



**MANITOBA
HIV PROGRAM**

Procedure: 6.5.3 PATHS acuity scale form

Approval date: August 1, 2024

Revised: October 10, 2024

Approved by: Director, MB HIV Program

PATHS Acuity scale initial assessment template

The following template is to be utilized by the PATHS care team as part of the initial acuity scale. Using this document ensures areas of care are being explored, with relevant information gathered. Once completed, clinical information should be entered into the EMR (corresponding care bands, demographics, etc.) and inform the “PATHS Acuity Scale” form.

Refer to procedure “4.7 Care planning” for additional information.

Medical Stability – Initial Ax

Name:

Date:

- 1 Health is stable; ongoing access and engagement with PCP and HIV care; independently manage health care with occasional referral.
- 2 Health is stable /moderate health problems; (chronic conditions or acute coinfections that are being managed; needs occasional help to access/maintain engagement with health services.
- 3 Medically fragile but able to tend to ADLs; comorbid or acute infections requiring treatment; attendance at appointments is sporadic; requires regular assistance to maintain engagement with health services.
- 4 Serious/severe medical issues that may be life-threatening or an acute medical crisis; new HIV dx; needs assistance navigating health care system; pregnant/recently delivered; uses ED as PCP; recent HIV related hospitalization (60 days).

Date/location of HIV dx:

Date of last negative HIV test:

VL and CD4 (with %) at dx:

CD4 (with %) Nadir/date:

Most recent VL and CD4 (with %):

Allergies:

Previous HIV Care: physician, care site

ART: current, hx

History of Opportunistic Infections/AIDS-Defining Illnesses:

Baseline Investigations completed: CD4, Viral Load, HIV-Genotype, HLA-B5701 Typing, Baseline serology, Baseline chemistry, Baseline hematology, HgbA1C, Lipids, IGRA, CXR, +/- pregnancy test, CrAg if CD4 <200.

STI current/hx date/treatment: HPV, HSV, GC, CT, Trich, Syphilis, PID.

PmHx: Hep C, hep B, TB, CVD, asthma, COPD, dyslipidemia, DM, renal disease, HTN, bone disease, cancer, liver problems/cirrhosis, thyroid, stomach ulcers/acid reflux/IBS, seizures, mental health disorders.

Current dx: date, details, treatment/management

Other relevant medical hx:

Previous hospital admissions: date, length, reason, discharge orders, voluntarily, EMS/WPS, discharge plan/follow up, AMA.

Surgeries:

Other Physicians currently involved in care: name, specialty, location.

Health screening

Eye exam:

Dental:

Mammography:

FIT:

PCP: last visit, clinic

Menstrual hx: length of cycles, regular/irregular, LNMP.

Pregnancy hx: G/P/TA/SA, other details/deliveries.

Contraception: current - details, past.

Cervical cancer screening: previous pap test, hx abnormal pap, previous colposcopy

Details of any treatment:

Immunizations

Hepatitis A -

Hepatitis B -

Pneumovax -

Td/Tdap -

Childhood immunizations –

Medications

Current prescriptions - dosage, indication, last fill, dispensing frequency, same provider, adherence.

Past prescriptions - dosage, indication, last fill

Medication reconciliation - DPIN, pharmacy lists

Review of Systems

Constitutional sx present: fever, night sweats, anorexia, weight loss, fatigue.
Lymphadenopathy.

HEENT: change in vision, blurred vision, vision loss, double vision, floaters, oral candidiasis, oral hairy leukoplakia, oral ulcers, sore throat, gum disease, nose bleeds, nasal congestion, hearing loss, ringing in ears, ear pain, ear discharge.

Cardiovascular: chest pain, chest pressure, palpitations, SOB on exertion, leg or pedal edema.

Respiratory: denies any symptoms, dry cough, productive cough, blood in sputum, dyspnea, wheezing.

