

A blue geometric graphic in the top left corner, consisting of several overlapping triangles and quadrilaterals in various shades of blue.

Practice Transformation Project

Organizational Assessment (PT-OA)

Instructions: The goal of this assessment is to describe the current capacity of your clinic to provide patient-centered HIV care, identify areas for strengthening staff skills and organizational capacity to support persons living with HIV (PLWH) achieve viral suppression, and to document changes over the course of the PT Project. For this assessment, the term “clinic” refers to the location at which PT activities occur. Your organization may have multiple clinic sites participating in this project. A *PT-OA* form should be completed for each participating clinic site.

This form is to be completed by the **PT Clinic Leadership Team**, which includes administrative, clinical, and quality management staff at the participating clinic site. The AETC PT Coach working with your clinic site will review and finalize the completed form with the PT Clinic Leadership Team.

Findings from the *PT-OA* completed at baseline should be used by the PT Coach to facilitate discussion of the clinic’s PT needs and capacity, and guide the development of your clinic’s PT work plan.

This assessment tool will be repeated every 12 months to examine changes in staff and organizational capacity as a result of participating in the PT Project. This form should be completed and submitted along with the *PT-Performance Measures Form (PT-PM)*.

BACKGROUND INFORMATION

1. Please list the professions of all the individuals providing input into this assessment.

(Select all that apply)

- Dentist
- Other Dental Professional
- Nurse Practitioner or other Nursing Professional who prescribes
- Nurse Professional who does not prescribe
- Midwife
- Pharmacist
- Physician
- Physician Assistant
- Case manager/Care Coordinator
- Dietician or Nutritionist
- Health Educator
- Mental/Behavioral Health Professional
- Community Health Worker (includes Peer Educator or Navigator)
- Social Worker
- Substance Use Professional
- Practice Administrator or Leader (e.g., Chief Executive Officer, Nurse Administrator)
- Other Allied Health Professional (e.g., Medical Assistant, Podiatrist, Physical Therapist), please specify: _____
- Other Public Health Professional, please specify: _____
- Non-clinical professional (e.g., Front Desk Staff, Grant Writer), please specify: _____

2. Which statement below best describes your clinic's participation status in the AETC PT Project?

(Select one and indicate the date; dates may be approximate.)

- The PT Project is not yet in development → Date development will begin
____/____/____ (MM/DD/YYYY)
- The PT Project is in development → Date implementation will begin
____/____/____ (MM/DD/YYYY)
- The PT Project is being implemented → Date implementation began
____/____/____ (MM/DD/YYYY)
- The PT Project is ending or completing → Date activities will formally end
____/____/____ (MM/DD/YYYY)
- Other status, specify: _____

3. What is the state/territory and zip code of your clinic?

____ (state/territory) and ____ (zip code)

4. Does your clinic currently participate in other federal, state, or local initiatives to improve the health care workforce or practice transformation at your site?

- Yes (*Continue to Question 4b*)
- No (*Skip to Question 5*)

4b. If yes, describe the funder, project time frame, and clinic department(s) involved:

5. Select all type(s) of funding your clinic currently receives:

(Select all that apply)

- Federal Qualified Health Center (FQHC) with operational funding under Section 330 of the Public Health Service Act
- Ryan White HIV AIDS Program (RWHAP) Part A funding
- RWHAP Part B funding
- Minority AIDS Initiative (MAI) funding
- Other types of funding received for HIV prevention and care services, please specify:

6. If your clinic is an FQHC, does your clinic provide HIV care services beyond HIV screening and testing?

- Yes
- No
- Not applicable, my clinic is not an FQHC

7. Is your clinic a recognized and/or certified Patient-Centered Medical Home (PCMH)?

- Yes (*Continue to Question 7a*)
- No (*Skip to Question 8*)
- Don't know (*Skip to Question 8*)

7a. If yes, what year was certification/recognition obtained? ____ ____ ____ ____ (YYYY)

7b. What type of certification/recognition was obtained? (*Select all that apply*)

- Joint Commission on Accreditation of Health Care Organizations (JACHO)
- National Committee for Quality Assurance (NCQA)
- Other, please specify: _____

8. Is your clinic a certified Patient-Centered Specialty Practice (PCSP)?

- Yes
- No
- Don't know

FOCUS OF TRAINING ACTIVITIES FOR THE PRACTICE TRANSFORMATION PROJECT

9. Please select all of the training topics of focus for the AETC PT Project at your clinic.

(Select all that apply)

