- HIV.gov. [Tools to Promote Gender Responsiveness in HIV Prevention Programs for Women and Girls](#).
- [LGBTQ primary care toolkit: A guide for primary care clinics to improve services for sexual and gender minority \(SGM\) patients](#). Albuquerque, NM: Pacific Institute for Research and Evaluation. Willging C., Sturm R., Sklar M., Kano M., Davies S., & Eckstrand K. (2021). Under Key Recommendations section it describes how to adopt affirming policies and procedures for Sexual and Gender Minority Patients.
- Berger, M. (2019). [A guide to how gender-neutral language is developing around the world](#). *The Washington Post*.
- University of Wisconsin. [Gender Pronouns](#).

Unstably Housed Populations

- Health Resources & Services Administration. [Supporting Replication \(SURE\) of Housing Interventions in the Ryan White HIV/AIDS Program – Implementation and Technical Assistance Provider](#).
- HIV.gov. [Quality Housing and HIV](#).
- HUD Exchange. [Housing Opportunities for Persons With AIDS](#).

Mental Health and Substance Use

Substance Abuse and Mental Health Services Administration. [Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders](#).

National Institutes of Health. [HIV and Substance Use](#).

HIV.gov. [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#).

National Institute of Mental Health. [HIV and AIDS and Mental Health](#).

National Institutes of Health. [HIV and Mental Health](#).

HIV.gov. [HIV and Mental Health](#).

No English or English as a Second Language

- Georgetown University. [National Center for Cultural Competence](#).
- Georgetown University. [National Center for Cultural Competence. Self-Assessments](#).

TOOLKIT USER FEEDBACK FORM

MATEC values your feedback about your experience with using this toolkit. Please access the following link to answer a short online survey. Thank you for your input!

[SURVEY LINK](#)

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