Gastrointestinal: dysphagia, odynophagia, dyspepsia or reflux, nausea, vomiting, diarrhea, constipation, blood in stools.

Genitourinary: lesions or sores on genital area, HSV outbreaks, lower abdominal pain, vaginal discharges, odor, dysuria, urinary frequency, urinary urgency, urinary incontinence, testicular pain, nocturia, penile discharge, erectile dysfunction.

Musculoskeletal: muscle aches or pain, joint pain, joint swelling, deformity, back pain, hx of injury or fracture, chronic pain.

Skin: skin rashes, bruises, bumps, moles, tinea infection, folliculitis, flaking or itching on skin or scalp.

Neurologic: headache, dizziness, peripheral neuropathy, weakness in arms or legs, gait, difficulty with memory or ability to concentrate.

Psychiatric: mood, hopeless, anger, sad, irritable, anxious, sleep pattern, appetite.

Head-to-Toe exam (Cater to client's presenting concerns)

Height-

Weight-

VS

BP-

Pulse-

SpO2-

Resps-

Temp-

Client goals:

1.

2.

Priority recommendations of care team:

1.

2.

Mental Health – Initial Ax

Name:

Date:

- 1 No known history/evidence of mental illness; high level social functioning; appropriate behavior and coping.
- 2 Mental illness/history of mental illness; stable from treatment, ongoing adherence; adequate emotional stability/coping to manage ADLs; minimal difficulty with personal relationships.
- 3 Chronic or major mental illness requiring ongoing diagnosis/treatment; limited access to mental health service; not engaged or demonstrated inability to maintain adherence to psychiatric meds; inappropriate social behaviors; mild to moderate impairment in ADLs.
- 4 May be a danger to self or others; highly depressed, suicidal, violent or potential for violence, psychotic, crisis state, significant social challenges; not presently engaged in treatment.

MH dx: year, provider

Co-occurring substance use and effects:

Current MH medications: Indication, adherence, start, dose adjustments, prescriber, effect

Past MH medications: Last use, trialed, reason for discontinuation.

Psychiatric admissions: date, length, reason, hospital/unit, treating psychiatrist, voluntary, involuntary, outpatient psychiatry.

Discharge summaries: inpatient, ED, CRC, SMHC

Community Psychiatrist/Psychologist: name, location, frequency, last appointment, next appointment.

Consultations: who, where, when, outcome.

Counsellor/Therapist: name, location, frequency, last appointment, next appointment.

Self-Harm behaviour: details of current, past

Suicidal ideation: current, pattern/intensity of thoughts, plan (means, access, timing, preparatory acts), intent, protective factors, risk factors, safety planning.

Hx of SI and attempts: date, how, outcome.

Homicidal ideation/acts of violence: current, past.

FmHx of MH:

Community supports/programming:

Hx of trauma:

Meaning of lived experience to client:

Self-described strengths and coping strategies:

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Substance Use – Initial Ax

Name:

Date:

- 1 No history or difficulties with substance use or evidence of dependence; no behavioral disturbances related to substance use.
- 2 History of substance use; no current indication of dependence; may be engaged in treatment/relapse prevention; may need education/referral.
- 3 Currently using substances; functional difficulties related to own or family member's use; inconsistent/unsuccessful treatment engagement; aware of need for treatment; addictions services are available and can be accessed with referral/support.
- 4 Substance use crisis state; major impairment in function; declines treatment/addictions services; indifference regarding consequences of use; engaged in dangerous high-risk behaviors.

Substance of choice: age of onset, route, frequency, quantity, pattern of using, hx of withdrawal, longest period of time without using and effects.

Other substance use: age of onset, route, frequency, quantity, pattern of using, benefit of use, hx of withdrawal. longest period of time without using and effects.

Community supports accessed: MOPS, shelters, Pit Stop, Street Connections, etc

Detox hx: date, length of stay, completed, reason for leaving.