- HIV education and counseling
- HIV Pre-exposure Prophylaxis (PrEP) assessment and prescribing
- HIV testing
- Interpretation of HIV testing results
- Linkage to HIV care
- Engagement and retention
- Prescribing, managing, and monitoring antiretroviral treatment
- Antiretroviral therapy adherence
- Hepatitis B and/or C co-infection
- Mental health disorders
- Substance use disorders
- Other chronic medical conditions
- Sexually transmitted infections
- Opportunistic infections
- Delivering team-based, interdisciplinary care
- Providing services to culturally diverse PLWH
- Care-coordination for non-medical needs
- Other, please specify: _____

10. Select the statement that best describes the target of the AETC PT Project activities at your clinic:

(Select one)

- PT Project training and TA are targeted at the entire clinic
- PT Project training and TA are targeted at a specific unit of the clinic only
- PT Project training and TA are targeted at multiple clinics housed at the same site
- PT Project training and TA are targeted at one clinic location in a network of multiple clinic locations
- Other, please specify: _____

11. Which of the following best describes the team model at your clinic?

(Select one)

- Prescribers almost always work with the same RN, LVN/LPN, or Medical Assistant
- Prescribers almost always work with the same group of RNs, LVN/LPNs, or Medical Assistants
- Prescribers rarely work with the same RN, LVN/LPN, or Medical Assistant

CLINIC'S PROVIDER/STAFF CHARACTERISTICS AND SERVICES PROVIDED

12. For the staff categories listed below, please specify the total number of current staff in each category, as well as the number that are racial/ethnic minorities, and the total full time equivalent (FTE). Racial/ethnic minorities include those who identify as non-white or Hispanic (any race).

	Total Number Unique Individuals	Total Number Racial/Ethnic Minorities	Total FTE
Prescribing clinical providers (MD/DO, PA, NP, PharmD, DDS, etc.)			
Non-prescribing clinical providers (RN, LPN/LVN, BSN, etc.)			
Clinical support staff (MA, CNA, med. tech., etc.)			
Behavioral health staff (psychologists, BSW, MSW, LCSW, nutritionists, etc.)			
Support services, outreach and navigation staff (case managers, CHW, patient navigators, etc.)			
Administrative non-clinical support staff (non-clinical, front desk, billing, admin support, quality improvement etc.)			

12a. For the staff categories below, please specify the turnover in full time equivalents (FTE) for each type of position during the past 12 months.

	Total Number of FTE for Staff who Left Position or on Leave of Absence	Total Number of FTE for Staff Hired	Total Number of FTE currently vacant
Prescribing clinical providers (MD/DO, PA, NP, PharmD, DDS, etc.)			
Non-prescribing clinical providers (RN, LPN/LVN, BSN, etc.)			
Clinical support staff (MA, CNA, med. tech., etc.)			
Behavioral health staff (psychologists, BSW, MSW, LCSW, nutritionists, etc.)			
Support services, outreach and navigation staff (case managers, care coordinators CHW, patient navigators, etc.)			
Administrative non-clinical support staff (front desk, billing, quality improvement etc.)			

13. Please indicate whether your clinic provides the following services to patients at risk for or living with HIV. If your clinic provides the service, indicate which staff member(s) is/are responsible for providing that service. (Select all that apply)

	Is service provided?	Prescribing clinical providers	Non-prescribing clinical providers	Clinical support staff	Behavioral health staff	Case management, support services, outreach & navigation staff	Administrative non-clinical support staff	Other staff
HIV testing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PrEP services to patients/partners	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Primary medical care for PLWH	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescription and monitoring of anti-retroviral therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prophylaxis and treatment for opportunistic infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Care and treatment for co-morbid conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Care and treatment for mental health conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Care and treatment for substance use disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oral health care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Please indicate whether your clinic provides the following services to patients living with HIV. If your clinic provides the service, indicate which staff member(s) is/are responsible for providing that service. (Select all that apply)

