PROJECT CONNECT

CLIENT-ORIENTED NEW PATIENT NAVIGATION TO ENCOURAGE CONNECTION TO TREATMENT

An Implementation Toolkit

EVIDENCE-INFORMED INTERVENTIONS (E2i)

HRSA
Health Resources & Services Administration

Acknowledgements

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Project CONNECT (Client-Oriented New Patient Navigation to Encourage Connection to Treatment)

Purpose

This toolkit consists of essential information and materials to help your planning team implement the Project CONNECT intervention. All materials can be adapted to meet the unique needs of your organization and local community.

Goal

» To promptly link and engage black men who have sex with men who are living with HIV into primary HIV medical care

Target Population

» Black men who have sex with men who are newly diagnosed with HIV, are transferring care from another HIV provider, or who have been out of care for over 12 months

Description

The Project CONNECT intervention guides newly-diagnosed, newly-transferred, or newly-reengaged people living with HIV (PLWH) into primary medical care by scheduling a new patient orientation (the CONNECT visit) with a linkage coordinator within 5 business days of initial clinic contact. The linkage coordinator builds rapport with the patient, takes a medical and psychosocial history, prepares the patient for their first primary care visit, and provides referrals.

Duration

» New patient orientation occurs within five days of initial contact

» First medical visit with primary care provider occurs within six weeks

» Ongoing support as needed to stay in care

OVERVIEW

Background

Project CONNECT was originally launched in 2007 at the University of Alabama at Birmingham *1917 HIV Outpatient Clinic*[a] to address the issue that one-third of clinic patients did not attend their first scheduled HIV primary care appointment.[1] Because the first year in outpatient HIV medical care is a dynamic and vulnerable time, missed visits are common as PLWH acclimate to new regimens. Patients who miss their first medical visit are less likely to become retained in care.[2-4]

Recognizing that the lag time between initial clinic contact and first appointment was strongly associated with missed visits, the Project CONNECT developers created an intervention that schedules an orientation for new patients within the first five business days of their initial call to the clinic. The Centers for Disease Control and Prevention Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention includes Project CONNECT as an evidence-informed intervention.[5]

Setting

» Primary care organizations that either specialize in, or have access to, providers with expert training in HIV care (e.g., AIDS service organizations, university-associated HIV clinics, and health centers)

Staffing

» ***Linkage coordinator(s):*** Masters-level licensed social worker, or other healthcare worker skilled at establishing rapport, and knowledgeable about the medical, social, and psychological aspects of HIV/AIDS. Acts as main initial point of contact for new (and re-entering) patients. Schedules and leads new patient orientations, assembles primary care teams, and accompanies patients to first medical visit

» ***Primary care provider:*** MD, physician's assistant, or nurse practitioner responsible for a patient's primary care and with prescribing privileges

a. www.uab.edu/medicine/1917clinic

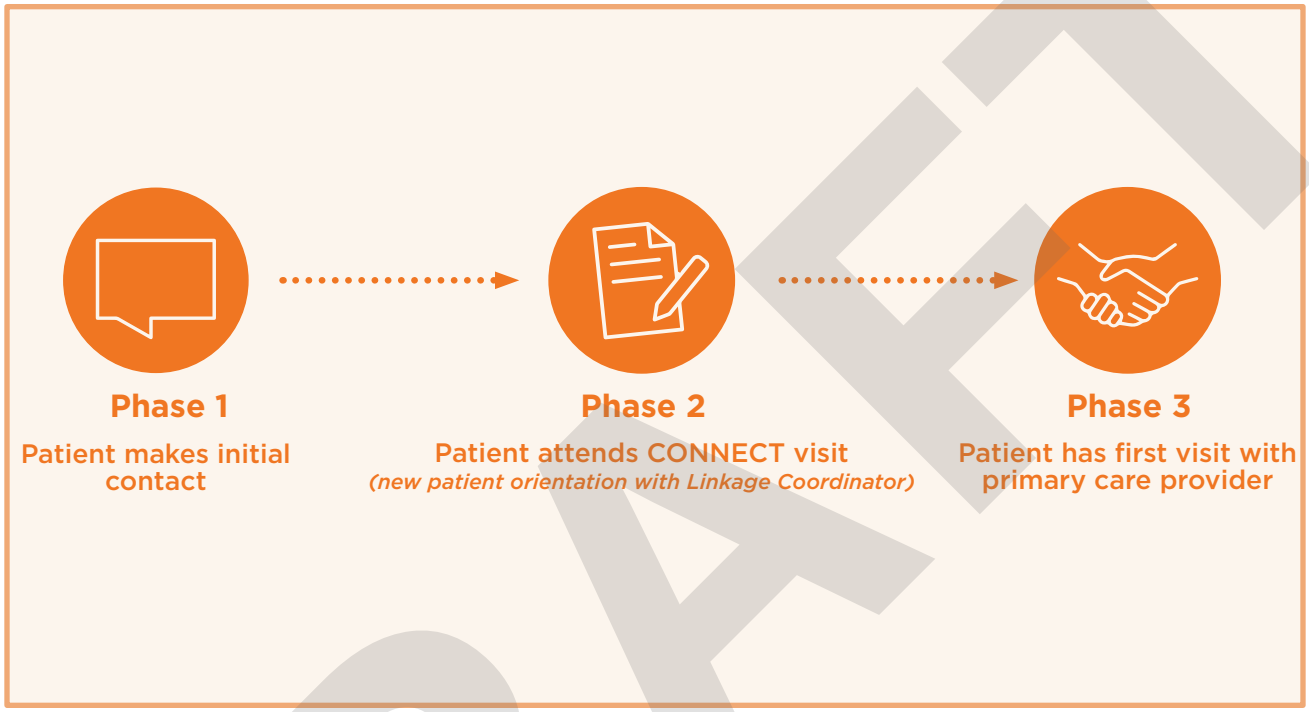
- ***Registered nurse:*** Main contact person between the patient and the provider once care is established
- ***Social worker:*** Helps patients with insurance and obtaining medication; initiates or follows-up on referrals, and provides psychosocial assessments and counseling

