NAVIGATION TEAM HOME VISIT PROCESS

START
Provider has patient in clinic to encourage scheduling for Navigation Services (NS), so staff alerts NS when patient is ready for a discussion about the program

Anyone available from NS Team (RN and Community Health Worker) meets patient before leaves clinic to enroll into Perinatal Navigation program

Did patient get fully enrolled?

No

Option for NS Team to call patient about opportunities over the phone

Option to enroll face to face at other locations (hospital, clinic, Lugar Center, Community location)

*Goal is to sign patient up early for program so patient will not be scheduling for home visits that allows time for individual planning. (ex. No home visit directly after testing positive in early 1st Trimester)

Patient led, so did all paperwork get filled out?

No

Yes

Yes

NS schedules patient in personal our Outlook calendar

*Refer to Key within Program Document for visit coding levels

NS Calendars are not standardized NOR easily available for others to see and can not create visit reports

NS Team create care plan for home visits based on "Risk Tier Level"

NS Team emails designated provider assistant the care plan to upload into patient electronic record and notes subject to change based on patient progress.

VISIT 1:
1. Ensure supplies and equipment are transportable
2. Ensure documentation is planned and NS are prepared for care plan and summary with patient
3. Provide home assessment if wearables or other technology is included in the care plan
4. Ensure plan in place if Telehealth visit is warranted after home & other assessments are completed (Telehealth with provider or Other Resource)

NS Team documents directly into WFS during home visit

NS Team checks each section within the care plan when completed

Was the care plan for the day completed?

No

The NS documents plan to ensure additional education is completed before next visit according to care plan. *No additional charges will be allowable.

Yes

The NS schedules time right away to finish the education (telephone is allowable as long as patient has documents that will be discussed)

NS Team creates formal patient record note in WFS. This training has not been established yet.

NS Team emails patient home visit document to provider assistant to upload into patient electronic record ensuring all components within care plan are documented including next steps so provider can sign off and create any additional instructions for assistant to share with NS Team

Between patient visits, NS will ensure provider care plan actions are taking place to align with NS Team care plan and makes scheduling changes as directed by provider of care.

Does patient warrant a provider home visit at any stage of the care plan?

Yes

NS Team discusses concerns at "Case Study" meeting with Traveling Nurse Practitioner (TNP) Lead

TNP discusses options with Primary Provider of Care

Primary Provider Approves?

TNP and CHW add visit (Virtual or Home) within NS Team care plan

No

VISIT 2
(and all subsequent visits in plan)
1. Ensure supplies and equipment are transportable
2. Ensure documentation is planned and NS Team is prepared for care plan and summary/Next Steps with patient
3. Provide home assessment if wearables or other technology is included in the care plan
4. Ensure plan in place if Telehealth visit is warranted after home & other assessments are completed (Telehealth with provider or Other Resource)

Are there issues or changes in patient condition?

Refer to "Change of Patient Status" Policy not completed yet: Categories need to be clear that reduce risk for all involved and when other resources or provider needs to be contacted vs 911.