Treatment hx: residential, inpatient, outpatient, transitional sober housing, drop-in.

Pharmacological interventions current: start date, dose, frequency, prescriber, benefit

Pharmacological interventions discontinued: when, why, interest in revisiting as option?

Overdose history: when, details, medical intervention.

Safer drug use knowledge: new supplies, carrying naloxone, red zones for IVU, doctor yourself, sterile water, start slow/go low, management of missed shots, etc.

Why do you use?

What are the good things?

The things you don't like about it anymore?

How does it make you feel?

How do you support your substance use?

Consequences to health as a result of your use: presence of abscesses, skin lesions, dentition, rhematic disease, etc.

Effects of mental health: depression, suicidal ideation, psychosis, anxiety, mania, etc.

Current stage of change: pre-contemplative, contemplative, preparation, action, and maintenance.

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

HIV Knowledge/Risk Reduction – Initial Ax

Name:

Date:

- 1 Clear understanding of HIV transmission, prevention and progression; able to initiate and maintain protective and positive behavior change; client is aware of treatment complexities and services availability; no recent history of STBBIs
- 2 Some understanding of HIV; knowledgeable about most available HIV behavior change interventions; may have difficulty initiating or maintaining protective behaviors; may not appropriately personalize risk and need education and referral; no STBBIs in past 12 months.
- 3 Little understanding of HIV; significant difficulties initiating and maintaining protective behaviors; inappropriately personalizes risk, with frequent relapse to risk behaviors; recent history of STBBIs in past six months.
- 4 No understanding of HIV; actively engages in risk behaviours; unable/unwilling to personalize transmission risk; denial about HIV diagnosis recent/current positive STBBIs.

Understands HIV as a lifelong dx that is treatable:

Can explain monitoring of HIV through CD4 count and VL:

Understands role of ARV's and need for adherence:

Understands risk of OI's and AIDS defining illness:

Can articulate how HIV is transmitted:

Understands treatment prevents sexual transmission when VL suppressed (U=U):

Clients current high risk transmission behaviors:

Past high risk transmission behaviors:

Understands principals of harm reduction:

Sites where client accesses harm reduction supplies:

Sexual activity: contraception

Partner(s): Genders, types of sex, barrier use, PrEP, serodiscordant or not, routine testing.

Client goals:

1.

2.

Priority recommendations of care team:

1.

2.

Treatment Plan Adherence – Initial Ax

Name:

Date:

- 1 Adherence to ARV's > 95%; treatment adherent for > 6 months; no barriers to adherence, good access to resources; strong self-advocacy with providers; keeps scheduled medical appointments; no co-morbidities/managed chronic co-morbidities; does not need help with treatment plan.
- 2 Adherence to ARV's 90%-95% for > 3 months but < 6 months; sporadic barriers to adherence; moderate self-advocacy skills; attends most medical appointments; chronic comorbidities that are manageable with minimal help.
- 3 Adherence to ARV's 80-90%; only treatment adherent with assistance; ongoing barriers to adherence and misses weekly doses; poor self-advocacy; misses 50% of medical appointments; chronic comorbidities that are not well managed.
- 4 Medication crisis; misses doses of daily meds; non-adherent to meds/medical appointments despite support and advice; denial of HIV diagnosis; not on ART; unmanaged acute/chronic conditions.

ART naïve:

Hx of interventions to support adherence: compliance pack, pharmacy - daily dispense, weekly delivery.

Perceived barriers to adherence:

Strategies to support adherence:

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Activities of Daily Living – Initial Ax

Name:

Date:

- 1 Basic needs are being adequately met; independent, has high level of skills, and has no evidence of inability to manage ADLs.
- 2 Ability to meet basic needs and manage ADLs but may need referral and information to identify available resources ie: nutrition support.
- 3 Needs assistance to identify, obtain and maintain basic needs and manage ADLs; poor ADL management is noticeable and pronounced.
- 4 Unable to manage ADLs without immediate, ongoing assistance; acute need of caregiver services; dependent on others for care.

