Enhanced Patient Navigation for HIV-Positive Women of Color

Dissemination of Evidence Informed Interventions
Boston University School of Public Health
AIDS United
Health Resources and Services Administration (HRSA) Special Programs of National Significance
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**Background**

The goal of the Enhanced Patient Navigation for HIV-Positive Women of Color intervention is to better address the needs of HIV-positive women of color by helping HIV-positive women of color to optimize care, supporting HIV-positive women of color in developing greater patient autonomy for their care, and to retain HIV-positive women of color in HIV primary care to achieve viral suppression.

The intervention focuses on providing enhanced patient navigation services tailored to each individual patient. These enhanced services typically include appointment scheduling, transportation assistance, accompaniment, assistance in completing medical and social service referrals, health education, and coaching. By providing enhanced navigation services in addition to the clinic’s existing case management standard of care, clinics will be able to:

- provide additional support to patients and build clinic-patient trust;
- address patient care and service priorities first (putting the patient priorities ahead of service provider priorities);
- increase patient health literacy; and
- support patients in developing self-efficacy to manage their care (moving towards viral suppression).

There are three main resources that will facilitate a successful implementation of this intervention. The Implementation and Technical Assistance Center (ITAC) at AIDS United, the Dissemination and Evaluation Center (DEC) at Boston University, and the Health Resources and Services Administration (HRSA) have collaborated to create the following:

1. Training Manual
2. Implementation Manual
3. Evaluation Protocol

This Implementation Manual is the road map for the implementation process. It follows the intervention’s logic model (Appendix A) and 3 year work plan (Appendix C). This manual complements the training provided by the ITAC, and is not meant to serve as a substitution for any training components provided by the ITAC. If your site feels as though it needs additional training on any of the content or activities addressed in this manual, contact the ITAC:

- **Erin Nortrup**  
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(202) 408-4848, ext 259

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All evaluation activities, protocols, and tools are included in the evaluation protocol. For all evaluation related questions or technical assistance needs, contact the DEC:
• Jane Fox  
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(617) 638-1937

• Alexis Marbach  
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Pre-implementation activities
The following are programmatic requirements that need to be addressed prior to implementation:

Hire/Identify and Train Intervention Staff

✓ Clinic administration will hire and/or identify appropriate intervention team members (navigators, administrative supervisor, clinical supervisor, and data manager) using job descriptions in Appendix B. The navigators, administrative supervisor, clinical supervisor, and data manager will collectively be referred to as the intervention team.

✓ Intervention team members will participate in training provided by the ITAC.

✓ Intervention team members will participate in training provided by the DEC.

Strengthen and formalize working relationships with community partners

✓ Intervention team members will establish formal and/or informal relationships with community based agencies and clarify the mechanisms to generate referrals.
  • The intervention team and the community partners will define roles and responsibilities for ongoing, consistent, and bidirectional communication between intervention staff and community partners (who provide social services).
  • Document protocol for receiving patient referrals from external partners, and protocol for referring patients to external partners.
  • Create and sign any MOU’s needed for referrals for patients who need more intensive services.

Prepare program logistics and operations

✓ Intervention team members will review the patient care plan and acuity tool (Appendix D) and make any site specific additions.

✓ Clinic administration will provide navigators access to patient electronic medical record (EMR) information. Ensure patient navigators have access to patient information to both record their activities and review record for pertinent information.

✓ Clinic administration will work with the intervention team to obtain Institutional Review Board (IRB) approval. Intervention team members will need to complete the Human Subjects training (if they have not already done so).

✓ Secure space for intervention activities.

✓ Plan for Medicaid reimbursements (if applicable).

✓ Plan billing codes for navigation services (if applicable).

✓ Obtain necessary technology and secure internet capabilities at all locations where data could be entered.
Clarify team member roles and communication strategies

- Intervention team members will define formal and informal mechanisms to promote communication between patient navigators, case managers, and clinical staff.

- Administrative and clinical supervisors will integrate patient navigators into clinical team and case conferencing meetings.

- Intervention team members will document protocol for creating the out-of-care list.

Patients on the out-of-care list will meet the following criteria:

Inclusion Criteria

- Age 18 or older; and
- HIV positive; and
- Self-identify as being a woman; and
- Identify as belonging to one or more of the following racial or ethnic categories: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and/or Hispanic or Latino, multiracial;
- Are receiving their HIV primary care at the clinic where the patient navigation services are offered;
- AND at least one of the following criteria:
  - have fallen out of care for 6 months or more; OR
  - are loosely engaged in care (have cancelled or missed 2 or more appointments in past 12 months); OR
  - are not virally suppressed; OR
  - have multiple co-morbidities that threaten their ability to be retained in care (at the discretion of the clinician and the clinical team).

Exclusion Criteria

- Under age 18;
- HIV negative;
- Self-identify as being male;
- White, non-Hispanics of no other race or ethnicity; and
- Are currently retained in care (existing patients of the clinic who have seen a provider at least 2 times in the past 12 months);
- are virally suppressed.

The intervention team will document which staff members (outside of the intervention team such as case managers and additional clinic providers) will be involved in reviewing the out-of-care list. The data manager will be the point person for all clinic staff members and community partners to report to regarding patients who meet the eligibility criteria.

Methods of identification will include:

- Review of clinic appointment and EMR data to identify women of color who have been out of care for six months or more, are not virally suppressed or have missed 2 or more appointments in the past 12 months; and
- Vetting of list at weekly clinical team meetings and using clinicians to assist in the identification of additional patients who may be of concern for not being retained in care (high-risk for dropping out of care due to co-morbidities).
**Supervision activities**

Scheduled supervision from the administrative supervisor and the clinical supervisor is vital to the success of navigator efforts with assigned patients, and is a key component to navigator well-being and retention in their role at the clinic. The Enhanced Patient Navigation for HIV-Positive Women of Color intervention requires weekly supervision meetings between the administrative supervisor and the navigator, and monthly supervision meetings between the clinical supervisor and the navigator. In addition, administrative and clinical supervisors, navigators, and case managers will participate in weekly case conferencing meetings to provide an opportunity for navigators and the clinical team to discuss pertinent patient issues.

The following activities are related to supervision:

☑ The administrative supervisor will provide weekly administrative supervision of the patient navigators and the data manager.

☑ The clinical supervisor will provide weekly clinical supervision of navigators.

☑ The intervention team will hold weekly case conferencing meetings with clinicians, case managers, navigation supervisors, and navigators.
Intervention Implementation Activities

Eligible clients identified in out of care list

Administrative Supervisor assigns patient to patient navigator (PN)

* PN offers intervention activities

Not offered intervention activities

Patient declines to participate

Patient agrees to participate

PN asks patient if they want to participate in MSE

No

Patient is not enrolled in MSE

* PN and patient complete patient care plan and acuity tool

Yes

Data Manager enrolls in MSE

PN supports the patient in making and attending visits with her PCP

PN provides weekly check-ins with the patient

PN provides practical and emotional support to help the patient meet the goals established in the care plan

* PN provides 6 structured education sessions

PN meets with case manager and client to determine if the client is ready to be transferred to the standard of care

* If the patient, case manager, and PN agree, the patient is transitioned to the standard of care

If the patient is not ready, the PN and the case manager review the patient’s acuity and care plan and determine what steps need to be taken before the patient is ready to transition to the standard of care
The following intervention activities take place with the client:

- The data manager will lead the process of developing an out-of-care list using the protocol developed in the pre-implementation phase.

- The administrative navigation supervisor uses the out-of-care list to screen eligible patients.

- The administrative navigation supervisor assigns patients to a patient navigator.

- The patient navigator makes contact with her assigned patients via phone, an in person meeting, or email (if the clinic permits email between the navigator and the patient).
  - The patient navigator will make and document 3 contact attempts per patient per month until the patient navigator is able to make direct contact with the patient. If the patient navigator is unable to make contact with the patient after 3 attempts, the patient will be put back on the out-of-care list and will be discussed at the next case conferencing meeting. All contact attempts will be recorded in the EMR so that all clinic team members have access to the record of number of attempts.
  - If after a second month, the patient navigator is still unable to contact the patient, the patient will be placed on a “hard to reach” list. This list will be made available to all clinic staff so that if a patient makes contact with a staff member other than the patient navigator, that staff member can attempt to connect the patient and the patient navigator. This list will be reviewed monthly to update and document any status updates of the listed patients.

- Once the patient navigator has connected with the patient, the patient navigator will explain the intervention including the role of the navigator, the services provided by the navigator, and the timeline of the intervention. The patient navigator will clarify that after 6 months, the navigator will work with the patient to decide if she should continue to work with the navigator or work directly with her case manager and doctor.

- If the patient decides that she wanted to participate in the intervention activities, the navigator will explain the multi-site evaluation to the patient and ask the patient if she wants to participate in the multi-site evaluation.
  - If the patient wants to participate in the multi-site evaluation, the patient navigator will make an appointment for the patient to meet with the data manager who will enroll her into the multi-site evaluation. The meeting with the data manager should ideally occur on that day. If this is not possible, the meeting between the data manager and the patient must occur within seven days from the initial meeting between the patient and navigator.
    - If the patient does want to participate in the multi-site evaluation, the data manager will consent the patient into the evaluation and administer the baseline survey (the data manager should refer to the evaluation protocol for specific instructions on administering the baseline survey).
    - The data manager will explain the process for withdrawing from the intervention and/or the evaluation:
      - If the patient chooses to withdraw from multi-site evaluation: The patient must tell a staff member. That staff member will inform the data manager and the administrative navigation supervisor. The patient can still be
enrolled in the intervention after discontinuing participation in the multi-site evaluation.

- If the patient chooses to withdraw from the intervention: The patient must tell a staff member and the staff member must then inform the administrative navigation supervisor. The patient can still be enrolled in the multi-site evaluation even after discontinuing engagement in the intervention.
  
  o If the patient decides that she does not want to participate in the multi-site evaluation, the patient navigator will explain her options for care (receiving the patient navigation intervention, the standard of care, or another program offered at the clinic). The patient navigator will complete a form (located in the evaluation manual) that asks why the patient has declined to participate and document what care plan the patient ultimately chose. Raw data on patients who decline to participate in the multi-site evaluation will not be submitted to the DEC (only aggregate data will be reviewed to ensure confidentiality).

☑ Once the patient has been consented into the study and completed the baseline survey, the patient navigator will set up an appointment to meet with the patient to assess patient barriers, needs, and acuity and develop a patient care plan with the patient (Appendix D).
  
  - The patient care plan will be reviewed every 3 months by the navigator and patient, and will be updated as needed (i.e., goals completed, goals added, etc.).
  - The acuity tool will be revisited after 6 months, and then every 3 months thereafter.

☑ The patient navigator will work with the patient to implement and monitor the patient care plan. The patient navigator will work in tandem with standard case management throughout the intervention time period to accomplish the goals set in the patient care plan.
  
  - The patient navigator will support patients in obtaining referrals for needed services (including transportation, housing, child care, etc.) using the protocols developed in the pre-implementation phase.
  - The patient navigator will offer accompaniment to internal and external appointments and assist as needed with completion of paperwork for appointments, benefits, and referrals.

☑ The patient navigator will conduct weekly patient check-ins (ultimately the patient navigator may transition to contacting the patient every other week after the patient has completed the structured education sessions and has a reduction in acuity score). Check-ins can be conducted by phone, electronic communication (if permitted by the clinic), or through in person meetings. During the weekly patient check-in, patient navigators will provide appointment reminders when appropriate.

Questions/Tasks for patient check-ins:
  
a. What services do you need? In particular:
   
i. Mental health?
   ii. Housing?
   iii. Substance use?
   iv. Income assistance?
   v. Food assistance?
   vi. Employment assistance?
vii. Assistance related to sexual assault, domestic violence, or intimate partner violence?
b. What referrals or appointments have been made for you, and which ones have you attended?
c. Would you like me to go with you to your medical or social services visit?
d. How can I help you connect with people/services you need?
e. How are things going for you in general?
f. Let’s schedule our next visit/check-in.

☑ The patient navigator will implement the structured health education curriculum (Appendix E). Structured sessions must be completed in person either at the clinic or at an agreed upon location.

