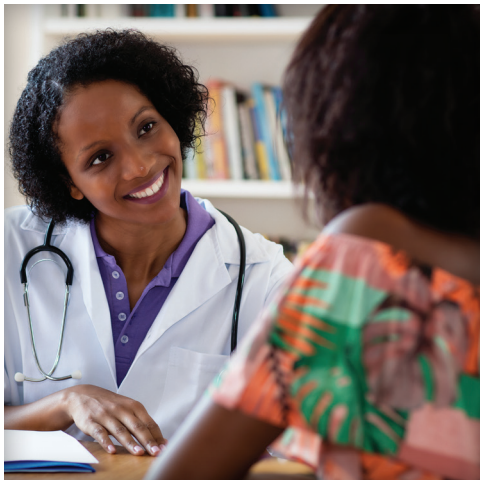
CARE AND TREATMENT INTERVENTIONS: Evaluation Tools



Enhanced Patient Navigation for Women of Color Living with HIV

DISSEMINATION OF
EVIDENCE-INFORMED
INTERVENTIONS

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Executive Summary

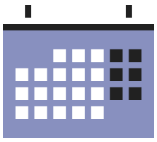
Purpose of This Manual

This manual is designed to share best practices for implementing an enhanced patient navigation intervention for women of color with HIV. It can be used by HIV primary care clinical providers, coordinators, and clinics.

Intervention Description

The Enhanced Patient Navigation for Women of Color with HIV intervention uses *patient navigators*, who are non-medical staff in clinical settings, to reduce barriers to health care and optimize care. The intervention combines client support and education activities to improve client autonomy as a means to retain women of color (WoC) in HIV primary care to increase retention in care and adherence to medication to achieve viral suppression.

The intervention focuses on providing services tailored to each individual client. These enhanced patient navigation services typically include:



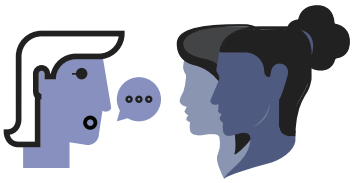
Appointment scheduling

Transportation assistance

Accompaniment to medical appointments

Assistance in completing medical and social service referrals

Health education



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 clients and build clinic-client trust;
- Address client care and service priorities first (putting the client priorities ahead of service provider priorities);
- Increase client health literacy; and
- Support clients in developing self-efficacy to manage their care (as they move towards viral suppression).

Rationale and Need

The intervention focuses on WoC who are loosely or not involved in care. People of color are less likely to be engaged in HIV care than other groups, and women are less consistently engaged in HIV care than men. In addition, WoC have lower retention in care and higher HIV/AIDS-related morbidity.[1, 2, 3]

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[1] CDC. *HIV in the United States: The stages of care*. Atlanta: CDC. 2012.

[2] Meditz AL, MaWhinney S, Allshouse A, et al. Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection. T*he Journal of Infectious Diseases.* 2011;203(4):442–451.

[3] Beer L, Mattson CL, Bradley H, Skarbinski J, Medical Monitoring P. Understanding Cross-Sectional Racial, Ethnic, and Gender Disparities in Antiretroviral Use and Viral Suppression Among HIV Patients in the United States. *Medicine (Baltimore).* 2016;95(13):e3171–e3171.



Intervention Summary

Essential Pre-Implementation Activities

- Hire patient navigators (PNs) with strong interpersonal skills; ideally, find PNs who are from the community or have experience within the medical system.
- Establish a supervision system for PNs within the HIV care team.
- Train PNs on the intervention, educational materials, content related to HIV, how to engage hard to reach clients, trauma-informed care, and other relevant topics.
- Prepare logistics, including granting access to the electronic medical record (EMR) to document client activities, and scheduling administrative and clinical supervision.
- Secure space and technology for intervention activities, such as private meeting space, personal computers, and cell phones.
- Strengthen and formalize relationships with community partners.
- Engage PNs as part of the clinical team and introduce and include them in staff meetings.
- Run out-of-care lists at the clinic to identify potential participants to approach about the intervention.

Essential Patient Navigator Tasks

- Conducting outreach to, finding, and re-engaging WoC lost to care or newly diagnosed.
- Conducting interactive education sessions on topics related to HIV.
- Supporting adherence to HIV care and treatment.
- Accompanying clients to medical services.
- Documenting services provided to the client in the medical record.
- Educating patients about medical and social services.
- Coaching on life skills.
- Assisting clients with transportation.
- Holding regular meetings with administrative and clinical supervisor.

Evaluation of the Enhanced Patient Navigation for Women of Color with HIV Intervention

Over the course of this project, a **total of 332 cis and transgender women received patient navigation services across the three sites from 2016–2019:**

76.3% of clients were linked to care in 90 days.

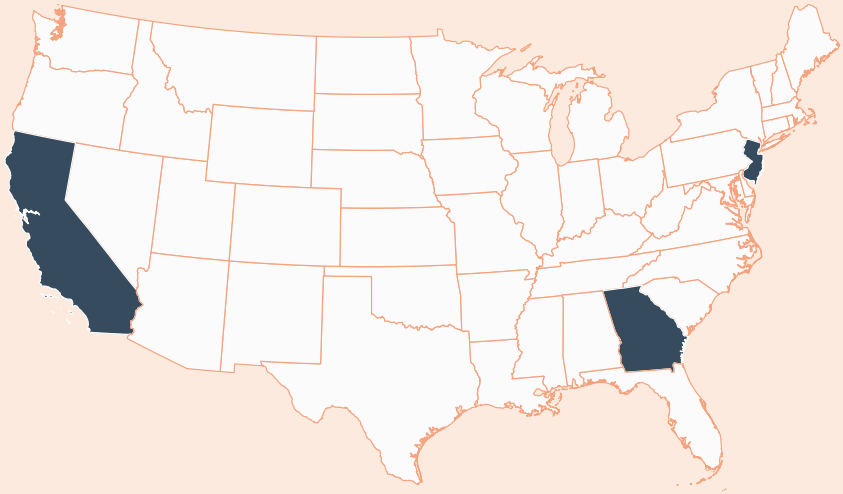
74.5% were retained in care (defined as 2 medical appointments at least 90 days apart in 12 months).

64.3% achieved viral suppression after 12 months.

INTRODUCTION

From 2016 to 2019, three clinics (Grady Health System, Infectious Disease Program in Atlanta, GA; Keck School of Medicine at University of Southern California in Los Angeles, CA; and Newark Beth Israel Medical Center in Newark, NJ) were funded through a grant made available to AIDS United through the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part F, Special Projects of National Significance. The funding was part of a project called the "Dissemination of Evidence-Informed Interventions (DEII) initiative," which used an implementation science framework to replicate models of care in diverse geographical and organizational settings.

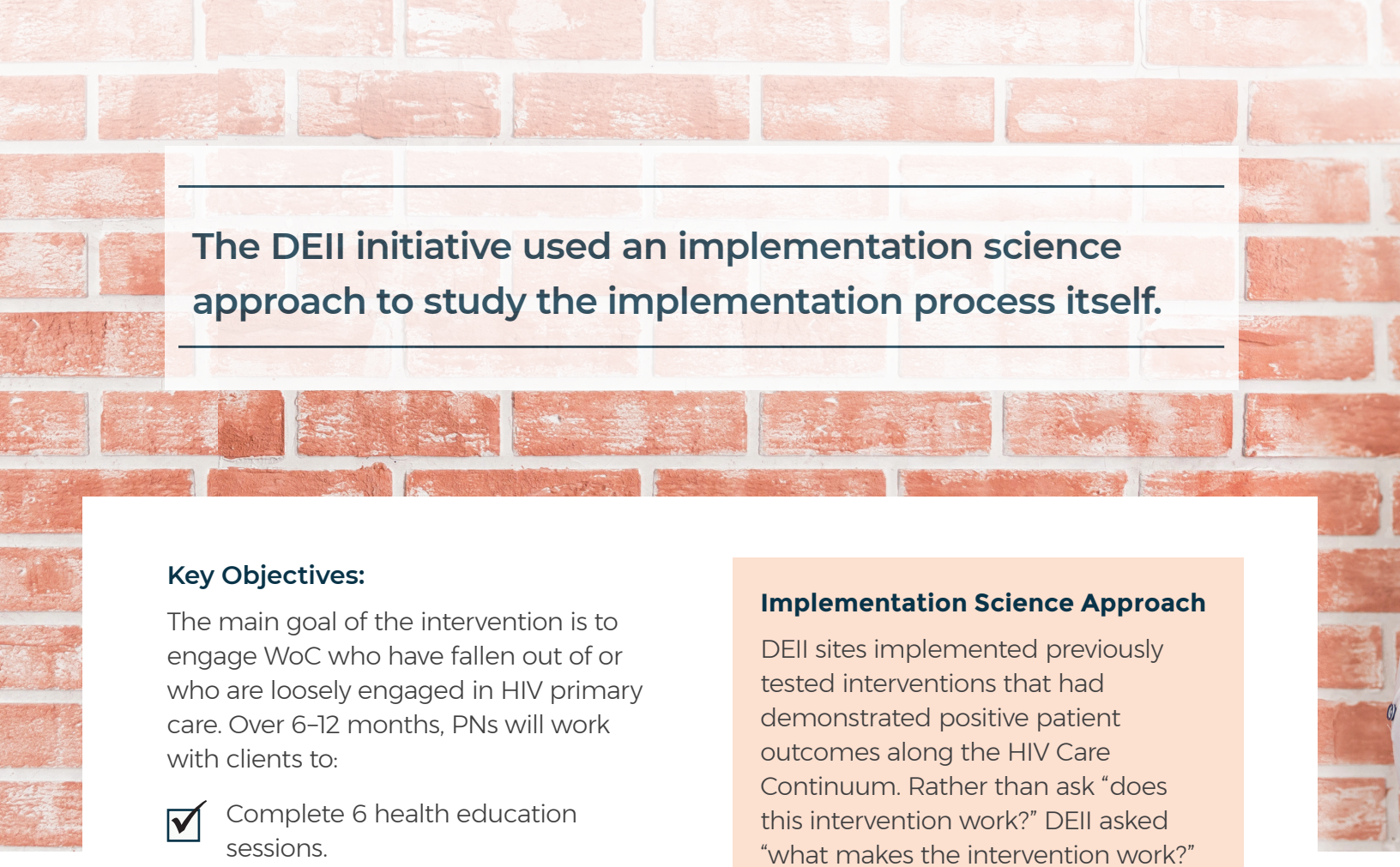
Three Ryan White HIV/AIDS Program providers implemented the Patient Navigation intervention through the Dissemination of Evidence-Informed Interventions project.



