STEPS TO CARE

Key Components Checklist

This checklist contains an overview of agency practices involved in implementing each of the three STEPS to Care strategies and the tools that are designed to support them. Program Directors can use this checklist to determine if and how these activities align with what their agency is already doing and which tools they can use or adapt.

As the agency prepares for implementation, the checklist can be used to create a "training curriculum" for individual staff members. For example, Program Directors can place a checkmark next to the tools that a Patient Navigator should complete or read prior to meeting with clients, as well as a targeted completion date for each. Program Directors should meet at least once a month (more frequently at first) to discuss staff progress in using these tools.

PATIENT NAVIGATION

Key Components	Available Tools in StC Toolkit to Support These Activities	
☐ Conduct initial case finding activities to identify new, eligible clients, including those newly diagnosed, lost to care, have difficulty keeping appointment, or have challenges staying adherent ☐ Assign one navigator to each client ☐ Support clients with keeping clinical and social service appointments, including scheduling, reminders, accompaniment, and transportation assistance. Appointments should be made with providers who can best meet client needs at times and locations convenient to the client. ☐ Build a network of referral sources for linking clients to care and to social & supportive services. ☐ Use "warm transitions" (i.e., active referrals with face-to-face or phone introductions between service providers and clients) and follow-up to	**Videos** ☐ Patient Navigation Introduction ☐ Scheduling Clients ☐ Care Team Communication **Trainings** ☐ Completing an Intake Assessment Form: The Client Interview ☐ Developing SMART Goals for a Client-Centered Comprehensive Care Plan ☐ Establishing Relationship Boundaries with Clients ☐ Staying Safe in the Field ☐ Out in the Field: Confidentiality with Clients	☐ Reassessment Form ☐ Referrals/Appointments Tracking Log/Checklist ☐ Services Tracking Log ☐ Care Plan form ☐ Intake Assessment form ☐ Logistics for Patient Navigation Form ☐ Patient Schedule Tracker Template **Topic Pages/Topic Page Sections** ☐ Patient Navigation Introduction ☐ Patient Navigation Meetings ☐ Service Coordination and Tracking

Key Components	Available Tools in StC Toolkit to Support These Activities	
ensure linkage to care, access to social and supportive services, etc. ☐ Conduct outreach procedures to clients who miss appointments, beginning with a phone call as soon as an appointment is missed and escalating to home visits, letters, search in other locations, as needed ☐ Arrange for face-to-face meetings in safe and confidential locations outside of the office and with client's choosing (e.g. client's home) to ensure engagement in services ☐ Develop care plan that reflects assessed client needs (e.g. medical care, ART adherence, social services, etc.), and with discussion and mutual agreement on service goals between client and care team	**Tools/Downloads** ☐ Adherence Assessment Form: Daily ☐ Adherence Assessment Form: Non-Daily	**Topic Pages/Topic Page Sections, cont.** ☐ Medical Appointment and Care Support ☐ Care Plans ☐ Care Team Coordination ☐ Client Intake ☐ HIV Self-Management ☐ Patient Navigation ☐ Scheduling Client Meetings ☐ Working with Clients in the Field ☐ Care Team Meeting Form ☐ Confidentiality with Clients ☐ Relationship Boundaries with Clients ☐ Field Safety Guidelines ☐ Missed Appointment Procedures ☐ Outreach Procedures ☐ Patient Selection Criteria ☐ Scheduling and Reminder Procedures

HIV SELF-MANAGEMENT

Key Components	Available Tools in StC Toolkit to Support These Activities	
☐ Deliver HIV Self-Management sessions with Patient Navigator based on client needs and care plan goals using the available tools on mystctools.org ☐ Arrange for client access to and use of tools on mystctools.org outside of Patient Navigation sessions, through a guided orientation of the tools and website ☐ Deliver HIV Self-Management sessions in a conversational, client-centered, non-judgmental manner	**Videos** ☐ HIV Self-Management Introduction ☐ MySTCTools.org Walkthrough ☐ HIV Self-Management Animation **Topic Pages/Topic Page Sections** ☐ HIV Self-Management Introduction ☐ Using the STEPS HIV Self-Management Sessions ☐ Delivering HIV Self-Management Sessions ☐ Motivational Interviewing	**Tools/Downloads** ☐ Motivational Interviewing Resources ☐ HIV Self-Management Tools for Clients (see mystctools.org for comprehensive list)

STEPS TO CARE

CARE TEAM COORDINATION

Key Components	Available Tools in StC Toolkit to Support These Activities	
☐ Hold a face-to-face or virtual formal care team meetings attended by, at minimum, the care coordinator and clinician, to review medication adherence, CD4 and viral load counts, clinical and social issues ☐ Hold care team meetings at least once every 3 months ☐ Review clients' care plans and clinical status at each care team meeting ☐ Identify clients with sub-optimal medical visits attendance, treatment adherence, and/or clinical outcomes, and develop strategies to address needs ☐ Update client care plan at each care team meeting ☐ Use informal care team meetings (generally not scheduled in advance), as needed, to address urgent or immediate issues that arise in between scheduled, formal care team meetings, and that do not require participation of full care team. These meetings may occur face-to-face, via phone or email ☐ Encourage Patient Navigators to participate in care team meetings (formal and informal, especially for clients with other non-care/social service needs)	**Videos** ☐ Care Team Coordination Introduction ☐ Care Team Communication ☐ Working with Primary Care Providers ☐ Care Team Staff Scheduling	**Tools/Downloads** ☐ Care Team Meeting form ☐ Care Plan form ☐ Sample Confidentiality Protocol ☐ Patient Selection Criteria ☐ Scheduling Protocol **Topic Pages/Topic Page Sections** ☐ Care Team Coordination Introduction ☐ Care Team Meetings ☐ Care Team Meeting Types ☐ Care Team Roles and Responsibilities ☐ Care Team Communication ☐ Best Practices for Success: Care Team Coordination ☐ Care Plans ☐ Confidentiality Guidelines ☐ Missed Appointment Procedures ☐ Patient Selection Criteria ☐ Scheduling and Reminder Procedures