Planning Steps

1. Assess clinic readiness. Use *Appendix A: Clinic Readiness Checklist* to assess whether your organization has, or can obtain, the essential components for Project CONNECT.
2. Train existing staff about Project CONNECT
3. Hire linkage coordinator(s)
4. Train linkage coordinator(s) in Project CONNECT, including how to screen and assess for medical and psychosocial factors
5. Develop program tracking tools
6. Adapt the intervention
7. Use technical assistance, as needed

OVERVIEW

Main Intervention Components



ACTIVITIES

ACTIVITIES

The Three Phases of Project CONNECT

Project CONNECT consists of three main phases:

- Phase One: Initial contact
- Phase Two: CONNECT visit
- Phase Three: First primary care provider visit

These three phases center on the idea of enhanced personal contact. Enhanced personal contact helps build personal relationships between patients and their HIV care teams by providing extended face-to-face communication. PLWH who receive enhanced personal contact have improved rates of retention in care and fewer "no show" visits.[6]

ACTIVITIES

Phase One: Initial Contact

The intervention begins as soon as a new patient calls the clinic for an appointment. The clinic notifies the linkage coordinator, who immediately schedules a within five business days of the initial call.

The rationale for scheduling within five days:

- Sometimes a clinic cannot immediately schedule medical visits for new patients. By scheduling the within five business days of initial contact, the clinic can begin the important step towards building a trusting relationship with the patient and facilitating timely linkage to care.
- Learning that one has tested positive for HIV can cause extreme stress, anxiety, and confusion, and not everyone has a social support system already in place. Scheduling a visit right away will help provide that crucial support.
- Patients who are returning to care or transferring care from another clinic need reassurance and comfortable re-entry.

Phase Two: CONNECT Visit (New Patient Orientation)

- The CONNECT Visit consists of a one and a half to two hour meeting between the patient and the linkage coordinator. This person may or may not be the linkage coordinator that initially spoke to the patient for the initial clinic contact, although limiting the number of new faces that a patient encounters during the orientation process is best. The linkage coordinator must have skills in establishing rapport, and have knowledge about the medical, social, and psychological aspects of HIV/AIDS.
- During the CONNECT Visit, the linkage coordinator obtains a detailed medical and psychosocial patient history, provides a tour of and answers any questions about the clinic, and completes initial lab work. The linkage coordinator also discusses the importance of staying in care for the patient and the patient's sexual partner(s).
    - *Appendix B: Project CONNECT Interview Form* provides a tool for taking an HIV history, social history, and insurance status.

ACTIVITIES

- *Appendix C: New Patient Health Questionnaire* consists of measures for depression and anxiety, alcohol consumption, substance use, safety, social support, quality of life, and HIV stigma.