Grady Health System, Infectious Disease Program (Atlanta, GA)

Keck School of Medicine at University of Southern California (Los Angeles, CA)

Newark Beth Israel Medical Center, a part of the RWJBarnabas Health System (Newark, NJ)



The DEII initiative used an implementation science approach to study the implementation process itself.

Key Objectives:

The main goal of the intervention is to engage WoC who have fallen out of or who are loosely engaged in HIV primary care. Over 6–12 months, PNs will work with clients to:

- ☑ Complete 6 health education sessions.
- ☑ Retain client in care by attending one medical visit in each 6 month time period with 60 days in between over the course of 12 months.
- ☑ Reduce acuity score from baseline acuity score (stored in the patient study record).

Implementation Science Approach

DEII sites implemented previously tested interventions that had demonstrated positive patient outcomes along the HIV Care Continuum. Rather than ask "does this intervention work?" DEII asked "what makes the intervention work?" To answer this question, the DEII initiative used an implementation science approach to study the implementation process itself. DEII evaluators used qualitative and quantitative instruments such as key informant interviews, patient encounter forms, and site visit reports to document key factors for successful implementation, challenges encountered by the interventionists, and adaptations needed for successful implementation. This manual reflects findings from implementation science data collected throughout the initiative.

At-a-Glance: Enhanced Patient Navigation for Women of Color with HIV

Main challenge: Reaching, linking, and retaining people with HIV, including Women of Color (WoC) in health care, are federal priorities aligning with the "Ending the HIV Epidemic: A Plan for America" initiative,[4] and are integral steps of the HIV Care Continuum due to their importance in increasing viral load suppression. Lower retention in HIV care is associated with client-level factors including: being female; ethnic and racial minority status; having minimal social support; having competing caregiver responsibilities; having mental health or substance use disorders; lack of understanding regarding health insurance; discomfort in talking to health care providers; stigma; and negative perceptions of the health care system.[5, 6, 7, 8, 9] Linkage and re-engagement in care leads to improved health outcomes and retention in care is an independent predictor of survival.[10, 11, 12]

Focus population: Cis or transgender women of color (referred to throughout this manual as WoC) with HIV who are 18 years or older, 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 the past 12 months); OR are not virally suppressed (>200 copies/ml); OR have multiple co-morbidities that threaten their ability to be retained in care (at the discretion of the clinician and the clinical team).

Description of the model: The three demonstration sites were Grady Health System, Infectious Disease Program in Atlanta, GA; Keck School of Medicine at University of Southern California in Los Angeles, CA; and Newark Beth Israel Medical Center in

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[4] https://www.hrsa.gov/ending-hiv-epidemic

[5] Blackstock, O. J., Blank, A. E., Fletcher, J. J., Verdecias, N., & Cunningham, C. O. (2015). Considering care-seeking behaviors reveals important differences among HIV-positive women not engaged in care: implications for intervention. *AIDS patient care and STDs, 29*(S1), S20–S26.

[6] Toth, M., Messer, L. C., & Quinlivan, E. B. (2013). Barriers to HIV care for women of color living in the Southeastern US are associated with physical symptoms, social environment, and self-determination. *AIDS patient care and STDs, 27*(11), 613-620.

[7] Blank, A. E., Fletcher, J., Verdecias, N., Garcia, I., Blackstock, O., & Cunningham, C. (2015). Factors associated with retention and viral suppression among a cohort of HIV+ Garcia, I. A., Blank, A. E., Eastwood, E. A., & Karasz, A. (2015).

[8] Barriers and facilitators to the implementation of SPNS interventions designed to engage and retain HIV positive women of color in medical care. *AIDS and Behavior, 19*(4), 655–665.

[9] Pantalone, D. W., Scanlon, M. L., Brown, S. M., Radhakrishnan, B., & Sprague, C. (2018). Unmet mental health and social service needs of formerly incarcerated women living with HIV in the Deep South. *Journal of the Association of Nurses in AIDS Care, 29*(5), 712–727.

[10] Webel AR, Cuca Y, Okonsky JG, et al. The impact of social context on self-management in women living with HIV. *Soc Sci Med.* 2013; 87:147–154.

[11] Horstmann E, Brown J, Islam F, et al. Retaining HIV-infected patients in care: Where are we? Where do we go from here? *Clin Infect Dis.* 2010;50:752–61.

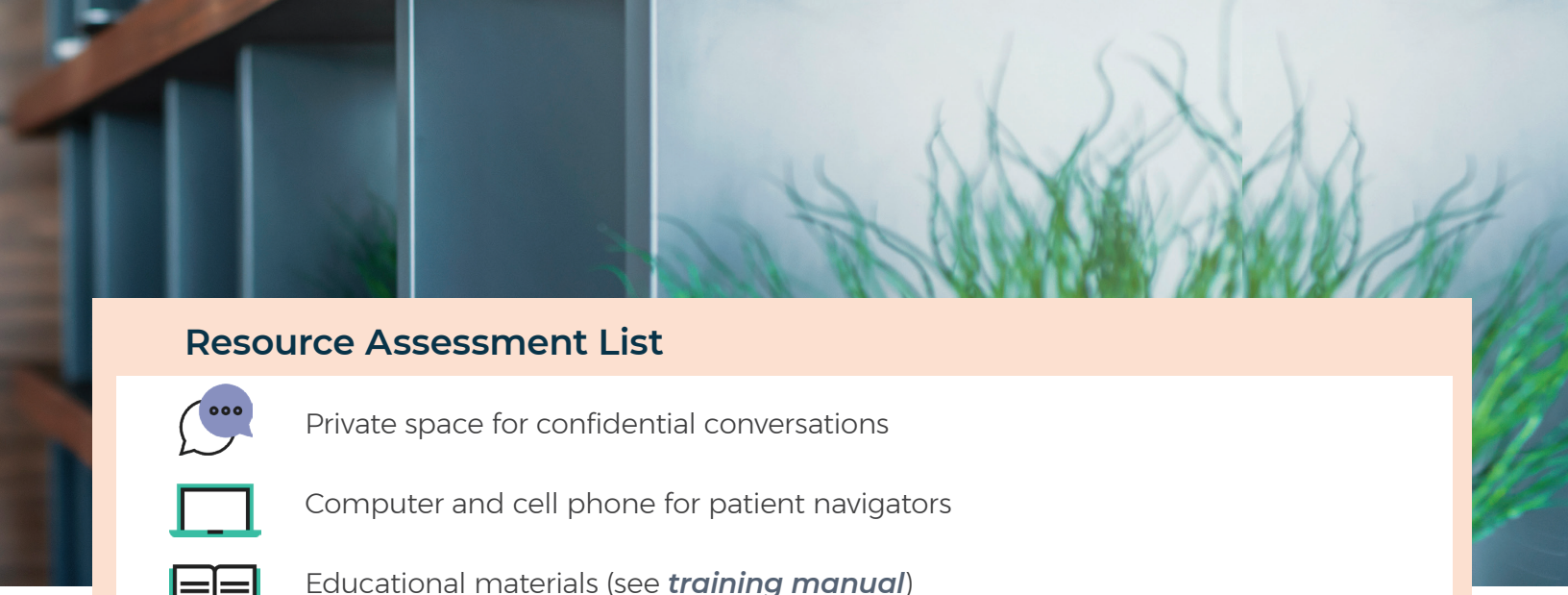
[12] Mugavero MJ, Lin HY, Willig JH, et al. Missed visits and mortality among patients establishing initial outpatient HIV treatment. *Clin Infect Dis.* 2009;48:248–56.