☑ The patient navigator will work with the patient, case managers, navigation supervisors, and the clinical team to determine if a patient is ready to be transitioned to the standard of care.
  • Patient completion of the Enhanced Patient Navigation for HIV-Positive Women of Color is a patient-driven process. The decision will be made collaboratively between the patient and patient navigator.
  • Patients will be considered for transition into standard-of-care case management once the following requirements are met:
      o Completion and documentation of 6 health education sessions
      o Patient retention in care:
        o Attending one medical visit in each 6 month time period with 60 days in between over the course of 12 months.
        o Reduction in acuity score from baseline acuity score (Completed assessment will be stored in the patient study record).
        o Agreement between navigator, case manager, and clinical team on patient transition to standard of care.

If a patient reassessment shows that she still needs enhanced navigation services after 12 months, the patient will still be eligible for enhanced navigation services. In the event the patient needs more intensive interaction, the patient navigator will discuss re-engaging the patient in to the intervention with the care team and the navigation supervisor.

Preparing a patient to transition to the standard-of-care: Patient navigators will meet with a patient who has completed the intervention activities to explain that she has completed the individual-level intervention with a patient navigator (i.e., educational sessions and retention in care) and that she will be transitioned to the standard-of-care case management and will receive referrals to support services that may be needed as a result of discontinued patient navigation support services. The patient navigator will notify the health care team when a patient has completed the intervention and is ready to be transitioned into standard-of-care case management. The patient navigator will convene a meeting with Case Manager and patient. At this point the patient can ask any questions and schedule her next appointment with her case manager.

Other Reasons for Patient Completion and Transition
  • If, at any point, the patient is no longer willing to work towards achievement of goals and no longer wishes to work with or be contacted by the patient navigator, the patient and patient
navigator will agree to discontinue the intervention activities. The transition protocol will be executed at this time. **Withdrawal from the intervention does not include withdrawal from the multi-site evaluation unless explicitly requested by the patient.

- If at any point, the patient relocates outside of the agency catchment area or chooses to receive care at another clinic the patient navigator will follow agency protocol regarding case closure under these circumstances.
- If the patient, at any point, is terminated from all agency services, the patient navigator will follow agency protocol regarding termination.

The patient can re-engage with the navigator in the following scenarios:

☑ If a patient is unresponsive to navigator outreach efforts and stops working towards completing the intervention goals, and later determines that she wants to re-engage with the navigator.
  - The navigator will complete a new patient care plan and acuity tool and “restart” the 6 month intervention time period.
☑ If a patient completes the transition to the standard of care and then becomes eligible for the intervention again at a later time, they will then be eligible for navigation services.
  - If they agree to receive navigation services, the navigator will complete a new patient care plan and “restart” the 6 month intervention time period.
Maintenance and Integration Activities

The following activities will be conducted by the intervention team members in partnership with clinic administration and clinical team members:

☑ Continue to recruit, hire, and train patient navigators.

☑ Provide ongoing professional development and mentorship to patient navigators.

☑ Incorporate patient navigation into the standard of care at the clinic.

☑ Train clinic staff who interact with patients (i.e. front desk staff, appointment scheduling staff, billing staff, etc.) to be able to identify patients who may benefit from enhanced patient navigation, and train these staff members on how to connect these patients to the patient navigation services.

☑ Routinely assess patients to determine which patients would benefit from enhanced patient navigation and facilitate continuous conversation among providers about patients who could benefit from patient navigation services.

☑ Continue to engage patient navigators in case conferencing.

☑ Add patient navigation as a regular field in the EMR.
### Appendices:

**Appendix A: Logic Model**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short Term Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intervention staff</td>
<td>• Pre-implementation training</td>
<td>• # eligible individuals identified</td>
<td>• Increase in patients:</td>
<td>• Increase in number of patients retained in care</td>
<td>• Improvement in the following patient level outcomes:</td>
</tr>
<tr>
<td>• Patient navigator</td>
<td>• For intervention staff</td>
<td>• # eligible individuals offered patient</td>
<td>• HIV knowledge</td>
<td>(attending one medical visit in each 6 month time</td>
<td>• HIV viral load suppression</td>
</tr>
<tr>
<td>• Administrative navigation supervisor</td>
<td>• For community Health centers and community partners</td>
<td>navigation services</td>
<td>• Adherence to ARV</td>
<td>period with 60 days in between)</td>
<td>• Reduction in barriers</td>
</tr>
<tr>
<td>• Clinical navigation supervisor</td>
<td>• Patient intake</td>
<td>• # Individuals who accept patient navigation services</td>
<td>• Reduction in patient barriers to care</td>
<td>(i.e. housing stability and food security)</td>
<td>• Improvement in barriers</td>
</tr>
<tr>
<td>• Data manager</td>
<td>• Create patient care plan</td>
<td>• # Intakes</td>
<td>• Reduction in patient need for services</td>
<td>• Quality of Life</td>
<td>• Integration of the Enhanced Patient Navigation for HIV-</td>
</tr>
<tr>
<td>• Community health centers</td>
<td>• Conduct health education sessions</td>
<td>• # patients completing health education sessions</td>
<td></td>
<td>Increase in patient satisfaction with care</td>
<td>Positive Women of Color Intervention into the clinic</td>
</tr>
<tr>
<td>• Community partners</td>
<td>• Provide referrals, accompaniments, appointment reminders</td>
<td>• # health education sessions completed per patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clinic support</td>
<td>• Transition patients to standard of care</td>
<td>• # patients who are transitioned into the standard of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Electronic health record/</td>
<td>• Document all services offered and provided</td>
<td>• # weekly encounters with patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RW service data collection and reporting system</td>
<td></td>
<td>• # unsuccessful outreach attempts with patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Evaluation support from the Dissemination and Evaluation (DCE) Team</td>
<td></td>
<td>• # patients needing transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implementation support from the Implementation Technical Assistance Team (ITAC).</td>
<td></td>
<td>• # patients need of social supports /ongoing care management (mental health, substance use disorder, dual diagnoses, homeless, continued history of incarceration)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # referrals made</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # referrals kept</td>
<td></td>
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</tbody>
</table>
### Appendix B: Staffing Plan and Job Descriptions

<table>
<thead>
<tr>
<th><strong>Patient Navigator</strong></th>
<th>The patient navigator is responsible for:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Engaging eligible patients;</td>
</tr>
<tr>
<td></td>
<td>• Providing patient education sessions;</td>
</tr>
<tr>
<td></td>
<td>• Documenting services to patient in the electronic health record and updating the patient care plan;</td>
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<tr>
<td></td>
<td>• Connecting patients to services (care coordination);</td>
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<td></td>
<td>• Accompanying patients to internal/external appointments;</td>
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<td></td>
<td>• Providing reminder phone calls;</td>
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<tr>
<td></td>
<td>• Arranging transportation;</td>
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<tr>
<td></td>
<td>• Assisting with medication and adherence support;</td>
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<td></td>
<td>• Assisting with child care (where applicable);</td>
</tr>
<tr>
<td></td>
<td>• Explaining information from medical providers;</td>
</tr>
<tr>
<td></td>
<td>• Developing a patient care plan to help patient achieve goals;</td>
</tr>
<tr>
<td></td>
<td>• Transitioning patients to standard of care; and</td>
</tr>
<tr>
<td></td>
<td>• Assist patients with making and keeping referrals.</td>
</tr>
</tbody>
</table>

Patient navigators in the Enhanced Patient Navigation for HIV-Positive Women of Color intervention will have a bachelors (or equivalent) level of education, training in a related social service or human service field, and experience working in the community and with patients with co-morbid conditions.

The patient navigator is expected to attend weekly conferences with the health care team and case conferences. Patient navigators are expected to report to their designated Supervisor and receive regular administrative and supportive supervision.

<table>
<thead>
<tr>
<th><strong>Administrative Navigation Supervisor</strong></th>
<th>The Administrative Navigation Supervisor is responsible for:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Providing weekly administrative supervision of navigator(s);</td>
</tr>
<tr>
<td></td>
<td>• Supervising the creation of a monthly eligible patient list;</td>
</tr>
<tr>
<td></td>
<td>• Conferring with clinical team to finalize monthly eligible patient list;</td>
</tr>
<tr>
<td></td>
<td>• Assigning eligible patients to the patient navigator; and</td>
</tr>
<tr>
<td></td>
<td>• Monitor and update “hard-to-reach” list</td>
</tr>
</tbody>
</table>
| **Clinical Navigation Supervisor** | The Clinical Navigation Supervisor is responsible for:  
- Participating in case conferencing (as needed);  
- Providing weekly (or as requested) individual clinical supervision to patient navigator(s); and  
- Providing monthly group clinical supervision to intervention team (as needed). |
| **Data Manager** | The Data Manager is responsible for:  
- Creating monthly out-of-care lists to identify eligible patients (may need to work with additional staff to create list);  
- Consenting patients into the study;  
- Collecting and submitting data required for multi-site evaluation;  
- Coordinating collection of patient surveys, encounter forms, basic chart data abstraction, and implementation measures, and reporting them to the Dissemination and Evaluation Center (DEC); and  
- Providing quality assurance reports and updates to intervention team about study referrals, enrollment retention, etc. |
Description of the Enhanced Patient Navigation for HIV-Positive Women of Color Intervention:
This intervention is focused on using patient navigators to retain HIV-positive Women of Color (WoC) in HIV primary care. Patient navigators are critical members of the health care team focused on helping reduce barriers to care for the patient at the individual, agency, and system level. Patient navigators lend patients emotional, practical, and social support; provide patients with education on topics related to living with HIV and navigating the health care system; and support patients and the health care team in coordinating services. In this intervention, patient navigators will work with HIV-positive WoC who are experiencing at least one of the following challenges: they have fallen out of care for 6 months or more, are loosely engaged in care (have cancelled or missed appointments), are not virally suppressed, and/or have multiple co-morbidities. The intermediate goal of the HIV Patient Navigation intervention is to retain HIV-positive WoC in care and the long-term goal is viral load suppression.

Purpose of Position
The patient navigator provides services within a broad range of focus areas to assist patients in accessing and adhering to care. Services provided may include patient assessments, assisting to reduce access and adherence barriers, follow-up to ensure referrals are completed, patient navigation assistance, and coordination with case managers and other clinic staff.

Key Responsibilities
1. Provide intensive care coordination to patients.
2. Develop and implement individualized care plans based on assessed needs and barriers.
3. Assist patients with access and adherence to care:
   a. Deliver skill-enhancing and educational sessions about adhering to HIV and general health care treatment planning.
   b. Help patients develop methods for self-management; assist patients in developing strategies to remember appointments.
   c. Provide support through phone calls, mailings, and in-person reminders in the clinic/hospital to ensure that patients return for follow-up visits.
   d. Reschedule appointments as necessary.
   e. Help patients attend health care appointments by escorting them or arranging for support services.
   f. Assist patients in obtaining eligibility and other required documentation for clinic enrollment.
   g. Assist patients in obtaining or arranging for services such as transportation or child care to eliminate possible barriers to care.
   h. Assist patients in navigating service delivery systems and agency procedures.
4. Assure patients are linked to care through referrals and follow-up:
   a. Monitor patients’ progress by reviewing attendance at HIV primary care appointments and by following up on status to ensure any referral appointments have been made and kept.
b. Work with case manager or HIV care team to ensure newly diagnosed patients have scheduled an eligibility appointment and have obtained all necessary documentation.
c. Provide linkage to insurance and medication benefits enrollment.
d. Support and facilitate care transitions, working towards helping patients achieve independence.

5. Collaborate with the clinical care team:
   a. Work within a team environment to collaborate on cases and provide feedback on service delivery model.
   b. Participate in multidisciplinary care team meetings.
   c. Work closely with both internal and external medical and social service providers to ensure follow up adherence to the treatment plan.

6. Maintain regular communication with patients.
7. Document patient information and encounters as required and guided by protocols.
9. Adhere to department and/or grantor guidelines and policies and procedures for the provision of patient services and the effective operation of the Department.
10. Participate in all training and departmental meetings as assigned by supervisor.
11. Perform administrative functions as assigned, including completion of study documentation or other documentation required.

**Qualifications/Requirements**

- Patient navigators in the HIV Patient Navigation intervention will have a bachelors (or equivalent) level of education, training in a related social service or human service field, and experience working in the community and with co-morbidities.
- Demonstrated ability to effectively implement evidence-based interventions including, but not limited to: Motivational Interviewing, Cognitive Behavioral Therapy, Harm Reduction, and Intensive Case Management.
- Demonstrated ability to work collaboratively in a team environment.
- Demonstrated computer literacy in Microsoft and web-based applications.
- Excellent verbal and written communication skills.
- Excellent interpersonal and organizational skills.
- Knowledge of community resources; demonstrated ability to network and build strong relationships with community organizations serving priority populations as identified by the agency and/or funder.
- Demonstrated ability working with patients of diverse backgrounds, underserved communities, sexual and gender minorities, and with complex cases or comorbid conditions.
- Demonstrated knowledge of working with patients with HIV/AIDS.

