Patient Navigation

OBJECTIVES

At the end of this unit, participants will be able to:

- Describe the purpose and elements of patient navigation meetings
- Share how patient navigators can help clients access necessary services
- Know which forms are needed to track patient navigation activities

INSTRUCTIONS

1. Prior to the session, review the slides and resources. Review the resource HRSA HAB Dissemination of Evidence Informed Interventions: Enhanced Patient Navigation for Women of Color with HIV: Modules 1, 2, 4. If desired, print out copies of the handouts: Care Plan and Acuity Tool. Adapt slides that may be relevant for your training programs, such as slides 4–7 in Module 2
2. Welcome participants and review the objectives (slide 2).
3. Review CHW Proactive Roles and Responsive Roles and how they impact the continuum of care. (slide 3).
4. Facilitate a discussion about roles at participants' agencies (slide 4–7).
5. Share samples forms (care plan and acuity tool) that CHWs may use when performing navigation roles. Ask participants to share any forms and describe how they document their work with clients at their agency.
6. Explain that participants do not have to use these specific forms, but they are a tool that is available online to help document work if you do not already have a method in place. They can also inspire you to improve your methods for higher quality outcomes.
7. Wrap up. Navigation is one of the roles of a CHW and affects the continuum of care by helping clients with access and retention in primary care, as well as support in secondary and tertiary care.

Related C3 Roles

Care coordination, case management, and system navigation; providing coaching and social support; providing direct service; implementing individual and community assessments

Related C3 Skills

Interpersonal and relationship skills, communication skills, capacity building skills, education and facilitation skills, documentation skills

Method(s) of Instruction

Lecture, group discussion

Facilitator's note: This session can also be conducted virtually as a webinar. It can easily be adapted if you have a platform such as Zoom or Skype and participants have access to a computer. If conducting as a webinar, allow 10 minutes to test the technology and aid participants in connecting.

Estimated time

95 minutes

Key Concepts

Continuum of care, navigation, care delivery

Materials

- Computer with internet access and projector
- PowerPoint slides

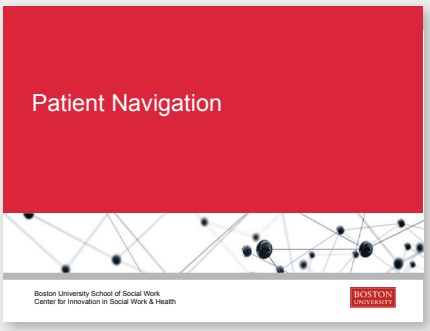
Handouts

- Care plan (optional)
- Acuity tool (optional)

Patient Navigation

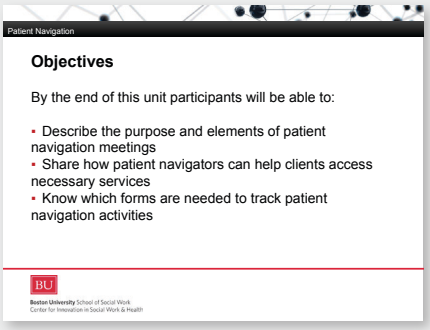
Resources

- Video: HRSA HAB Dissemination of Evidence Informed Interventions/AIDS United Treatment Tips *https://www.youtube.com/playlist?list=PLmeLn9qRyk-hdU_ueS_QQCY8wHkKLqN0g*
- HRSA HAB Dissemination of Evidence Informed Interventions: Enhanced Patient Navigation for Women of Color with HIV: Modules 1, 2, 4 available at: *https://targethiv.org/library/dissemination-evidence-informed-interventions-2017*
- A Guide to Implementing a Community Health Worker (CHW) Program in the Context of HIV Care. Available at: *https://targethiv.org/library/hiv-chw-program-guide*



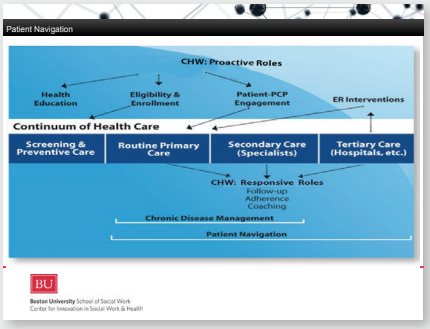
SLIDE 1

Welcome participants.