Requires support with ADLs: bathing, dressing, ambulating, toileting, feeding.

Requires support with instrumental ADLs: cleaning, transportation, laundry, finances.

Involvement of professional supports: name, location, frequency of support.

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Housing – Initial Ax

Name:

Date:

- 1 Permanent, fully adequate, stable housing; client is independently capable of financial and physical maintenance and is in no danger of losing housing.
- 2 Currently has adequate housing but may infrequently need short-term rent or utilities assistance or may have mild stress in their living situation.
- 3 Transitional or unstable housing; may have unhealthy, stressful living environment; may be in continuous financial strain; at risk of eviction and/or utility shut off.
- 4 Homeless, living in shelters, living rough, in crisis; immediate danger of becoming homeless; in custody or recently released from prison; living situation presents immediate health hazard or physical danger from abuse; unable to qualify for housing opportunities due to justice involvement and conditions.

Current housing: shelters, couch surfing, independent housing, transitional housing, supported independent housing, shift-staffed home, foster home, hospital, custodial setting, living rough.

Hx of housing:

Involvement of professional supports: name, location, frequency of support.

Referrals to: Manitoba Housing, Winnipeg Housing, Winnipeg Rehabilitation Housing Corporation, SAM management.

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Nutritional Needs – Initial Ax

Name:

Date:

- 1 Eating at least two meals/day and client does not request any food assistance; does not require any nutritional intervention; no weight loss or excessive weight gain.
- 2 Eating at least two meals/day 75% of the time or more; may need food assistance; changes in eating habits in the past 3 months; some nutritional needs that are being met; no significant weight loss or gain in the past 12 months and/or occasional episodes of nausea, vomiting, or diarrhea.
- 3 At risk of malnourishment; nutritional needs that are not being addressed and health is significantly affected; chronic nausea, vomiting, diarrhea, and/or other physical maladies; observable that there is weight loss in the last 6 months.
- 4 Considered malnourished; nutritional status is profoundly affecting health; severe eating problems, nausea, vomiting diarrhea, and/or other physical maladies; that there is significant weight loss in the last 3 months.

Current resources:

Community supports utilized: Siloam, Lighthouse Mission, Agape Table, UGM, MSP, RaY, Tina's Safe Haven, Crossways, St. Matthews Community Ministry.

Referrals to: Foodbanks (MBHIVP or other locations), dietician, EIA benefits.

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Support System and Meaningful Activities – Initial Ax

Name:

Date:

- 1 Strong, appropriate and supportive relationships providing emotional support (partner, family, friends); disclosed HIV status to support system; engaged in meaningful activities independently.
- 2 Moderate gaps in availability and adequacy of support system from family and friends; requesting additional support (support groups and peer support); many members of support system are aware of HIV status; engaged in meaningful activities with support.
- 3 Inconsistent and/or no dependable support system; isolated from family, social groups and/or may be new to community; few individuals are aware of HIV status; regularly requires emotional support from case manager; expressed interest in exploring meaningful activities but has not engaged.
- 4 No support system; in imminent danger of being in crisis; isolated from others; has not disclosed HIV status outside care providers; recent loss of primary emotional support; support system members are abusive; not engaged in or discussions related to meaningful activities.

Identified supports:

Meaningful activities:

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Children/Dependents – Initial Ax

Name:

Date:

- 1 No children/dependents living with them; needs no assistance.
- 2 Has children/dependents living with them; requires minimal or occasional assistance with children/dependents; requires occasional support with childcare and childcare subsidy; needs assistance to disclose HIV status to children/dependents.
- 3 Has children/dependents living with them or has a child/dependent with special needs; at-risk of crisis without support for children/dependents; needs ongoing childcare support; requires support navigating CFS system; children are in short or long-term care.
- 4 Has children/dependents living with them at risk of physical harm; active crisis involving children/dependents; client unable to provide care and/or is faced with possibility of losing children without supportive intervention; active involvement of CFS; single parent without support system and compromised health; client's children are in involuntary or permanent care; client is under 18 years of age.

