ICAP Columbia University Mailman School of Public Health

Screening Tool to Identify and Support P@HR of HIV Disease Progression

For patients who have been on ART for at least six months

**NOTE THAT THESE QUESTIONS HAVE NOT BEEN VALIDATED*

HIV Learning Network
The CQUIN Project for Differentiated Service Delivery

Name of patient:	**Where was this questionnaire administered?** *(Write: ART Facility, Community ART Group, Other Venue):*
Name of provider completing this form:	**Date:** *(dd/mm/yyy)*

Part 1: Composite Index for Peer/Adherence Support

Notes/Referrals:

Instructions for Part 1:
Read each question to the patient, and circle his/her response (e.g., "yes," "no," or "not applicable").
At the end of Part 1, total the scores for questions 1-9. The total score will tell you if a referral for peer support and/or adherence support is indicated. Document the result, and move to Part 2.

Add notes to this column and/or circle the arrows relevant to the patient to help you organize and prioritize referrals

Poverty & Economic Struggles	**Yes (Circle Number Below)**	**No or Not Applicable (Circle Number Below)**
1. Is it sometimes difficult for you to keep your HIV clinic appointments because you do not have money for transportation?	1	0
Food Insecurity	**Yes (Circle Number Below)**	**No (Circle Number Below)**
2. Do you ever miss taking your HIV medications because you are hungry/lack food?	2	0
Alcohol & Substance Use	**Yes (Circle Number Below)**	**No or Not applicable (Circle Number Below)**
3. Do you ever miss taking your HIV medications because you use alcohol or other drugs?	4	0
HIV Disclosure	**Yes (Circle Number Below)**	**No (Circle Number Below)**
4. Have you told anyone, such as your partners, family, or friends, about your HIV status?	0	2
Stigma & Discrimination	**Yes (Circle Number Below)**	**No (Circle Number Below)**
5. Do you feel like you are looked at or treated differently because of your HIV status?	2	0
Family / Partner Relationship / Inadequate Psychosocial Support	**Yes (Circle Number Below)**	**No (Circle Number Below)**
6. Is there usually someone who can remind you about taking your HIV treatment?	0	1
Distance from the Health Facility (Access)	**Yes (Circle Number Below)**	**No (Circle Number Below)**
7. Does it take too long for you to get to a place where you can get HIV services (clinic, hospital, community, etc.)?	2	0
Sub-Optimal Functional Status	**Yes (Circle Number Below)**	**No (Circle Number Below)**
8. Do you find it difficult to do your usual day-to-day activities because you feel sick, weak, or have other health problems?	2	0

Co-Morbid Health Conditions	Yes (Circle Number Below)	No (Circle Number Below)	
9. Do you have any other health conditions (hypertension, heart disease, diabetes, cancer) that interfere with taking your HIV treatment?	2	0	
Add up the total score f*or questions #1-9.* ***If the total score is 4 or more, refer the recipient of care for peer support or additional adherence support.***	**TOTAL_____**		≥ 4 → Refer for peer support and/or adherence counseling

Part 2: Other Indicators for Referral

At the end of each question below, complete the total score for the question, determine if a referral is indicated, and circle the arrows to the right when they are.

Instructions for Part 2:
Questions 10a & 10b come from the PHQ-2 for major depressive disorder. A PHQ-2 score ranges from 0-6. The cut-off score is 3 for referral on questions 10a & 10b. Question 11 comes from the GAD-2 for generalized anxiety disorder. A GAD-2 score ranges from 0-6. The cutoff is 3 for referral on questions 11a & 11b.

Emotional Issues/Depression/Mental Health				
10. Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
Add up the total score f*or question 10a & 10b.* ***If 3 or more, refer the recipient of care for prompt clinical mental health support.***	**TOTAL_____**			≥ 3 → Refer for clinical mental health support
11. Over the last 2 weeks, how often have you been bothered by the following problems?	**Not At All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
a. Feeling nervous, anxious, or on edge	0	1	2	3
b. Not being able to stop or control worrying	0	1	2	3
Add up the total score f*or questions 11a & 11b.* ***If 3 or more, refer the recipient of care for prompt clinical mental health support.***	**TOTAL_____**			≥ 3 → Refer for clinical mental health support

Pill Burden	YES	NO	
Read the following to recipient of care before question #12: Some people on ARVs have told us that they have no diffculty taking their medications as prescribed. Others have told us that they sometimes find it difficult taking their ARVs as prescribed. Now I'm going to ask about your experience.			
12. Do you sometimes feel that taking your ARVs or other medications is tiresome because you are taking too many tablets/pills?	☐	☐	
13. Do you sometimes feel that you want to stop taking your ARVs and other medications?	☐	☐	
14. Have you missed taking your ARV medication on any day in the last one week?	☐	☐	
Any reponse of YES to questions 12-14 means that patient should receive adherence counseling today, after screening is complete.			YES → Refer for adherence counseling

Missed Clinic Appointment(s) in Past 6 Months	YES	NO	
15. Have you missed any HIV clinic appointment in the past six months?	☐	☐	
A YES answer to question 15 means that patient should be referred for peer support.			YES → Refer for peer support

Viral Load & CD4 [Also check clinic records if these test results are available.]	YES	NO	Unknown, or no test in past 12 months
16. Was the result of your last viral load test greater than 1,000 copies/ML?	☐	☐	☐
17. Was the result of your last CD4 test less than or equal to 200 cells/ML?	☐	☐	☐
Questions 16-17: Any response of YES means patient should be referred for peer support and/or enhanced adherence counseling, following national guidelines. If unknown or no test in past 12 months, follow up with clinical team to see if repeat testing is indicated.			

YES → **Refer for peer support and/or adherence counseling and/or clinical evaluation**

Side Effects of Treatment	YES	NO
18. Do you sometimes experience side effects from your medications that make it difficult for you to take your treatment?	☐	☐
Question 18: A YES answer means patient should be referred to a clinician to receive further assessment.		

YES → **Refer for clinical evaluation**

Experienced Violence at Home	YES	NO
Provider to read question 19 prompt: Many women and men do not realize that violence can lead to many kinds of health problems. Violence (hitting, kicking, slapping, physical abuse, being verbally threatened, or sexually abused) is common in both women's and men's lives. There is help available for both women and men who have experienced such abuse.		
19. In the past 12 months, have you experienced any verbal, physical, or sexual violence?	☐	☐
Question 19: A YES answer means that patient should be screened for exposure to gender-based violence (GBV) and referred as necessary/appropriate.		

YES → **Screen for GBV and refer as needed**

Scoring and Next Steps:

Review the scores above and any notes/circles in the right-hand column. If the patient meets criteria for **peer support, adherence counseling**, **clinical assessment**, or **GBV screening**, explain your recommendations to the patient and arrange appropriate appointments and follow-ups.

Provider Script for Patient Referral *(if patient needs to be referred)*

Thank you for answering the questions. Based on your responses, we have been able to determine that you need some additional support to make sure that you continue to stay healthy and on course with your ART regimen. I am going to refer you for additional support, as well as provide some guidance on other issues that came up in your answers to my questions (for example, how much medicine to take, the importance of getting your viral load test, etc). Do you have any questions for me?

Was Patient Referred? *Please circle yes or no, and add completed screening tool to patient file.*	**YES**	**NO**		Additional comments: *Which referrals were made? List appointment dates, locations, and contact persons*
If Referrals were made at a previous assessment, did patient follow through? *Please circle yes, no or not applicable (N/A) and add completed screening tool to patient file.*	**YES**	**NO**	**N/A**	Additional comments: W*hich referrals were completed? What services were provided or recommended?*