- The linkage coordinator also ensures the patient has a primary care team assembled, which will include:
  - Primary care provider (PCP) – responsible for primary care and prescribing medications.
  - Registered nurse – acts as the main contact between the patient and provider once care is established.
  - Social worker – helps patients with insurance and obtaining medication; initiates or follows-up on referrals, and provides psychosocial assessments and counseling once care is established.
- Before the end of the CONNECT visit, the linkage coordinator helps the patient make a first primary care appointment as soon as possible, but within 6 weeks.
- The linkage coordinator may also help patients identify additional sources of care, such as:
  - HIV specialist: e.g., infectious disease fellow, physician, physician's assistant, or nurse practitioner
  - Chaplain (spiritual, faith, and grief issues)
  - Dentist
  - Endocrinologist (for issues related to diabetes, thyroid, etc.)
  - HIV testing for spouse/partner
  - Mental health counselor (for depression, anxiety, emotional support, etc.)
  - Nephrologist (for renal or kidney issues)
  - Nutritionist (for healthy eating, vitamin/supplement consultation, etc.)

ACTIVITIES

- Palliative care
- Peer-navigator (support from experienced patient who is retained in HIV care)
- Psychiatric services
- Substance use support group/counseling (for drug and alcohol use disorders)

New patient meets with linkage coordinator for 1.5-2 hours

Detailed medical and psychosocial history

Tour of clinic

Initial lab work

Discussion of staying in care & discussion of primary care team

Scheduling of first primary care appointment

Identification of additional sources of care and services, as needed

ACTIVITIES

Phase Three: First Primary Care Provider Visit

- Phase three of the intervention marks the beginning of the patient's transition into medical treatment. To provide patients with support at this critical juncture, the linkage coordinator should attend the first PCP appointment.
- The primary care visit comes last in the Project CONNECT intervention framework to help maximize the patient's comfort and security while transitioning them into HIV care. Patients who feel they have a relationship with clinic staff before beginning treatment regimens are more likely to be retained in care.
- Although the linkage coordinator will not attend every PCP appointment, they should continue to follow-up with patients to ensure that patients stay engaged and retained in care. The linkage coordinator, or another previously-identified member of the primary care team such as the registered nurse and/or social worker, should also check-in regularly with patients to:
    - Monitor patient health
    - Reinforce health literacy and action plans
    - Confirm medication and appointment adherence, and
    - Discuss laboratory results

APPENDICES

APPENDIX A

Clinic Readiness Checklist

Please check the box under the column that most accurately represents your clinic. You should choose ONE answer for each of the essential components listed.

Essential Clinic Components for Implementation	Yes, we have this	No, but it is possible to obtain	No, and it is not possible to obtain this
Clinic provides medical services to PLWH on-site			
PLWH have access to a primary care provider			
PLWH have access to a social worker			
PLWH have access to a registered nurse			
Clinic has the financial means necessary to provide new patients with intensive care and oversight			
Clinic's governing body supports Project CONNECT implementation and maintenance			
Clinic has key ancillary services on-site or is able to provide referral and transportation to access ancillary services			
Clinic uses a secure Electronic Health Record (EHR) system for storing patient data (suggested, not essential)			
Clinic has an ongoing program evaluation plan and has access to and proficiency with data analysis software (suggested, not essential)			

APPENDIX B

Project CONNECT Interview Form *(sample)*

Date: ____ /____ /____ Time Began: _____ Time Ended:_____ Team Member's Initials:_____

Project CONNECT Interview

NAME:_____ PREFERRED NAME:_____
MR#:_____ DOB: _____ AGE: _____
I
NSURANCE: ☐ None - Ryan White/ADAP ☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Aetna
☐ Other _____

1. INTRODUCTION

Marital Status: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Partner ☐ Widowed
Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Other
Gender: ☐ Male ☐ Female ☐ Trans. (M TO F) ☐ Trans. (F TO M)
Height: ____ ____ Weight: _____lbs.

2. HOUSEHOLD

Lives in City: _____ State: _____
Recntly Moved from City:_____ State: _____

Presently lives with/at:
☐ Lives Alone ☐ Spouce ☐ Partner ☐ Mother ☐ Father
☐ Both Parents ☐ Brother ☐ Sister ☐ Friends ☐ Roommates
☐ Stepfather ☐ Stepmother ☐ Relative ☐ Alethia House
☐ The Rectory ☐ Fellowship House ☐ Neighborhood House
☐ Other _____

3. FAMILY HISTORY

Biological Family
Mother is ☐ Living ☐ Deceased Date _____, Cause _____
Father is ☐ Living ☐ Deceased Date _____, Cause _____
_____ Biological brothers living; _____ Biological brothers deceased
_____ Stepbrothers living; _____ Stepbrothers deceased
_____ Biological sisters living; _____ Biological sisters deceased
_____ Stepsisters living; _____ Stepsisters deceased
Children
_____ I do not have any children
_____ Sons living; _____ Sons deceased
_____ Daughters living; _____ Daughters deceased

4. HIV DIAGNOSIS

WHEN did you find out that you were HIV Positive? ____ / ____ / ____

APPENDIX B *(CONTINUED)*

Do you remember *WHY* you got tested?