Children:

CFS involvement:

Involvement of supports:

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Violence – Initial Ax

Name:

Date:

- 1 No history of interpersonal violence.
- 2 Remote history of interpersonal violence, no current risks reported or observed.
- 3 Interpersonal violence or engagement in behaviours that increase risk of interpersonal violence in past 12 months are reported or observed.
- 4 Interpersonal violence or engagement in behaviours that increase risk of interpersonal violence is ongoing, reported or observed. Abuse may be physical, sexual and/or emotional. Gang involvement or associations that increase risk of violence.

Active abuse:

Hx of abuse:

Engagement in sex work:

Gang involvement:

Hx of aggression toward health care staff (VPP):

Involvement of supports:

Safety planning:

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Culture and Spirituality – Initial Ax

Name:

Date:

- 1 Identifies culture/spirituality and has own practice, engages in community independently; requires no assistance; no difficulty accessing services and is at ease in environments.
- 2 Identifies culture/spirituality, engaged in practices when opportunity arises; requires some assistance to connect with community; requires minimal assistance navigating systems related to cultural needs.
- 3 Some identification with culture/spiritual practice; expresses interest in learning or connecting with community; may be experiencing moderate barriers to services due to lack of cultural sensitivity of providers; requires more intensive assistance to navigate systems.
- 4 Disconnected from culture/spirituality due to systemic and structural barriers; related to crisis, likely would benefit from support within culturally safe system; requires intensive resources to engage.

Identified culture:

Identified spirituality:

Current practices:

Level of interest to engage in cultural/spiritual practices:

Involvement of supports:

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Legal – Initial Ax

Name:

Date:

- 1 No unmet legal issues.
- 2 May need minimal assistance in completing documents or referral to appropriate legal services.
- 3 Recent or minor legal issues; on probation/parole; has child support issues; immigration related issues; needs assistance identifying legal needs and may require ongoing follow up.
- 4 Crisis involving legal issues; incarcerated or recently released from correctional setting; current or extensive justice involvement; in need of legal services to access health benefits.

Current justice involvement:

Lawyer: name, location, consent.

Probation/parole officer: name, location, consent.

Recognizance order/bail conditions: details, for how long.

Hx of justice involvement:

Triggers: insight, recidivism, protective factors.

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Financial – Initial Ax

Name:

Date:

- 1 Steady and stable source of income that is sufficient for basic needs.
- 2 Income may occasionally be inadequate for basic needs; may infrequently need emergency financial assistance.
- 3 Difficulty maintaining sufficient income from available sources to meet basic needs; requires frequent, ongoing referrals and benefits advocacy.
- 4 No income and cannot currently meet basic needs; financial crisis and in danger of losing basic needs; needs immediate, emergency intervention to address financial crisis; engaged in dangerous employment in order to meet financial needs.

Employment: current, past, interest.

Highest level of education:

EIA: office, cheque schedule, disability.

CPP:

Treaty Status:

Eligible for settlement claims:

Hi5 Funds:

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.

Self-efficacy – Initial Ax

Name:

Date:

- 1 Capable of initiating and maintaining access to all required medical and social services independently and is an effective self-advocate.
- 2 Able to initiate and seek out services with minimal assistance; may need information and support with referral.
- 3 Needs frequent assistance getting motivated for and completing tasks related to their own care and often needs active follow-up to ensure continued care.
- 4 In crisis, unable to access needed care; unable to identify appropriate needs or actions; unable to follow through with interventions that may increase self-efficacy.

Established supports:

Utilization of ED/UC/Crisis Services:

Experience with systems:

Client goals:

- 1.
- 2.

Priority recommendations of care team:

- 1.
- 2.