	Is service provided?	Prescribing clinical providers	Non-prescribing clinical providers	Clinical support staff	Behavioral health staff	Case management, support services, outreach & navigation staff	Administrative non-clinical support staff	Other staff
Referring and linking newly HIV diagnosed patients to care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Care coordination for HIV patients (identifying and organizing needed resources)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follow-up with patients who miss appointments	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV medication adherence counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benefits/services enrollment (health insurance, payment for medications, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Translation services including interpretation services for hearing impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation for medical appointments	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. Within your clinic, patients with HIV... (Select one)

- Receive primary care and are referred out of the practice for HIV specialty care
- Receive HIV care from an HIV expert and are referred out of the practice for primary care
- Receive primary care and basic HIV care from the same clinician who can access expert HIV consultation when needed
- Receive both primary and expert HIV care from the same clinician
- Receive HIV care and primary care from different clinicians within our clinic

16. HIV care workflows for clinical teams are... (Select one)

- Not documented and/or are different for each person or team
- Documented, but are not used to standardize workflows across the practice
- Documented, and are utilized to standardize practice
- Documented, and utilized to standardize workflows, and are evaluated and modified on a regular basis

17. Standing orders for HIV-related care that can be completed by non-physicians under protocol... (Select one)

- Do not exist for the clinic
- Exist, but are not used
- Exist, and sometimes used
- Exist, and are used all the time

18. Support services (provided by case management, care coordinators, community health workers, patient navigators, or outreach workers) for high-risk HIV patients are... (Select one)

- Not available
- Provided by external staff with limited connection to the practice
- Provided by external staff who regularly communicate with the care team
- Provided by a member of the practice team, regardless of location

19. Linking HIV patients to supportive (wrap-around) services is... (Select one)

- Not done routinely
- Limited to providing patients a list of identified resources in an accessible format
- Accomplished through a designated staff person or resource responsible for connecting patients with resources within the practice team
- Accomplished through active coordination between the health system, support service agencies and patients, and accomplished by a designated staff person in the clinic but not the practice team
- Accomplished through active coordination between the health system, support service agencies and patients, and accomplished by a designated staff person external to the clinic
- Other, please specify: _____

CLINIC'S EHR SYSTEM AND DATA USE CAPACITY

20. Does your clinic use an electronic patient portal?

- Yes (Continue to Question 20a)
 No (Skip to Question 20b)

20a. If yes, is there a specific person on the HIV care team who provides patient education on the use of the portal?

- Yes (Skip to Question 21)
 No (Skip to Question 21)

20b. If no, is your clinic planning to develop a patient portal?

- Yes
 No

21. Does your clinic regularly remind and/or confirm patient appointments prior to their planned visit?

- Yes
 No

22. Please rate your clinic's ability to generate annual reports from your EHR on data related to the HIV care continuum outcomes as part of this AETC PT Project.

	Currently can generate annual reports	Please select how reports are generated
Prescribed PrEP	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Manually <input type="checkbox"/> Electronically
HIV testing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Manually <input type="checkbox"/> Electronically
Linkage to care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Manually <input type="checkbox"/> Electronically
Retention in care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Manually <input type="checkbox"/> Electronically
Prescribed ART	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Manually <input type="checkbox"/> Electronically
Viral suppression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Manually <input type="checkbox"/> Electronically

CLINIC'S POLICIES AND PROCEDURES RELATED TO HIV SERVICES

23. Select all the statement(s) that describe your clinic's HIV testing policies and practices. We test...

- All patients without a result on record
- All new patients at intake
- High risk patients annually
- Patients based on risk factors
- At patients' request
- Based on recommendation made by the clinical provider

23a. Is confirmatory HIV testing conducted onsite?

- Yes (*Continue to Question 23ai*)
- No (*Skip to Question 23b*)

23ai. If yes, how many days on average does it take to give test results to the patient?
 ____ (# days)

23b. Please answer the following questions about how HIV test results are delivered to patients at your clinic.

23bi. Are results given in person?

- Yes
- No

23bii. Who gives test results? (*Select all that apply*)

- Nurse Practitioner
- Nurse/Advanced Practice Nurse (non-prescriber)
- Registered Nurse
- Physician
- Physician Assistant
- Case Manager/Care Coordinator
- Health Educator
- Mental/Behavioral Health Professional
- Community Health Worker (includes Peer Educator or Navigator)
- Social Worker
- Substance Use Professional
- Other, please specify: _____

23biii. Are the results given using a team-based approach?