- ☐ I thought my sexual partner might be HIV positive.
- ☐ I was contacted by the local health department to come in for a test.
- ☐ I was donating blood or plasma.
- ☐ I shared needles with someone who might be positive.
- ☐ My physician recommended I get tested when I was sick.
- ☐ I was incarcerated (in prison or jail) at the time.
- ☐ I went to a hospital emergency room and they tested me.
- ☐ I was in the hospital and they tested me.
- ☐ I went to my doctor's office and they tested me.
- ☐ I am/was pregnant and my doctor's office tested me.
- ☐ I just thought it was a good thing to be tested.
- ☐ I had a possible exposure at work.
- ☐ I was born with HIV.
- ☐ I don't remember.
- ☐ Other _____

HIV Test Facility:

☐ Home ☐ Work ☐ Hospital ☐ ER ☐ Doctor's Office
☐ Jail/Prison ☐ Health Department ☐ Other _____

HIV Test Location City: _____ State: _____

Have you *EVER* participated in an HIV/AIDS Vaccine Trial?

☐ YES ☐ NO Approximate date ____ / ____ / ____

Did you ever have a Negative HIV test *BEFORE* you were tested Positive?

☐ YES ☐ NO Approximate date ____ / ____ / ____

Did you ever *GIVE BLOOD BEFORE* you tested Positive?

☐ YES ☐ NO Approximate date ____ / ____ / ____

5. HIV TREATMENT HISTORY

☐ New DX ☐ NDX - 1 (New dx in Hosp. or ER) ☐ TRC - 1r (Transferring Care) ☐ TRC - 2 (Out of care >1 yr)

☐ NEW PT to Clinic ☐ RETURN PT to the Clinic
☐ Previous Provider Managing HIV ☐ No Previous Provider Managing HIV

Name: _____

Address: _____

Phone: _____ Fax: _____

Do you know your most recent CD4 count? ☐ YES ☐ NO
If yes, most recent CD4: _____ Date: ____ / ____ / ____

APPENDIX B *(CONTINUED)*

Do you know your most recent Viral Load count? ☐ YES ☐ NO
If yes, most recent Viral Load: _____ Date: ____ / ____ / ____

Have you ever taken HIV medications? ☐ YES ☐ NO
If yes, hen did you start taking HIV meds: Date: ____ / ____ / ____

Are you taking HIV medications now? ☐ YES ☐ NO

Would you like for us to get a copy of your records faxed to us?
☐ YES, permission form signed ☐ NO ☐ NOT NEEDED

Have you brough previous medical records? ☐ YES ☐ NO

6. MEDICATIONS and ALLERGIES

Presented Medications: If the patient is on ANY medications, please list below while the patient is filling out the Health Questionnaire.

Medicine	mg	Frequency	Route	Dispense Date
1.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
2.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
3.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
4.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
5.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___

APPENDIX B *(CONTINUED)*

Medicine	mg	Frequency	Route	Dispense Date
6.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
7.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
8.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
9.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
10.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
11.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
12.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
13.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___
14.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___

APPENDIX B *(CONTINUED)*

Medicine	mg	Frequency	Route	Dispense Date
15.		___ tab ___ cap ___ dailiy ___ weekly ___ prn	☐ Oral ☐ Rectal ☐ Mucosal ☐ Patch/skin ☐ Injection	___ / ___/ ___

Do you have any medication allergies? ☐ YES ☐ NO (skip to #7 if answer is NO)

If YES, what medicine(s)?
☐ Penicillin ☐ Sulfa drugs ☐ Inculin preparations
☐ Muscle relaxants ☐ Local anesthetics ☐ Other _____

If YES, what type of reactions?
☐ Itching ☐ Hives ☐ Throat swelling ☐ Loss of consciousness
☐ Asthma ☐ Drop in blood pressure ☐ Irregular heart rhythm
☐ Nausea ☐ Vomitting ☐ Abdominal Cramping

7. HIV DISCLOSURES/EMOTIONAL SUPPORT

Since you found out that you are HIV positive, who have you told about your diagnosis in your family?