Newark, NJ. All three sites were outpatient clinics within large hospital-based settings. They conducted the following activities to retain WoC in care:

- Contacting eligible clients, developing rapport, and providing support to clients using motivational interviewing and trauma-informed care principles by:
  1. Assessing client barriers, needs, and acuity
  2. Developing, Implementing, and Monitoring the patient care plan with client
- Conducting structured sessions on health education topics including:
  1. HIV, the viral life cycle, and understanding antiretroviral therapy (ART)
  2. Communicating with health care providers about adherence and managing side effects
  3. Basic lab work and adherence
  4. Stigma and disclosure
  5. HIV and substance use
  6. HIV and mental health
- Supporting clients in obtaining referrals for needed services (including transportation, housing, etc.)
- Offering accompaniment to internal and external appointments
- Working in tandem with standard case management throughout the intervention, and transitioning the client to the standard of care (standard case management) using a standard transition protocol

PNs work with clients for a minimum of 6 months and a suggested maximum of 12 months. After 6 months, clients are reassessed every 3 months using an acuity-based system to determine if they still need the support of the PN. If a client's reassessment shows they still need patient navigation services after 12 months, the client will still be eligible for navigation services. Clients who are transitioned to the standard of care after receiving the intervention and are subsequently lost to care will be eligible to receive services from a PN again.

Intensity of services: On average across the three sites, clients received two encounters per month, and three different activities performed per encounter. The median length of time clients were active in the intervention was 10 months, with a range of 2–25 months.



Resource Assessment List

- Private space for confidential conversations
- Computer and cell phone for patient navigators
- Educational materials (see ***training manual***)
- List of community resources including mental health and substance use treatment services, housing support services, food banks, shelters, intimate partner violence support, legal services, and employment agencies
- Transportation assistance for clients

Staff background and training:

- 2 FTE PNs with experience related to HIV or other chronic conditions and experience in a medical setting
- Administrative supervisor with experience with HIV or other chronic conditions
- Clinical supervisor, who is a licensed mental health professional

Management and integration: An administrative supervisor supervised PNs to help identify women who were recently diagnosed or out of care. The clinical supervisor provided regular support to PNs for managing client cases and addressing self-care. All project staff met weekly for project and client updates, and at some sites, regular meetings were held with the health care team as part of clinic huddles. All staff communicated via email or phone when participation in team huddles was not realistic.

Financing: The adjusted average cost per participant per year across the three sites was $2,894 (2019 dollars). The number of clients served ranged from 157–299 per year. The calculated costs included: salary and fringe benefits for intervention staff and supervisors, materials and consumables for non-research related activities, transportation cost for staff and clients, other direct costs to provide client services such as incentives to attend medical appointments and agency overhead rates. Medical and behavioral health provider salary was included in salary and personnel only if it was a direct charge to the grant. Startup costs for the intervention, including staff training and salaries, averaged $40,833 (range: $40,005–$42,062). Data were gathered from monthly administrative reports for cost reimbursement provided by the agency to AIDS United.

Resource Assessment Checklist

The Enhanced Patient Navigation for Women of Color with HIV intervention was specifically tailored for implementation in health care settings that provide HIV primary medical care and have medical case management services readily available.

Questions to consider prior to implementation include:

- ☐ Does the organization have private, confidential space available for PNs to meet with clients?
- ☐ Does the organization have computers and phones available for PNs to use to document services and communicate readily with providers and clients?
- ☐ Does the organization have the capacity to hire or have a person available to supervise the PNs as part of the care team?
- ☐ Does the organization have the capacity and a staff person to generate "out of care" lists for clients who have not seen the health care provider in the past six months?
- ☐ Does the organization have a referral system in place, including releases of information, to discuss and refer clients for services?
- ☐ Does the organization have a community resources list so PNs can link clients directly to needed services?
- ☐ Are staff trained effectively on managing trauma, addressing treatment adherence, supporting HIV disclosure, and motivating clients to address their medical and social needs?
- ☐ Does the organization have sufficient resources to address transportation needs for clients, including use of bus/train passes, gas cards, Uber, Lyft or taxi rides?
- ☐ Does the organization have a plan for staff self-care, managing burn out, and professional development opportunities?

PRE-IMPLEMENTATION ACTIVITIES

The following are programmatic requirements for the PN intervention that need to be addressed* prior *to implementation:

Hire/Identify and Train Intervention Staff

- ☑ Clinic administration hire and/or identify appropriate intervention team members (PNs, administrative supervisor, clinical supervisor) using job descriptions in ***Appendix A***. The PNs, administrative supervisor, and clinical supervisor are collectively referred to as the "intervention team."
- ☑ Intervention team members receive training on the intervention, including on education sessions. See the ***Training Manual*** for this information. Other suggested trainings include: HIV 101, how to engage with hard to reach clients, vicarious trauma and trauma-informed care, motivational interviewing, mental health first aid, harm reduction, health literacy, how to communicate with physicians and other clinical staff, and person-first language education.

Consider Hiring from Within

Clinics are complex. By hiring staff who already work in the health system, PNs may be able to dive into the role more easily. The navigators for this intervention had worked as case managers, front desk staff, and medical assistants.

Initial and Ongoing Training and Supervision is Vital to Intervention Success

- The role of the PN is challenging, with many competing demands and difficult situations.
- PNs need ongoing training and support not only on the "facts" and "skills" of the job (e.g. HIV 101 and Motivational Interviewing), but on how to maintain resiliency within the role (e.g. vicarious trauma and how to engage with hard to reach clients). Establish supervision early in implementation to build the trust and rapport needed to provide this support.
- PNs need to learn to establish and maintain boundaries with clients; encourage PNs to turn off their cell phone when they are not at work and to keep boundaries strong to prevent burnout, compassion fatigue, and vicarious trauma.
- Consider training that demonstrates how to talk to providers about cases (establishing/adopting to case conferencing norms) as well as organizational norms related to professional boundaries.
- Ensure that PNs know who they can go to for questions, and how to communicate across the intervention team (e.g. who do they call if the administrative supervisor is on vacation).

Strengthen and Formalize Working Relationships with Community Partners

Intervention team members establish formal and/or informal relationships with community based agencies and clarify the mechanisms to generate referrals.

- The intervention team and the community partners define roles and responsibilities for ongoing, consistent, and bidirectional communication between intervention staff and community partners who provide social services.
- Document protocols for receiving client referrals from external partners, and protocols for referring clients to external partners.
- Create and sign any Memorandums of Understanding needed for referrals for clients who need more intensive services.
- Develop Release of Information forms for clients to provide consent to share information across agencies.
- Continue to update community partnerships list and reach out to new partners as the project continues.
- Participate in community meetings, roundtables, or forums about related topics to continue to engage in conversations in the community. For example, USC Keck had established strong relationships with the Los Angeles County Commission on HIV, and was able to share information about the intervention there.

How to Train PNs on Community Partners

Create a "scavenger hunt" of local partners, encouraging PNs to visit each place and learn about services, then follow up with their administrative supervisor.

Prepare Logistics and Operations

- ☑ Intervention team members develop and review the patient care plan and acuity tool (***Appendices B*** and ***C***) and make any site-specific additions.
- ☑ Obtain necessary technology and secure internet capabilities at all locations where data could be entered.
- ☑ Provides PNs with read/write access to patient electronic medical record (EMR) information. PNs should be able to both review patient information and access and update their interactions with clients. By being able to update the EMR, PNs are seen as legitimate members of the care team providing needed outreach and support activities.
- ☑ Secure space to conduct intervention activities, such as meeting with clients, conducting education sessions, documenting activities in the EMR, and conducting outreach calls.
- ☑ Plan for Medicaid reimbursements (if applicable).
- ☑ Plan for billing codes for navigation services (if applicable).
- ☑ Consider providing ways for the PN to communicate with clients using web-based means (e.g. texting or video chat), based on client preference and site rules.
- ☑ Become familiar with local clinic rules related to engaging with clients. This would include phone-based engagement (texting, video chat, Facebook messenger), visiting clients outside the clinic, and transporting clients in personal vehicles.

Office Space Matters

It is important to provide the PNs with a physical, personal workspace, preferably within the clinic. PNs need to have a strong presence in the clinic to gain buy-in and be available to clients. Having assigned space will create legitimacy for the role in the clinical team and consistency for clients.

Identifying Clients for the Intervention

In this intervention, clients met the following criteria:

1. Age 18 or older
2. Living with HIV
3. Receiving (or had previously received) HIV primary care at the clinic where the intervention is offered
4. Identify as a woman
5. 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, or multiracial

In addition to the above criteria, the client also needed to have ONE of the following criteria:

1. Fallen out of care for 6 months or more
2. Loosely engaged in care (have cancelled or missed 2 or more appointments in the past 12 months)
3. Not virally suppressed (>200 copies/ml)
4. Have multiple co-morbidities that threaten their ability to be retained in care (at the discretion of the clinician and the clinical team)

As this intervention is designed to be a transitional program, lasting between 6 and 12 months, it may not be as effective for clients who have severe mental health and/or cognitive limitations (for example, dementia) who may need longer term support. Some sites also struggled to work with clients who spoke different languages than the PNs where interpretation services were unavailable.