("Team-based" is defined as results given by two or more members of the HIV care team as listed above.)

- Yes
- No

23biv. Is there a staff member designated to link a newly diagnosed patient to medical care?

- Yes
- No

23bv. How soon is a patient seen for medical care after receiving a positive HIV test?

- Same day
- Within a week
- Within a month
- Other, please specify: _____

24. Which statement(s) below describe(s) your clinic's practices for linking patients newly diagnosed with HIV into medical care? (Select all that apply)

- Referral and linkage to HIV medical care is a standardized practice across teams and providers
- Follow-up is conducted to ensure patients are successfully linked to HIV medical care
- Assessment and care planning for HIV support services (e.g., emergency housing, case management, food services) and referral to these services are provided as needed
- Other, please specify: _____

25. If your clinic provides HIV services beyond HIV testing, does your clinic review records to identify patients with HIV who may currently be out of care or at risk of "falling out of care?"

- Yes (*Continue to Question 25a*)
- No (*Skip to Question 26*)
- Not applicable, my clinic does not provide services other than HIV testing (*Skip to Question 26*)

25a. If yes, please describe how this is accomplished:

26. Does your clinic review records to identify patients with HIV who may be currently or at risk of ART non-adherence or virologic failure?

- Yes (*Continue to Question 26a*)
- No (*Skip to Question 27*)

26a. If yes, please describe how this is accomplished:

27. Please indicate whether your clinic screens for the conditions and circumstances listed in the table below, and, if yes, whether a standardized assessment is used.

	Does your clinic screen for the condition?	If yes, is a standardized screening assessment used?
Depression and/or anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Misuse of illicit drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Homelessness or unstable housing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

28. Select the category that best describes your clinic’s implementation of the following HIV-specific policies and procedures.

	We do not have a formal written policy or procedure	Policies & procedures are being established	Policies & procedures developed, but not yet implemented	Policies & procedures developed and implemented
PrEP medication prescription or dispensing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Universal HIV screening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Notification of HIV test results	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partner notification	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Initial linkage to HIV services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Engagement and retention in HIV care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Monitoring and outreach to patients that have not seen in 6 or more months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Re-engagement patients into care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ART adherence monitoring and support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV viral suppression monitoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Outreach to patients who have a detectable viral load	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CLINIC'S CAPACITY DEVELOPMENT RELATED TO HIV

29. Which statement below best describes your clinic's approach to identifying and meeting the HIV-related training needs of providers and staff?

- Do not have a formal approach
- Periodically assess HIV-related training needs and provide opportunities for staff to be trained
- Routinely assess HIV-related training needs and assure staff are trained
- Other, please specify: _____

30. Rate your clinic's current capacity and priority level for implementing the following aspects of patient-centered care and delivery of HIV-related services. Enter the number corresponding to your clinic's capacity level and the priority level.

	Capacity Level: 1. Very Low Capacity 2. Low Capacity 3. Medium Capacity 4. High Capacity 5. Very High Capacity	Priority Level: 1. Very Low Priority 2. Low Priority 3. Medium Priority 4. High Priority 5. Very High Priority
Aspects of Patient-Centered Care		
Developing a practice-wide vision with concrete goals and objectives		
Enhancing the use of performance monitoring data and quality improvement practices		
Enhancing the coordination of care through the use of provider teams and improved referrals		
Linking each patient to a care team and a primary care clinician		
Creating teams with well-trained clinical support staff to add primary care capacity		
More effectively engaging patients on clinical decision-making regarding their care		
Periodically checking the registry to identify patients who are due for routine HIV-related services		
HIV-Related Services		
Providing primary medical care to HIV patients		
PrEP counseling and prescribing		
Initiating ART		
Conducting adherence counseling and monitoring adherence		
Managing HIV treatment when drug resistance is present		
Initiating care to prevent and treat co-morbid conditions (e.g., opportunistic infections, cancer)		
Achieving viral suppression among patients receiving medical care		



Thank you for completing this survey!

To Be Completed by AETC

AETC Region Number: ____ ____

Local Partner Site Number: ____ ____ ____

Clinic ID: ____ ____ ____

Indicate Survey Phase:

____ Baseline

____ 1st Follow-up

____ 2nd Follow-up

____ 3rd Follow-up

Date Survey Completed (MM/DD/YYYY): ____ / ____ / ____