☐ Everyone in my family knows about my HIV diagnosis.
☐ No one in my family knows about my HIV diagnosis.
☐ Only the following persons in my family know (mark all that apply):

☐ Husband ☐ Wife ☐ Partner ☐ Cousin(s)
☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s)
☐ Aunt(s) ☐ Uncle(s) ☐ Stepsister(s) ☐ Stepbrother(s)
☐ Stepparent ☐ G-Mother ☐ G-Father ☐ Other _____

Since you found out that you are HIV positive, who have you told about your diagnosis outside your family (friends)?

☐ I am totally open with my friends about my HIV diagnosis.
☐ Only a few friends know about my HIV diagnosis.
☐ Only one friend knows about my HIV diagnosis.
☐ None of my friends know about my HIV diagnosis.

8. HIV TESTING OF PARRNER OR SPOUSE

Are you sexually active with anyone presently?
☐ YES ☐ NO (if No, skip to next section for Spirituality of Faith Beliefs)

Has he or she been tested for HIV?
☐ YES ☐ NO (skip to next section) ☐ Don't Know

His/Her latest test result was ☐ HIV Positive ☐ HIV Negative
If Yes, approximate date of the test: _____ / _____ / _____

APPENDIX B *(CONTINUED)*

Would he or she like to be tested for HIV?
☐ YES ☐ NO ☐ NOT SURE

9. SPIRITUALITY OR FAITH BELIEFS

Are your spiritual beliefts or faith important to you?
☐ YES ☐ NO ☐ NOT SURE

Do you attend a church, synagogue, mosque or other spiritual community?
☐ YES ☐ NO ☐ IN THE PAST, BUT NOT ANYMORE

Are there any spirtual needs or concerns that you would like to discuss with one of our Chaplains?
☐ YES ☐ NO ☐ NOT SURE

10. EDUCATION HISORY/LEARNING ABILITY

The last grade I completed in schol was the
☐ 1ST grade ☐ 2ND grade ☐ 3RD grade ☐ 4TH grade ☐ 5TH grade ☐ 6TH grade
☐ 7TH grade ☐ 8TH grade ☐ 9TH grade ☐ 10TH grade ☐ 11TH grade ☐ 12TH grade
☐ GED ☐ Some college ☐Undergraduate Degree
☐ Post graduate degree ☐ Other _____

Are your reading skills adequate to understand material we may give you?
☐ YES ☐ NO ☐ Yes, but may need a little help

Are your writing skills adequate to fill out information for contact information?
☐ YES ☐ NO ☐ Yes, but may need a little help

Do you have any other learning disabilities?
☐ NO ☐ Attention deficit ☐ Dyslexia ☐Auditory/Visual

11. WORK HISTORY

Type of work (or what field)?
In the past, I worked at _____☐ None
Presently working at _____☐ Not Working
Since _____ (year), I have been on disability ☐ On Disability

Is your income greater thatn $31,200 annualy or $2,600 monthly?
☐ YES ☐ NO ☐ If NO, pleae introduce to SocialWorker before lab work.

12. INCARCERATION HISTORY

Have you ever been in prision? ☐ YES ☐ NO

APPENDIX B *(CONTINUED)*

13. REFERRALS COMPLETED

☐ **Chaplain** (Grief, Spiritual issues, make appt. with Malcolm Marler)
☐ **CompSAT** (Substance Use History, make appointment with Paige Ingle-Pang)
☐ **Dental Clinic** (fill out blue referral form and give to Tonesa Spivey, encourage pt. to make own appt)
☐ **HIV Testing for Spouse/Partner** (Overhead page a member of Testing Team, or give contact information to Kelly Ross-Davis/Chris Hamlin)
☐ **Mental Health Counselor** (Depression, anxiety, emotional support, make appt. w/Charles Wright)
☐ **Nutritionist** (healthy eating, vitamins/supplement consult, make appt. with Donna Yester)
☐ **OB-GYN**
☐ **Peer Navigator** (support from experienced patient, get consent form signed, assignment made)
☐ **Research Study Possibility** - HAART naive (email patient's contact information and Provider appt to Karen Savage)
☐ **Social Services** (Ryan White/ADAP, Houseing, Medicine Acquisition,
☐ **Volunteering or Patient Advisory Board** (give contact information to Kelly Ross-Davis)

14. DOCUMENTATION REQUESTED TO BRING TO FIRST PHYSICIAN APPOINTMENT

☐ Present Medicines
☐ Proof of Residence
☐ Proof of Income
☐ Previous medical records
☐ Other _____

REMINDER FOR INTERVIEWER

☐ **IF YOU DO NOT HAVE INSURANCE**
We will need to meet with one of our social workers TODAY BEFORE we do lab work to get you enrolled into the Ryan White and ADAP programs to help cover most of the cost of doctor's visists and HIV medicines. (Note to INterviewer: Overhead page Wes or Kathy or Crystal and let them know you have a new patient who needs Ryan White and ADAP. Meet him/her in lab or office.)

