Assessing and providing for needs of Ryan White clients with standardized, validated tools

Casey Messer, DHSc, PA-C, AAHIVS

Daisy Krakowiak (Wiebe), PhD, MPH

Ryan White Part A Palm Beach County

Outline

- Purpose of Client Assessment
- Previous Client Assessment
- Process to Improve Client Assessment
- Comprehensive Assessment Tool within the Ryan White System of Care
- Comprehensive Assessment Tool
  - Access, Linkage and Retention Assessment
  - Comprehensive Assessment Tool
  - Achieving Treatment Goals Assessment
- COVID-19 Assessment

Purpose of Client Assessment

- To comprehensively screen for and identify issues clients may be facing, including food insecurity, housing instability, mental health conditions, substance abuse, domestic violence, along with other life domains, in order to improve:
  - Client linkage to needed services
  - Retention to care by addressing these needs
  - Data on what services clients actually need for HIV Planning Council purposes, including for Priorities and Allocation process

Previous Client Assessment

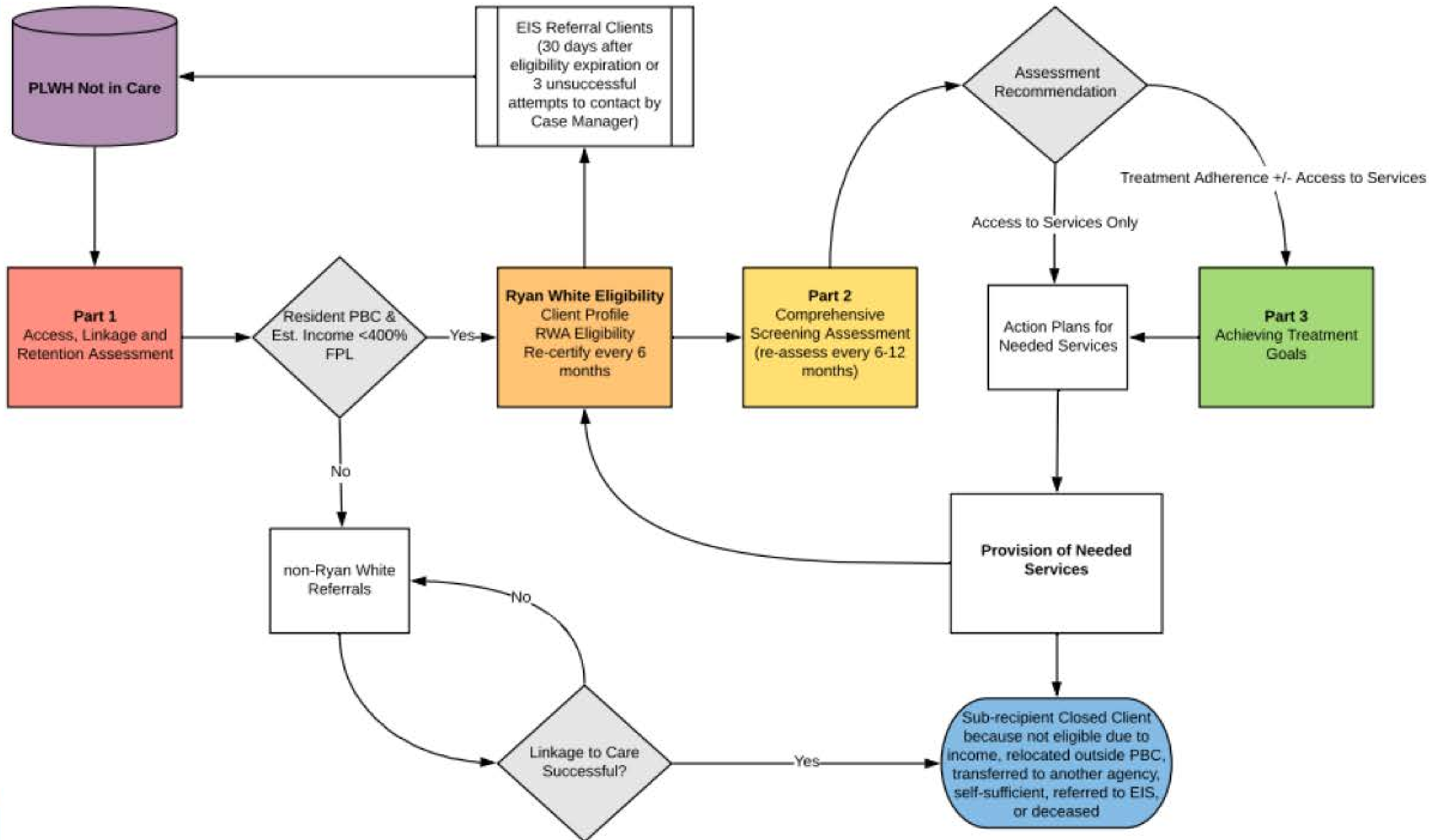
- Case Management Assessment in data management information system
- Responses to questions were based on self-report or by discretion of case manager
- Questions included:
  - Food Bank Needs: Yes/No
  - Depression: No Depression, Depressed, Severe Depression, Harm to Self or Others
  - Substance Abuse: Yes/No