**Preferred Skills**

- Experience working in a medical, clinical, or social services environment (including documenting patient needs)
- Experience working in, and familiarity with, the local community
- Bilingual as needed to serve patient population
Description of the Enhanced Patient Navigation for HIV-Positive Women of Color Intervention:
This intervention is focused on using patient navigators to retain HIV-positive Women of Color (WoC) in HIV primary care. Patient navigators are critical members of the health care team focused on helping reduce barriers to care for the patient at the individual, agency, and system level. Patient navigators lend patients emotional, practical, and social support; provide patients with education on topics related to living with HIV and navigating the health care system; and support patients and the health care team in coordinating services. In this intervention, patient navigators will work with HIV-positive WoC who are experiencing at least one of the following challenges: they have fallen out of care for 6 months or more, are loosely engaged in care (have cancelled or missed appointments), are not virally suppressed, and/or have multiple co-morbidities. The intermediate goal of the HIV Patient Navigation intervention is to retain HIV-positive WoC in care and the long-term goal is viral load suppression.

Purpose of Position
The purpose of the Administrative Navigation Supervisor is to coordinate and support the administrative components of the intervention.

Key Responsibilities
1. Supervise the creation of a monthly eligible patient list, confer with clinical team to finalize monthly eligible patient list.
2. Ensure that up-to-date data from the electronic medical record system are provided to patient navigators.
3. Assign eligible patients to patient navigators.
4. Recruit, train, supervise, coach, and evaluate intervention team staff.
5. Provide administrative supervision to the patient navigator.
6. Coordinate clinical supervision of the patient navigator.
7. Facilitate and support communication between patient navigators, clinical supervisor, case managers, and clinical team.
8. Assist data manager with the implementation and monitoring of the evaluation plan, ensuring timely data collection.
9. Determine long-term strategic alliances with external partners and maintain program collaborative relationships.
10. Facilitate intervention team meetings and case conferencing meetings.

Qualifications/Requirements
- Bachelor’s level required, Masters preferred.
- 10 years working with people living with HIV/AIDS, patients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color.
- Minimum of 5 years of experience supervising staff.
- Minimum of 5 years of experience with budget, contract, and program management.
Clinical Navigation Supervisor

Job Description

Description of the Enhanced Patient Navigation for HIV-Positive Women of Color Intervention:
This intervention is focused on using patient navigators to retain HIV-positive Women of Color (WoC) in HIV primary care. Patient navigators are critical members of the health care team focused on helping reduce barriers to care for the patient at the individual, agency, and system level. Patient navigators lend patients emotional, practical, and social support; provide patients with education on topics related to living with HIV and navigating the health care system; and support patients and the health care team in coordinating services. In this intervention, patient navigators will work with HIV-positive WoC who are experiencing at least one of the following challenges: they have fallen out of care for 6 months or more, are loosely engaged in care (have cancelled or missed appointments), are not virally suppressed, and/or have multiple co-morbidities. The intermediate goal of the HIV Patient Navigation intervention is to retain HIV-positive WoC in care and the long-term goal is viral load suppression.

Purpose of the Position
The purpose of the Clinical Navigation Supervisor is to coordinate and provide clinical support to the intervention staff.

Key Responsibilities
1. Participate in case conferencing (as needed).
2. Conduct 1 hour, monthly, or as needed, individual clinical supervision with each patient navigator.
3. Conduct 1 hour, monthly group clinical supervision with the intervention team.

Qualifications/Requirements
• Licensed mental health clinician (e.g., licensed clinical social worker, psychologist, or psychiatrist).
• 2-4 years counseling or case management experience in assessing and managing the psychosocial needs of persons with HIV/AIDS.
• Experience in working with patients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color.
• Knowledge of harm reduction philosophy, patient centered counseling, and motivational interviewing techniques.
• Excellent oral and written communication skills.
• Excellent interpersonal skills. Able to build relationships with individuals, groups, and organization
Data Manager
Job Description

**Description of the Enhanced Patient Navigation for HIV-Positive Women of Color Intervention:**
This intervention is focused on using patient navigators to retain HIV-positive Women of Color (WoC) in HIV primary care. Patient navigators are critical members of the health care team focused on helping reduce barriers to care for the patient at the individual, agency, and system level. Patient navigators lend patients emotional, practical, and social support; provide patients with education on topics related to living with HIV and navigating the health care system; and support patients and the health care team in coordinating services. In this intervention, patient navigators will work with HIV-positive WoC who are experiencing at least one of the following challenges: they have fallen out of care for 6 months or more, are loosely engaged in care (have cancelled or missed appointments), are not virally suppressed, and/or have multiple co-morbidities. The intermediate goal of the HIV Patient Navigation intervention is to retain HIV-positive women of color in care and the long-term goal is viral load suppression.

**Purpose of the Position**
The Data Manager is responsible for the overall coordination of the data collection and management for the Enhanced Patient Navigation for HIV-Positive Women of Color intervention at the site level. The Data Manager will work with the Dissemination and Evaluation Center (DEC) at the Boston University School of Public Health to insure that data collection and management is consistent with the multi-site evaluation protocol.

**Key Responsibilities**
1. Work with the administrative supervisor and clinical team to create monthly lists of potential eligible patients from internal clinic records.
2. Consent patients into the study and track and manage follow up interviews.
3. Implement data collection procedures developed by the DEC.
4. Coordinate the collection of:
   a. Patient surveys
   b. Encounter forms
   c. Basic chart data abstraction
   d. Implementation measures
   e. Monthly eligible patient list
5. Review and monitor quality of the incoming data collection forms to ensure data are complete and consistent.
6. Ensure that all data collection and management activities are performed with the utmost attention to participant confidentiality, as well as HIPAA and IRB requirements.
7. Serve as a liaison between the Dissemination and Evaluation Center and clinic for all data collection and reporting.
8. Communicate problems with data collection and management to the DEC.
9. Participate in technical assistance and training sessions conducted by the DEC.

Qualifications/Requirements

- Knowledge of fundamental concepts of collecting and processing research data.
- Ability to communicate clearly and concisely, both verbally and in writing.
- Understanding of HIPAA and IRB requirements for health care research.
- Ability to manage competing priorities; willing and able to work flexible hours.
- Ability to work in a team as well as independently and to establish and maintain cooperative, supportive relationships with project staff.
- Experience with MS Office software (e.g. Access, Excel) is strongly preferred.
- Familiarity with basic computer programming and statistical software packages (SAS, Stata, SPSS) is preferred.
- Bachelor’s degree required.
### Appendix C: 3 Year Work Plan

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action Steps</th>
<th>Project Staff Responsible</th>
<th>Post-notice of award</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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<tbody>
<tr>
<td></td>
<td><strong>Pre-implementation</strong></td>
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<tr>
<td></td>
<td><strong>Assess internal clinic and external systems</strong></td>
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<tr>
<td></td>
<td>Assess clinic space and secure space for intervention activities</td>
<td>Clinic administration</td>
<td>X</td>
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<tr>
<td></td>
<td>Plan for possible future Medicaid reimbursements for navigation services (if applicable)</td>
<td>Clinic administration</td>
<td>X</td>
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<tr>
<td></td>
<td>Plan for obtaining billing codes for navigation services (if applicable)</td>
<td>Clinic administration</td>
<td>X</td>
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<tr>
<td></td>
<td>Assess current documentation in and reading of the EMR system, determine how to improve report generation for documenting patient flow and comprehension of the system by intervention providers if necessary</td>
<td>Clinic administration</td>
<td>X</td>
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<tr>
<td></td>
<td>Establish/strengthen and document relationships with community referral networks. Create MOU for referrals of patients who need more intensive services (with an agreed upon timeline for referral appointments).</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Obtain any necessary technology (laptop, tablet, etc.) and secure internet capabilities at all locations where data could be entered</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Provide patient navigators with access to the EMR system</td>
<td>Clinic administration</td>
<td>X</td>
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<td></td>
<td><strong>Hire or identify intervention team members</strong></td>
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<td></td>
<td>Hire or identify intervention team members (patient navigators, administrative navigation supervisor, clinical navigation supervisor, and data manager)</td>
<td>Clinic administration</td>
<td>X</td>
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<tr>
<td>Goal</td>
<td>Action Steps</td>
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<tr>
<td>Complete trainings provided by the ITAC</td>
<td></td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td>Complete trainings provided by the DEC</td>
<td></td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td>Develop, review, implement protocols and materials</td>
<td>Develop protocol and train intervention staff on developing the “out-of-care” list</td>
<td>Intervention team</td>
<td>X</td>
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<td></td>
<td>Develop protocol and train intervention staff on accepting and making internal referrals</td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Develop protocol and train intervention staff on accepting and making external referrals</td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Review the patient care plan and the acuity tool</td>
<td>Intervention team</td>
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<td></td>
<td>Prepare patient education materials</td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Review consent forms, HIPAA, intake forms, patient care plans and make any necessary updates</td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td>Prepare for evaluation</td>
<td>Complete human subjects training</td>
<td>Intervention team</td>
<td>X</td>
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<td></td>
<td>Obtain IRB approval</td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td>Establish communication timing and methods, and mechanisms for staff integration</td>
<td>Establish regular meetings for the intervention team</td>
<td>Intervention team</td>
<td>X</td>
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<td></td>
<td>Define roles and responsibilities around communication</td>
<td>Intervention team</td>
<td>X</td>
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<td></td>
<td>Establish weekly, individual administrative supervision meetings</td>
<td>Administrative supervisor, patient navigators</td>
<td>X</td>
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<tr>
<td></td>
<td>Establish and sustain monthly, individual clinical supervision meetings</td>
<td>Clinical supervisor, patient navigators</td>
<td>X</td>
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<tr>
<td></td>
<td>Establish and sustain regular case-conferencing meetings</td>
<td>Intervention team, clinical team</td>
<td>X</td>
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<tr>
<td>Goal</td>
<td>Action Steps</td>
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<tr>
<td>Establish and sustain regular meeting schedule with ITAC</td>
<td>Establish and sustain regular meeting schedule with the DEC</td>
<td>Intervention team, ITAC</td>
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<tr>
<td>Establish and sustain regular meeting schedule with the DEC</td>
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<td>Intervention team, DEC</td>
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<tr>
<td><strong>Implementation and Maintenance</strong></td>
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<tr>
<td>Identify eligible patients</td>
<td>Create monthly out-of-care list following protocol established in pre-implementation</td>
<td>Data manager</td>
<td>X</td>
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<tr>
<td>Review list with clinical team</td>
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<td>Intervention team, clinical team</td>
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<tr>
<td>Assign patients to patient navigators</td>
<td></td>
<td>Administrative supervisor</td>
<td>X</td>
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<tr>
<td>Initiate contact with eligible patients</td>
<td>Contact eligible patients</td>
<td>Patient navigator</td>
<td>X</td>
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<tr>
<td>Consent patients into the study and conduct baseline survey</td>
<td></td>
<td>Data manager</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Initiate intervention</td>
<td>Assess patient barriers, needs, and acuity</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Develop patient care plan with the patient</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Provide patient support</td>
<td>Connect patients to appropriate medical and social services</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Accompany patients to appointments (as requested/needed)</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>Provide appointment reminders</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Conduct weekly patient check-ins</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Arrange for transportation for patients to and from medical and social service appointments</td>
<td>Patient navigator</td>
<td>X</td>
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<tr>
<td>Goal</td>
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<td></td>
<td>Assist with medication and adherence support</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Explain information a patient receives from her medical provider</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Monitor patient care plan, and make adjustments as necessary</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>Provide health education by conducting 6 structured health education sessions</td>
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<td></td>
<td>Conduct Session 1: HIV, the Viral Life Cycle &amp; Understanding HAART</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>Conduct Session 2: Communicating with Health Care Provider about adherence &amp; managing side effects</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Conduct Session 3: Review understanding of basic lab tests: CD4 &amp; Viral Load</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>Conduct Session 4: Stigma &amp; Disclosure</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<td>Conduct Session 5: HIV and Substance Use</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Conduct Session 6: HIV and Mental Health</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Transition</td>
<td>Transition patients to the standard of care</td>
<td>Patient navigator, clinical team, case manager</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Supervision</td>
<td>Conduct weekly administrative supervision meetings</td>
<td>Administrative supervisor, patient navigator</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td></td>
<td>Conduct monthly clinical supervision meetings</td>
<td>Clinical supervisor, patient navigator</td>
<td>X</td>
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<td></td>
<td></td>
<td>Participate in case conferencing</td>
<td>Intervention team, clinical team</td>
<td>X</td>
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</table>
## Maintenance and Integration

