STEPS TO CARE

Staff Roles & Responsibilities

The roles described below should be used as a reference. Depending on your agency structure and needs, you may have staff with overlapping responsibilities.

	Patient Navigator	Care Coordinator	Program Director	Primary Care Provider
	Provides individualized support for clients to overcome barriers to care	Manages client cases by supporting Patient Navigators, coordinating care, and staying on top of client care plans	Oversees program implementation and delivery of care coordination	Provides clients with solution-focused medical care and communication
Strategies	**Role & Responsibilities**			
Patient Navigation	▪ Establishes close relationships with and serves as primary point of contact for clients ▪ Visits clients' homes on a regular basis ▪ Accompanies clients to medical and social services appointments ▪ Communicates medical advice from primary care providers and other service providers in an understandable language ▪ Assesses ART readiness if not on ART and adherence if on ART. ▪ Supports clients' needs for healthcare, benefits, entitlements, social services, housing, childcare and transportation, etc. ▪ May meet with client along with Care Coordinator after primary care physician appointments to review and update care plan	▪ Performs intake assessments ▪ Pairs clients with Patient Navigator ▪ Provides support and programmatic supervision to Patient Navigators ▪ Reviews patient cases with Patient Navigator and provides advice, direction, and support as needed ▪ In some cases, organizes or leads Patient Navigator training sessions ▪ In most cases, provides clinical supervision to Patient Navigators ▪ May meet with client along with Patient Navigator after primary care physician appointments to review and update care plan ▪ Conducts outreach to find clients lost to care. (Patient Navigator can also have this role.)	▪ Provides programmatic, quality, and clinical supervision ▪ In some cases, organizes or leads staff training sessions ▪ In most cases, provides clinical supervision to Patient Navigators and/or Care Coordinators ▪ In some cases, pairs clients with Patient Navigators	▪ Relay clinical concerns to agency staff ▪ Meets with clients after primary care physician appointments to review and update care plan
Care Team Coordination	▪ Provides input during care team meetings on client needs based on interactions with clients ▪ Works with members of the care coordination team to facilitate client health care	▪ Coordinates care team meetings with health providers to discuss client caseloads ▪ Facilitates interdisciplinary conversation between agency staff members health providers	▪ Establishes relationships and collaborates with health providers to ensure full care is provided to clients	▪ Participates in care team meetings to discuss clients' needs and medical treatment
HIV Self-Management	▪ Delivers field-based health promotion and skill-building education material that is suitable to the clients needs	▪ Provides clinic-based health education	No role in this activity	▪ Provides clinic-based health education during appointments
Agency Administration	▪ Maintains key documentation of client encounters and electronic medical records	▪ Maintains key documentation of client encounters and electronic medical records	▪ Oversees monitoring and reporting of the care coordination program ▪ Manages budgeting and reporting with grantors	▪ Documents medical treatment plan in clients' medical records