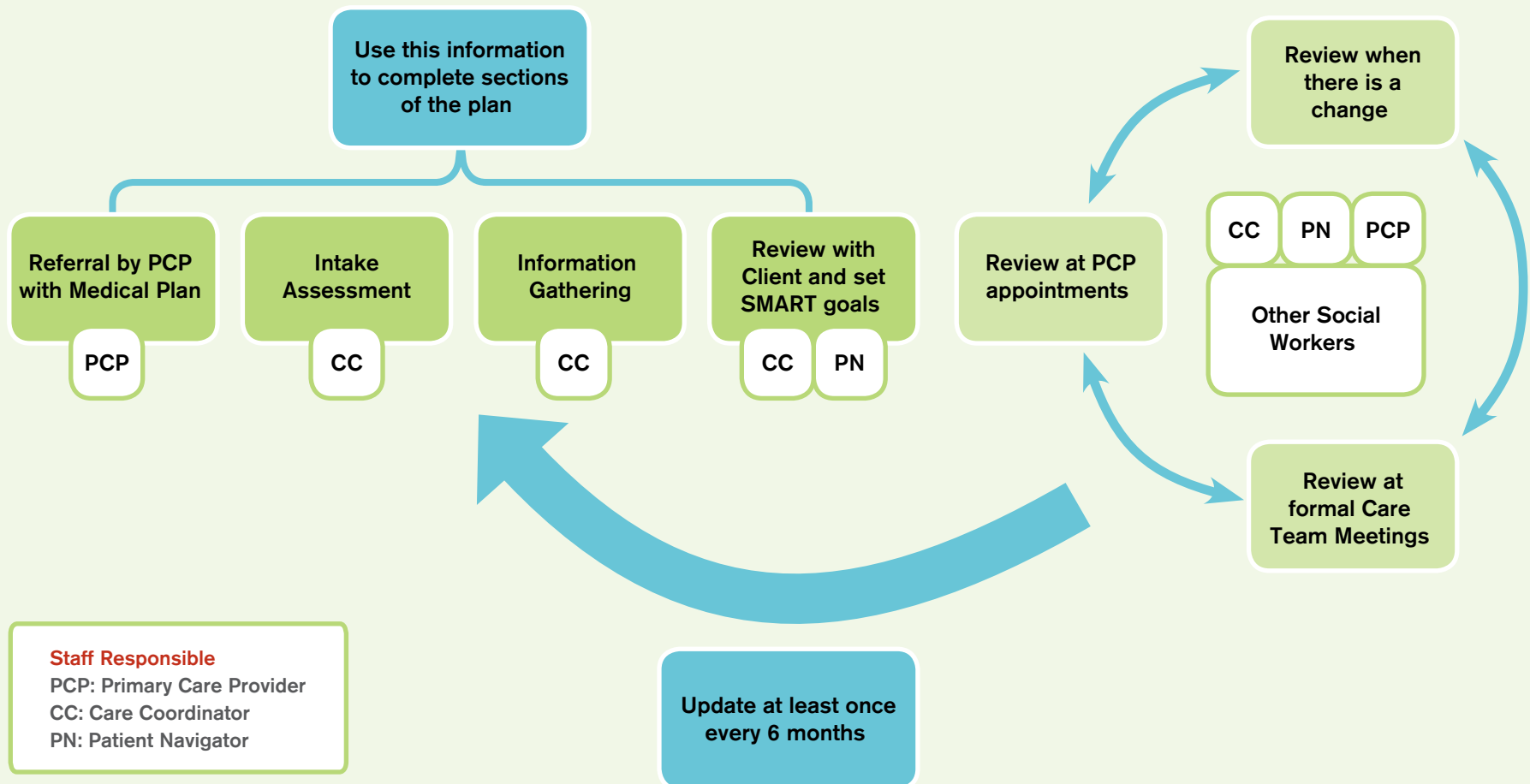


The comprehensive care plan is a key part of STEPS to Care and its three strategies. It is a vital tool that requires effort from all members of the care team. The care plan makes sure the patient's treatment goals remain at the forefront of their care.

This flowchart below shows the lifecycle of a care plan, from initial referral into the program by the PCP to ongoing review by the care team and the patient.



Referral by PCP and Intake Assessment

Care plan development begins when the client is referred into the program by his or her **primary care physician** (PCP), who completes a medical treatment plan and goals for the client. During enrollment into the program, the **care coordinator** completes an intake assessment form with the client. For the intake assessment, the care coordinator collects information related to a client's social services, logistical needs, and benefits.

Outreach and Information Gathering

The **care coordinator** reviews the medical treatment plan, the intake assessment, and any other relevant information from other involved programs to begin creating the client's comprehensive care plan. The involvement of interdisciplinary team members ensures that the client's care plan provides a whole picture of the patient's care.

Sections of Care Plan

The care plan has four sections:

- **Section 1**—Includes goals on PCP visit attendance as well as any other medical, program, or service issues
- **Section 2**—Addresses goals related to patient's HIV self-management, including which topics should be covered with the patient and by when.
- **Section 3**—Addresses goals related to adherence
- **Section 4**—Provides space to include any other new or emerging goals or issues

Review with Client and Set SMART Goals

The **PCP** and the **care coordinator** or **patient navigator** work with the client to finalize the care plan and establish SMART (Specific, Measurable, Achievable, Realistic, and Timely) goals for each of the four sections of the care plan, as needed. The plan should be completed within two weeks of enrollment in the program. The **patient navigator** then uses these goals to inform each session with the client.

The Review and Change Cycle

The care plan is meant to be a "living" document. Elements of the care plan—goals, action steps, and dates—are consistently reviewed and updated, and a new care plan is created if a client's situation changes significantly.

Goals are reviewed and updated after every PCP appointment or at least once every six months by the **patient navigator** and the client. The care plan is also reviewed during care coordination team meetings, which are regularly scheduled meetings of the interdisciplinary care coordination team members. These meetings may include the PCP, care coordinator, patient navigator, and social workers. It's important that all team members come prepared to care coordination team meetings with recent labs, assessments, and notes from recent patient visits, so the Care Plan can be discussed with the most current information.

The care plan is a key tool to maintain a plan that aligns with the client's needs, goals, and lifestyle. It is essential that all care team members are familiar with the care plan cycle and his or her role in it.