SLIDE 2

Review the objectives.



SLIDE 3

Let's take a look at the care continuum and what areas patient navigation influences.

This diagram reflects the key components of care: Screening and preventive care, routine primary care, secondary care (specialist), and tertiary care (hospitals). The CHW roles are separated into two categories:

Proactive roles

- Health education
- Eligibility and enrollment
- Patient and PCP engagement
- Emergency room interventions

Responsive roles

Follow-up, Adherence, and Coaching

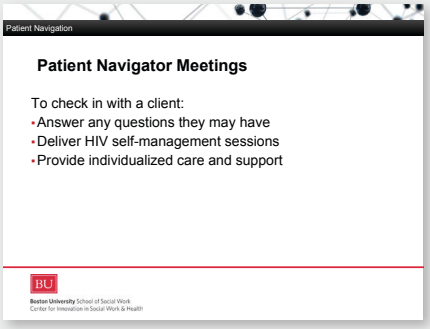
- Routine primary care
- Specialty care
- Tertiary care (e.g., hospitals)

The two areas that chronic disease management falls under are:

- Routine primary care: working with clients on adherence, making appointments, and reaching their health care goals on their care plan.
- Tertiary care: supporting clients in hospice situations, end stage liver disease and hospitalization transitions.

Patient navigation encompasses both of these, plus secondary care which might entail escorting a client to specialty appointments and understanding instructions from the PCP, or helping form questions they can ask the PCP. These roles are responding to the needs and goals of the client. Proactive roles are those supportive roles that help the client gain access to and navigate the health systems.

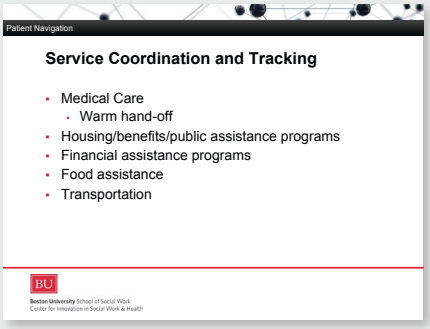
Ask, "Considering this diagram what roles are you playing at your organization?"



SLIDE 4

Tell participants: These meetings are where you bond and gain trust with the client as you support them in identifying and developing health-related goals, as well as answer their questions and clear up myths that they may have using your communication skills such as motivational interviewing.

Ask Participants, "Do you perform these tasks at your organization, or does someone else?" "How do you perform these activities?" "How do you document and track your meetings with a client?"



SLIDE 5

Tell participants: These are some of the services that you as a CHW may perform and help a client navigate the service system in addition to linking and staying in medical care. You may work closely with the care team and other community partners to communicate client needs that may arise out of these meetings in order to support them in reaching their goals and increasing their investment in their health outcomes.

Ask Participants, "Do you perform these tasks at your organization, or does someone else?" "How do you perform these activities?" "Who do you contact?" "How do you document and track your work with clients on obtaining services?"

Write participant responses on a flip chart and note similarities and differences.

SLIDE 6

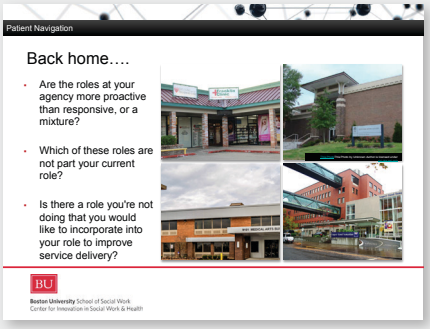
Tell participants: The need for assistance will vary from client to client. Some will require more support than others, especially in the beginning. You may have to physically escort or accompany them to appointments at first; that might be a good opportunity to educate a client about scheduling, identifying types of reminders that work best, and assisting them in setting up appointments. Remember, always make time for documentation as soon as possible after the visit and review the care plan and update what was and wasn't accomplished.

Ask participants, "Do you perform these tasks at your organization, or does someone else?" "How do you perform these activities?" "Who do you contact?" "How do you document and track your work with clients on obtaining services?"