Process to Improve Client Assessment

- Workgroup was convened in October 2019
- All sub-recipients of Ryan White Part A had a presence on the workgroup
- Meetings were called to brainstorm life domains that should be included and to review standardized assessment tools
- Proposed Ryan White System of Care Flow Chart was created and approved by the workgroup
- Comment for final feedback and review provided in January-February 2020
- Sent tool for programming into database management information system in May 2020
- Currently, this is in queue for a number of requested enhancements in our database management information system

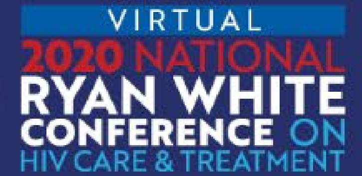
Life Domain List from Workgroup

- Depression
- Alcohol use
- Substance use
- Anxiety
- Trauma/adverse childhood events
- Dementia/cognitive deficit/HIV-associated neurocognitive disorders
- Adherence-medication
- Adherence-appointments
- Adherence-care plans
- Food security
- Housing stability
- Transportation access
- Health insurance/health care access
- Financial stability/self-sufficiency/income/budget
- Emotional/social support
- Stigma-internalized/experienced
- Cultural barriers/language barriers
- Medical needs/co-morbidities/oral/vision
- Social security
- Immigration
- Discrimination/harassment
- Education/knowledge/health literacy
- Domestic/intimate partner violence/safety
- Risky behaviors/survival sex/risk reduction
- Religion/personal belief system
- Trust of healthcare system/service providers
- Sexual and gender minority barriers
- Healthcare Fatigue
- Disabilities/activities of daily living/quality of life
- Time/competing priorities/external obligations
- Fear/confidentiality/information disclosure
- Human trafficking
- History of criminal/civil/required registration barriers
- Migrant/seasonal/continuity of care

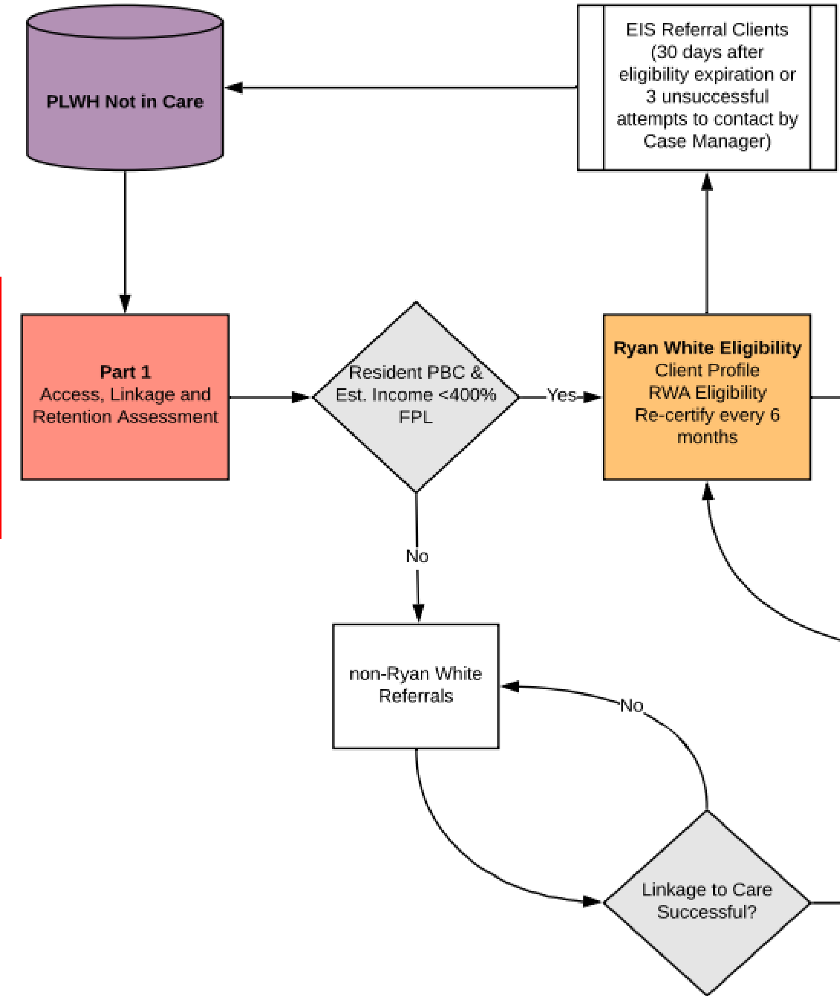


Proposed Ryan White Part A System of Care for Grant Year 2020
Palm Beach County
PLWH Not in Care
EIS Referral Clients (30 days after eligibility expiration or 3 unsuccessful attempts to contact by Case Manager)
Assessment Recommendation
Treatment Adherence +/- Access to Services
Access to Services Only
Part 1
Access, Linkage and Retention Assessment
Resident PBC & Est. Income <400% FPL
Yes
Ryan White Eligibility
Client Profile
RWA Eligibility
Re-certify every 6 months
Part 2
Comprehensive Screening Assessment (re-assess every 6-12 months)
Action Plans for Needed Services
Part 3
Achieving Treatment Goals
No
non-Ryan White Referrals
No
Provision of Needed Services
Linkage to Care Successful?
Yes
Sub-recipient Closed Client because not eligible due to income, relocated outside PBC, transferred to another agency, self-sufficient, referred to EIS, or deceased

Access, Linkage and/or Retention (ALR) Assessment



- Module to be completed among clients who are entering Ryan White care, whether returning or new clients



Client Assessment Tool Part I: ACCESS, LINKAGE AND/OR RETENTION (ALR) ASSESSMENT

The database will skip this if newly diagnosed within 30 days AND in care individuals (information from above)

1. Have you ever had trouble with getting into or staying in HIV care and treatment because of … (read each one and ask if it is a current, recent barrier, or past barrier). (Of all current barriers selected) Please rank current items in order of their influence on your access, linkage and/or retention in HIV care and treatment (with 1 having the most influence on access, linkage and/or retention).