☐ **IF YOU ARE NEWLY DIAGNOSED OR HAVE JUST MOVED TO ALABAMA AND ALREADY HAD A DIAGNOSIS OF HIV?**
Because HIV is a transmissible virus and in the interest of Public Health, the County Health Department in the county where you live is going to contact you by phone to set up an interview with you. We encourage you to call te County Health Department in the county where you live if you have not talked with them yet. and ask to speak to the HIV Coordinator.

APPENDIX C

New Patient Health Questionnaire

TODAY'S DATE: _____ / _____ / _____

NAME:_____

Thank you for printing clearly

MEDICAL RECORD #:_____

DATE OF BIRTH: _____

HIV TREATMENT HISTORY:

_____New Diagnosis (NDX)

_____New Diagnosis in hospital of Emergency Room (NDX-1)

_____Diagnosed over 6 months ago, new to treatment (NDX-2)

_____Transferring care (TRC-1)

_____Out of care for >1 year (TRC-2)

_____Released from prison in the last 30 days (TRC-P1)

_____Released from prison over 30 days ago (TRC-P2)

What is the highest grade you completed?

_____1-6

_____7-9

_____10

_____11

_____12

_____GED

_____Technical training

_____Some college

_____College graduate

_____Post graduate

APPENDIX C *(CONTINUED)*

Instructions

Please take a few minutes to fill out the Patient Health Questionnaire in order for your medical team to understand your history.

We appreciate your honesty in answering all of the questions so that we can have the most accurate information possible to be able to be your partner in caring for your health.

This questionnaire includes the following areas:

- Depression and Anxiety
- Alcohol Consumption
- Substance Use
- Safety
- Social Support
- Quality of Life
- HIV Stigma

APPENDIX C *(CONTINUED)*

Depression and Anxiety

Please indicate how often over the LAST 2 WEEKS you have been bothered by any of the following problems.

For each question, please indicate the answer that best applies by checking the box.

Have you felt?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thought that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

APPENDIX C *(CONTINUED)*

1. In the last 4 weeks, have you had an anxiety attack - suddenly feeling fear or panic?

   ❑ Yes

   ❑ No (If NO, go to the next page)

   If YES,

2. Has this ever happened before?

   ❑ Yes

   ❑ No

3. Do some of these attacks come suddenly out of the blue - that is, in situations where you don't expect to be nervous or uncomfortable?

   ❑ Yes

   ❑ No

4. Do these attacks bother you a lot or are you worried about having another attack?

   ❑ Yes

   ❑ No

5. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?

   ❑ Yes

   ❑ No

APPENDIX C *(CONTINUED)*

Alcohol Consumption

This portion of the questionnaire is about your use of alcoholic beverages during the **past year**.

For each question, please indicate the answer that best applies by checking the box.

1. How often do you have a drink containing alcohol?
   - ❑ Never
   - ❑ Monthly or less
   - ❑ 2-4 times a month
   - ❑ 2-3 times a week
   - ❑ 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - ❑ 1 or 2
   - ❑ 3 or 4
   - ❑ 5 or 6
   - ❑ 7 or 8
   - ❑ 9 or more
3. How often do you have 5 or more drinks on one occasion?
   - ❑ Never
   - ❑ Less than monthly
   - ❑ Monthly
   - ❑ Weekly
   - ❑ Daily or almost daily

APPENDIX C *(CONTINUED)*

Substance Use

Now we are going to ask you about drug use.

For each question, please indicate the answer that best applies by checking the box.