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action Steps</th>
<th>Project Staff Responsible</th>
<th>Post-notice of award</th>
<th>Year 1</th>
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<th>Year 3</th>
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<tbody>
<tr>
<td></td>
<td><strong>Integrate intervention into the clinic setting</strong></td>
<td><strong>Continue to recruit, hire, and train patient navigators</strong></td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td><strong>Provide ongoing professional development and mentorship to patient navigators</strong></td>
<td><strong>Provide ongoing professional development and mentorship to patient navigators</strong></td>
<td>Clinic administration, intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td><strong>Incorporate patient navigation into the standard of care at the clinic</strong></td>
<td><strong>Incorporate patient navigation into the standard of care at the clinic</strong></td>
<td>Clinic administration, intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td><strong>Train clinic staff who interact with patients (i.e. front desk staff, appointment scheduling staff, billing staff, etc.) to be able to identify patients who may benefit from patient navigation, and train these staff members on how to connect these patients to the patient navigation services.</strong></td>
<td><strong>Train clinic staff who interact with patients (i.e. front desk staff, appointment scheduling staff, billing staff, etc.) to be able to identify patients who may benefit from patient navigation, and train these staff members on how to connect these patients to the patient navigation services.</strong></td>
<td>Clinic administration, intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td><strong>Routinely assess patients to determine which patients would benefit from patient navigation and facilitate continuous conversation among providers about patients that could benefit from patient navigation services</strong></td>
<td><strong>Routinely assess patients to determine which patients would benefit from patient navigation and facilitate continuous conversation among providers about patients that could benefit from patient navigation services</strong></td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td><strong>Continue to engage patient navigators in case conferencing.</strong></td>
<td><strong>Continue to engage patient navigators in case conferencing.</strong></td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td><strong>Add patient navigation as a regular field in the EMR.</strong></td>
<td><strong>Add patient navigation as a regular field in the EMR.</strong></td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Goal</td>
<td>Action Steps</td>
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<tr>
<td>Track program outcomes and conduct quality assurance review</td>
<td>Follow DEC protocols for tracking process outcomes</td>
<td>Intervention team, DEC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Review and audit intervention encounter forms for quality</td>
<td>Data manager, DEC</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Conduct monthly data cleaning</td>
<td>Data manager, DEC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Map each piece of chart collection to a location in the EMR</td>
<td>Data manager, DEC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Evaluation
Appendix D: Patient Care Plan

Note: Sites will need to add this to their current contact form that includes contact information, emergency contacts, etc. as well as their HIPAA and Confidentiality forms.

Patient Name: 
Patient Record Number: 
Date Created: 

What days and times are best for you to meet with the patient navigator in person?

<table>
<thead>
<tr>
<th>Day(s) of Week:</th>
<th>Time(s) of Day:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Monday</td>
<td></td>
</tr>
<tr>
<td>☐ Tuesday</td>
<td></td>
</tr>
<tr>
<td>☐ Wednesday</td>
<td></td>
</tr>
<tr>
<td>☐ Thursday</td>
<td></td>
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<tr>
<td>☐ Friday</td>
<td></td>
</tr>
<tr>
<td>☐ Saturday</td>
<td></td>
</tr>
<tr>
<td>☐ Sunday</td>
<td></td>
</tr>
<tr>
<td>☐ Other answer (Specify: ______________________)</td>
<td></td>
</tr>
</tbody>
</table>

Where would you most like to meet?

☐ At home
☐ At another person’s home (Specify the home and relationship: )* 
☐ Your PCP’s office
☐ Other location. Specify: )*__________________________

For reasons of confidentiality, how would you like me to identify myself, when calling you or visiting you? (For example, should I go by my first name, say I am a “friend,” or say they “work with so-and-so?”)

Would you like to communicate by text? Y/N

Section 1: Coordination of Care
1a. Goal: First PCP Visit Attendance

Date of first PCP visit attended:

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ PCP</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other</td>
<td>Notes:</td>
</tr>
<tr>
<td>☐ Navigator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1b. Goal: Case management visit attendance

**Date of case management visit:**

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PCP</td>
<td>□ CM</td>
<td>□ Navigator</td>
<td>□ Patient</td>
<td>□ Other:</td>
</tr>
</tbody>
</table>

Notes:
### Section 2: Patient identified goals

#### 2a: Patient identified goal:

Date Resolved:

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Navigator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Completed? Y/N/Other

Notes:
### 2b. Patient identified goal:

**Date Resolved:**

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Navigator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Completed? Y/N/Other

Notes:
### Section 3: Curriculum

2b. Patient identified goal

**Date Resolved:**

<table>
<thead>
<tr>
<th>3a. CURRICULUM TOPICS TO BE COVERED</th>
<th>Target Date</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please list topics to be completed before next plan update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 1: HIV, the Viral Life Cycle &amp; Understanding HAART</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 2: Communicating with Health Care Provider about adherence &amp; managing side effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 3: Review understanding of basic lab tests: CD4 &amp; Viral Load</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 4: Stigma &amp; Disclosure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 5: HIV and Substance Use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 4: Acuity
# HIV/AIDS Medical Case Management Acuity Tool Form

**Massachusetts Department of Public Health**

**Boston Public Health Commission**

<table>
<thead>
<tr>
<th>Area of Functioning</th>
<th>Intensive Need</th>
<th>Moderate Need</th>
<th>Basic Need</th>
<th>Self Management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
<td>(0)</td>
</tr>
</tbody>
</table>

## Adherence to Medical Care and Treatment & HIV Health Status

<table>
<thead>
<tr>
<th>HIV Care Adherence</th>
<th>Intensive Need</th>
<th>Moderate Need</th>
<th>Basic Need</th>
<th>Self Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires on-going accompaniment or assistance with medical appointments due to limited language or cognitive ability</td>
<td>Has missed 2 or more consecutive HIV medical appointments in the last 6 months</td>
<td>Has missed 1 or 2 (non-consecutive) HIV medical appointments in the last 6 months but has been seen by member of HIV medical team</td>
<td>Has attended HIV medical appointments in the last 6 months as indicated by HIV medical provider</td>
<td>Has attended all scheduled HIV medical appointments in the last 12 months as indicated by HIV medical provider</td>
</tr>
<tr>
<td></td>
<td>Requires referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.)</td>
<td></td>
<td>Needs assistance with making and keeping HIV medical appointments</td>
<td>Does not require any assistance or reminders to schedule or keep medical appointments</td>
</tr>
<tr>
<td>Acuity Score:</td>
<td>Has not been seen by HIV medical team in the last 6 months</td>
<td>Requests accompaniments to medical appointments from MCM or other member of the care team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments (include referrals needed):**

<table>
<thead>
<tr>
<th>Current HIV Health Status</th>
<th>Has detectable VL and CD4 below 200</th>
<th>Has detectable VL and is working towards viral suppression with the medical team</th>
<th>Is on ARVs, in care, and being monitored by medical team, but unable to achieve viral suppression</th>
<th>Is virally suppressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has current OI and is not being treated</td>
<td>Has history of OI in last 6 months which are treated and/or client using prophylaxis (if indicated)</td>
<td>Has no history of OIs in last 6 months</td>
<td>Has no history of OIs in last 12 months</td>
<td></td>
</tr>
<tr>
<td>Has been hospitalized or visited the ER in last 30 days due to HIV related illness</td>
<td>Has been hospitalized or visited the ER in last 6 months due to HIV related illness</td>
<td>Has had no hospitalizations or visited the ER in last 6 months, but at least 1 hospitalizations or visit to the ER in the last 12</td>
<td>Has no history of hospitalizations or visits to the ER in last 12 months due to HIV related illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Newly diagnosed within last 6 months and concurrently diagnosed with AIDS</td>
<td>Newly diagnosed within the last 6 months and/or is new to the MCM program</td>
<td>Newly diagnosed within the last 12 months</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Acuity Score:</strong></td>
<td>Demonstrates no understanding of HIV labs and lab results</td>
<td>Demonstrates minimal understanding of HIV labs and lab results</td>
<td>Demonstrates understanding/Knows of HIV labs and lab results</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comments (include referrals needed):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Non-HIV Related Medical Issues</td>
<td>Has been hospitalized or visited the ER for non-HIV related illness in last 30 days</td>
<td>Has been hospitalized or visited the ER in last 6 months due to non-HIV related illness</td>
<td>Has had no non-HIV related hospitalizations or visits to the ER in last 6 months, but at least 1 in the last 12</td>
<td>Has no history of non-HIV related hospitalizations or visits to the ER in last 12 months</td>
</tr>
<tr>
<td></td>
<td>Has 2 or more non-HIV related illnesses (chronic or non-chronic) that impact health and/or care adherence</td>
<td>Has a non-HIV related illness (chronic or non-chronic) that impacts health and care adherence</td>
<td>Has a non-HIV related medical issue, but it does not impact HIV care and/or is not receiving treatment</td>
<td>Has no non-HIV related illnesses</td>
</tr>
<tr>
<td>Status</td>
<td>Needs Assistance</td>
<td>Comments (include referrals needed):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------------</td>
<td>-------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently receiving treatment for non-HIV related medical conditions (e.g. chemo, dialysis, HCV, on-going dental complications, etc.) that impacts daily living</td>
<td>Requires assistance to make and keep non-HIV related medical appointments due to language or cognitive ability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently recovering from treatment for non-HIV related medical conditions (e.g. chemo, dialysis, HCV, on-going dental complications, etc.) that impacts daily living</td>
<td>Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.) for non-HIV related medical issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has no current non-HIV related medical issues, but past illnesses require monitoring by a medical provider</td>
<td>Requests assistance with reminders for non-HIV related medical appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Acuity Score:**

<table>
<thead>
<tr>
<th>Status</th>
<th>Needs Assistance</th>
<th>Comments (include referrals needed):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires accompaniments to specialty medical appointments due to language or cognitive ability</td>
<td>Requires accompaniments to specialty medical appointments from MCM or other member of the care team</td>
<td>Requests assistance with coordinating non-HIV related medical care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No assistance needed with coordinating non-HIV related medical care</td>
</tr>
<tr>
<td>HIV Medication Adherence</td>
<td>Misses HIV medication doses daily</td>
<td>Misses HIV medication doses weekly</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Needs and is not currently enrolled in directly-observed therapy (DOT) or other intensive adherence support</td>
<td>Needs and is enrolled in DOT or other intensive adherence support</td>
<td></td>
</tr>
<tr>
<td>Experiences adverse side effects that consistently impact adherence to HIV medication</td>
<td>Experiences adverse side effects that occasionally impact adherence to HIV medication</td>
<td>Experiences side effects, but manages them with no impact on adherence to HIV medication</td>
</tr>
<tr>
<td>Demonstrates no understanding of correlation between medication adherence and achieving/sustaining viral load suppression</td>
<td>Demonstrates minimal understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression</td>
<td>Demonstrates some understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression</td>
</tr>
<tr>
<td>Demonstrates no understanding of basic health or prescription information (e.g. drug resistance, drug interactions, etc.) due</td>
<td>Needs assistance to understand health and prescription information due to language barrier or cognitive function</td>
<td>Needs some assistance to understand health and prescription information</td>
</tr>
<tr>
<td>Language barriers or cognitive function</td>
<td>Not on ARVS against medical providers advice</td>
<td>Is starting new ARV treatment regimen</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Acuity Score:</td>
<td>Cultural beliefs around medication prevent client from taking medication as prescribed by medical provider</td>
<td></td>
</tr>
</tbody>
</table>

