

Patient Pathway Chart



Patient tests positive for HIV

Remote testing facility, clinic, other health care facility

Patient referred to site for confirmatory testing.

Care team is moblized and patient records are reviewed to determine program eligibility.



Patient meets with PCP to determine program eligibility and health needs. Patient meets with Care Coordinator (CC) for program intake.

Patient

in the

agrees to

program.

enrollment

Patient declines enrollment in the program.

Recommendations are made for alternate case-management programs/external referrals are made.

First client/PN session. Intake form is completed (if necessary) and care plan in made

CC or Program
Director (PD) pair
patient to a Patient
Navigator (PN)
based on availablity
and patient
preference (male/
female, language,
etc.). Initial contact
between PN and
patient occurs in
1-7 days.

Common demographics and logistics for patient navigation forms completed. Intake form started (and sometimes completed)by CC and patient. Client is placed on a weekly track to begin the program.

Frequency of PN sessions can increase or decrease as deemed clinically appropriate by the care team.

Weekly

Quarterly

Care Team Coodination takes place during this time. Formal conferenes must be held every 90 days at least, though formal conferences can be held as often as once a week. Informal conferences with navigators take place as needed, such as when a patient comes in for clinical appointments.

Adherence assessments should be conducted by the PN every 90 days at least, and can be held as often as once a week.

Graduation:
Patient is able to
remain adherent to
medications and
attend medical
appointments without
support. The goal
for graduation in
generally 12 months,
although many clients
require more time.