Ask participants, "Do you perform patient education?" If yes how for volunteers to share how they educate materials on what topics and what materials they use.

Share with participants: the video clips from AIDS United HRSA DEII initiative that can be used to educate clients.

Write participant responses on a flip chart and note similarities and differences.

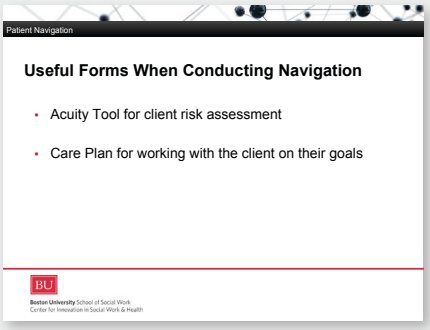


SLIDE 7

Review the slide.

Break participants in to groups of 3–4 persons. Ask them to discuss the 3 questions on the slide for about 15 minutes.

Bring participants back and ask them to share what they learned from each other.

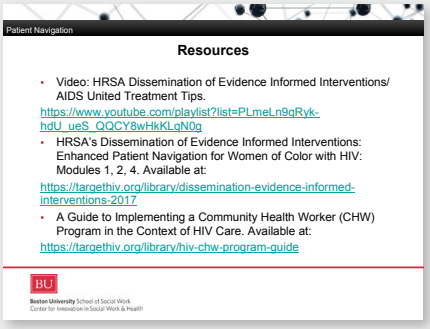


SLIDE 8

In the HRSA Dissemination of Evidence Informed Interventions: Enhanced Patient Navigation for Women of Color with HIV tool kit you will find useful forms to help track client progress and health outcomes.

Ask participants if their agencies has forms they need to complete and how they document their services. Ask if they have access to the patients electronic medical record or paper chart. Note responses on a flip chart.

Tell participants: Whether your work is proactive or responsive, remember to schedule regular meetings with the client, take care to communicate changes and progress to your team, and document all the work you do concerning the client.



SLIDE 9

Share the resources with participants and wrap up the session.

Sample Care Plan I

CHW Care Plan Protocol

Each **care plan** with include a health goal to include the following:

- The team agreed on incorporating a team approach in following each client which will promote a health network with the goal of VLS, RIC and VLS

The following **interventions** will be incorporated to assist that client achieve goals:

- BHC consult (phone visit if necessary)
- PharmD appointment (phone visit if necessary)
- MCV
- Educational module
- Weekly contact via call or text. Efforts to contact the patient will be documented
- Quarterly cross checks and balances from teammate to check in with client to make sure things are going well and to offer assistance if needed.
- Client will receive a thank you card with affirmation if meeting goals

0-6 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC and TA	CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC and TA
INTERVENTION 1. Bi-weekly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a card affirming them and celebrating their goals	INTERVENTION 1. Continue weekly check-ins 2. Conduct home visit 3. Reassess client for barriers & explore options to overcome the identified barriers 4. Reinforce previous goals 5. CHW referral for support with achieving goals of obtaining positive health outcomes 6. Educational Modules 7. Quarterly cross checks & balances by teammate

NOTE: The BHC, PharmD and provider visits should occur within 6-8 weeks of the LTCM assessment

The team will celebrate milestones and achievements with the client.

6-9 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 1. MCV 2. LABS 3. PharmD visit (by phone if needed) 4. VLS, RIC and TA 5. Goals identified by the client
INTERVENTION 1. Monthly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a card affirming them and celebrating their goals	INTERVENTION 1. Continue weekly check-ins 2. Home visit from LTCM and CHW 3. Reassess client for barriers & make referral to community agency 4. Call from provider w/concerns re: NVLS & NRIC 5. CHW referral for support with achieving goals of obtaining positive health outcomes 6. Educational Modules 7. Quarterly cross checks & balances by teammate to include interventional assessment
9-12 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 6. MCV 1. LABS 2. PharmD visit (by phone if needed) 3. VLS, RIC and TA 4. Goals identified by the client
INTERVENTION 1. Monthly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a certificate and gift bag to CELEBRATE this milestone and affirming them.	INTERVENTION 1. Readiness for change assessment 2. Monthly check-ins 3. Educational Modules if it is determined that the client is ready 4. Quarterly cross checks & balances by teammate to include interventional assessment 5. Place client on an inactive list if it is determined that the client is not ready