**Comments (include referrals needed):**

**Insurance**

| Health Insurance & HDAP Status | Lacks health insurance (e.g. MassHealth/Medicaid, no access to employer-based health insurance, outside open enrollment period for private insurance, with no "qualifying event", etc.) | Has health insurance and needs but lacks HDAP coverage | Has health insurance, HDAP and/or other health benefits, but requires support to maintain coverage and complete re-certifications | Has health insurance, HDAP and/or other health benefits and requires no support to maintain coverage and complete re-certifications |
| Acuity Score: | Has health insurance, HDAP and/or other benefits, but faces significant deductibles and/or medical co-pays (e.g. client is underinsured) | Client needs or currently utilizes the CHII program and needs regular assistance to maintain coverage |
| Comments (include referrals needed): |  |  |

**Sexual and Reproductive Health Status**

| Sexual and Reproductive Health Status | Does not or is unable to communicate with sexual partner(s) around sex and sexual health needs (e.g. disclosure, negotiating condom use, PrEP use, partner's health status, etc.) | Inconsistently communicates with sexual partner(s) around sex and sexual health needs (e.g. disclosure, negotiating condom use, PrEP use, partner's health status, etc.) | Requests support to communicate with sexual partner(s) around sex and sexual health needs (e.g. disclosure, negotiating condom use, PrEP use, partner's health status, etc.) | Consistently communicates with sexual partner(s) around sex and sexual health needs (e.g. disclosure, can negotiate condom use, PrEP use, partner's health status, etc.) |
| Demonstrates no understanding of HIV/HCV/STI transmission, and/or no understanding of correlation between HIV transmission and viral load suppression | Demonstrates minimal knowledge of HIV/HCV/STI transmission, and minimal understanding of correlation between HIV transmission and viral load suppression | Needs occasional assistance understanding HIV, HCV, STI transmission and/or assistance understanding correlation between HIV transmission and viral load suppression | Demonstrates understanding of HIV, HCV, STI transmission, and/or understanding of correlation between HIV transmission and viral load suppression |
| Reports at least 1 STI in the past 6 months | Reports at least 1 STI in the past 12 months | No history of STI in the past 12 months, but no STIs in the last 24 months | Reports sexual abstinence |
| Engages in transactional sex (e.g. for money, drugs, a place to stay, etc.) | | No discussion of HIV status with sexual partner(s), but maintains a suppressed viral load | Sexual partner(s) currently on PrEP (need to put this elsewhere) |

**Acuity Score:**
- HIV+ female not on treatment and pregnant or desires pregnancy
- HIV+ female on treatment and is pregnant or desires pregnancy

**Comments (include referrals needed):**
- Mental Health
<table>
<thead>
<tr>
<th>Current Mental Health Status</th>
<th>Clinical diagnosis with no current mental health provider, no pending appointments, no desire and/or is resistant to seek treatment</th>
<th>Clinical diagnosis or otherwise engaged with a mental health provider, but inconsistent with appointment attendance and/or treatment adherence</th>
<th>Engaged with a mental health provider and is consistent with mental health treatment and/or appointments</th>
<th>No indication of need for clinical mental health assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently awaiting treatment or appointment with mental health professional</td>
<td>Referral to a new mental health professional in the past 6 months</td>
<td>Receives MCM support to make and keep appointments with mental health professional</td>
<td>No support needed to make and keep appointments with mental health professional</td>
<td></td>
</tr>
<tr>
<td>Consistent challenges with adherence to prescribed psychiatric medicines or treatment protocol</td>
<td>Moderate challenges with adherence to prescribed psychiatric medicines or treatment protocol (missed doses more than a few times a month)</td>
<td>Some challenges with adherence to prescribed psychiatric medicines or treatment protocol (occasional missed doses)</td>
<td>No challenges with adherence to prescribed psychiatric medicines or treatment protocol</td>
<td></td>
</tr>
<tr>
<td>Acuity Score:</td>
<td>Indication of need for mental health support, clinical mental health assessment, and/or treatment and does not receive it</td>
<td>Needs referral to or help accessing a culturally competent mental health provider (e.g. LGBT, linguistically appropriate, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments (include referrals needed):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Alcohol and Drug Use

<p>| Current Substance Use | Chronic daily drug or alcohol use or dependence that consistently interferes with adherence to HIV care and treatment and/or activities of daily living and expresses no desire for treatment (e.g. methadone, Suboxone, detox, etc.) | Current or recent drug or alcohol use or dependence that sometimes interferes with adherence to HIV care and/or daily living | Current or recent drug or alcohol use does not interfere with adherence to care, treatment, and/or activities of daily living but MCM assesses a need for additional support or regular check-in | Current or recent drug or alcohol use that does not interfere with adherence to care, treatment, or activities of daily living. |</p>
<table>
<thead>
<tr>
<th>Intermittent engagement in drug and alcohol treatment (e.g. methadone, Suboxone, detox, etc.)</th>
<th>Currently on a wait list to receive treatment for substance use disorder</th>
<th>Experienced harm associated with substance use and/or has some ability to engage in harm reduction practices (e.g. sharing needles, narcan, etc.)</th>
<th>No current or past issues with drug or alcohol use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expresses a need or desire for drug or alcohol treatment (e.g. suboxone, methadone, detox, etc.) but has not yet received it</td>
<td>Currently in residential or in-patient treatment for drug or alcohol use</td>
<td>Expresses some harm associated with substance use and/or has some ability to engage in harm reduction practices (e.g. sharing needles, narcan, etc.)</td>
<td>No harm associated with current or past alcohol and drug use. Is able to engage in harm reduction practices (e.g. no needle sharing, carries narcan, etc.)</td>
</tr>
<tr>
<td>Imminent harm associated with substance use and/or no engagement/interest in harm reduction practices (e.g. sharing needles, narcan, etc.)</td>
<td>Currently receiving treatment for drug and alcohol use in an out-patient setting</td>
<td>Experiences harm associated with substance use and/or has minimal ability to engage in harm reduction practices (e.g. sharing needles, narcan, etc.)</td>
<td>No current or past substance use and/or no indication of need for additional support</td>
</tr>
</tbody>
</table>

**Acuity Score:**

| Ongoing alcohol use in the context of liver disease (e.g., HIV/HCV co-infection etc.) |

**Comments (include referrals needed):**
<table>
<thead>
<tr>
<th>Current Housing Status</th>
<th>Currently lives in shelter or any place not meant for human habitation (e.g. street, car, etc.)</th>
<th>Has chronic challenges maintaining housing</th>
<th>Lives in permanent or stable/safe housing but needs short term rent or utility assistance to remain housed</th>
<th>Has stable and affordable housing that meets client's needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current living situation has major health or safety hazards or limits the client's ability to care for themselves</td>
<td>Has difficulties managing ADLs (e.g. navigating stairs, showering) in current living situation</td>
<td>Requests assistance from MCM to complete paperwork to maintain eligibility for housing subsidies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs a referral to a supportive housing program and/or other in-home support services to remain safe in their home</td>
<td>Currently resides in a supportive housing program and/or receives a non-permanent housing subsidy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is expected to be released from incarceration in the next 3 months or was released from incarceration within the last 6 months</td>
<td>Lives in transitional/temporary housing or is doubled-up with no imminent loss of housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acuity Score:</strong></td>
<td><strong>Faces eviction or imminent loss of current housing</strong></td>
<td><strong>Seeks to relocate in order to improve proximity to medical care, safety of housing environment, or access to services and supports</strong></td>
<td><strong>Currently working with a housing search and advocacy case manager</strong></td>
<td><strong>Comments (include referrals needed):</strong></td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Legal Status</strong></td>
<td><strong>Has urgent legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, disability, eviction, or CORI</strong></td>
<td><strong>Has pending legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, or disability (e.g. appeal for SSI)</strong></td>
<td><strong>Needs assistance completing standard legal documents</strong></td>
<td><strong>No current or recent legal issues</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Has time-sensitive need to complete or obtain standard legal documents (e.g., will, guardianship, identification, birth certificate, etc.)</strong></td>
<td><strong>Needs linkage to services to address legal issues that impact ability to obtain needed services or benefits</strong></td>
<td><strong>Currently working with a provider to address legal issues</strong></td>
<td><strong>All desired legal documents are complete</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Has issues relating to immigration status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhancement</td>
<td>Implementation Manual - pg. 47</td>
<td></td>
<td></td>
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<tr>
<td>-------------</td>
<td>--------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Currently on parole or probation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acuity Score:</strong></td>
<td>Has outstanding warrants and/or open legal cases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comments (include referrals needed):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Relationships and Support Systems</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Support Systems and Relationships</strong></td>
<td>Reports no close relationships, family, or supportive relationships</td>
<td>Reports feeling isolated or unsupported in current relationships (e.g. family and friends)</td>
<td>Reports having a support system, but identified need for regular check-ins from MCM</td>
<td>Has satisfactory social support</td>
</tr>
<tr>
<td></td>
<td>Has not shared HIV status with any members of social support system due to stigma, language barriers, cultural beliefs around HIV, etc. which directly impacts social supports</td>
<td>Has not shared HIV status with many members of support system due to stigma, language barriers, cultural beliefs around HIV, etc. which impacts social supports</td>
<td>Has shared HIV status to members of support system but requests assistance in talking with others to decrease social isolation</td>
<td>Client reports feeling comfortable with the number of people in their social circle/family who know their HIV status and it does not impact their social support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Relies on MCM, peer, or other program staff for social support</td>
<td></td>
</tr>
<tr>
<td>Acuity Score:</td>
<td>Reports current or potential intimate partner violence and needs immediate intervention</td>
<td>Has experienced intimate partner violence in the past that impacts current relationships, financial situation, housing status, etc.</td>
<td>Past experience with intimate partner violence does not impact present care</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
</tbody>
</table>

**Comments (include referrals needed):**

### Income

<table>
<thead>
<tr>
<th>Current Income/Personal Finance Management Status</th>
<th>Has no stable income or benefits established and no identified source of financial support</th>
<th>Income inadequate to meet basic needs at the end of every month for 3 or more months in a 6 month period</th>
<th>Income occasionally (no more than 2 times in a 6 month period) inadequate to meet basic needs</th>
<th>Has steady income; manages all financial obligations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires but does not receive public benefits such as SSI/SSDI and/or has pending applications</td>
<td>Requests support with benefits applications or other means to increase and manage income</td>
<td>Receives benefits and requires no assistance with maintaining benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receives no public benefits such as SSI/SSDI and is ineligible to receive them due to immigration status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has immediate need for financial assistance to stay housed, maintain utilities, Expenses currently exceed income Requests assistance with budgeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comment</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain food, or access medical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs referral to representative payee</td>
<td>Currently uses a representative payee</td>
<td>No need for representative payee</td>
</tr>
</tbody>
</table>

**Acuity Score:**

Application for benefits such as SSI/SSDI have been denied or are under appeal

**Comments (include referrals needed):**

**Transportation**

<table>
<thead>
<tr>
<th>Current Transportation/Mobility Status</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has limited or no access to transportation (e.g. ineligibly for PT-1, no public transportation options) which impacts engagement in medical care, appointments, and other support services</td>
<td>Has PT-1 or agency transport vouchers/passes but requires MCM assistance to complete applications and/or maintain eligibility</td>
<td>Relies on PT-1 or agency supported transportation vouchers or family/friend</td>
</tr>
<tr>
<td>Has physical limitations or other mobility issues that impacts ability to access transportation and/or engage in medical care and other support services</td>
<td>Has consistent and reliable access to transportation with no need for agency support</td>
<td></td>
</tr>
<tr>
<td>Client’s available transportation options put the client legally or physically at risk (e.g. unregistered car, uninsured driver, hitchhiking)</td>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td></td>
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</tr>
<tr>
<td>Acuity Score:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has limited language or cognitive functioning that limits ability to coordinate transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasionally needs assistance with transportation to stay engaged in medical care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments (include referrals needed):**

**Nutrition**

<table>
<thead>
<tr>
<th>Current Nutritional Status</th>
<th>Relies on food pantries, soup kitchens or other community food resources on a weekly basis</th>
<th>Relies on food pantries, soup kitchens, and other community food resources 1x per month or more</th>
<th>Relies on food pantries, soup kitchens, or other community food resources less than 1x per month</th>
<th>All nutritional needs are met and/or MCM assistance not needed to access food assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs immediate linkage to medical care due to problems related to low body weight, poor appetite, nausea, vomiting, or other urgent health issues that are impacted by lack of nutrition</td>
<td>Needs linkage to nutritional counseling or other education to help manage nutrition and diet which impact overall health and/or other medical issues</td>
<td>Needs information about nutrition, and/or food preparation to improve or maintain health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs a referral to obtain food related benefits (e.g. SNAP, WIC, etc.) and/or assistance to access community food resources</td>
<td>Needs assistance completing applications to maintain current food related benefits (e.g. SNAP, WIC, etc.)</td>
<td>Receives food related benefits (e.g. SNAP, WIC, etc.) to meet nutritional needs for self or household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs assistance completing applications to maintain current food related benefits (e.g. SNAP, WIC, etc.)</td>
<td>Relies on access to an agency food program in order to obtain adequate food</td>
<td>Client benefits from utilizing an agency nutrition program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is ineligible for food related benefits (e.g. SNAP, WIC, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Acuity Score:**

| Needs nutritional supplements to maintain health | Needs and is prescribed nutritional supplements to maintain health (e.g. Ensure) | |

**Comments (include referrals needed):**

**Summary & Signatures**

**Acuity Score:** 0  
**Level of Need:** (29-42) Intensive Need

**Client Name/Client Code:**  
**PN Name:**
<table>
<thead>
<tr>
<th>PN Signature:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Curriculum

Overview
As part of the Enhanced Navigation intervention, patient navigators will conduct a series of one-on-one educational sessions with their patients. The Intervention navigator-patient sessions are 30-60 minute face-to-face meetings that are roughly scheduled on a weekly or every other week basis.