1. In your life, have you EVER used marijuana?
   - ❑ No (If NO, Skip to Question 6 on the next page)
   - ❑ Yes
2. In the PAST 3 MONTHS, how often have you used marijuana?
   - ❑ Never
   - ❑ Once or twice
   - ❑ Monthly
   - ❑ Weekly
   - ❑ Daily or almost daily
3. During the PAST 3 MONTHS, how often have you been preoccupied or concerned about your use of marijuana?
   - ❑ Never
   - ❑ Once or twice
   - ❑ Monthly
   - ❑ Weekly
   - ❑ Daily or almost daily
4. During the PAST 3 MONTHS, how often has your use of marijuana led to problems with family, friends, legal authorities, your employment (or school), your personal finances or your health?
   - ❑ Never
   - ❑ Once or twice
   - ❑ Monthly
   - ❑ Weekly
   - ❑ Daily or almost daily

APPENDIX C *(CONTINUED)*

5. Have you tried to control, cut down or stop using marijuana?
   - ❑ No
   - ❑ Yes, but not in the last 3 months
   - ❑ Yes, in the past 3 months
6. In your life, have you EVER used cocaine or crack?
   - ❑ No (If NO, Skip to Question 6 on the next page)
   - ❑ Yes
7. In the PAST 3 MONTHS, how often have you used cocaine or crack?
   - ❑ Never
   - ❑ Once or twice
   - ❑ Monthly
   - ❑ Weekly
   - ❑ Daily or almost daily
8. During the PAST 3 MONTHS, how often have you been preoccupied or concerned about your use of cocaine or crack?
   - ❑ Never
   - ❑ Once or twice
   - ❑ Monthly
   - ❑ Weekly
   - ❑ Daily or almost daily
9. During the PAST 3 MONTHS, how often has your use of cocaine or crack led to problems with family, friends, legal authorities, your employment (or school), your personal finances or your health?
   - ❑ Never
   - ❑ Once or twice
   - ❑ Monthly
   - ❑ Weekly
   - ❑ Daily or almost daily

APPENDIX C *(CONTINUED)*

10. Have you tried to control, cut down or stop using cocaine or crack?

    - ❑ No
    - ❑ Yes, but not in the last 3 months
    - ❑ Yes, in the past 3 months

11. In your life, have you EVER used amphetamines (crystal meth, speed, crank)? (non-medical use only)

    - ❑ No (If NO, Skip to Question 11)
    - ❑ Yes

12. In the PAST 3 MONTHS, how often have you used amphetamines (crystal meth, speed, crank)?

    - ❑ Never
    - ❑ Once or twice
    - ❑ Monthly
    - ❑ Weekly
    - ❑ Daily or almost daily

13. During the PAST 3 MONTHS, how often have you been preoccupied or concerned about your use of amphetamines (crystal meth, speed, crank)?

    - ❑ Never
    - ❑ Once or twice
    - ❑ Monthly
    - ❑ Weekly
    - ❑ Daily or almost daily

14. During the PAST 3 MONTHS, how often has your use of amphetamines (crystal meth, speed, crank) led to problems with family, friends, legal authorities, your employment (or school), your personal finances or your health?

    - ❑ Never
    - ❑ Once or twice
    - ❑ Monthly
    - ❑ Weekly
    - ❑ Daily or almost daily

APPENDIX C *(CONTINUED)*

15. Have you tried to control, cut down or stop using amphetamines (crystal meth, speed, crank)?

    - ❑ No
    - ❑ Yes, but not in the last 3 months
    - ❑ Yes, in the past 3 months

16. In your life, have you EVER used opiates (heroin or non-prescribed opioid pain medications)? (non-medical use only)

    - ❑ No (If NO, skip to Question 16)
    - ❑ Yes

17. In the PAST 3 MONTHS, how often have you used opiates (heroin or non-prescribed opioid pain medications)?

    - ❑ Never
    - ❑ Once or twice
    - ❑ Monthly
    - ❑ Weekly
    - ❑ Daily or almost daily

18. During the PAST 3 MONTHS, how often have you been preoccupied or concerned about your use of opiates (heroin or non-prescribed opioid pain medications)?

    - ❑ Never
    - ❑ Once or twice
    - ❑ Monthly
    - ❑ Weekly
    - ❑ Daily or almost daily

APPENDIX C *(CONTINUED)*

19. During the PAST 3 MONTHS, how often has your use of opiates (heroin or non-prescribed opioid pain medications) led to problems with family, friends, legal authorities, your employment (or school), your personal finances or your health?

    - ❑ Never
    - ❑ Once or twice
    - ❑ Monthly
    - ❑ Weekly
    - ❑ Daily or almost daily

20. Have you tried to control, cut down or stop using opiates (heroin or non-prescribed opioid pain medications)?

    - ❑ No
    - ❑ Yes, but not in the last 3 months
    - ❑ Yes, in the past 3 months

21. Have you EVER used any drug by injection (non-medical use only)?

    - ❑ No
    - ❑ Yes, but not in the last 3 months
    - ❑ Yes, in the past 3 months

22. During the past year, have you received any treatment for drug or alcohol use?

    - ❑ No
    - ❑ Yes

APPENDIX C *(CONTINUED)*

Safety

In this clinic, we are concerned about your health and safety. Many people have experienced violence or are in relationships where they are afraid their partners or others who are close to them may hurt them. Because of this, we are going to ask you about safety in relationships.