	Not a Barrier	Recent Barrier (within 2 years)	Current Barrier	Current Barrier Ranking
Food Insecurity (not enough food)				
Housing Instability (homeless, staying somewhere temporarily or name not on lease)				
Financial Insecurity (not enough to money to cover expenses)				
Unemployment				
Lack of Transportation				
Location of Services (too far to get services)				
Lack of Health Insurance				
Lack of Health Education and Knowledge				
Illiteracy (unable to read and/or write)				
Depression				
Anxiety				
Other Mental Illness				
Trauma/Adverse Childhood Events				
Alcohol Use				
Substance Use				
Other Medical Conditions				
Disabilities (physical or mental)				

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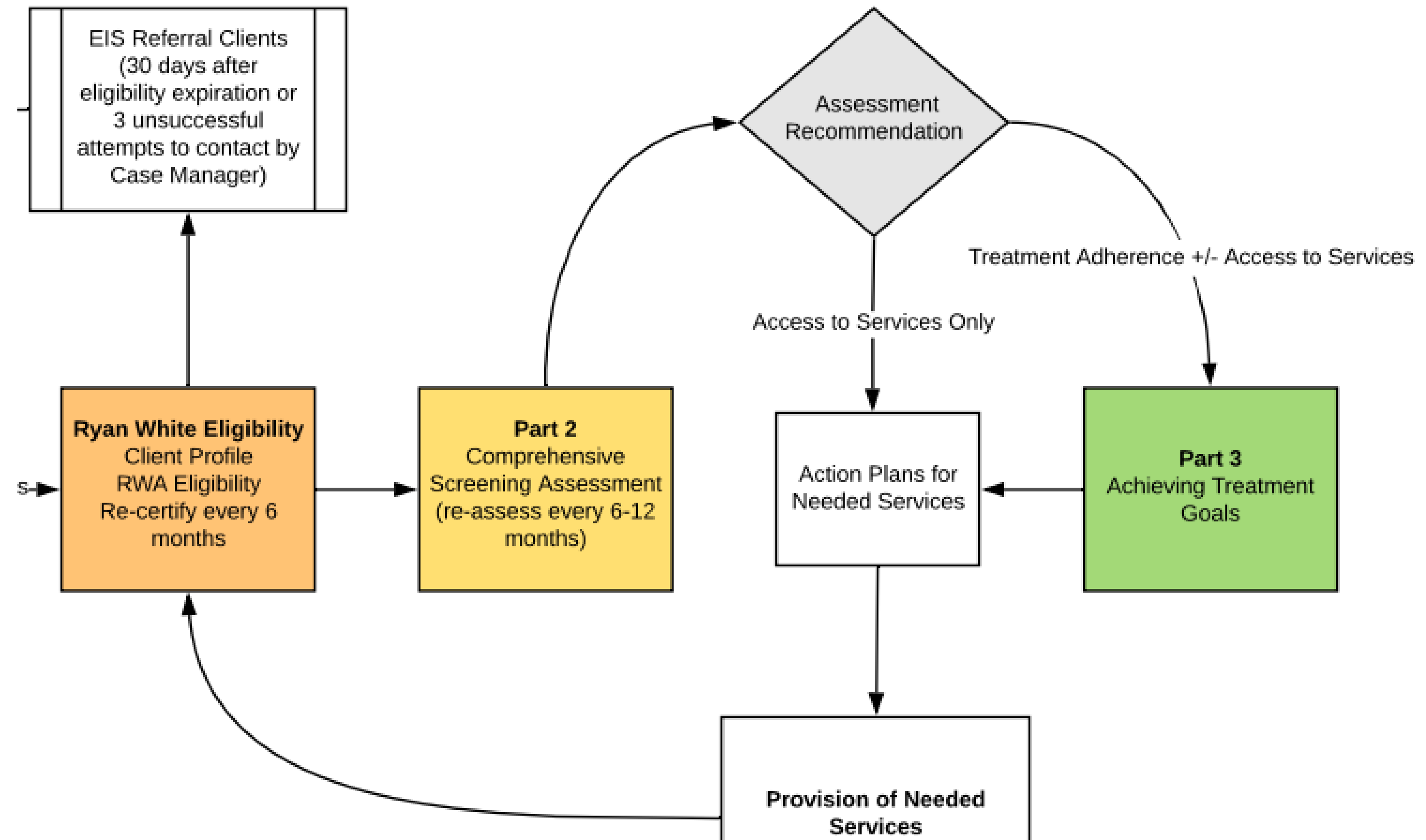
	Not a Barrier	Recent Barrier (within 2 years)	Current Barrier	Current Barrier Ranking
Domestic Violence (abuse by a partner)				
Human Trafficking (forced to work, incl. sex work)				
Legal/Criminal/Civil Issues				
Immigration Status (no status or other)				
Relocations/Moving				
Incarceration (jail, prison)				
Cultural Barriers				
Language Barriers (you speak another language more fluently)				
Racial Barriers				
Gender or Sexual Orientation Barriers				
Fear of having HIV (fear about health/future and coping with denial)				
HIV Stigma Internalized (own negative beliefs, feelings and attitudes)				
HIV Stigma Experienced (own experienced negative beliefs, feelings and attitudes)				
Discrimination/Harassment				
Not Wanting to Disclose Status to Others				
Lack of Trust of Healthcare Providers				
Other Competing Priorities and Obligations (lack of time, caregiving responsibilities, lack of childcare)				
Healthcare Fatigue (tired of going to the doctor)				
Lack of Social Support (no friends or family to help out or talk to)				