The goals of the education sessions are to:
1. Document enhanced knowledge of patient in health maintenance activities for the management of HIV
2. Improve patient’s involvement in their HIV care
3. Assist patient in making healthy life choices
4. Improve patient attitudes toward antiretroviral therapies
5. Reduce patient fears regarding antiretroviral therapy
6. Reduce patient isolation and decrease stigma

During the initial visit, patient navigators assess the needs of their patient by asking a variety of open-ended questions designed to elicit descriptive responses regarding the patient’s history and current life circumstances. Depending on needs and knowledge levels of each patient, the patient navigator is enabled to adapt a curriculum for that particular patient using the six sessions outlined above. Patient navigators will determine which sessions to cover more in-depth, which topics to review regularly, which topics can be combined, and which topics the patient doesn’t not need to spend as much time on. During each session, patient navigators reassess the needs of the patient and can adapt this curriculum according to patient health, circumstances, or emotional well-being in order to strategically determine which topics might be most useful at that time. However, each patient navigator is required to address these six topics at least briefly.

The sessions are meant to be flexible in a few ways. As described above, the content of the curriculum can be adapted to suit the needs of the particular patient as long as the session learning objectives are demonstrated. At times, patient navigators may need to be flexible because life events may interfere with educational sessions. Part of the navigator’s role is to provide emotional and practical support as needed, and if this is the case it will often cut into the time of the more structured educational sessions. Patient navigators will need to be flexible in determining whether to provide this support or to conduct an educational session during their scheduled time with each patient.

Patient navigators are also flexible in terms of the frequency of these sessions. Although the protocol for this program states that sessions should be completed with patients on a weekly to every other week basis, the length of time between sessions may vary from patient to patient in order to schedule around existing co-located medical (or other) visits, which reduces the likelihood of having to reschedule the session.

The location of meetings can also vary to improve the likelihood that the patient will engage in these sessions. Patient navigators may do home visits, meet patients at residential treatment centers, visit them in the hospital, or meet them at other locations depending on what the patient prefers or the particular circumstance. This is particularly helpful if there is a lack of private space at the agency at any given time.
Patient navigators often ask patients if they are having any particular issues in terms of their health, health care, or emotional well-being during these sessions in order to strategically determine which topic might be most useful for that individual in that moment. Sessions can also be combined if the patient navigator feels that the patient will benefit from this. In general, even after the entire curriculum has been completed, it is helpful for patients to complete refreshers if the topic is relevant at the time or as a strategy to help patients absorb the information better.

Education sessions also create an environment for patient navigators to learn more about the particular needs of the patient, for the patients to get to know more about their patient navigators, their experiences, and the resources that they have to offer. Ultimately, these meetings enable the patient navigators and their patients to build rapport. Once educational sessions are completed, patient navigators continue their emotional and practical support by continuing weekly or bi-weekly check-ins with patients (by phone or in-person).

The education sessions will address the following learning objectives:

**Session 1: HIV, the Viral Life Cycle & Understanding HAART**

- By the end of session 1, the patient will be able to define:
  - the stages of HIV infection
  - routes of HIV transmission
  - HIV viral life cycle
  - How medications works in body
  - How HIV medications help the body’s immune system get stronger (CD4 increase)
  - How medications can reduce the amount of HIV in the body (reduce viral load)

**Session 2: Communicating with Health Care Provider about adherence & managing side effects**

- By the end of session 2, the patient will understand:
  - The relationship between missing doses of HIV pills and the amount of HIV virus in the body
  - The relationship between the time of day when medications are taken and HIV drug resistance
- By the end of session 2, the patient will be confident in her ability to talk to her doctor about:
  - How and when meds are taken and when meds are not taken
  - Potential side effects of treatment (nausea, diarrhea, dizziness)
  - Ways to cope with side effects

**Session 3: Review understanding of basic lab tests: CD4 & Viral Load**

- By the end of session 3, the patient will be able to identify the relationship between CD4 count and her immune system.
- By the end of session 3, the patient will be able to define viral load and the relationship between viral load and disease progression.

**Session 4: Stigma & Disclosure**

- By the end of session 4, the patient will be able to identify issues related to stigma and potential positive and negative outcomes from disclosure.
• By the end of session 4, the patient will be able to identify one person with whom she can talk about her HIV status and turn to for support.

**Session 5: HIV and Substance Use**
• By the end of session 5, the patient will be able to identify recreational drugs and define their impact on the effectiveness of HIV medications, as well as acknowledge their own recreational drug use (if applicable) and potential impact on HIV-specific health outcomes.
• By the end of session 5, the patient, if currently using recreational drugs, will be able to develop a harm reduction plan

**Session 6: HIV and Mental Health**
• By the end of session 6, the patient will be able to identify ways in which mental health might impact her ability to care for herself.
• By the end of session 6, the patient will be able to identify individuals, resources, and tools to support her mental health.

**Curriculum Session Outlines**
For navigators: **Tips for Preparing for a Patient Session**
• Check notes from previous encounters
• Check progress notes from other providers (if have access to these)
• Check latest labs
• If possible, meet with team to discuss progress of particular patients (during team huddles) for patients who are having difficulty engaging in care or are dealing with particularly difficult issues at the time.
Session 1: HIV Life cycle and medications at work

Conversation starter: transmission:

• Today I’d like to discuss how HIV is transmitted and the different stages it goes through once it enters your blood. This includes the body fluids that transmit HIV and the ones that don’t, the pathways that allow HIV to enter the body, HIV symptoms and AIDS symptoms.
• We’ll also discuss the immune system, the stages of HIV infection, and how HIV invades CD4 cells to multiply and then destroy those cells. This is called the viral life cycle.
• Knowing how the virus works gives you the power to control it.
• In a couple of weeks, we will learn where/how medications work in reducing replication of HIV that allows the viral load to be low and your immune system strong.
• Let’s plan to meet again on ____________________

Handouts for patients:

• Stages of HIV Infection
• Routes of Transmission Risk
• HIV Life Cycle—the Big Picture
• Videos to show: https://www.youtube.com/watch?v=HL02LjVDElw
STAGES OF HIV INFECTION

Person becomes infected with HIV

Acute
Person may have flu-like symptoms:
- Fever
- Headache
- Tiredness
- Enlarged lymph glands

Asymptomatic
Person may look and feel well.

Symptomatic
Person may have enlarged lymph glands, tiredness, weight loss, fever, chronic diarrhea or yeast infections (oral or vaginal) among other conditions.

AIDS
The virus weakens and eventually destroys the immune system. When a person with HIV develops AIDS, his or her body has lost most of its ability to fight off certain bacteria, fungi, parasites and other germs.

A diagnosis of AIDS is made if:
- T-cell count is below 200ml or
- There is a confirmed appearance of certain illnesses called opportunistic infections or,
- CD4% < 14%.

- A person who has HIV can infect others even if they look healthy and feel well.
- One person with HIV may have different combinations of signs and symptoms from someone else who is also infected.
- Only an HIV test can show if someone is infected with HIV.
- Only a doctor can diagnose AIDS.

1. Window Period: Time it takes for antibodies to become detectable in the body; usually within three months.
2. Incubation Period: Time from point of infection to development of AIDS.

Building Blocks to Peer Success
HIV Life Cycle - The Big Picture

1. Attachment
   - HIV binds to receptors on the CD4 T-cell.
   - A message is sent to the CD4 T-cell to let the virus in.

2. Fusion
   - Once bound, the virus is allowed to dump its contents into the CD4 T-cell.
   - Included in its contents are HIV RNA and reverse transcriptase.

3. Reverse Transcription
   - The HIV RNA is turned into double-stranded DNA within the CD4 T-cell.
   - The enzyme reverse transcriptase aids in this process.

4. Integration
   - Once the DNA is formed, it hides itself in the human DNA housed in the CD4T-cell nucleus.

5. Transcription
   - Copies of HIV DNA are made and released from the nucleus in small packages.

6. Assembly
   - The protease enzyme in the cell combines the DNA 'packages' to create active virus.
   - Each of the small packages contains information for creating a new HIV.

7. Budding
   - Once the new HIV is formed, it pushes itself out of the CD4 T-cell.
   - The virus steals part of the CD4 T-cell protective coating.
HIV Transmission

**Modes of Transmission:**
1. Oral, vaginal, anal ________________________
2. Sharing _________________________________
3. ______________________________________

**Fluids:**
1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

**What is HIV?**
H –
I –
V –

________________________________________

A –
I –
D –
S –
Session 2: Coaching/Mentoring patients

Conversation starter:

- Let’s review the importance of communicating effectively with your providers and how that impacts your health, as well as the importance of advocating for yourself.
- Having a partnership with your health provider is important because you want to have equal ownership about health decisions. Usually, as a patient we follow whatever the doctor/nurse tells us to do; however research has shown that patients who ask questions increase their knowledge of their health/disease and have better health outcomes when fully involved in making health decisions.
- Suggestions to communicate more effectively include:
  - To come prepared with a list of questions for your medical appointments and/or I can help you prepare the list before your appointment.
  - Writing down any symptoms you experience between medical appointments is helpful – it’s called a “symptom log,”
  - Letting your provider know if you have missed appointments,
  - Honestly telling your doctor that you are uncomfortable with changes they may be recommending, and
  - Being truthful with your providers
- These suggestions are all ways to increase communication with your health provider while advocating for yourself.
- Sometimes it may take a while to gain a trusting relationship, but know that I can attend your appointments with you, or if there is a supportive person in your life, you can ask them to attend the appointments with you.
- Let’s plan to meet again on ____________________

Handouts

- How to Prepare for a Visit with your Doctor
- Symptoms Log
### PREPARING FOR A VISIT WITH YOUR DOCTOR

<table>
<thead>
<tr>
<th>Task</th>
<th>Questions/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep a journal or calendar of your symptoms.</td>
<td></td>
</tr>
<tr>
<td>Be prepared to describe side effect including symptom.</td>
<td></td>
</tr>
<tr>
<td>Bring a list of your medications and dosages, or bring your medications in a bag.</td>
<td></td>
</tr>
<tr>
<td>Be prepared to let your provider know how many doses you missed in the past week and month.</td>
<td></td>
</tr>
<tr>
<td>Bring a list of questions.</td>
<td></td>
</tr>
<tr>
<td>Bring snacks/water and something to help you stay busy while waiting.</td>
<td></td>
</tr>
<tr>
<td>Bring a friend, family member or navigator to help you during your visit.</td>
<td></td>
</tr>
</tbody>
</table>

Questions to ask your provider:

1. **Why have I been prescribed this medication?**
2. **How should I take it?**
3. Are there any special storage requirements?
4. Should I take it with or without food?
5. How many and how often should I take the medication?
6. Will it make me feel worse? What are the side effects?
7. What do I do if I forget a dose?
8. How long will I have to take it?
9. ____________________________________________________________
   ____________________________________________________________
10. ____________________________________________________________
    ____________________________________________________________
11. ____________________________________________________________
    ____________________________________________________________
12. ____________________________________________________________
    ____________________________________________________________
Symptoms Log

NAME ______________________________________________________  DATE _________________

1. Is it hard for you to take your HIV medicines the way your healthcare provider told you to?
   □ Yes     □ No

2. How hard are your HIV medicines to take? Mark an X on the line below.

   [Very Easy]   [Easy]   [Not too bad]   [Sometimes difficult]   [Difficult]

3. If you miss a dose, is it in the morning, evening, or middle of the day?
   □ Morning     □ Evening     □ Middle of the day     □ I don’t forget or skip doses

4. Do you ever skip a dose because the medicines make you feel bad?  □ Yes   □ No

5. Do you ever go a day without taking your HIV medicines?
   □ Yes; why? ________________________________________________________________  □ No

6. Do you ever have any of these possible side effects?

   Feeling sick to my stomach
   Vomiting

   Side Effect  How many times a month?  How long have you had this side effect?  How much does it affect your daily activities?
   0=none; 1=somewhat; 2=always

Diarrhea
Headache
Feeling tired
Rash
Shortness of breath
Trouble sleeping
Change in skin color
Bad dreams
Nervousness

7. Has your energy changed since you started taking your current HIV medicines? Mark an X on the line below.

[ ] Less energy  [ ] Same energy  [ ] More energy

8. Are you concerned that the HIV medicines you are taking now might cause either of these side effects?

a. Weight loss in the arms, legs, buttocks, or face
   [ ] Yes  [ ] No

b. Weight gain in the upper back and neck, breast, or trunk
   [ ] Yes  [ ] No

9. Would you be interested in talking to your healthcare provider about whether a change to your HIV regimen is right for you?
   [ ] Yes  [ ] No

10. If you could change one thing about your HIV treatment, what would it be?

____________________________________________________________________________________

____________________________________________________________________________________

Use your answers to talk to your healthcare provider.
HIV PATIENT BILL OF RIGHTS

- The person with HIV has the right to considerate and respectful care regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender, or payment source.

