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|  | Coordinator Weekly Calendar |  |
|  | **Morning** | **Evening** |
|  | Attend morning huddles & report on P-5 pts scheduled for care  Comb Mon/Tues MD & dental schedules- add to OT’s   * add “message” w paperwork * add dental ins to appt notes for MD visits   Check referral inbox (Daily) | Call Tues pts to remind of appts  Complete patient outreach from monthly lists  Update P-5 Patient Roster with new patients and with updated data based on the last month’s patient encounters (risk score, ASQ, vax, dental visit, f/u needs) |
|  | Comb Tues/Thurs MD & dental schedules- add to OT’s   * add “message” w paperwork * add dental ins to appt notes for MD visits   Check referral inbox (Daily) | Call Thurs pts to remind of appts  Complete patient outreach from monthly lists |
|  | Meeting w community partner   * Go over referrals and shared goals * Document on goal discussion in the pt’s EHR * Outreach to new referrals * Order referral in patient’s chart   Comb Thurs/Mon MD, dental schedules- add to OT’s   * add “message” w paperwork * add dental ins to appt notes for MD visits   Check referral inbox (Daily) | Comb Mon WCC scheds:   * if we accept dental ins, call family and see if they want visit w Rachel *after* the WCC visit * Add pt to Rachel’s schedule   Outreach to moderate high and high risk dental patients to schedule for group f/u visit (2nd Thursday of each month at 3pm for 1-3 yr olds & 4pm for 4-5 yrs) |
|  | Follow up with any no shows for the week  Send out letters for pts you can’t reach by phone  Comb Monday schedule and make notes for morning huddles on medical/dental pts for week  Comb Thurs/Mon MD, dental schedules- add to OT’s   * add “message” w paperwork * add dental ins to appt notes for MD visits   Check referral inbox (Daily) | Call Mon pts to remind of appts  Outreach to newly assigned dental and medical 0-5 year olds |

Coordinator Monthly Calendar

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|  | Check front desk paperwork files and help front desk print more as needed |
|  | Check dental team’s parent resources/handout files and print more as needed |
|  | Gather list of assigned 0-5 year old patients from dental lead |
|  | Gather list of assigned 0-5 year old patients from Care Oregon team |
|  | Gather Alert data on children who are due/overdue for vaccinations |
|  | Comb P-5 Patient Roster to identify patients overdue or due in the next 0-2 months for WCC, Vaccinations, ASQs, and dental visits |
|  | Update P-5 team on current patient needs, workflow issues, and coordinator specific topics at monthly team meeting |
|  | Comb previous month schedule for no-showed medical/dental appointments and late cancels & provide outreach as needed |
|  | Check local resources for community events and update calendar or request flyers which can posted or given to families |
|  | Clear out old events/resources that are no longer applicable or are outdated |

**On-going Meetings:**

Every Monday morning- 7:15-7:30am, team huddle in dental department

Every morning at 8-8:15am, clinic-wide huddles in conference room

Every first Monday of the month 11-12pm, team meeting in conference room

**Shared Self-Management Goal Workflow**

* New pregnant patients are referred to NHC P-5 PATH program from community partner for establishment of primary care services
* New pregnant patient is seen for establishing visit with PCP and OT.
* At end of visit, OT asks patient to set a self-management health goal based on everything discussed with the PCP and based on the patients goals and desires.
* OT documents goal in Epic “Goals” section and pulls this information into the chart note at end of note.
* P-5 PATH Coordinator meets weekly via phone with patient navigator from community partner.
* P-5 PATH Coordinator and Patient Navigator discuss all referrals, including which patients were not able to be schedule and all patients seen for establishing visits.
* For each patient seen, P-5 PATH Coordinator shares the self-management health goal documented in chart with Patient Navigator, who documents this goal within community partner’s EHR for review by OB-Gyn/Midwife for discussion during next prenatal care visit.
* P-5 PATH coordinator drops interim note in patient’s chart documenting case management with dotphrase, “.NHCP5SHAREDGOALS” to track that goal was discussed.
* P-5 PATH Coordinator to reach out to patient in 1 month to track progress on goal and to bring patient in for dental services or follow up medical care if needed.

**Scripts and Guidelines for Support Staff**

Sample Script for Support Staff (Coordinator in this situation) for patient outreach calls to bring patients in for dental visit on the same day as a Well Child visit.

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| COORDINATOR: Hello, I am [NAME] calling from Neighborhood Health Center Tanasbourne, is this the parent of [PATIENT’S NAME]? I’m calling to schedule [PATIENT’S NAME] an appointment, is this a good time for you?  COORDINATOR: Great! Let me pull up the schedule.  COORDINATOR: While I am pulling up the schedule It does look like [PATIENT’S NAME] is also due for dental services. Would you be interested in also seeing Rachel our dental hygienist the same day you come in for [PATIENT’S NAME] appointment? These appointments are currently only available in the afternoon on Monday’s with [DRs NAME]. Do Monday afternoons work with your schedule?  COORDINATOR: How it works is [HYGIENIST’S NAME] comes in after your visit with the doctor to do an oral health assessment and if [PATIENT’S NAME] is due for a cleaning and you have the time to stay she can perform a cleaning at our dental department across the hall. if you are unable to stay she can at least get you scheduled for a future dental appointment. Is this something you would be interested in?  PARENT: No/Yes  IF NO: COORDINATOR: - No problem, we can get the medical appointment scheduled and then look into a future appointment for dental.  IF YES: COORDINATOR: - Yes: Great! Besides [PATIENT’S NAME] do you have any other children that you would like me to schedule? I have scheduled you with [DOCTOR’S NAME] and added [HYGIENIST’S NAME] to the appointment. Do you have any questions for me or anything else I can help you with?  COORDINATOR: Please call in advance if you are unable to keep your appointment and well see you then.  [Once it is scheduled]  COORDINATOR: Great! If you could come 20 minutes earlier to do some paperwork, that would be great. Have a good day, bye. |

Sample Script for Support Staff (Coordinator in this situation) for patient outreach calls to bring patients in for OT services.

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| COORD: Hello! I’m [NAME] calling from Neighborhood Health Center, Tanasbourne, is this the parent of [PATIENT’S NAME]? I’m calling because your child’s pediatrician [NAME OF PROVIDER] has referred you to [NAME OF OT], our occupational therapist here at the clinic. Has she talked to you about this referral?  Pt: Yes/No.  IF YES: COORD: Great. Do you have any questions about the program?  IF NO: COORD: Would you like me to tell you more about it?  COORD: Well, our OT’s name is [OT’S NAME].  OTs are healthcare professional that can help you look at your habits and routines, as well your child’s development, behavior, and abilities to help you keep [NAME OF CHILD] healthy. She’ll talk with you and find out what your goals are, then work with you to support you and your child. [if you know the specific area that the OT or PCP wanted addressed, you can mention this to the parent, such as bedtime, mealtime, toileting, or language for example.]  Pt: [might ask question or two]  COORD: [answers to the best of your ability or directs the patient back to PCP or to OT directly if needed]  COORD: This is a free service that NHC offers because your child’s health is important to us.  Are you ready to schedule your first visit with our OT?  **Additional tips:**   * If patient seems unsure or is confused, giving examples relevant to the patient’s referred condition is a good way to help them visualize what a session might look like.  For example, saying, “The OT can work with you and your son on brushing his teeth since you mentioned in your visit that this can be a battle.” |