Comprehensive Screening Assessment

- Module to be completed among all Ryan White clients, both current or new clients
- Standardized tools used when available; if not available, questions were sourced from other jurisdictions or were created
- For adherence, questions from a peer-reviewed published article were used (details on next slide)



AIDS Behav. 2018 Mar;22(3):948-960. doi: 10.1007/s10461-017-1772-z.

Estimating HIV Medication Adherence and Persistence: Two Instruments for Clinical and Research Use

David A Wohl[1], A T Panter[2], Christine Kirby[3], Brooke E Magnus[4], Michael G Hudgens[5], Andrew G Allmon[5], Katie R Mollan[6]

Affiliations + expand

PMID: 28447269 DOI: 10.1007/s10461-017-1772-z

Using 10-item instrument for routing individuals to treatment adherence in the Comprehensive Assessment Tool

Using 30-item instrument for motivational interviewing purposes for actual treatment adherence

Lasso-10 marginal reliability = .77	Response options	Item origin	Lasso prediction rank
Items			
1. In the next 30 days, how confident are you that you can continue with the HIV medicines even when you are feeling discouraged about your health?	Scale ranging from 0 (''cannot do at all'') to 10 (''completely certain can do'')	ASES	1
2. In the past month, have you missed taking your HIV medications because you forgot?	No/yes	ABQ	3
3. I find it easy to take my HIV meds with the other medication I take	(a) Strongly disagree, (b) Disagree, (c) Neither disagree nor agree, (d) Agree, (e) Strongly agree, (f) Does not apply	New	7
4. I have reduced my illegal drug use because I am taking my HIV medications		New	8
5. If I could stop taking illegal drugs, I would be able to take my HIV medications regularly		New	2
6. People often make me feel badly about being HIV+	(1) Strongly disagree, (2) Disagree, (3) Neither disagree nor agree, (4) Agree, (5) Strongly agree	New	4
7. Taking pills everyday is not a big deal		New	5
8. It is hard for me to keep track of taking my HIV meds		New	6
9. Taking my HIV medications gives me hope		New	9
10. I can count on my family and friends to make sure I am taking my HIV meds consistently		New	10

The 10-item tool was incorporated into the Comprehensive Tool under appropriate categories, mostly under Adherence, but also under the Mental Health Module

List of Standardized Tools Used

- Food Insecurity
  - U.S. Adult Food Security Survey Module
- Housing Instability
  - VI-SPDAT
- Transportation and Social Support
  - PRAPARE
- Activities of Daily Living
  - Lawton Instrumental Activities of Daily Living Scale (IADL)
  - Physical Self-Maintenance Scale
- Mental Health and Substance Abuse
  - PHQ-2 + self harm question, if positive then PHQ-9
  - GAD-2, if positive then GAD-7
  - PC-PTSD-5
  - AUDIT-C
  - TICS
  - DAST-10 PLUS
  - ACES (Adverse Childhood Events)
- Domestic Violence
  - HARK
  - HITS – adding only sexual violence question to complement HARK question
- Human Trafficking
  - Adult Human Trafficking Screening Tool and Guide

U.S. ADULT FOOD SECURITY SURVEY MODULE:
THREE-STAGE DESIGN, WITH SCREENERS
Economic Research Service, USDA
September 2012

https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement

FOOD SECURITY – USDA
EVERY 12 MONTHS

Now I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months – that is since (name of current month).
[If one person in household, use "I" in parentheticals, otherwise, use "we."]

HH1. Which of these statements best describes the food eaten in your household in the last 30 days: —enough of the kinds of food (I/we) want to eat; —enough, but not always the kinds of food (I/we) want; —sometimes not enough to eat; or, —often not enough to eat? *

- Enough of the kinds of food we want to eat (Skip to Economic/Housing Stability Section)
- Enough but not always the kinds of food we want
- Sometimes not enough to eat
- Often not enough to eat
- Don't know or refused

Continue on for those who answered in the affirmative or don't know/refused (i.e. answered any of the above except the first option)

HH2. "(I/we) worried whether (my/our) food would run out before (I/we) got money to buy more." Was that often true, sometimes true, or never true for (you/your household) in the last 30 days?*

- Often true (1)
- Sometimes true (1)
- Never true (0)
- Don't know or refused (0)

HH3. "The food (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 30 days?*

- Often true (1)
- Sometimes true (1)
- Never true (0)
- Don't know or refused (0)

HH4. "(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 30 days?*

- Often true (1)
- Sometimes true (1)
- Never true (0)
- Don't know or refused (0)

If affirmative response ("often true" or "sometimes true" selected for any of the above 3 questions), then continue to AD1-AD4

https://www.ers.usda.gov/media/8279/ad2012.pdf. Used 30 day reference period per instructions on the screening tool.