- The person with HIV has the right to, and is encouraged to obtain current and understandable information concerning diagnosis, treatment and prognosis.

- The person with HIV has the right to know the identity of the physician, nurses and others involved in her care, including those who are students, residents or other trainees.

- The person with HIV has the right to work with the physician or nurse in establishing their plan of care, including the refusal of a recommended treatment, without the fear of reprisal or discrimination.

- The person living with HIV has the right to privacy.

- The person living with HIV has the right to expect that all records and communication are treated as confidential except in the case of abuse.

- The person living with HIV has the right to review his/her own medical records and request copies of them.

- The person living with HIV has the right to expect that an advance directive (such as a living will, health care power of attorney) will be honored by the medical staff.

- The person living with HIV has the right to receive timely notice and explanation of changes in fees or billing practices.

- The person living with HIV has the right to expect an appropriate amount of time during their medical visit to discuss her their concerns and questions.

- The person living with HIV has the right to expect that his/her medical caregivers will follow universal precautions.

- The person living with HIV has the right to voice his/her concerns, complaints and questions about care and expect a timely response.

- The person living with HIV has the right to expect that the medical caregivers will give the necessary health services to the best of their ability. If a transfer of care is recommended, she should be informed of the benefits and alternatives.
• The person living with HIV has the right to know the relationships his/her medical caregivers have with outside parties (such as health care providers or insurers) that may influence treatment and care.

• The person living with HIV has the right to be told of realistic care alternatives when the current treatment is no longer working.

• The person living with HIV has the right to expect reasonable assistance to overcome language (including limited English proficiency), cultural, physical or communication barriers.

• The person living with HIV has the right to avoid lengthy delays in seeing medical providers; when delays occur, he/she should expect an explanation of why they occurred and, if appropriate, an apology.

**HIV PATIENT BILL OF RESPONSIBILITIES**

• Provide your medical caregivers with accurate and complete information, and convey your understanding about what is expected of you in regard to your treatment. If you believe you cannot follow through with your treatment, let them know.

• Meet your financial obligations as promptly as possible.

• Be considerate of the rights of other patients and medical personnel in the control of noise and respect of property at your appointments or in the hospital.

• Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.

• Be aware of the health care provider’s obligation to be reasonably efficient and equitable in providing care to other patients and the community.

• Become knowledgeable about your health care plan.

• Report wrong doing and fraud to the appropriate personnel or legal authorities.

• Keep appointments and notify the clinic if unable to do so.

• Inform the clinic of the existence of, and any changes to, advance directives.

• Notify the clinic of changes in your condition or care situation.
Session 3: Understanding lab values and medication adherence

Understanding Lab Values Conversation starter:

- Your doctor will order blood tests on a regular basis to check HIV progression, see if your medications are working (if you’re taking medications), and determine the effects of HIV and medications on your organ function. This is why it’s so important to come in to get your blood drawn every 3-4 months; if you don’t, it will be very hard to take control of HIV and understand how the medications impact the virus.
- We’re not going to cover every single blood test in this session, just the most common ones including: CD4 count, CD4 percent, viral load count, complete blood-cell count, liver function, kidney function, lipid profile, blood pressure, glucose levels, cholesterol, etc. These tests tell a story about your health and what needs to be done to keep you healthy.
- We’ll also discuss healthy heart health and the effects of HIV disease.
- Another reason to get your labs done regularly and understand what the numbers mean is that you and your doctor can do certain things to change the lab values if they’re not normal. For example, if your cholesterol is too high, you and your doctor can intervene to lower it. If your CD4 is too low, you and your doctor can intervene to increase it.
- It’s kind of like checking the oil in a car engine or taking a car in for a tune-up. If you don’t do these things, what will happen to your car eventually? [Responses: A car will need costly repairs or a person may need a new car.]
- Routine screenings for preventive care are very important such as: eye exams, mammograms, PAPS, prostate, STD screenings. In addition, preventive care vaccines like flu, pneumonia and hepatitis are essential to maintaining good health.
- Have you had labs done, and what were the results?
- Let’s review them to ensure that you understand the different labs that are monitored. [Pull up patient’s record/Share printed copy of labs] We can also track your results on a spreadsheet or a grid. That way you can monitor independently and increase understanding of labs and your health. Always ask for a copy of your labs and keep them in one place so that if you move or change physicians, your new physician has a history of your care and treatment. If you are interested in making a spreadsheet, let’s make one together that you can update as you visit your doctor.
- Let’s plan to meet again on ________________

HIV medications conversation starter:

- HIV medications are beneficial for you. Because of HIV meds, many people are living longer, fuller lives. I don’t think many of us would be alive today if it weren’t for HIV meds. Many people are living longer – 10, 20, 30 years and beyond – because of HIV meds. You can too!
- Taking meds is one of the most important things you can do to take control of HIV.
- Each individual responds differently to meds: some people get intense side effects, while others get mild or no side effects; some people have side effects in the first 30 days and then they disappear. Because of this, it is important not to judge how your body will respond to medications by other people’s experiences but from your own experience.
- Remember: the benefits of taking meds outweigh any difficulty taking them. Remember, too, that if they don’t work for you, your doctor can put you on different meds until you find the ones that are just right for you.
- We’re fortunate that today there are many meds to choose from, and newer meds have fewer side effects than the older ones.
Taking meds can feel complicated at first, but once you develop a daily routine, it gets easier.

I can give you ideas about how to remember to take meds on time, how to take them correctly, and I will be here for you whenever you need to talk about them.

It’s a big commitment, but one that eventually becomes second nature for most, and one that could bring you good, stable health and long life.

Together we – you, me, the doctor, case manager and anyone else involved in your care – can minimize any negative experiences that may (or may not) develop.

Now, let’s take a look at the goals of HIV meds and how they work to stop HIV from multiplying in order to give your immune system a fighting chance.

Let’s look at the different combination of medications that are available and where they work in the viral life cycle to reduce the virus.

Let’s plan to meet again on ____________________

Drug resistance & adherence conversation starter:

Today’s session builds on the last session we had on HIV medications: adherence, resistance and managing side effects.

Adherence means “sticking to your medication schedule” at least 95% of the time. It means taking your meds correctly and on time every day. It also means managing side effects so that you’re not discouraged from continuing to take your meds.

Most people who stop taking meds do so because of side effects. Perhaps they didn’t have information about how to manage side effects, or no one helped them learn how to manage them. But you have a team of people supporting you in sticking to your meds and identifying possible barriers to adherence, including me. In addition, there are many methods and tools (e.g. pillboxes, calendars, alarm watches, etc.) available to help.

We’ll also talk about medication resistance; there are different types, and some are the direct result of non-adherence.

Resistance means that the meds no longer work in blocking HIV from multiplying. HIV usually becomes resistant when it is not totally controlled by medications. Now, let’s get started.

- (USE Handout Viral load and non-adherence).
- When you take medications correctly your viral load goes down because the treatment stops the virus from growing in the body.
- If you miss one or two doses—the virus becomes “resistant” to treatment and can start growing in the body.
- Eventually if you keep missing doses or stop taking meds as directed by your doctor, the treatment will not work to stop the virus. The virus will become resistant until your doctor can find a new treatment.

Managing side effects conversation starter:

Many side effects are related to your digestive system, e.g., nausea, diarrhea, bloating, gas, etc. Many people manage these with other medications or certain foods:

- BRAT diet: Bananas, Rice, Applesauce, and Toast
  - Apples and apple products like apple juice and apple sauce
  - Black or green decaf tea
  - Boiled white rice
  - White toast
- Monitoring Tests for People with HIV
- How medications work:
  - Youtube videos:
    - How HIV treatment works: https://www.youtube.com/watch?v=06mQyXQjR08
    - Understanding HIV treatments: https://www.youtube.com/watch?v=8O03tTj2XfE
- Assessing Adherence
- Resistance and Viral load

**Addressing Adherence: 10 questions patient navigators should ask their patients**

1. Which medications are you currently taking?
2. How frequently do you have to take each one of your meds?
3. What are the food restrictions for each of your meds (i.e. with or without food)?
4. Why do you think some meds need to be taken with food and some on an empty stomach?
5. Why do you think that some medications are taken once a day and others twice a day?
6. What helps you remember to take your meds?
7. What do you do when you miss a dose?
8. What problems have you encountered from taking meds?
9. How soon before you run out of medications do you order refills?
10. Do you believe the meds are helping you and if so, how?

**Boundaries to Adherence: To be filled out by the patient navigator and the patient**

Date:
Patient name:
Navigator name:

Past/current barriers to adherence

Strategies to overcome barriers

- Ginger and ginger products like ginger tea, candied ginger, ginger ale, ginger snaps, etc.
- Yogurt
- Soda crackers or saltines
- Fiber-rich foods or supplements
- Medication: Imodium AD (loperamide)

- It’s always important to contact your provider immediately to let them know if you’re experiencing side effects.
- Never stop taking your medications without getting guidance from your providers.
Viral Load and Non-adherence
Session 4: Managing stigma and disclosure

Conversation starter: Disclosure and Stigma

- To tell or not to tell.
- Whom should I tell: everyone or a few?
- Whether you’ve been positive for a while or newly diagnosed, disclosing your status is different for each of us and sometimes can be complicated. There is no exact way of knowing when the right time is or the right way.
- Is there anyone you feel that you must tell, like a spouse, a partner, or perhaps someone whom you've been dating? It takes time to adjust to being HIV-positive, but keep in mind that there are HIV laws and statutes in each state that are different. In some states, it is unlawful for a person living with HIV to engage in sexual activity with another person, donate organs or blood, or share needles. Condoms are not always a defense, despite the fact that condoms have been proven to reduce the risk of HIV infection, so know the laws in your state. With that in mind, it's a good idea not to rush into disclosing your status without first giving it some thought.

There are some general tips:

Consider the five “W’s”- who, what, when, where and why.

- Who do you need to tell?
- What do you want to tell them about your HIV infection, and what are you expecting from the person you are disclosing your status to?
- When should you tell them? Where is the best place to have this conversation?
- What are you telling them?
- Keep it simple. You don’t have to tell your life story.