Methods of identifying potential clients include:

- Review of clinic appointment and EMR data to identify WoC who have been out of care for 6 months or more, are not virally suppressed, or who have missed 2 or more appointments in the past 12 months
- Vetting of client list at weekly clinical team meetings and using clinicians to assist in the identification of additional clients who may be at high risk for dropping out of care due to co-morbidities, or who are not virally suppressed
- Direct referrals from clinical staff
- Direct referrals from partner agencies

Integrate PNs into Clinical Team in an Intentional Way

- ☑ Intervention team members define formal and informal mechanisms to promote communication between PNs, case managers, and clinical staff.
- ☑ Roles and responsibilities of PN are explained to clinic staff via an all staff or department meeting.
- ☑ Administrative and clinical supervisors integrate PNs into clinical team and case conferencing meetings. If applicable, PNs are also integrated into daily clinic huddles to review scheduled patients.

Continue to Reiterate the Role of the PN

Reiterating the role of the PN can help to integrate the PN into the care team, and clarify and distinguish the roles of clinical staff who have overlapping clinic tasks (e.g. different types of PNs, or PNs compared to social workers/ case managers/community health workers). Grady Health System in Atlanta created a visual checklist to compare the role of different types of PNs in different clinics, noting their varied responsibilities and roles (see ***Appendix D***).

Highlight the role of the PNs in regular staff meetings. Share early successes to gain legitimacy and respect for the role.

SUPERVISION ACTIVITIES

Scheduled supervision from the administrative supervisor and the clinical supervisor is vital to the success of a PN's work with clients, and is a key component to PN well-being and retention in their role at the clinic. The Enhanced Patient Navigation for Women of Color with HIV intervention requires weekly supervision meetings between the administrative supervisor and the PN, and monthly supervision meetings between the clinical supervisor and the PN. In addition, administrative and clinical supervisors, PNs, and case managers should participate in weekly case conferencing meetings to provide an opportunity for PNs and the clinical team to discuss pertinent client issues.

Supervision should include the following steps:

- ☑ The administrative supervisor provides weekly administrative supervision of the PNs.
- ☑ The clinical supervisor provides monthly clinical supervision of PNs (individually or in groups, as needed by the PN).
- ☑ The clinical and administrative supervisors meet regularly to maintain consistent approaches to providing support to PNs and discuss challenges and potential solutions.
- ☑ The intervention team holds regular (ideally weekly) case conferencing meetings to discuss clients with clinicians, case managers, navigation supervisors, and PNs.

Ways to Support PNs

- Coach PNs on how to manage time and tasks; this is a complex job with many competing demands.
- Regularly discuss all clients to share strategies and approaches for different issues.
- Include check in about PN's mental health and workload; encourage strong boundaries and self-care.
- Develop ways to support staff through emotional challenges, such as planning for the potential death of a client.
- Establish a plan for emergencies. Identify who can be contacted for guidance, advice, or support in the absence of a supervisor.
- Clinical supervision should both include mental health support (to encourage PN well-being and prevent burnout) as well as support related to HIV knowledge (to best support clients and implement education activites).

ESSENTIAL INTERVENTION IMPLEMENTATION ACTIVITIES

Connecting with Clients

- ☑ The PN is assigned a client. The PN collects background information on the client through reviewing the client history and speaking with the care team (case manager, medical providers, and/or social workers). Suggestions of information to gather include: 1) best strategies for approaching the client, 2) previous barriers to care, and 3) information related to the client's personal life or living situation.

- ☑ The PN makes contact with their assigned clients via phone, in-person meetings, or email (if the clinic permits email between the PN and the client).

  - The PN should make and document three contact attempts per client per month until the PN is able to make direct contact with the client. If the PN is unable to make contact with the client after three attempts, the client will be put back on the out-of-care list and will be discussed at the next case conferencing or supervision meeting. All contact attempts should 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 PN is still unable to contact the client, the client will be placed on a "hard-to-reach" list. This list will be made available to all clinic staff as appropriate so that if a client makes contact with a staff member other than the PN, that staff member can attempt to connect the client and the PN. The hard-to-reach list will be reviewed monthly to update and document any status updates of the listed clients.

Reaching Out-of-Care Clients

Connecting with out-of-care clients can be challenging. Here were some strategies that that can make it easier to connect:

- Conduct home visits to engage clients; leave a note signed with their doctor's name to encourage clients to come back to the clinic. Be sure to write this note so that it does not disclose someone's HIV status (e.g., remove the name of the clinic, remove mention of HIV).
- Check with the local Department of Health for help with contact information (up to date addresses/phone numbers) or whether the client is being seen elsewhere.
- Use all means of communication—texting, letters, and phone calls.
- If possible, create an alert in the EMR that the PNs are looking for the client so that other providers can help facilitate connections between the PN and the client.

Once the PN has connected with the client, the PN explains the intervention, including the role of the PN (how the PN differs from other clinical team members), the services provided by the PN, and the timeline of the intervention. The PN will explain that after 6 months, the PN and client will reassess the client's goals or transition to work with their case manager and/or doctor. The intervention timing and transition to the case manager may need to be explained and reiterated over multiple visits (see: ***Challenges to Transitioning*** in the next section).

What Is the Role of the Patient Care Plan?

The patient care plan (***Appendix B***) is a tool to help guide the work the PN and client will do together. It establishes expectations and preferences for communication. The care plan also asks the client to identify goals related to HIV care visits, case management visits, and other goals identified by the client. Finally, it lists the six education sessions to identify target dates to complete those sessions.

What Is the Role of the Acuity Tool?

The acuity tool (***Appendix C***) helps the PN learn about complexities of the patient's life. Acuity tools are often used by case managers to assess client needs. PNs can use this tool to understand services the participant may need, and to begin to build a relationship with the participant.

Developing a Patient Care Plan

- ☑ Meet with the client to assess client barriers, needs, and acuity and develop a patient care plan with the client.
  - The patient care plan (***Appendix B***) will be reviewed every 3 months by the PN and client, and will be updated as needed (i.e., goals completed, goals added).
  - The acuity tool (***Appendix C***) will be revisited after 6 months, and then every 3 months thereafter. While this may seem frequent, understanding the changing acuity is important to tailoring the intervention.
- ☑ The PN and client implements and monitors the patient care plan. The PN works in tandem with standard case management throughout the intervention time period to accomplish the goals set in the patient care plan.
  - The PN supports clients in identifying and obtaining referrals for needed services in tandem with the case manager, such as transportation, housing, or child care.
  - The PN offers accompaniment to internal and external appointments and assists as needed with completion of paperwork for appointments, benefits, and referrals.

What's the Difference Between a Patient Navigator and a Case Manager?

In most clinics, **case managers** are responsible for service referrals and general patient support. However, case managers often have a caseload of 200+ patients, and only have so much time to support each one.

In this intervention, **patient navigators** provide education and support for clients, working with case managers to identify referrals to services and assist clients in accessing referral services. These clients have high acuity and high levels of needs. PNs provide added support for these hardest-to-reach clients.

Ongoing Tasks

- ☑ The PN conducts regular client check-ins. The frequency of client check-in may be a case-by-case basis; some clients prefer weekly check-ins, while others find that too intrusive. Check-ins can be conducted by phone, through electronic communication (if permitted by the clinic), or through in person meetings.
- ☑ The PN implements the structured health education curriculum (See: ***Training Manual***). The PN works with the client to review the structured health education sessions.
  - Some education sessions may be grouped together into one session, depending on the client's previous knowledge and experience. Education sessions may also be done in any order. Allowing this to be a client-driven process will improve buy-in and interest.
  - Use the acuity tool (***Appendix C***) at the beginning of the intervention to get a sense of educational needs.
  - If it is difficult to get clients to meet for an education session, consider doing education sessions over the phone or using an approved video chat software. The effectiveness of non-face-to-face education sessions should be weighed compared to the likelihood of otherwise completing the session.
- ☑ Document check-ins and education sessions in the EMR to keep the status of the PN's work with the client up-to-date.

Tasks for the Client Check-In

1. Ask how the client is, build rapport.
2. Review client interests/goals.
3. Ask what services they need: "How can I help you connect with the people/services you need?"
4. Ask about recent appointments or referrals, and what other appointments are needed.
5. Ask if they would like you to accompany them to a visit.
6. Review medications.
7. Schedule the next visit/check-in.

How to Approach an Education Session

- Work with clients to identify the topics that are most important to them, and conduct those sessions first.
- Education sessions should be a conversation, not a lecture.
- Start by asking clients how familiar they are with the session information—assess their knowledge.
- Affirm knowledge they have, and fill in gaps where they don't.
- Tailor the conversation to the client's interests.
- Use creative ways to share information to connect the content to the client's life: videos, storytelling, the client's experiences and data (for example, their labs). One PN from Newark found it helpful to visually track the client's viral load at each session, allowing the client to see their progress.
- Information can and should be repeated and reiterated over time—it may be helpful to repeat sessions.

Preparing a Client to Transition to the Standard of Care

The PN works with the client, case managers, navigation supervisors, and the clinical team to determine if a client is ready to be transitioned to the standard of care. This is designed to be a 6 to 12-month intervention.