AD1. In the last 30 days, did (you or other members in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?*

- Yes (1)
- No (0) (skip next question)
- Don't know or refused (0) (skip next question)

AD1a. (If yes above, ask) In the last 30 days, how many days did this happen?*

___ days (1-30 range possible) (1)

- Don't know or refused (0)

AD2. In the last 30 days, did you ever eat less than you felt you should because there wasn't enough money for food?*

- Yes (1)
- No (0)
- Don't know or refused (0)

AD3. In the last 30 days, were you ever hungry but didn't eat because there wasn't enough money for food?*

- Yes (1)
- No (0)
- Don't know or refused (0)

AD4. In the last 30 days, did you lose weight because there wasn't enough money for food?*

- Yes (1)
- No (0)
- Don't know or refused (0)

If affirmative response (yes to AD1-AD4 questions above), ask the last two questions:

AD5. In the last 30 days, did you or other members in your household ever not eat for a whole day because there wasn't enough money for food?*

- Yes (1)
- No (0)
- Don't know or refused (0)

AD5a. (If yes above, ask): In the last 30 days, how many days did this happen?*

___ days (1-30 range possible)

- Don't know or refused

Action Plan:

(For those who had a score of 0 in above 10 items, excludes HH1): Household is food secure. No assistance for food necessary. Rescreen in 6 months or at case manager's discretion.

(For those who had a score of 1-2 in above 10 items, excludes HH1): Household has marginal food security. Some assistance may be needed. Rescreen in 6 months or at case manager's discretion.

(For those who had a score of 3-5 in above 10 items, excludes HH1): Household has low food security. Assistance is needed.

(For those who had a score of 6-10 in above 10 items, excludes HH1): Household has very low food security. Assistance is needed.

(For those 60+ years or older):

Refer client to Division of Senior Services (DOSS) for home-delivered meals and congregate meal site transportation in addition to Ryan White food assistance

Build in information for other food assistance programs based on eligibility (income, children in home, etc.)

For those with a score of 1 or higher:

1. Did client apply or is enrolled in any of the following food assistance programs?* *Check all that apply.*
   - Supplemental Nutrition Assistance Program (SNAP)
   - Department of Senior Services (DOSS) Home Delivered Meals
   - Department of Senior Services (DOSS) Congregate Meal Sites
   - Women, Infants & Children (WIC) Program
   - Food4OurKids
   - Free or reduced lunch at school for kids
   - Food Banks or Pantries
   - None of the above

2. Is client eligible for food cards or food assistance from Ryan White Part A, based on current policy and procedures manual?
   - Yes
   - No

   (If yes):
3. Did client receive food cards or food assistance from Ryan White Part A?*
   - Yes
   - No

(For those who received food cards or food assistance and income rose from eligibility assessment):

4. Now with an increase in income, would you be able to buy enough food to cover your and your family's needs without food cards or food assistance?*
   - Yes (Discontinue food card or food assistance)
   - Unsure (Continue to provide food cards or food assistance)
   - No (Continue to provide food cards or food assistance)

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.01

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1 (800) 355-0420 info@orgcode.com www.orgcode.com

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

IMPLEMENTATION AND ACTION TOOLKIT

MARCH 2019

PRAPARE Implementation and Action Toolkit

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients' social determinants of health, transform care to meet the needs of their patients, and ultimately improve health and reduce costs. PRAPARE is both a standardized patient risk assessment tool as well as a process and collection of resources to identify and act on the social determinants of health.

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or from getting my medications
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a week		1 or 2 times a week
	3 to 5 times a week		5 or more times a week
	I choose not to answer this question		

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National HIV Curriculum

Sign In or Register

Antiretroviral Medications | Course Modules | Question Bank | Clinical Challenges | Tools & Calculators | Clinical Consultation | HIV Resources

Mental Disorders Screening

- Dementia: IHDS
- Anxiety: GAD-2
- Anxiety: GAD-7
- **Depression: PHQ-2**
- Depression: PHQ-9
- PTSD: PC-PTSD-5

Substance Use Screening

- Alcohol: AUDIT-C
- Alcohol: CAGE
- CAGE-AID

Patient Health Questionnaire-2 (PHQ-2)

Share

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is to screen for depression in a "first-step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Over the **last 2 weeks**, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	+1	+2	+3
2. Feeling down, depressed or hopeless	0	+1	+2	+3

PHQ-2 score obtained by adding score for each question (total points)

https://www.hiv.uw.edu/page/

BMC Fam Pract. 2007; 8: 49.
Published online 2007 Aug 29. doi: 10.1186/1471-2296-8-49
PMCID: PMC2034562
PMID: 17727730

The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice

Hardip Sohal,[1] Sandra Eldridge,[1] and Gene Feder[1]

Comparative Study > Fam Med. Jul-Aug 1998;30(7):508-12.