Let’s plan to meet again on ________________

Materials:

- Considerations before you disclose (below)

Considerations before you disclose:

1. What do you need most from the person you are telling? Have the patient think about how this person knowing can help their situation or make it worse.
2. Who are you most comfortable telling? Have the patient think of someone who can support them in a non-judgmental way while coping with their own feelings.
3. How important is privacy to you? Have the patient consider how the person she is considering disclosing to regularly deals with others’ confidential information.
4. Prepare for reactions. Have the patient consider if the person she is going to tell might get upset, emotional, scared, etc. Have the patient consider what kind of information (written or verbal) they could practically provide to this person.
5. Where will you tell? Have the patient choose a place that is comfortable and that provides enough privacy.
6. What are some of the risks? Have the patient think about the risks of associated with disclosing, such as jeopardizing a job or telling someone who might become violent.
Session 5: Substance use and harm reduction

Conversation starters/prevention messages: drug use (for patients who use alcohol and/or drugs)

- Alcohol and other drugs can suppress your immune system. Drugs and alcohol also may cause you to take risks you wouldn’t normally take. Using drugs and alcohol with our HIV treatment can seriously affect our health.
- Because all drugs are processed through your liver, it is important to know that too many drugs being processed at the same time can increase liver function and make you feel sick; it can cause liver failure or permanent liver damage.
- If you take HIV meds and then recreational drugs, the recreational drug has to “wait in line” to get into the liver and be processed. This can lead to a situation called “inhibition” which can cause an overdose of the recreational drug.
- If you take recreational drugs and then HIV meds, this could lead to a situation called “inducing” which means that your HIV meds would get processed too quickly and not get fully absorbed by your body. It could also lead to harmful drug interactions.
- If you inject drugs, make sure you use a new needle every time to avoid abscesses.
- Do not share your needle with anyone else, as this is the easiest way to transmit HIV.
- If you use a needle that someone else has used, you may acquire hepatitis C (this is the easiest way to acquire hepatitis C).
- If you do share needles and works, make sure you clean your needle and works with bleach and water (add cleaning instructions here).
- Risk reduction strategies include: There are other things you can do to protect yourself when you have HIV. For example, having fewer exposures, having fewer partners, having regular STI screening (at least twice a year), being vaccinated against hepatitis A & B, avoiding vaginal sex during menstruation, and avoiding alcohol and drugs when before or during sex (impairs decision making).

Handouts:

- HIV and Substance use: Drug interactions (below)
- HIV Drug Chart (PDF)
HIV and Substance Use:

**Drug Interactions**

*The liver is involved in metabolism of most HIV medications & recreational drugs. Metabolism is the body’s mechanism for processing, using, inactivating and ultimately eliminating foreign substances (including both HIV meds and recreational drugs). When HIV meds and other substances are taken at the same time, there can be different effects. Drugs can act as inhibitors or inducers (or both), which determine the kind of drug interactions that occur.*

**HIV Meds & Opioids**

<table>
<thead>
<tr>
<th>Inhibitors</th>
<th>Inducers</th>
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</thead>
<tbody>
<tr>
<td><strong>Competition</strong></td>
<td><strong>Enhancement</strong></td>
</tr>
<tr>
<td>• When 2 drugs are “waiting in line” to be broken down by the liver, they must compete to be processed. The drug that wins this competition (usually HIV meds) is acting as an inhibitor.</td>
<td>• Inducers are the drugs that, once present in the liver, have the effect of triggering more rapid clearance of drugs that follow leading to lower drug level (meds or other recreational drugs).</td>
</tr>
<tr>
<td>• The liver is so busy processing the HIV meds (inhibitors), that recreational drug processing is delayed, eventually resulting in a high level of recreational drug and potential overdose.</td>
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*Methodone* an opioid analgesic (a.k.a. painkiller) used as treatment for heroin addiction because it reduces cravings and blocks the ability of heroin to produce euphoria, making it less desirable.

- Acts as inducer and inhibitor: Hinders absorption of didanosine (ddl) and stavudine (d4T) (inhibitor), and increases AZT (inducer)
- Research has shown that methadone hinders absorption of the drugs didanosine (ddl) and stavudine (d4T), due to damage in the gastrointestinal tract.
- When taken together, research has shown that protease inhibitors (PIs) act as inducers (leading to reduced methadone concentrations), or methadone acts as an inhibitor (causing PI toxicity).
- PI-related toxicity (and other HIV meds-related toxicity) include nausea, vomiting, diarrhea, which are also symptoms of heroin or methadone withdrawal.

*Heroin* is an opioid used as an analgesic, but also used as a recreational drug. Frequent and regular use of heroin is associated with increased tolerance and physical dependence, which can develop into addiction.
• PIs acting as inducers can decrease heroine levels in the blood by 50%, causing a more rapid onset of and/or more severe withdrawal symptoms.
• This also leads to a desire to increase dose to compensate for the lesser effect, leading to even more dependence.

**HIV Meds & Hallucinogens**

_Ketamine_, also called “K,” is a mild hallucinogen. K causes feelings of mind/body separation, possible seizures, respiratory depression, mild hallucinations (referred to as ‘K-Holes’), and increased heart rate (HR).

• PIs intensify the already harmful effects of K, including increased HR, blood pressure, increased sedation.
• K increases the likelihood of experiencing “chemical hepatitis,” drug induced hepatitis: an inflammation of the liver that is permanently damaging.
• Norvir, Kaletra, Viracept, Agenerase, Lexica, Rescriptor and Sustiva have the greatest potential to cause toxicity.

_PCp_ is a powerful hallucinogen which can cause feelings of empowerment and invulnerability. Potentially dangerous effects include seizures, hypertension, hyperthermia, and rhabdomyolysis.

• Mixed use with PIs, Delavirdine & possibly Efavirenz, may result in elevated PCP concentrations & resultant toxicity.

_LSD_ is a powerful hallucinogen that is easily available which causes intense hallucinations, agitation, psychosis, perception disorders known as ‘flashbacks.’ Side effects of the drug include higher body temperatures, increased heart rate, blood pressure, sweating, sleeplessness & tremors.

• The likelihood of experiencing these effects is greater when mixed with PIs.

**HIV Meds & Erectile Dysfunction (ED) Drugs**

_Viagra, Levitra_ and _Cialis_ are all medications prescribed for ED which are also used recreationally.

• For example, many individuals mix ED drugs with crystal meth (which can cause a loss of erection) and engage in sexual activity for an incredibly long duration of time w/multiple partners. Individuals are less likely to use protection because crystal makes them less inhibited.
• When ED drugs, crystal meth, and HIV meds are mixed: extended half-life and drug toxicity (due to elevated drug levels in the blood) means there is a greatly increased likelihood of experiencing adverse side effects: stroke, changes in blood pressure and heart attacks.

**HIV Meds & Alcohol**
Alcohol is a drink containing ethanol which is a psychoactive drug that has a depressant effect. High blood alcohol content is considered to be drunkenness because it reduces attention and slows reaction speed. The state of alcohol addiction is known as alcoholism.

- Chronic use causes liver damage, making it unable to perform its bodily function as effectively; weakens immune system; can cause peripheral neuropathy (meaning nerves don’t work properly) and pancreatitis (inflammation of the pancreas).
  - Alcohol acts as an inducer, triggering the liver to process PIs more rapidly resulting in insufficient amounts to fight HIV.
  - When d4T or ddi are mixed with alcohol, there is an increased risk of pancreatitis.
- Acute use can cause alcohol poisoning.
  - PIs act as inhibitors, preventing alcohol from being processed properly. The consequence is alcohol toxicity, and an elevated risk of alcohol poisoning.
  - Some cases have been reported of individuals experiencing increased levels of Ziagen because of acute alcohol use, which means an increased risk of corresponding side effects (life threatening body rash and fever)

Key Points

It is essential to have intensive discussions about potential drug interaction problems with patients using recreational drugs who are simultaneously taking HAART. Routinely discuss use of all drugs with your patients.

PARTY DRUGS

Ecstasy: Protease Inhibitors slow down the liver enzyme that breaks down Ecstasy. As a result, Ecstasy dose becomes 5-10 times stronger. Norvir is most dangerous Protease Inhibitor.

Crystal Meth: Norvir makes dose 2-3 times stronger

GHB: The date rape drug: Interaction with Norvir makes GHB 5-10 times stronger and longer lasting. High dose can cause sedation, confusion, come and death. Chemically unstable, interacts negatively with many drug categories.

MDMA is the chemical name for ecstasy.

Ecstasy is amphetamine-derived. Furthermore, ecstasy pills are often ‘cut’ with other hard drugs—particularly crystal meth or heroin, to increase their effects. More importantly (for this training), this increases the likelihood of problematic interactions w/HIV meds. Users are more likely to experience adverse side effects.

Ecstasy primary effect is to stimulate the release of large amounts of serotonin as well as dopamine and noradrenaline in the brain, causing a general sense of openness, energy, euphoria & well-being.

Tactile sensations are enhanced for some users, making general physical contact with others more pleasurable.
Crystal meth can be huffed, injected, snorted or smoked. Crystal meth use is characterized by the following: angry, hostile, and anxious feelings; violent behavior; confusion; mental illness that looks like schizophrenia (paranoid feelings picking at your skin, hallucinations).

The user also frequently experiences the following: being haunted by his or her thoughts; increased physical activity; loss of appetite, which can result in severe weight loss (anorexia); inability to sleep; increased heart and pulse rate; permanent damage to the blood vessels in the brain, which can lead to strokes; convulsions and body tremors; chest pain and raised blood pressure, which could lead to a heart attack and then death; irregular heartbeat; AIDS or hepatitis resulting from shared needles; mental dependence; tolerance & addiction to the drug.

However, of all HIV meds that can interact with party drugs, PI’s are considered to be the most dangerous.

In the past, GHB was used medically as a general anesthetic & as a hypnotic in the treatment of insomnia. GHB is highly potent when combined w/ Rescriptor (NNRTI) and possibly Sustiva. However, when mixed w/all PI’s, its effect is much stronger. There is a greater risk of adverse side effects.

Norvir is dangerous when mixed with GHB because it greatly slows down the liver enzymes that break down GHB.
Session 6: HIV and Mental Health

Conversation Starters

- We all have things that create stress in our lives. The stress of living with HIV, taking medications every day that may not make us feel great all the time is common and challenging to live with.
- Many people living with HIV experience depression, anxiety or other forms of mental health problems. You are not alone. Many people who are depressed are not even aware of it.
- Many people may not even like to talk about HIV or depression because they fear what other people might say or how they will be treated if they find out.
- I can share with you some tips on how to manage stress, such as exercising, talking with a trusted friend, writing in journals, or attending a support group.
- I am here to listen and if you are experiencing any of these symptoms I can help you find a professional who can help you find a way get the treatment you need.

Handouts:
- Tips for coping with stress, anxiety, or depression
- Symptoms of clinical depression
- Symptoms of anxiety disorders

Tips for dealing with stress, anxiety, or depression

- Talk to a trusted friend, family member, or religious leader
- Exercise (has been found to be as effective as medication in treating depression)
- Volunteer or help others
- Journal
- Build in a breath practice, reminding yourself to focus on breathing
- Spend time in nature
- Pray, meditate, and/or connect with your spirituality
- Participate in creative projects such as arts and crafts, hobbies, or gardening
- Attend a support group or community gathering
- Other self-care tips that work well for you:

Symptoms of clinical depression

Not everyone experiences clinical depression in the same way. Different people have different symptoms. The National Mental Health Association recommends that you see a doctor or a qualified mental health professional if you experience five or more of these symptoms for longer than two weeks, or if the symptoms are severe enough to interfere with your daily routine:

- A persistent sad, anxious, or “empty” mood
- Sleeping too little or sleeping too much
- Changes in appetite or weight
- Loss of interest or pleasure in activities once enjoyed
- Restlessness or irritability
- Persistent physical symptoms that don’t respond to treatment (such as headaches, chronic pain, or constipation and other digestive disorders)
- Difficulty concentrating, remembering, or making decisions
- Fatigue or loss of energy
- Feeling guilty, hopeless, or worthless
- Thoughts of death or suicide

**Symptoms of anxiety disorders**
There are several types of anxiety disorders and not everyone experiences the same symptoms. An accurate diagnosis and treatment should be made by a qualified mental health provider. Contact your doctor or a mental health provider if you experience any of the following symptoms:

- Excessive worry more days than not
- Inability to control the worry
- Restlessness, feeling “keyed up” or on edge
- Fatigue or feeling easily tired
- Irritability or sudden outbursts of anger
- Muscle tension
- Trouble falling asleep or staying asleep
- Repeated and unexpected “attacks” where you suddenly feel overwhelmed by intense fear or discomfort for no apparent reason
- Repeated and distressing memories or dreams of a life-threatening event you previously experienced
- Feeling on-guard or hypervigilant
- Feeling detached from other people
- Intense, persistent fear of a social situation in which people might judge you
- Extreme anxiety with pounding heart, trembling or shaking, sweating, nausea, or abdominal discomfort
- Fear of losing control
- Feeling worthless or guilty