12-18 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 1. MCV 2. LABS 3. PharmD visit (by phone if needed) 4. VLS, RIC and TA 5. Goals identified by the client
INTERVENTION 1. Monthly check-ins for 12-18 months. At the 18 month mark the client will be contacted bi-monthly. 2. RWE/ADAP reminder 3. Continue with modules & client goals 4. Re-evaluation/screening 5. Appt reminders 6. Quarterly cross checks & balances by teammate 7. Client will receive a card celebrating milestones with affirmations.	INTERVENTION 1. Continue monthly check-ins 2. Place client on an inactive list if it is determined that the client is not ready

Source: East Caroline University Adult Specialty Care Clinic

Sample Care Plan II

Southern Nevada Health District
Case Management
Ryan White Program
Client Service Plan

Client Name:		
Problem/Need Goal:	Intervention:	Progress Note: Date/Note
Linkage to Medical Care	Client will: Case manager will: CHW will:	
Linkage to Community Assistance	Client will: Case manager will: CHW will:	

I have read, understand and agree with the above service plan. Signing below indicates that you have read, understand and will comply with the terms above. Your signature also verifies that you have received a copy of your service plan.

Client Signature:		**Date:**	
Case Manager Signature:		**Date:**	
CHW Signature:		**Date:**	
Other/Signature:		**Date:**	

Ryan White Part A Client Acuity Tool

Las Vegas TGA Ryan White Part A HIV AIDS Program

Client Name _____ Date _____

☐ Initial Assessment ☐ Follow-up Assessment

Barriers	**Level 0-1** "0"-no intervention needed. "1"-short term, focused, education/support/referrals.	**Level 2** "2" multiple barriers, provide education/support.	**Level 3** "3"-Multiple, complicated barriers, and/or is in crisis.	**Level**
Housing	Stable, clean housing.	Requires short term assistance with/rent, utilities.	Homeless, shelter resident, or frequent moves.	
Finances	Steady, adequate source of income.	Income source is inconsistent or too low to meet basic needs.	Has no income. Is in financial crisis. Consistently unable to meet basic needs.	
Transportation Issues	Has own transportation to get to and from clinic visits.	Some difficulties with access to transportation.	Consistent problems with accessing transportation.	
Social Support/Family Issues	Dependable network/family/friends/partner .	Gaps in support system (family/friends periodically) Pregnant but adherent.	No stable support other than professionals. Family in crisis. Pregnant but not adherent. Fear of disclosure.	
Behavior	Functions appropriately in most settings.	Repeated incidences of inappropriate behavior.	Abuse or threats to others; lack of control.	
Communication Issues	Speak, read and understand English at an adult level.	Some difficulties with speaking, reading and understanding English.	Not able to represent themselves in English. Unable to read or write.	
Cultural Issues	Minimal system barriers	Requires some assistance acclimating to system.	Chooses not to/unable to acclimate to system.	
System Issues	Minimal system barriers.	Needs help accessing the system.	Distrust of system/not accessing services.	
Legal Issues	Client reports no recent or current legal problems; all pertinent legal documents completed.	Needs assistance completing standard legal documents; recent or current legal problems.	Involved in civil or criminal matters; incarcerated or recently incarcerated; undocumented immigrant; unaware of standard documents, i.e. living will.	
Mental Health Issues	No current mental health illness but has a history of mental illness, now stable.	Mild to moderate symptoms or disorders.	Severe symptoms/disorders; long history of mental disorders.	
Substance Use/Abuse	No current use and/or history.	History of abuse and/or intermittent abuse.	Chaotic life, regular substance abuse.	
Side Effects	On medication, having no side effects.	Minimal side effects affecting some quality of life.	Moderate to severe side effects affecting quality of life.	
Adherence History	Reports ability or willingness to adhere to medications.	Reports inconsistent ability to adhere to medications.	Reports inability to adhere to medications. Treatment naïve.	
Educational Issues	Has been informed, able to verbalize basic knowledge of the disease.	Some understanding of the disease.	No understanding of HIV disease. New diagnosis. <18 years of age.	
Medical Needs	Stable health; goes for periodic MD appointments and lab monitoring.	Needs primary care referral. Being seen by MD for short term illness.	Poor health; medical emergency; rapidly deteriorating; with opportunistic infections. Pregnant.	
Comments Section:			**Combined Total**	0