HITS: a short domestic violence screening tool for use in a family practice setting

K M Sherin [1], J M Sinacore, X Q Li, R E Zitter, A Shakil

Affiliations + expand

PMID: 9669164

ADMINISTRATION FOR CHILDREN & FAMILIES
Office on Trafficking in Persons

NATIONAL HUMAN TRAFFICKING TRAINING AND TECHNICAL ASSISTANCE CENTER

Adult Human Trafficking Screening Tool and Guide

A guide for training public health, behavioral health, health care, and social work professionals who wish to use trauma-informed and survivor-informed practices to assess adult clients and patients for human trafficking victimization or risk of potential trafficking victimization.

January 2018

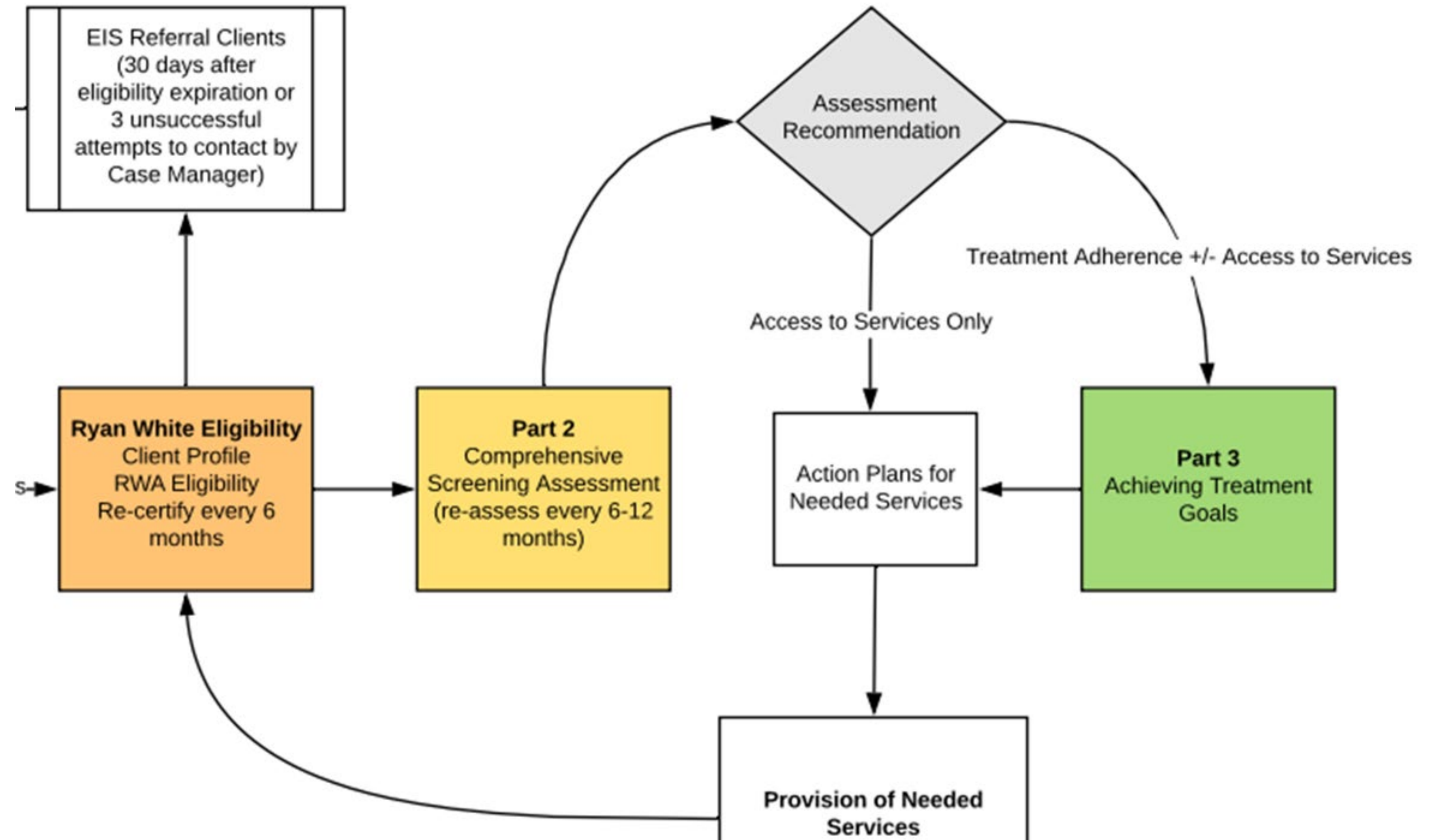
Table 2. Adult Human Trafficking Screening Tool

