BH Care Coordinator workflow

EXISTING REFERRAL

NEW REFERRAL

Call community partner to determine if active

Did patient follow through with BH referrall?

Yes

No

Pts ID w/ DM & Dep

CC Meets with pt after OV
- Explain referral
-Assess potential barriers for follow through to the referral appointment

Follow existing referral process per workflow.

Determine provider BH goal Last appt

Determine reason no longer active

Gather information
-Last PHQ9
-Recent labs

Phone Call
Explaine BHCC role
Determine next OLE appt
Resend labs if needed
Rerefer if appropriate
Document in eCW

No contact

- CC leaves vm up to 3X
- CC sends letter
- CC attempts to catch pt during next medical OV

Is next appointment within 21 days?

Yes

NO

Schedule appt with BHCC

Pt cx or n/s

Phone call to PT To schedule inperson or phone appt.

Plan to meet with patient after OV in exam room or consult room

CC will:
-Determine baseline:
  PHQ9
  Social determinants
-Re-refer pts not engaged
-Develop social determinants goal.

CC will:
-Explain Care Team approach
-Determine baseline:
  PHQ9
  Social determinants
-Re-refer pts not engaged
-Develop brief action plan (goals to be in pt's own words)
-Develop social determinants goal.

Schedule F/U appt to complete brief action plan

Schedule follow-up appointment in 2 weeks. (Phone call or F2F)

Create 4 goal care plan

CC will provide:
health education to increase health literacy (will use "teach back")

CC will review:
-Action plan and goals
-Weekly phone calls (Ask pt best # and time to call)
-Upcoming appointments
-Explore any barriers to care for those appts.
-Develop strategies to address barriers

-CC wlil send Care Plan via TE to OLE Health providers
-Send Care Plan to Virtual Care Team

- CC will send TE/ template to OLE Health Providers
- Send clinical contact (virtual CT) baseline information
- Set up monthly contact with virtual CT

Second or Third appt