For each question, please indicate the answer that best applies by checking the box.

1. Are you presently emotionally or physically abused by your partner or someone important to you?

   ❑ No

   ❑ Yes

2. Are you presently being hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you?

   ❑ No

   ❑ Yes

3. Are you presently forced to have sexual activities?

   ❑ No

   ❑ Yes

4. Are you afraid of your partner or any one of the following?

   ❑ Current or former intimate partner

   ❑ Other family member

   ❑ Acquaintance or friend

   ❑ Coworker

   ❑ Other

   ❑ Does not apply

5. (If pregnant) Have you ever been hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you during your pregnancy?

   ❑ No

   ❑ Yes

   ❑ Does not apply

APPENDIX C *(CONTINUED)*

6. Prior to now, have you EVER been emotionally or physically abused by your partner or someone important to you?

   ❑ No

   ❑ Yes

7. Prior to now, have you EVER been hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you?

   ❑ No

   ❑ Yes

8. Prior to now, have you EVER been forced to have sexual activities?

   ❑ No

   ❑ Yes

APPENDIX C *(CONTINUED)*

Social Support

People sometimes look to others for friendship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? For each question, please indicate the answer that best applies by checking the box.

1. How often do you have someone to turn to for suggestions about how to deal with a personal problem?
   - ❑ None of the time
   - ❑ A little of the time
   - ❑ Some of the time
   - ❑ Most of the time
   - ❑ All of the time
2. How often do you have someone to help with daily chores if you were sick?
   - ❑ None of the time
   - ❑ A little of the time
   - ❑ Some of the time
   - ❑ Most of the time
   - ❑ All of the time
3. How often do you have someone to love you and make you feel wanted?
   - ❑ None of the time
   - ❑ A little of the time
   - ❑ Some of the time
   - ❑ Most of the time
   - ❑ All of the time
4. How often do you have someone to do something enjoyable with?
   - ❑ None of the time
   - ❑ A little of the time
   - ❑ Some of the time
   - ❑ Most of the time
   - ❑ All of the time

APPENDIX C *(CONTINUED)*

Quality of Life

For each question, please indicate the answer that best applies by checking the box.

1. Mobility
   - ❑ I have no problems in walking about
   - ❑ I have some problems in walking about
   - ❑ I am confined to a bed or wheelchair
2. Self-care
   - ❑ I have no problems with self-care
   - ❑ I have some problems with washing and dressing myself
   - ❑ I am unable to wash or dress myself
3. Usual activities (e.g., work, study, housework, family, or leisure activities)
   - ❑ I have no problems with performing my usual activities
   - ❑ I have some problems with performing my usual activities
   - ❑ I am unable to perform my usual activities
4. Pain/discomfort
   - ❑ I have no pain or discomfort
   - ❑ I have moderate pain or discomfort
   - ❑ I have extreme pain or discomfort
5. Anxiety/depression
   - ❑ I am not anxious or depressed
   - ❑ I am moderately anxious or depressed
   - ❑ I am extremely anxious or depressed

APPENDIX C *(CONTINUED)*

HIV Stigma

This questionnaire asks about some of the social and emotional aspects of having HIV. For each of the questions, circle the letters that go with your answer. There are no right or wrong answers. If a question refers to something that has not happened to you, please imagine yourself in that situation. Then give your answer based on how you think you would feel, or how you think others would react to you.

	Strongly Disagree (SD)	Disagree (D)	Agree (A)	Strongly Agree (SA)
1. I have been hurt by how people reacted to learning I have HIV.	SD	D	A	SA
2. I have stopped socializing with some people because of their reactions to my having HIV.	SD	D	A	SA
3. I have lost friends by telling them I have HIV.	SD	D	A	SA
4. I am very careful about whom I tell that I have HIV.	SD	D	A	SA
5. I worry that people who know I have HIV will tell others.	SD	D	A	SA
6. I feel that I am not as good a person as others because I have HIV.	SD	D	A	SA
7. Having HIV makes me feel unclean.	SD	D	A	SA
8. Having HIV makes me feel that I'm a bad person.	SD	D	A	SA
9. Most people think that a person with HIV is disgusting.	SD	D	A	SA
10. Most people with HIV are rejected when others find out.	SD	D	A	SA

Thank you for letting us know more about your health history.

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