Adult Human Trafficking Screening Tool		
This screening tool is part of a guide and is to be used with the "Adult Human Trafficking Screening Tool and Guide." It has been provided as part of a screening toolkit to a professional who is trained to administer it. For information about this screening tool or the recommended training for its application, please contact the National Human Trafficking Training and Technical Assistance Center (NHTTAC) at info@nhttac.org or 844–648–8822.		
Question	Respondent Answers	Notes
1. Sometimes lies are used to trick people into accepting a job that doesn't exist, and they get trapped in a job or situation they never wanted. Have you ever experienced this, or are you in a situation where you think this could happen?	Yes No Declined to Answer Don't Know	
2. Sometimes people make efforts to repay a person who provided them with transportation, a place to stay, money, or something else they needed. The person they owe money to may require them to do things if they have difficulty paying because of the debt. Have you ever experienced this, or are you in a situation where you think this could happen?	Yes No Declined to Answer Don't Know	
3. Sometimes people do unfair, unsafe, or even dangerous work or stay in dangerous situation because if they don't, someone might hurt them or someone they love. Have you ever experienced this, or are you in a situation where you think this could happen?	Yes No Declined to Answer Don't Know	

https://www.acf.hhs.gov/otip/resource/nhhtacadultscreening

Achieving Treatment Goals

- Module to be completed among clients who screen positive for needing treatment adherence counseling in the Comprehensive Assessment



ACHIEVING TREATMENT GOALS (ATG) ASSESSMENT

COMPLETED WITH ITEMS IDENTIFIED FOLLOWED UP WITH ACTION PLANS. EVERY 12 MONTHS.

1. Have you had trouble achieving your HIV treatment goals (viral suppression) because of … (read each one and ask if it is a current or recent barrier):*

	Not a Barrier	Recent Barrier (within 2 years)	Current Barrier	Current Barrier Ranking
Food Insecurity (not enough food)				
Housing Instability (homeless, staying somewhere temporarily or name not on lease)				
Financial Insecurity (not enough to money to cover expenses)				
Unemployment				
Lack of Transportation				
Location of Services (too far to get services)				
Lack of Health Insurance				
Lack of Health Education and Knowledge				
Illiteracy (unable to read and/or write)				
Depression				
Anxiety				
Other Mental Illness				
Trauma/Adverse Childhood Events				
Alcohol Use				
Substance Use				
Other Medical Conditions				
Disabilities (physical or mental)				

	Not a Barrier	Recent Barrier (within 2 years)	Current Barrier	Current Barrier Ranking
Domestic Violence (abuse by a partner)				
Human Trafficking (forced to work, incl. sex work)				
Legal/Criminal/Civil Issues				
Immigration Status (no status or other)				
Relocations/Moving				
Incarceration (jail, prison)				
Cultural Barriers				
Language Barriers (you speak another language more fluently)				
Racial Barriers				
Gender or Sexual Orientation Barriers				
Fear of having HIV (fear about health/future and coping with denial)				
HIV Stigma Internalized (own negative beliefs, feelings and attitudes)				
HIV Stigma Experienced (own experienced negative beliefs, feelings and attitudes)				
Discrimination/Harassment				
Not Wanting to Disclose Status to Others				
Lack of Trust of Healthcare Providers				
Other Competing Priorities and Obligations (lack of time, caregiving responsibilities, lack of childcare)				
Healthcare Fatigue (tired of going to the doctor)				

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PMID: 28447269 DOI: 10.1007/s10461-017-1772-z

Using 10-item instrument for routing individuals to treatment adherence in the Comprehensive Assessment Tool

Using 30-item instrument for motivational interviewing purposes for actual treatment adherence

IRT-30 scale marginal reliability = .90
Items
In the next 30 days, how confident are you that you can: (11-point scale from 0 [cannot do at all] to 10 [completely certain can do])
1. Stick to taking your HIV medicines even when side effects begin to interfere with daily activities?
2. Integrate taking your HIV medicines into your daily routine?
3. Integrate taking your HIV medicines into your daily routine even if it means taking them around other people who don't know you are HIV-infected?
4. Stick to your HIV medicine schedule even when your daily routine is disrupted?
5. Stick to your HIV medicine schedule when you aren't feeling well?
6. Stick to your HIV medicine schedule when it means changing your eating habits?
7. Continue with taking your HIV medicines even if doing so interferes with your daily activities?
8. Continue with the HIV medicines plan your physician prescribed even if your T-cells drop significantly in the next 3 months?
9. Continue with the HIV medicines even when you are feeling discouraged about your health?
10. Continue with taking your HIV medicines even when getting to your clinic appointments is a major hassle?
11. Continue with taking your HIV medicines even when people close to you tell you that they don't think that it is doing any good?
12. Continue taking your HIV medicines even if it doesn't make you feel better?

In the past month, have you missed taking your medications because you: *Please check one box for each question (No/Yes)*
13. Forgot?
14. Didn't get prescription; ran out of pills?
15. Busy doing other things (e.g., working, trying to survive, getting food?)?
16. Having to wake up very early to go to work and no time to eat?
17. Was too busy at work, school, or home?
18. Didn't want to bring my pills to social activities (restaurant, friend's home)?
19. Wanted to have a free day without pills?
20. Lost track of time?
21. Didn't have a good night sleep?

5-point Likert scoring for agreement*
22. I have physical health problems that make it hard for me to take my HIV meds regularly
23. I have mental health problems that make it hard for me to take my HIV meds regularly
24. It is hard for me to keep track of my HIV meds
25. It's hard for me to take my HIV meds when I am taking other types of medications
26. HIV medications interfere with my ability to have fun
27. I feel pretty healthy when I take my HIV medications
28. When I take my HIV medications, I feel better about myself
29. Taking my HIV medications gives me hope
30. Taking HIV medication reminds me to take care of my personal health

Patient Satisfaction Survey for HIV Ambulatory Care

New York State Department of Health
AIDS Institute

http://nationalqualitycenter.org/resources/patient-satisfaction-survey-for-hiv-ambulatory-care-pdf/

This satisfaction survey is unique in that it was created specifically for HIV ambulatory care. To this end, feedback was solicited from HIV patients and providers across New York State throughout the development process. In addition, the survey underwent a rigorous validation process to help make sure that each item measures the aspect of patient satisfaction intended.