If a client scores a 3 in any life categories of Medical Needs, Educational Issues, or Adherence History, a referral to Intensive Medical Case Management is strongly encouraged. If a client scores a 3 in the life categories of Cultural Issues, Educational Issues, Social Support/Family Issues, Housing or Finances, a referral to Moderate Medical Case Management is strongly encouraged.

Client Level Acuity Guidelines:

Acuity Level	***Range***	***Case Management Level***	***Referral Criteria***
Life Area 0-1	15 Points or Less	Medical or Non-Medical Case Management	Self referral as needed
Life Area 1 & 2	16-30 Points	Intensive Medical Case Management-Social	Refer to appropriate community partners
Life Area 2 & 3	31 Points or Higher	Intensive Medical Case Management-Medical	Intensive Medical Case Manager to follow

Signature of Case Manager _____

HIV/AIDS Medical Case Management Acuity Tool Form
Massachusetts Department of Public Health
Boston Public Health Commission

Area of Functioning		Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Adherence to Medical Care and Treatment & HIV Health Status									
HIV Care Adherence		☐	Has missed 2 or more consecutive HIV medical appointments in the last 6 months	☐	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	☐	Has attended HIV medical appointments in the last 6 months as indicated by HIV medical provider	☐	Has attended all scheduled HIV medical appointments in the last 12 months as indicated by HIV medical provider
		☐	Requires on-going accompaniment or assistance with medical appointments due to limited language or cognitive ability	☐	Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.)	☐	Needs assistance with making and keeping HIV medical appointments	☐	Does not require any assistance or reminders to schedule or keep medical appointments
Acuity Score:		☐	Has not been seen by HIV medical team in the last 6 months	☐	Requests accompaniments to medical appointments from MCM or other member of the care team				

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Current HIV Health Status	☐	Has detectable VL and CD4 below 200	☐	Has detectable VL and is working towards viral suppression with the medical team	☐	Is on ARVs, in care, and being monitored by medical team, but unable to achieve viral suppression	☐	Is virally suppressed
	☐	Has current OI and is not being treated	☐	Has history of OI in last 6 months which are treated and/or client using prophylaxis (if indicated)	☐	Has no history of OIs in last 6 months	☐	Has no history of OIs in last 12 months
	☐	Has been hospitalized or visited the ER in last 30 days due to HIV related illness	☐	Has been hospitalized or visited the ER in last 6 months due to HIV related illness	☐	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	☐	Has no history of hospitalizations or visits to the ER in last 12 months due to HIV related illness
	☐	Newly diagnosed within last 6 months and concurrently diagnosed with AIDS	☐	Newly diagnosed within the last 6 months and/or is new to the MCM program				
Acuity Score:	☐	Demonstrates no understanding of HIV labs and lab results	☐	Demonstrates minimal understanding of HIV labs and lab results	☐	Demonstrates some understanding of HIV labs and lab results	☐	Demonstrates understanding/ Knows of HIV labs and lab results

