Practice Transformation Project
Provider Assessment (PT-PA)

Instructions: The goal of this assessment is to describe current skills and services delivered by staff/providers participating in the PT activities and assess changes in practices and skills over time in delivering patient-centered HIV care.

This survey should be completed by ALL staff/providers participating in the PT Project at each of the selected PT sites. The staff/providers will be identified at the start of the project by the AETC PT Coach and Clinic Leadership Team. The *PT-PA* should be sent to staff/providers after completion of the *PT-OA* and annually following the *PT-OA.*

BACKGROUND INFORMATION

1. **Please create your participant ID by completing the following:**
   You should use the same ID for all AETC trainings

   First two letters of first name: ___ ___
   First two letters of last name: ___ ___
   Birth month in numbers (two digits): ___ ___
   Birth day (two digits): ___ ___

2. **How long have you worked at this clinic?**

   [ ] Less than 1 year
   [ ] 1 to 2 years
   [ ] 3 to 5 years
   [ ] More than 6 years

3. **What is your primary profession/occupation?** (*Select one*)

[ ] 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/Clinic 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: _____

3a. When did you complete your health profession education/training for the work you now do (e.g., residency or fellowship for physicians, graduate schools for APNs and social workers, etc.)?

[ ] Currently in residency/training
[ ] Less than 1 year
[ ] 1 to 5 years
[ ] More than 6 years

4. **Do you serve as a primary care provider to patients/clients at this clinic?**

[ ] Yes
[ ] No

5. **From the list below, check the types of services you provide to your patients/clients with HIV at this clinic.** *(Select all that apply)*

[ ] Social support services (e.g., psychological, behavioral, social and preventive services)
[ ] Case management services/patient navigation
[ ] Clinical support services (e.g., rooming patient/clients, taking patient/client vital signs)
[ ] Medical care
[ ] I do not currently provide care/services to patients/clients with HIV

6. In your role, do you provide HIV testing at this clinic?

[ ] Yes *(Continue to question 7)*
[ ] No *(Skip to Question 8)*

7. From the list below, check the statements that describes your HIV testing practices. I offer HIV testing...

[ ] To all patients (13 to 64 years of age, as recommended by CDC)
[ ] To all new patients/clients at intake
[ ] To all pregnant patients/clients, early in pregnancy
[ ] To high risk patients/clients annually
[ ] To any patients/clients who have risk factors
[ ] When patient/clients request testing
[ ] Other, please specify: _____

8. Do you prescribe medication to patients/clients?

[ ] Yes *(Continue to Question 8a)*
[ ] No *(Skip to Question 9)*

8a. Have you ever prescribed the following medications?

Medication	Ever prescribed?
Tenofovir/emtricitabine (Truvada) for pre-exposure prophylaxis (PrEP) to prevent HIV infection	[ ] Yes [ ] No
Antiretroviral therapy (ART) for non-occupational post-exposure prophylaxis (nPEP)	[ ] Yes [ ] No
ART for ongoing treatment of HIV	[ ] Yes [ ] No

9. Please rate your <u>current ability</u> to perform HIV-related services listed below.
Please select "N/A" if you do not provide the particular service.

	Needs considerable improvement	Needs improvement	Adequate	Very good	Excellent	N/A
HIV Prevention						
HIV education and counseling	○	○	○	○	○	○
PrEP assessment and prescribing	○	○	○	○	○	○
HIV Testing						
HIV testing	○	○	○	○	○	○
Interpretation of HIV testing results	○	○	○	○	○	○
HIV Care and Treatment						
Linkage to HIV care	○	○	○	○	○	○
Engagement and retention	○	○	○	○	○	○
Prescribing, managing, and monitoring antiretroviral therapy	○	○	○	○	○	○
Antiretroviral therapy adherence	○	○	○	○	○	○
Screening, Evaluation, and Management of Co-Occurring Conditions						
Hepatitis B and/or C co-infection	○	○	○	○	○	○
Mental health disorders	○	○	○	○	○	○
Substance use disorders	○	○	○	○	○	○
Other chronic medical conditions	○	○	○	○	○	○
Sexually transmitted infections	○	○	○	○	○	○
Opportunistic infections	○	○	○	○	○	○
HIV Service Delivery						
Delivering team-based, interdisciplinary care	○	○	○	○	○	○
Providing services to culturally diverse PLWH	○	○	○	○	○	○
Care-coordination for non-medical needs	○	○	○	○	○	○
Other HIV-Related Service						
Other, please specify:_____ _____	○	○	○	○	○	○

10. To what extent do policies and procedures at your clinic support provision of team-based HIV services?

[ ] Needs considerable improvement
[ ] Needs improvement
[ ] Adequate
[ ] Very good
[ ] Excellent

11. Please select the category that best reflects the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
This clinic has adequate policies and procedures to support HIV testing and linkage to care for patients who test positive.	○	○	○	○	○
This clinic has policies and procedures to identify those who are out of care and re-engage in them in care.	○	○	○	○	○
This clinic has adequate policies and procedures for ensuring patients at risk of HIV infection have full information and access to PrEP.	○	○	○	○	○
This clinic has adequate policies and procedures to support ART prescribing, monitoring, and strategies to support patients in achieving HIV viral suppression.	○	○	○	○	○

12. Please select the category that best reflects the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I do not have enough time during clinical encounters to meet patient/client medical needs.	○	○	○	○	○
Medical providers and staff at this clinic operate as a team.	○	○	○	○	○
Patient/clinical care is well coordinated among physicians, nurses, and clinic staff within this clinic.	○	○	○	○	○
Candid and open communication does not exist between physicians and other staff at this clinic.	○	○	○	○	○
This clinic has high provider/staff turnover.	○	○	○	○	○
Providers and staff at this clinic are given adequate release time from their regular job duties for training and development of skills.	○	○	○	○	○

13. What comments would you like to share about your participation in the AETC PT Project?

_____

_____

_____

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)**:** ___ ___ / ___ ___ / ___ ___ ___ ___