The patient satisfaction survey consists of a core survey, which covers the basic HIV medical visit, and five modules, which address case management, outpatient substance use services, mental health services, women's health services, and Medicaid managed care. While the core survey is applicable to all HIV-positive patients in your program, the additional modules are designed for specific services relevant to HIV care. You may administer any combination of the modules, or none at all, based on whether your clinic offers the services and whether you're interested in collecting the data. Both the core survey and all five modules are available in English and Spanish.

<u>International HIV Dementia Scale (IHDS)</u>

FOR THOSE WHO ARE 65 YEARS AND OLDER OR DISABLED IN MEDICAL CASE MANAGEMENT EVERY 12 MONTHS OR MORE FREQUENTLY PER CASE MANAGER'S DISCRETION

Use this link to access the link: https://www.hiv.uw.edu/page/mental-health-screening/ihds

Number of taps in non-dominant hand in 5 seconds ________ (0-25 range possible)

Number of hand sequences in 10 seconds ________ (0-10 range possible)

Memory recall score _______ (0-4 range possible)

Action Plan:
(For those who had a score of 11+):
Client has screened negative for dementia using the International HIV Dementia Scale (IHDS) (repeat screening in 24 months or earlier per case manager's discretion).

(For those who had a score of 0-10):
Client has screened positive for dementia using the International HIV Dementia Scale (IHDS). Encourage referral to neurologist for further investigation (send along documentation so clinician understands to evaluate dementia further).

COVID-19 Assessment

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HIV CARE & TREATMENT

COVID-19 Individual Needs Assessment

This individual needs assessment will help us better understand the effect COVID-19 is having on individuals, families, and our communities, and allow us to target resources and support to assist in recovery.

Please consider all ways you have been affected by COVID-19, including personal COVID-19 illness or caring for someone with COVID-19, closure of businesses and schools, lack of childcare, safer/stay at home orders, quarantine/isolation orders, etc.

Since March 1, 2020 have you experienced any of the following because of COVID-19:

	No	Yes	Ranking
Food insecurity (not enough food for household)			
Housing instability (experiencing homelessness, staying somewhere temporarily, not able to pay rent/mortgage, threat of eviction/foreclosure, etc.)			
Financial insecurity (not enough money to cover expenses other than food or housing, such as utilities, transportation, credit cards, loans, other bills)			
Unemployment or reduced employment (reduced income due to loss of employment, reduction of hours, reduction in take home pay, laid off or furloughed, or lack of childcare due to school or daycare closures and unable to work or working less)			
Increased out-of-pocket medical expenses (due to illness, prescription drug costs, loss of health insurance coverage, etc.)			
Mental/behavioral health concerns (due to anxiety, depression, feelings of hopelessness, social isolation, lack of social support, etc.)			
Increase in or high use of alcohol or drugs			
Domestic violence (assault or abuse by a partner or family member on anyone in the household)			

For items that you answered "Yes" above, please rank in order of most concerning to least concerning to your safety, health, and financial security. Most concerning=1, next most concerning=2, etc.

Since March 1, 2020 have any of the following circumstances affected your ability to keep you and/or your family safe, healthy, and financially secure:

	No	Yes	Ranking
Lack of internet and/or devices to access information, applications for assistance, and healthcare (i.e. telehealth)			
Lack of or inadequate supply of face coverings or masks for trips outside the home, work or school for yourself			
Lack of or inadequate supply of face coverings or masks for trips outside the home, work or school for those in your household			
Lack of ability to wash face coverings every time when used in public or ability to continue getting disposable masks			
Lack of soap and running water or hand sanitizer for personal hygiene at home, at work, or at school			
Lack of ability to adhere to social distancing guidelines in public, at work or at school. That is, keeping at least six feet between yourself and others who are not in your household			
Lack of ability for others in your household to be able to adhere to social distancing guidelines in public, at work or at school			
Lack of ability to quarantine sick or symptomatic individuals, or isolate persons who have had contact with someone who has tested positive for COVID-19 in your home away from other members of your household			
Lack of access to COVID-19 testing through a healthcare provider or public testing sites throughout the county			

For items that you answered "Yes" above, please rank in order of most concerning to least concerning to your safety, health, and financial security. Most concerning=1, next most concerning=2, etc.

Contact Information

Casey Messer, DHSc, PA-C, AAHIVS
Program Manager, Ryan White
Palm Beach County Community Services
810 Datura Street
West Palm Beach, FL 33401

Email: cmesser@pbcgov.org
Phone: (561) 355-4730
E-Fax: (561) 242-7609
Pronouns: He/Him/His

Daisy Wiebe, PhD, MPH
Quality Management Clinician, Ryan White
Palm Beach County Community Services
810 Datura Street
West Palm Beach, FL 33401

Email: dwiebe@pbcgov.org
Phone: (561) 355-4760
Published under: Krakowiak
Pronouns: She/Her/Hers