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Other Non-HIV Related Medical Issues	☐	Has been hospitalized or visited the ER for non-HIV related illness in last 30 days	☐	Has been hospitalized or visited the ER in last 6 months due to non-HIV related illness	☐	Has had no non-HIV related hospitalizations or visits to the ER in last 6 months, but at least 1 in the last 12	☐	Has no history of non-HIV related hospitalizations or visits to the ER in last 12 months
	☐	Has 2 or more non-HIV related illnesses (chronic or non-chronic) that impact health and care adherence	☐	Has a non-HIV related illness (chronic or non-chronic) that impacts health and care adherence	☐	Has no current non-HIV related medical issues, but past illnesses require monitoring by a medical provider	☐	Has no non-HIV related illnesses
	☐	Currently receiving treatment for non-HIV related medical conditions (e.g. chemo, dialysis, HCV, on-going dental complications, etc.) that impacts daily living	☐	Currently recovering from treatment for non-HIV related medical conditions (e.g. chemo, dialysis, HCV, on-going dental complications, etc.) that impacts daily living				
	☐	Requires assistance to make and keep non-HIV related medical appointments due to language or cognitive ability	☐	Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.) for non-HIV related medical issues	☐	Requests assistance with reminders for non-HIV related medical appointments	☐	No assistance needed for reminders for non-HIV related medical appointments
Acuity Score:	☐	Requires accompaniments to specialty medical appointments due to language or cognitive ability	☐	Requests accompaniments to specialty medical appointments from MCM or other member of the care team	☐	Requests assistance with coordinating non-HIV related medical care	☐	No assistance needed with coordinating non-HIV related medical care
Comments (include referrals needed):								

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
HIV Medication Adherence	☐	Misses HIV medication doses daily	☐	Misses HIV medication doses weekly	☐	Misses HIV medication doses monthly, or on occasion	☐	Rarely or never misses a dose of HIV medications
	☐	Needs and is not currently enrolled in directly-observed therapy (DOT) or other intensive adherence support	☐	Needs and is enrolled in DOT or other intensive adherence support				
	☐	Experiences adverse side effects that consistently impact adherence to HIV medication	☐	Experiences adverse side effects that occasionally impact adherence to HIV medication	☐	Experiences side effects, but manages them with no impact on adherence to HIV medication	☐	No side effect concerns reported
	☐	Demonstrates no understanding of correlation between medication adherence and achieving/sustaining viral load suppression	☐	Demonstrates minimal understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression	☐	Demonstrates some understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression	☐	Demonstrates full understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression
	☐	Demonstrates no understanding of basic health or prescription information (e.g. drug resistance, drug interactions, etc.) due language barriers or cognitive function	☐	Needs assistance to understand health and prescription information due to language barrier or cognitive function	☐	Needs some assistance to understand health and prescription information	☐	Manages health and prescription information with no assistance
	☐	Not on ARVS against medical providers advice	☐	Is starting new ARV treatment regimen	☐	Not on ARVs in consultation/support from medical provider	☐	On ARVs and does not need additional assistance
Acuity Score:	☐	Cultural beliefs around medication prevent client from taking medication as prescribed by medical provider						

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
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
	☐	Is ineligible for Masshealth or other comprehensive insurance coverage (e.g. receives Health Safety Net)	☐	Client is uninsured and is awaiting enrollment (pending applications) in health insurance and/or other health benefits.				
Acuity Score:	☐	Has health insurance, HDAP and/or other benefits, but faces significant deductibles and/or medical co-pays.						
Comments (include referrals needed):								

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
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. negotiating condom use, PrEP use, partner's health status, etc.)	☐	Inconsistently communicates with sexual partner(s) around sex and sexual health needs (e.g. 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. negotiating condom use, PrEP use, partner's health status, etc.)	☐	Consistently communicates with sexual partner(s) around sex and sexual health needs (e.g. can negotiate condom use, PrEP use, partner's health status, etc.)
	☐	Has not disclosed HIV status to sexual partner(s) and does not plan to	☐	Sometimes discloses HIV status to sexual partner(s)	☐	Has not disclosed HIV status to sexual partner(s) and requests assistance to do so	☐	Always discloses HIV status to sexual partner(s)
	☐	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	☐	Reports sexual abstinence
	☐	Engages in transactional sex (e.g. for money, drugs, a place to stay, etc.)			☐	No disclosure of HIV status to sexual partner(s), but maintains a suppressed viral load	☐	Sexual partner(s) currently on PrEP
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):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Mental Health								
Current Mental Health Status	☐	Clinical diagnosis with no current mental health provider, no pending appointments, no desire and/or is resistant to seek treatment	☐	Clinical diagnosis or otherwise engaged with a mental health provider, but inconsistent with appointment attendance and/or treatment adherence	☐	Engaged with a mental health provider and is consistent with mental health treatment and/or appointments	☐	No indication of need for clinical mental health assessment
	☐	Currently awaiting treatment or appointment with mental health professional	☐	Referral to a new mental health professional in the past 6 months	☐	Receives MCM support to make and keep appointments with mental health professional	☐	No support needed to make and keep appointments with mental health professional
	☐	Consistent challenges with adherence to prescribed psychiatric medicines or treatment protocol	☐	Moderate challenges with adherence to prescribed psychiatric medicines or treatment protocol (missed doses more than a few times a month)	☐	Some challenges with adherence to prescribed psychiatric medicines or treatment protocol (occasional missed doses)	☐	No challenges with adherence to prescribed psychiatric medicines or treatment protocol
	☐	Indication of need for mental health support, clinical mental health assessment, and/or treatment and does not receive it	☐	Needs referral to or help accessing a culturally competent mental health provider (e.g. LGBT, linguistically appropriate, etc.)				
Acuity Score:	☐	Behavior relating to mental health status negatively impacts daily living, interactions with providers, and/or other social supports	☐	MCM or other member of the care team is an integral part of mental health support (e.g. regular check-ins etc.)				