- Completion of the Enhanced Patient Navigation for Women of Color with HIV intervention is a client-driven process.
- Clients will be considered for transition into standard-of-care case management once the following requirements are met:
  - ◊ Completion and documentation of 6 health education sessions
  - ◊ Client retention in care:
    - » Attending one medical visit in each 6-month time period with 60 days in between visits over the course of 12 months.
    - » Sustained viral suppression (at least 2 undetectable viral load lab reports).
    - » Reduction in acuity score from baseline acuity score.
    - » Agreement between PN, case manager, and clinical team on client. transition to standard of care.

Is Six Months Enough?

For some clients, six months was enough time. For most clients, it ultimately took more than six months to complete the intervention. Relationships often took at least three months to build.

Clients may also experience significant life events (e.g. loss of housing, loss of a job, health difficulties) which may cause them to be engaged longer or "re-started" into the intervention.

If a reassessment shows that the client still needs enhanced navigation services after 12 months and has not completed all of the above requirements, the client is still eligible to continue the enhanced navigation services. In the event the client needs more intensive interaction, the PN will discuss re-engaging the client in the intervention with the care team and the navigation supervisor.

Challenges to Transitioning

Client interest in completing education sessions waned over time. Mandating completion of all sessions prior to transition was difficult. Some clients will likely always need additional support. Some struggled to retain the changes made—they couldn't sustain viral suppression. Others opted out of using medication. It is important to always meet clients where they are and support them in what they need.

Ways to Improve the Transition

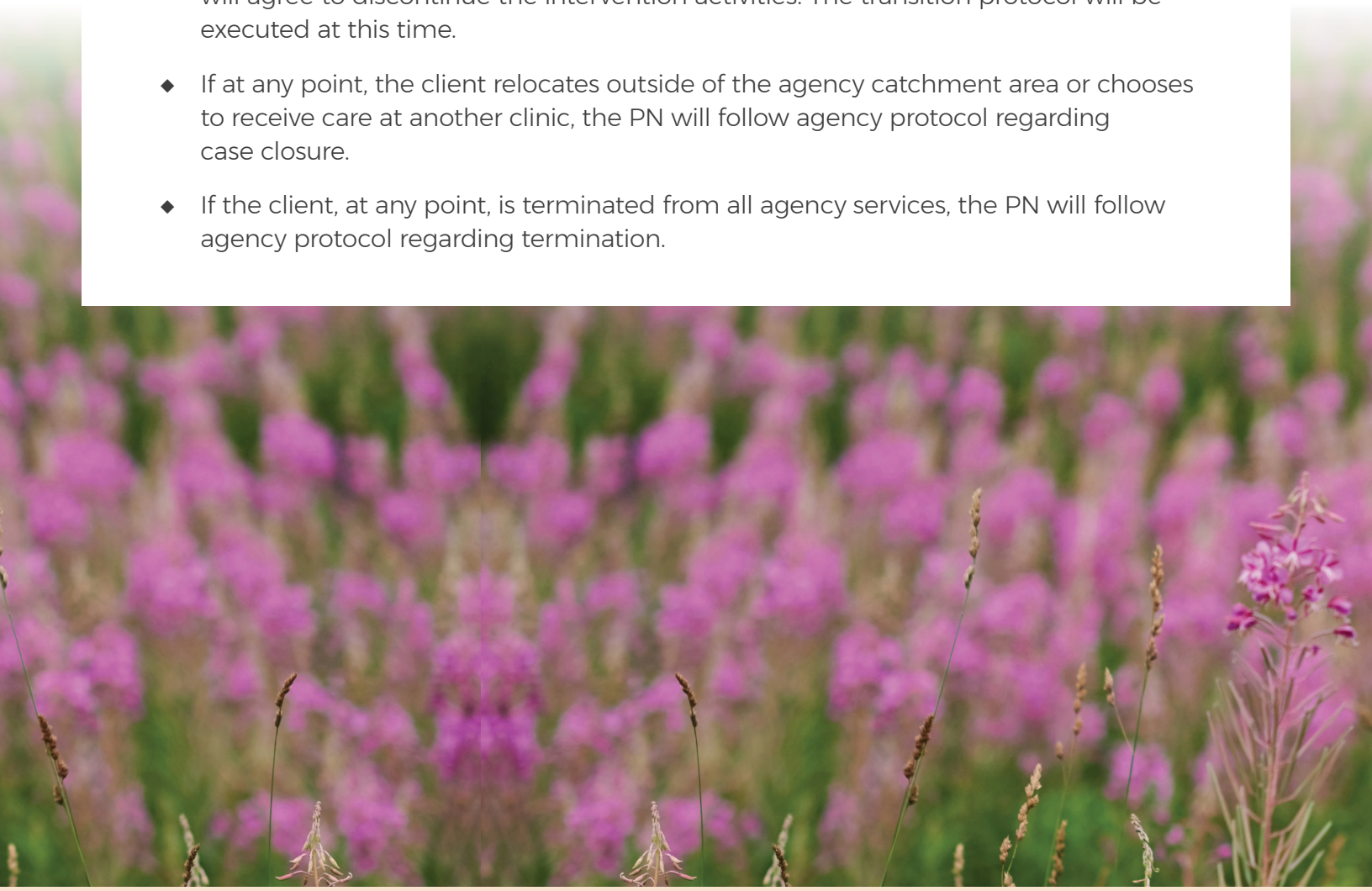
- Be clear with the intervention's timeline from the beginning of the PN and client relationship.
- Engage case managers early to build the relationship between the case manager and the client.
- Encourage self-sustaining behaviors throughout the intervention to improve self-efficacy. For example, taper medication reminders, e.g. the PN gives a reminder for 4 days, and the client reminds herself for 3 days.
- Considering using language related to "graduating" versus "transitioning." "Graduation" aligns with a growth-mindset. The Newark Beth Israel site even held a graduation ceremony for their clients.

Process for Transitioning Clients to the Standard of Care

PNs meet with a client who has completed the intervention activities to explain that she has completed the intervention and will be transitioned to standard-of-care case management. The PN also notifies the health care team when a client has completed the intervention and is ready to be transitioned into standard-of-care case management. The PN then convenes a meeting with the case manager and client to establish a "warm handoff" between the PN and the case manager, allowing the opportunity for the client to ask questions of the case manager and schedule follow up appointments with their case manager.

Other Reasons for Ending Intervention Participation

- If, at any point, the client is no longer willing to work toward achievement of goals and no longer wishes to work with or be contacted by the PN, the client and PN will agree to discontinue the intervention activities. The transition protocol will be executed at this time.
- If at any point, the client relocates outside of the agency catchment area or chooses to receive care at another clinic, the PN will follow agency protocol regarding case closure.
- If the client, at any point, is terminated from all agency services, the PN will follow agency protocol regarding termination.



Re-Engagement with the Patient Navigator

The client can re-engage with the PN in the following scenarios:

- ☑ If a client is unresponsive to PN outreach efforts and stops working toward completing the intervention goals, but later determines that they want to re-engage with the PN.
  - The PN will need to complete a new patient care plan and acuity tool and "restart" the 6-month intervention time period.

- ☑ If a client 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 the client agrees to receive navigation services, the PN will need to complete a new patient care plan and acuity tool and "restart" the 6-month intervention time period.

PROMOTING SUSTAINABILITY AND INTEGRATION ACTIVITIES

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

- ☑ Provide ongoing professional development and mentorship to PNs.
- ☑ Incorporate patient navigation into the standard of care at the clinic.
- ☑ Train clinic staff who interact with clients (i.e. front desk staff, appointment scheduling staff, billing staff, etc.) to identify clients who may benefit from enhanced patient navigation, and explain how staff members can connect these clients to PN services.
- ☑ Routinely assess clients to determine which clients would benefit from enhanced patient navigation and facilitate ongoing conversation among providers about clients who could benefit from PN services.
- ☑ Continue to engage PNs in case conferencing.
- ☑ Add patient navigation as a regular field in the EMR.
- ☑ Explore the potential for funding through Medicaid programs and other agencies such as Accountable Care Organizations, and other program income streams.

How to Support Transitioned Patients

Grady found it helpful to continue to check in with clients after transition to support engagement in care.

Newark found success in having a group of participants and graduates provide support to each other. PNs used the group time to provide "booster" education sessions.

Consider engaging interested clients in training to become a peer coach to support new clients.

Sustainability is an important component of implementing this evidence informed intervention—both to support continuity of services for clients as well as strengthen investments by individual staff and organizations. DEII grantees had the option to use the Program Sustainability Assessment Tool (PSAT) to evaluate the sustainability capacity of their program and engage in sustainability planning processes. The PSAT was developed by the Center for Public Health Systems Science (CPHSS), Brown School, Washington University in St. Louis through a comprehensive literature review and expert-informed Concept Mapping. Whether your organization uses the PSAT or another resource, have conversations about sustainability early and often.

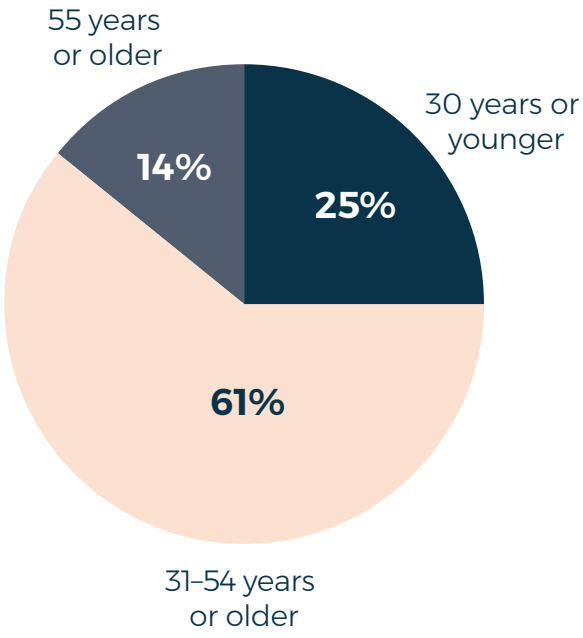
What Does Success Look Like?

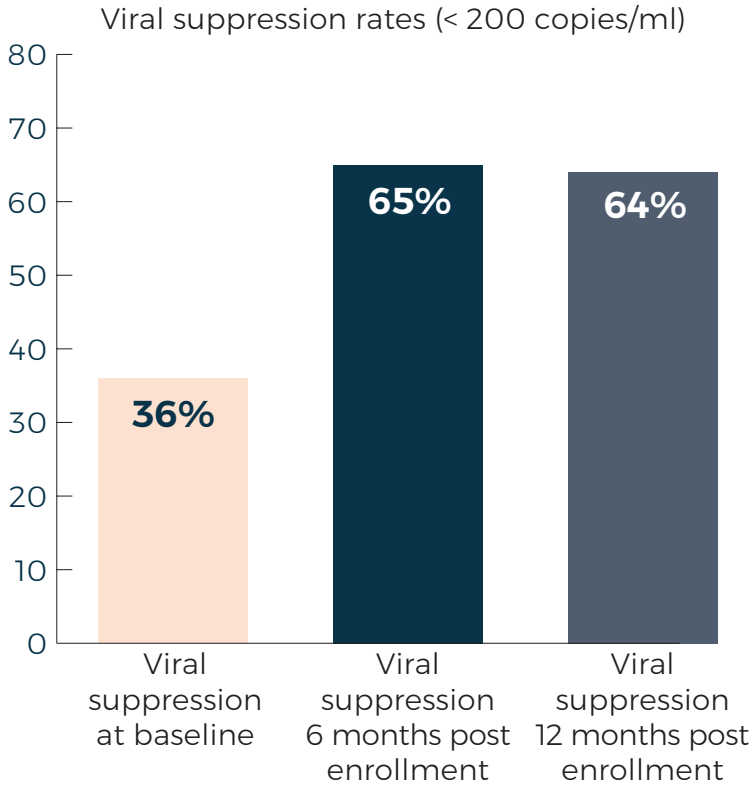
This intervention focuses on clinical outcomes—improving viral load, attending clinic visits, adhering to treatment, and improving viral suppression. The intervention teams identified other, less tangible or measurable successes.

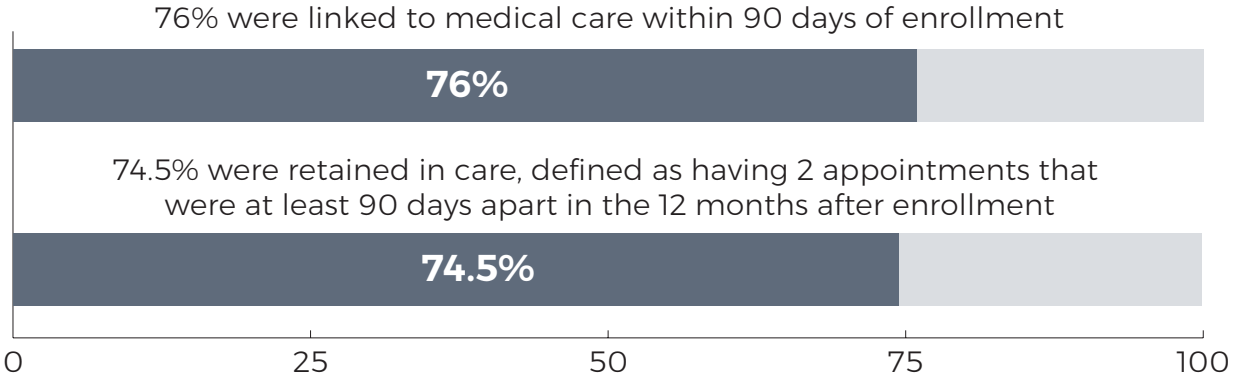
- "Success is in the eye of the clients—clients who were called, that got them back to care. Clients knew that someone would call about their care, who would be there for their appointment."
- "Success was often a moving target—not always tangible; some successes weren't 'deliverables.' It was reducing the walls built up around patients, or having those walls come down—the development of trusting relationships."
- "Success is having clients feel like there was someone there they could connect to."
- "Success is clients spreading what they learned to other clients—using what they learned and the resources that are available."
- "Success is a client feeling empowered while living with HIV, that they can live and thrive."

OUTCOMES

332 participants received services through the Enhanced Patient Navigation for Women of Color with HIV intervention







Considerations for Replication

- Identify a champion (health care provider, program manager supervisor) to maintain support and integration of the PNs as part of the care team.
- Provide private, confidential space for a PN to meet with clients.
- Set up an orientation and training program for up to 30 hours of skills development for PN staff and for other clinic staff to ensure smooth implementation.
- Use a variety of recruitment strategies to identify and outreach to WoC. Potential ideas include: Generating out-of-care lists and working with Early Intervention Specialists (EIS) and outreach teams to find women, use of support groups, and social media and marketing in high risk communities.
- Ensure access to EMR for documentation.
- Conduct regular in-person administrative and clinical supervision.
- Encourage PNs to make education sessions interactive and conversational.
- Involve case managers early in the process to work with the PN and clients to ensure smooth transition from intense services to standard of care.
- Create opportunities for self-care and professional development for PNs.

Conclusions

PNs can be a vital member of a care team to support linking and retaining women of color to care. Findings from this DEII intervention show that having PNs work with clients for a median of 10 months as part of the health care team can help address the unmet needs for medical and social services that can hinder care and treatment, and lead toward viral suppression.

Care and Treatment Intervention (CATIs) are a series of evidence informed interventions supported by HRSA/HAB to promote link, retention and viral suppression across Ryan White Programs. The CATIs replicate four previously HRSA/HAB/SPNS initiatives:

- Transitional Care Coordination from Jail Intake to Community HIV Primary Care
- Peer Linkage and Re-engagement for Women of Color with HIV
- Integrating Buprenorphine Treatment in Opioid Use Disorder in HIV Primary Care
- Enhanced Patient Navigation for Women of Color with HIV

Where to find resources from the HRSA/HAB's Dissemination of Evidence Informed Interventions Initiative:

https://targethiv.org/

APPENDICES

Appendix A: Staffing Plan and Job Descriptions

Patient Navigator	The Patient Navigator (PN) is responsible for: ◆ Engaging eligible clients; ◆ Providing client education sessions; ◆ Documenting services provided to clients in the electronic medical record and updating the patient care plan; ◆ Connecting clients to services (care coordination); ◆ Accompanying clients to internal/external appointments; ◆ Providing reminder phone calls; ◆ Arranging transportation; ◆ Assisting with medication and adherence support; ◆ Assisting with child care (where applicable); ◆ Explaining information from medical providers; ◆ Developing a patient care plan to help clients achieve goals; ◆ Transitioning clients to the standard of care; and ◆ Assisting clients with making and keeping referrals. The PN is expected to attend weekly conferences with the health care team and case conferences. PNs are expected to report to their designated supervisor and receive regular administrative and supportive supervision.
Administrative Navigation Supervisor	The Administrative Supervisor is responsible for: ◆ Providing weekly administrative supervision of PN(s); ◆ Supervising the creation of a monthly eligible client list; ◆ Conferring with the clinical team to finalize monthly eligible client list; ◆ Assigning eligible clients to the PN(s); and ◆ Monitoring and update “hard-to-reach” list.
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 PN(s); and ◆ Providing monthly group clinical supervision to intervention team (as needed).

Patient Navigator

Job Description

Description of the Enhanced Patient Navigation for Women of Color with HIV Intervention:
This intervention uses Patient Navigators (PNs) to retain Women of Color (WoC) with HIV in HIV primary care. PNs are critical members of the health care team focused on helping reduce barriers to care for the client at the individual, agency, and system level. PNs lend clients emotional, practical, and social support; provide clients with education on topics related to living with HIV and navigating the health care system; and support clients and the health care team in coordinating services. In this intervention, PNs will work with WoC with HIV 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 Enhanced Patient Navigation for Women of Color with HIV intervention is to retain WoC with HIV in care and the long-term goal is viral load suppression.