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Alcohol and Drug Use								
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.
	☐	Intermittent engagement in drug and alcohol treatment (e.g. methadone, Suboxone, detox, etc.)	☐	Currently in residential or in-patient treatment for drug or alcohol use	☐	Currently receiving treatment for drug and alcohol use in an out-patient setting	☐	Receives sufficient supports around past substance use and/or no indication of need for additional support
	☐	Expresses a need or desire for drug or alcohol treatment (e.g. suboxone, methadone, detox, etc.) but has not yet received it	☐	Currently on a wait list to receive treatment for substance use disorder	☐	Currently attends 12-step groups (e.g. AA, NA, etc.)	☐	No current or past issues with drug or alcohol use
	☐	Imminent harm associated with substance use and no engagement/interest in harm reduction practices (e.g. sharing needles, narcan, etc.)	☐	Experiences harm associated with substance use with minimal ability to engage in harm reduction practices (e.g. sharing needles, narcan, etc.)	☐	Experiences harm associated with substance use with some ability to engage in harm reduction practices (e.g. sharing needles, narcan, etc.)	☐	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.)
Acuity Score:	☐	Ongoing alcohol use in the context of liver disease (e.g., HIV/HCV co-infection etc.)						

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Housing								
Current Housing Status	☐	Currently lives in shelter or any place not meant for human habitation (e.g. street, car, etc.)	☐	Has chronic challenges maintaining housing	☐	Lives in permanent or stable/safe housing but needs short term rent or utility assistance to remain housed	☐	Has stable and affordable housing that meets client's needs
	☐	Current living situation has major health or safety hazards or limits the client's ability to care for themselves	☐	Has difficulties managing ADLs (e.g. navigating stairs, showering) in current living situation	☐	Requests assistance from MCM to complete paperwork to maintain eligibility for housing subsidies		
	☐	Needs a referral to a supportive housing program and/or other in-home support services to remain safe in their home	☐	Currently resides in a supportive housing program	☐	Currently working with a MCM to maintain housing subsidy		
	☐	Is expected to be released from incarceration in the next 3 months or was released from incarceration within the last 6 months	☐	Lives in transitional/temporary housing or is doubled-up with no eminent loss of housing				
Acuity Score:	☐	Faces imminent eviction or loss of current housing	☐	Seeks to relocate in order to improve proximity to medical care, safety of housing environment, or access to services and supports	☐	Currently working with a housing search and advocacy case manager		
Comments (include referrals needed):								

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Legal								
Current Legal Status	☐	Has urgent legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, disability, eviction, or CORI	☐	Has pending legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, or disability (e.g. appeal for SSI)	☐	Needs assistance completing standard legal documents	☐	No current or recent legal issues
	☐	Has time-sensitive need to complete standard legal documents (e.g., will, guardianship, etc.)	☐	Needs linkage to services to address legal issues that impact ability to obtain needed services or benefits	☐	Currently working with a provider to address legal issues	☐	All desired legal documents are complete
	☐	Has issues relating to immigration status						
	☐	Currently on parole or probation						
Acuity Score:	☐	Has outstanding warrants						