Purpose of Position
The PN provides services within a broad range of focus areas to assist clients in accessing and adhering to care. Services provided may include client assessments, assistance 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 clients.
2. Develop and implement individualized care plans based on assessed needs and barriers.
3. Assist clients 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 clients develop methods for self-management; assist clients in developing strategies to remember appointments.
    c. Provide support through regular phone calls, mailings, and in-person reminders in the clinic/hospital to ensure that clients return for follow-up visits.
    d. Reschedule appointments as necessary.
    e. Help clients attend health care appointments by escorting them or arranging for support services.

f. Assist clients in obtaining eligibility and other required documentation for clinic enrollment, as applicable.

g. Assist clients in obtaining or arranging for services such as transportation or child care to eliminate possible barriers to care.

h. Assist clients in navigating service delivery systems and agency procedures.

4. Assure clients are linked to care through referrals and follow-up:
   a. Monitor clients' 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 clients have scheduled an eligibility appointment and have obtained all necessary documentation.
   c. Provide linkage to insurance and medication benefits enrollment when applicable.
   d. Support and facilitate care transitions, working toward helping clients 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 when available or possible.
   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 clients.
7. Document client information and encounters as required and guided by protocols.
8. Collect and document outcomes, challenges, and barriers.
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.

Qualifications/Requirements

- A bachelors (or equivalent) level of education, or training in a related social service or human service field with experience working in the community and/or with health conditions.
- Experience working in a medical, clinical, or social services environment (including documenting client needs).
- Demonstrated ability to work collaboratively in a team environment.
- Demonstrated computer literacy in Microsoft and web-based applications.
- Excellent verbal communication skills with both clients and medical providers and written communication skills through documenting in the EMR and other written communication.
- Excellent interpersonal and organizational skills.
- Self-directed.
- 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.
- Comfort and willingness to have a flexible work schedule and home visits with clients.
- Comfort with engaging and recruiting clients, building rapport, and advocating for clients' needs in a nonjudgmental way.
- Demonstrated ability working with clients of diverse backgrounds, underserved communities, communities of color, sexual and gender minorities, and with complex cases or comorbid conditions.

Preferred Skills

- Bilingual as needed to serve client population.
- Experience with motivational interviewing.
- Experience working with clients with HIV/AIDS.

Administrative Navigation Supervisor

Job Description

Description of the Enhanced Patient Navigation for Women of Color with HIV Intervention:
This intervention uses Patient Navigators (PNs) to retain Women of Color (WoC) with HIV in HIV primary care. PNs are critical members of the health care team focused on helping reduce barriers to care for the client at the individual, agency, and system level. PNs lend clients emotional, practical, and social support; provide clients with education on topics related to living with HIV and navigating the health care system; and support clients and the health care team in coordinating services. In this intervention, PNs will work with WoC with HIV 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 Enhanced Patient Navigation for Women of Color with HIV intervention is to retain WoC with HIV 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 client list, confer with clinical team to finalize monthly eligible client list.
2. Ensure that up-to date data from the electronic medical record system are provided to PNs.
3. Assign eligible clients to PNs.
4. Recruit, train, supervise, coach, and evaluate intervention team staff.
5. Provide administrative supervision to the PN.
6. Coordinate clinical supervision of the PN.
7. Facilitate and support communication between PNs, clinical supervisor, case managers, and clinical team.
8. Determine long-term strategic alliances with external partners and maintain program collaborative relationships.
9. Facilitate intervention team meetings and case conferencing meetings.

Qualifications/Requirements
- Bachelor's level required, Masters preferred.
- 10 years working with people with HIV/AIDS, clients 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 Women of Color with HIV Intervention:
This intervention uses Patient Navigators (PNs) to retain Women of Color (WoC) with HIV in HIV primary care. PNs are critical members of the health care team focused on helping reduce barriers to care for the client at the individual, agency, and system level. PNs lend clients emotional, practical, and social support; provide clients with education on topics related to living with HIV and navigating the health care system; and support clients and the health care team in coordinating services. In this intervention, PNs will work with WoC with HIV 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 Enhanced Patient Navigation for Women of Color with HIV intervention is to retain WoC with HIV 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
- Participate in case conferencing (as needed).
- Conduct 1-hour individual clinical supervision sessions with each PN, monthly, or as needed.
- Conduct 1-hour group clinical supervision sessions with the intervention team, monthly.

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 clients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color.
- Demonstrated skill implementing and supervising harm reduction skill development, client centered counseling, Motivational Interviewing, Community Resiliency Model, Restorative Justice process, conflict management, and trauma interventions.
- Excellent oral and written communication skills.
- Excellent interpersonal skills. Able to build and maintain relationships with individuals, groups, and organization.

Appendix B: 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 to their HIPAA and confidentiality forms. This template may be adapted to site-specific areas of focus, including personal goals related to housing, education, or legal services.

Patient Name: _____

Patient Record Number: _____

Date Created:_____

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

Day(s) of Week:	Time(s) of Day:
❑ Monday	
❑ Tuesday	
❑ Wednesday	
❑ Thursday	
❑ Friday	
❑ Saturday	
❑ Sunday	
❑ Other answer (Specify:)	

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 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? ❑ Yes ❑ No

Section 1: Coordination of Care

1a. Goal: First PCP Visit Attendance

Date of first PCP visit attended: ____________________

Action Steps	Responsible Party	Dates	Outcome
________ ________ ________ ________ ________ ________	❑ PCP ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ________		
________ ________ ________ ________ ________ ________	❑ PCP ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ________		
________ ________ ________ ________ ________ ________	❑ PCP ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ________		
________ ________ ________ ________ ________ ________	❑ PCP ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ________		

1b. Goal: Case management visit attendance

Date of case management visit: ______________________

Action Steps	Responsible Party	Dates	Outcome
______ ______ ______ ______ ______ ______	❑ PCP ❑ CM ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ______		
______ ______ ______ ______ ______ ______	❑ PCP ❑ CM ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ______		
______ ______ ______ ______ ______ ______	❑ PCP ❑ CM ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ______		
______ ______ ______ ______ ______ ______	❑ PCP ❑ CM ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ______		

Section 2: Client-identified goals

2a. Client-identified goal: ______________________________

Date Resolved: ____________________

Action Steps	Responsible Party	Dates	Outcome
____________________	❑ PCP ❑ PN ❑ Client ❑ Other: ________	Target date: ________ Outcome date: ________	Completed? ❑ Yes ❑ No ❑ Other: ________
	Notes: ______________________________		
____________________	❑ PCP ❑ PN ❑ Client ❑ Other: ________	Target date: ________ Outcome date: ________	Completed? ❑ Yes ❑ No ❑ Other: ________
	Notes: ______________________________		
____________________	❑ PCP ❑ PN ❑ Client ❑ Other: ________	Target date: ________ Outcome date: ________	Completed? ❑ Yes ❑ No ❑ Other: ________
	Notes: ______________________________		
____________________	❑ PCP ❑ PN ❑ Client ❑ Other: ________	Target date: ________ Outcome date: ________	Completed? ❑ Yes ❑ No ❑ Other: ________
	Notes: ______________________________		

2b. Client-identified goal: ______________________________

Date Resolved: ____________________

Action Steps	Responsible Party	Dates	Outcome
______ ______ ______ ______ ______ ______	❑ PCP ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ______		
______ ______ ______ ______ ______ ______	❑ PCP ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ______		
______ ______ ______ ______ ______ ______	❑ PCP ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ______		
______ ______ ______ ______ ______ ______	❑ PCP ❑ PN ❑ Client ❑ Other: ______	Target date: ______ Outcome date: ______	Completed? ❑ Yes ❑ No ❑ Other: ______
	Notes: ______		

Section 3: Curriculum

2b. Client-identified goal: _____

Date Resolved: _____

3a. Curriculum Topics to be Covered	Target Date	Date Completed
Please list topics to be completed before next plan update		
Session 1: HIV, the Viral Life Cycle & Understanding HAART		
Session 2: Communicating with Health Care Provider About Adherence and Managing Side Effects		
Session 3: Review understanding of basic lab tests: CD4 & Viral Load		
Session 4: Stigma and Disclosure		
Session 5: HIV and Substance Use		
Session 6: HIV and Mental Health		

Appendix C: Sample Acuity Tool

Prior to the start of the intervention, the Acuity Tool should be reviewed and adapted to the local context.

Instructions:[13]

Acuity Tool Form: This form examines eleven areas of functioning. Staff check off statements that apply best to the client's current status using the following process:

Based on available information (from the medical record, client, care team) check the boxes for all applicable criteria in each area of functioning.

If a client meets criteria in two or more levels of need for any area of functioning, the client is automatically assigned the number corresponding to the highest level of need for that area of functioning. For example, if two boxes are checked in Basic Need and one box is checked in Moderate Need, the final level of need for that area of functioning is Moderate.

Enter the number that corresponds to the client's level of need for each area of functioning on the form.

Checked boxes within an area of functioning should not be added up. For example, a client that has a detectable viral load and CD4 below 200 and refuses ARVs (intensive need column, score of 3) and has been hospitalized in the last 30 days (intensive need column, score of 3) would receive a score 3 (not 6) for that area of functioning.

Acuity Summary Sheet: This 1-page summary sheet can be used twice to track the individual scores for each area being assessed. After the Acuity Tool Form is completed, staff complete the Acuity Summary Sheet using the following process:

- Add the numbers from each area of functioning.
- Use the total score to assign the client to the appropriate level of MCM.
- Note the dates when the acuity assessments were completed.

[13] https://www.bphc.org/whatwedo/infectious-diseases/Ryan-White-Services-Division/Documents/Acuity%20Toolkit.pdf

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 and HIV Health Status				
HIV Care Adherence **Acuity Score:** _____	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 ongoing 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
	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 **Acuity Score:** _____	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 Opportunistic Infection (OI) and is not being treated	Has history of OIs 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 ER visits in last 6 months, but at least 1 hospitalization 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 Medical Case Management (MCM) program	Newly diagnosed within the last 12 months	
	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 **Acuity Score:** _____	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 months	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/or care adherence	Has a non-HIV related illness (chronic or non-chronic) that impacts health and care adherence	Has a non-HIV related medical issue, but it does not impact HIV care and/or is not receiving treatment	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	Has no current non-HIV related medical issues, but past illnesses require monitoring by a medical provider	
	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
	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 **Acuity Score:** **_____**	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 medication
	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 to 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 provider's advice	Is starting new ARV treatment regimen	Not on ARVs in consultation/support from medical provider	On ARVs and does not need additional assistance
	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 and ADAP Status **Acuity Score:** _____	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 ADAP coverage	Has health insurance, ADAP and/or other health benefits, but requires support to maintain coverage and complete re-certifications	Has health insurance, ADAP 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		
	Has health insurance, ADAP and/or other benefits, but faces significant deductibles and/ or medical co-pays (e.g. client is underinsured)	Client needs or currently utilizes the intervention and needs regular assistance to maintain coverage		
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 **Acuity Score:** _____	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)
	Female living with HIV not on treatment and pregnant or desires pregnancy	Female living with HIV 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 **Acuity Score:** _____	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.)		
	Client's behaviors negatively impact 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 **Acuity Score:** _____	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, buprenorphine, 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, buprenorphine, detox, etc.)	Currently in residential or in-client 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.) or engaged in other types of recovery support	No current or past issues with drug or alcohol use
	Imminent harm associated with substance use and/or no engagement/interest in harm reduction practices (e.g. sharing needles, Narcan, etc.)	Experiences harm associated with substance use and/or has minimal ability to engage in harm reduction practices (e.g. sharing needles, Narcan, etc.)	Experiences some harm associated with substance use and/or has 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.)
	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 **Acuity Score:** _____	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 and/or receives a non-permanent housing subsidy	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 imminent loss of housing		
	Faces eviction or imminent 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 **Acuity Score:** _____	Has urgent legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, disability, or eviction	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 or obtain standard legal documents (e.g., will, guardianship, identification, birth certificate, 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			
	Has outstanding warrants and/or open legal cases			
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 **Acuity Score:** _____	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 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	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	Has shared HIV status to members of support system but requests assistance in talking with others to decrease social isolation	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
		Relies on MCM, peer, or other program staff for social support		
	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 **Acuity Score:** _____	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/or has 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
	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/Mobility Status **Acuity Score:** _____	Has limited or no access to transportation which impacts engagement in medical care, appointments, and other support services	Has agency transport vouchers/passes but requires MCM assistance to complete applications and/or maintain eligibility	Relies on agency supported transportation vouchers or a family/friend	Has consistent and reliable access to transportation with no need for agency support
	Has physical limitations or other mobility issues that impacts ability to access transportation and/or engage in medical care and other support services			
	Client's available transportation options put the client legally or physically at risk (e.g. unregistered car, uninsured driver, hitchhiking)			
	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 **Acuity Score:** _____	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 problems related to low body weight, poor appetite, nausea, vomiting, or other urgent health issues that are impacted by lack of nutrition	Needs linkage to nutritional counseling or other education to help manage nutrition and diet which impact overall health and/or other medical issues	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.) and/or assistance to access community food resources	Needs assistance completing applications to maintain current 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	
	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	Client benefits from utilizing an agency nutrition program	
	Needs nutritional supplements to maintain health	Needs and is prescribed nutritional supplements to maintain health (e.g. Ensure)		
Comments (include referrals needed):				

Summary and Signatures

Acuity Score Subtotals	**Score**
Adherence to Medical Care and Treatment and HIV Health Status	
HIV Care Adherence	_____
Current HIV Health Status	_____
Other Non-HIV-Related Medical Issues	_____
HIV Medication Adherence	_____
Subtotal	_____
Insurance	_____
Sexual and Reproductive Health Status	_____
Mental Health	_____
Alcohol and Drug Use	_____
Housing	_____
Legal	_____
Relationships and Support Systems	_____
Income	_____
Transportation	_____
Nutrition	_____
Total Acuity Score	_____

Acuity Score	**Level of Need**
0–20	no need
21–29	moderate need
30–42	intensive need

Corresponding Level of Need: _____

Client Name/Client Code: _____

PN Name: _____

PN Signature: _____

Date: _____

Appendix D: Visual Checklist to Compare Different PN Programs Across Grady IDP's Clinics

Clinics sometimes have different "patient navigator" or non-clinical support staff programs to assist clients. Using similar labels like "Patient Navigator" but having different responsibilities can result in confusion. Grady IDP instituted four different PN programs across their different clinical spaces. They developed this chart to specify the different roles and tasks of the different types of navigators (which varied by clinic). Using tools like this checklist can be helpful to reinforce different goals across separate programs that are designed to support clients. This checklist helped clinical staff know which navigator program could provide the needed services for each client.

Task	Family & Youth Clinic 1 FTE	Women's Clinic 2 FTEs	Main Clinic 2 FTEs	Youth, Women's & Main Clinic 2 FTEs
Support of patient around the clinic				
Greeting new patients as they enter the building	•			
Escorting patients to the clinic and ensuring that they are checked in for their appointment	•		•	•
Accompanying/directing patients to the pharmacy, lab, psychologist, social worker or other areas as needed or directed by their provider	•	•	•	•
Ensuring patients have and know about their follow up appointment before they leave	•	•	•	•
Ensuring patients have and know about any referral appointments before they leave	•	•	•	•
Reminding patients to keep up to date with their insurance and ADAP information	•	•	•	•
Communicating and working with social work and care teams to support patients needs to stay in care				
Contacting patients to remind them of their upcoming appointments (medical, dental, mental health, financial, etc.)	•		•	•
Calling or attempting to make contact with patients who miss their medical appointments per protocol	•	•	•	•
Assist other clinic staff with contacting patients with whom the Patient Navigator has already been working if there is an urgent need to return to clinic and attempts by other staff have been unsuccessful	•	•	•	•
Assisting patients experiencing barriers to accessing care by strategizing with the care team on ways to address and overcome challenges	•	•	•	•
Empowering patients to take ownership of their health including				
Providing health education to patients		•		
Linking patients to appropriate services to address the patient's needs including information on support groups at the IDP	•	•	•	•
Accompanying patients to their IDP appointments to enhance communication between the patient and care team	•	•	•	•
Navigating healthcare in Grady Health System	•	•	•	•

Appendix E: Logic Model

Resources	Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
◆ Intervention team (patient navigator, administrative navigation supervisor, clinical navigation supervisor) ◆ Community health center/ clinic space ◆ Community partners ◆ Clinic champion and administrative support ◆ Resources for patient navigators (access to private meeting rooms, computers) ◆ Access to clinic EMR ◆ Case managers or social workers who can work with clients in collaboration with the patient navigator and for transition to standard of care	◆ Hire and train patient navigators ◆ Establish supervision and referral systems for recruitment and enrollment of participants ◆ Client intake ◆ Create individualized care plan using acuity tool ◆ Conduct health education sessions ◆ Provide referrals, accompaniments, appointment reminders ◆ Conduct administrative and clinical supervision ◆ Transition clients to standard of care ◆ Document all services offered and provided	◆ # eligible individuals identified ◆ # eligible individuals offered patient navigation services ◆ # intakes ◆ # client completing health education sessions ◆ # health education sessions completed per client ◆ # client who are transitioned into the standard of care ◆ # weekly encounters with client ◆ # unsuccessful outreach attempts with clients ◆ # clients needing transportation ◆ # clients need of social supports/ ongoing care management (mental health, substance use disorder, dual diagnoses, homeless, continued history of incarceration) ◆ # referrals made ◆ # referrals kept	◆ Increase in clients: – HIV knowledge – Adherence to ART – Self-management of HIV ◆ Reduction in client barriers to care ◆ Reduction in unmet needs	◆ Increase in number of clients retained in care (attending one medical visit in each 6-month time period with 60 days in between)	◆ Improvement in the following client-level outcomes: – HIV viral load suppression – Reduction in barriers (e.g., housing stability and food security) – Engagement in behavioral health treatment as needed (substance use disorder, mental health) – Quality of life ◆ Increase in patient satisfaction with care ◆ Integration of the Enhanced Patient Navigation for Women of Color with HIV intervention into the clinic

For more resources from the Dissemination of Evidence-Informed Interventions Initiative visit:
https://targethiv.org/deii