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Relationships and Support Systems								
Support Systems and Relationships	☐	Reports no close relationships, family, or supportive relationships	☐	Reports feeling isolated or unsupported in current relationships (e.g. family and friends)	☐	Reports having a support system, but identified need for regular check-ins from MCM	☐	Has satisfactory social support
	☐	Has not disclosed HIV status to any members of social support system due to stigma, language barriers, cultural beliefs around HIV, etc. which directly impacts social interactions	☐	Has disclosed HIV status to some members of support system which moderately impacts social isolation	☐	Has disclosed HIV status to most members of support system	☐	Has disclosed HIV status to all members of support system
			☐	Relies on MCM, peer, or other program staff for social support				
Acuity Score:		Reports current or potential intimate partner violence and needs immediate intervention	☐	Has experienced intimate partner violence in the past that impacts current relationships, financial situation, housing status, etc.			☐	Past experience with intimate partner violence does not impact present care

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Income								
Current Income/Personal Finance Management Status	☐	Has no stable income or benefits established and no identified source of financial support	☐	Income inadequate to meet basic needs at the end of every month for 3 or more months in a 6 month period	☐	Income occasionally (no more than 2 times in a 6 month period) inadequate to meet basic needs	☐	Has steady income; manages all financial obligations
	☐	Requires but does not receive public benefits such as SSI/SSDI and has no pending applications			☐	Requests support with benefits applications or other means to increase and manage income	☐	Receives benefits and requires no assistance with maintaining benefits
	☐	Receives no public benefits such as SSI/SSDI and is ineligible to receive them due to immigration status						
	☐	Has immediate need for financial assistance to stay housed, maintain utilities, obtain food, or access medical care	☐	Expenses currently exceed income	☐	Requests assistance with budgeting		
	☐	Needs referral to representative payee	☐	Currently uses a representative payee			☐	No need for representative payee
Acuity Score:	☐	Application for benefits such as SSI/SSDI have been denied or are under appeal						

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Transportation				
Current Transportation Status	☐ Has limited or no access to transportation which impacts engagement in medical care, appointments, and other support services	☐ Has PT-1 or agency transport vouchers/passes but requires MCM assistance to complete applications and/or maintain eligibility	☐ Relies on PT-1 or agency supported transportation vouchers or family/friend	☐ Has consistent and reliable access to transportation with no need for agency support
Acuity Score:	☐ Has limited language or cognitive functioning that limits ability to coordinate transportation		☐ Occasionally needs assistance with transportation to stay engaged in medical care	
Comments (include referrals needed):				

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Nutrition								
Current Nutritional Status	☐	Relies on food pantries, soup kitchens or other community food resources on a weekly basis	☐	Relies on food pantries, soup kitchens, and other community food resources 1x per month or more	☐	Relies on food pantries, soup kitchens, or other community food resources less than 1x per month	☐	All nutritional needs are met and/or MCM assistance not needed to access food assistance
	☐	Needs immediate linkage to medical care due to acute problems related to low body weight, poor appetite, nausea, vomiting, or other urgent health issues that impact nutritional status	☐	Needs linkage to nutritional counseling to help manage chronic or non-urgent health issues that impact nutritional status	☐	Needs information about nutrition, and/or food preparation to improve or maintain health		
	☐	Needs a referral to obtain food related benefits (e.g. SNAP, WIC, etc.)	☐	Receives food related benefits (e.g. SNAP, WIC, etc.) to meet nutritional needs for self or household	☐	Needs assistance completing applications to maintain current food related benefits (e.g. SNAP, WIC, etc.)		
	☐	Is ineligible for food related benefits (e.g. SNAP, WIC, etc.)	☐	Relies on access to an agency food program in order to obtain adequate food				
Acuity Score:			☐	Needs and is prescribed nutritional supplements to maintain health (e.g. Ensure)				
Comments (include referrals needed):								

Summary & Signatures			
Acuity Score:		Level of Need	(1-14) Basic Need
Client Code:			
MCM Name:			
MCM Signature:			

Acknowlegements

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